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How Therapists Use and Choose Mindfulness to Treat Trauma

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HOW THERAPISTS USE AND CHOOSE MINDFULNESS TO TREAT TRAUMA

THESIS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science in the
College of Agriculture, Food, and Environment
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By

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ABSTRACT OF THESIS

HOW THERAPISTS USE AND CHOOSE

MINDFULNESS TO TREAT TRAUMA

This qualitative study used the phenomenological method to examine how therapists use mindfulness therapies and interventions to address trauma-salient issues with their clients. Specifically, it explored therapists' use of and choices about mindfulness-based treatments when addressing post-traumatic stress symptoms, and trauma-relevant emotion dysregulation and attachment injury. Informants were associate and fully-licensed local therapists, recruited using convenience sampling and snowball sampling by word-of-mouth referrals. Data was collected by semi-structured interviewing. Interview data was analyzed with Moustakas' (1994) recommended procedures for analysis of phenomenological data. Results, Discussion, Limitations and Suggestions for Future Research are described at the end.

KEYWORDS: Mindfulness, Trauma, PTSD, Emotion Dysregulation, Attachment

Jessica King

August 23, 2016

HOW THERAPISTS USE AND CHOOSE MINDFULNESS TO TREAT TRAUMA

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August 23, 2016

Dedicated to my husband, Kenneth,

for all that you do to keep me grounded and at peace;

and to my own therapists, for all that you have taught me about

living a mindful life in a chaotic world.

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Introduction

> The problem is to not allow that anxiety to take over. When these feelings arise, you have to practice in order to use the energy of mindfulness to recognize them, embrace them, look deeply into them. It's like a mother when the baby is crying. Your anxiety is your baby. You have to take care of it. You have to go back to yourself, recognize the suffering in you, embrace the suffering, and you get relief. And if you continue with your practice of mindfulness, you understand the roots, the nature of the suffering, and you know the way to transform it.
>
> - Thich Nhat Hanh (2010)

Thich Nhat Hanh, the world-renowned Buddhist monk and author of the books *Peace Is Every Step: The Path of Mindfulness in Everyday Life* and *The Miracle of Mindfulness: An Introduction to the Practice of Meditation,* is not alone in his suggestion to use mindfulness practices in addressing anxiety and emotional suffering. The concept of mindfulness is ancient and foundational to Buddhist meditation practices, but it was recently introduced into Western psychology with researchers showing interest in using it therapeutically (Follette, Palm & Pearson, 2006; Chiesa, Brambilla & Serretti, 2010). Mindfulness has been defined as "the effort to intentionally pay attention, nonjudgmentally, to present-moment experience and sustain this attention over time… to cultivate a stable and nonreactive present awareness." (Miller, Fletcher & Kabat-Zinn, 1995).

Brown, Ryan and Creswell's (2007) research showed a positive association between increased mindfulness and multiple factors of psychological wellbeing; as well as a negative association between increased mindfulness and characteristics of

psychopathology. Additionally, mindfulness gained attention in the field of mental health for treating issues such as chronic pain, anxiety, depression, emotional dysregulation, and panic (Kearney, McDermott, Malte, Martinez & Simpson, 2012; Miller et al., 1995). Trauma survivors suffer from many of these psychological issues, and experiencing posttraumatic stress has been shown to lower life quality in a number of areas, including mental health, personal well-being, and relationship functioning (Kearney et al., 2012; Erbes, Meis, Polusny, Compton & Wadsworth, 2012).

There is still much unknown about how mindfulness might potentially work as a treatment specifically for trauma-related issues. There has been some recent research on various mindfulness practices as treatments for Posttraumatic Stress Disorder (PTSD), but the overall volume of this research is small. However, there is a large volume of research associating trauma with a more anxious and/or avoidant attachment style; and, distinctly, between the constructs of emotion regulation, attachment, and mindfulness.

At first glance these bodies of research seem disparate, but their nexus can be found in the relationship between emotion and social interaction. Human beings learn to regulate and manage their emotions through social experience; for example attachment has long been recognized as a key factor in early development of emotional adjustment in infants (Seedall & Wampler, 2013). Difficulty with emotion regulation is a shared characteristic of individuals with anxious-avoidant attachment style and individuals with posttraumatic stress (Erbes et al., 2012; Seedall & Wampler, 2013). In contrast to natural attachment processes, mindfulness practices address difficult emotions by attaining conscious present-moment awareness of them as they are felt, and accepting their

presence without self-judgment. This is a potentially useful practice for people experiencing trauma symptoms or emotional reactivity due to insecure attachment.

Viewed together, these research findings paint a picture of possible association between emotion regulation, trauma, and attachment security. Given this connection, therapeutic mindfulness offers a treatment method that could "kill several birds with one stone", as the saying goes, by making clients aware of how these connections play out in their daily lives. However, it is unclear whether therapists from various backgrounds recognize these connections, and utilize mindfulness in this way. This study aims to capture a descriptive understanding of how therapists already utilize mindfulness in the treatment of trauma, as well as how they make clinical decisions in selecting a mindfulness-based treatment method. Methods of the study are explained after the literature review on the constructs of attachment, posttraumatic stress, emotion regulation, and mindfulness.

Background

Literature Review

Readers will need a clear understanding of the construct definitions and relevant research literature in order to understand the theoretical support for this study. Following is a description of the research literature findings for each construct, and evidence for associations between attachment security, trauma symptomology, and emotion regulation.

Trauma and posttraumatic symptoms. The *Diagnostic and Statistical Manual of Mental Disorders 5* (5th ed.; *DSM–V*; American Psychiatric Association, 2013) defines trauma as "witnessing or directly experiencing actual or threatened death, serious injury,

or sexual violation." This definition encompasses a wide scope of experiences. Some of the etiologies of trauma researched in literature include, *but are not limited to*: abuse, in all its forms; intimate partner violence; neglect of children, elderly, or those with disabilities; sexual assault, in all its forms; being stalked; military combat experiences; witnessing or experiencing war violence; refugee experiences; genocide; experiencing a natural disaster; the unexpected death of a loved one; experiencing an accident that did or could have caused severe injury; witnessing horror in the workplace as a first-responder to traumatic situations; and witnessing or experiencing crime- and gang-related violence. Definitions of trauma and qualifying experiences continue to expand as these concepts are challenged, explored, and tested through research.

The effects of trauma are just as varied and complex as the experience of trauma across individuals. Having a traumatic experience does not always lead to severe psychological problems. In a sample of 5,877 people from the National Comorbidity Survey, just over half of informants had experienced a traumatic event; however, less than 10% had PTSD (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Although PTSD is now publicly well-recognized, it is not the only disorder associated with a traumatic origin. The DSM-V currently classifies five Trauma- and Stressor-Related Disorders: Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, and Adjustment Disorder (DSM-V, American Psychiatric Association, 2013). The specific constellation of symptoms, as well as the duration, frequency, and intensity of symptoms, is crucial in determining whether a person may be diagnosed with a trauma- or stressor-related disorder.

Over the past 30 years, neurological research has provided very strong evidence that posttraumatic symptoms are associated with changes to the brain and nervous system. This is especially true of the limbic system, which regulates survival mechanisms and some emotional processing. Multiple studies have found differences specifically in the volumetric size of and blood flow to the hippocampus, amygdala, and anterior cingulate cortex regions of the limbic system in trauma survivors (Schore, 2001; Karl, Schaefer, Malta, Dorfel, Rohleder & Werner, 2006; Creeden, 2009). These areas are responsible for processing memory, emotion, responses to danger (fight or flight), consciousness, pain, and empathy. Changes in the amygdala are specifically associated with the posttraumatic symptoms of anhedonia, increased negative emotionality, hyperarousal, and avoidance or numbing of feelings (Frewen, Dozios & Lanius, 2012). Additionally, in a twin-pair study of veteran men researchers found more continuous activation of the limbic-regulated autonomic nervous system, which orchestrates the fight, flight and freeze responses, in those who had combat exposure and/or PTSD diagnosis (Shah, Lampert, Goldberg, Veledar, Bremner & Vaccarino, 2013).

Attachment: theory and construct. As research and theoretical discussion on attachment has expanded, the conceptualizations of attachment have shifted and methods of research have transformed considerably. Operational definitions of attachment can be difficult to follow because of these changes and terminology is used more interchangeably (Werner-Wilson & Davenport, 2003). A brief review of childhood attachment research, and a more extensive review of adulthood attachment research, is presented here. For the purposes of this study, “attachment issues” refer to both the

quality of attachment bond a client experiences in close relationships (or attempted close relationships) and the related attachment behaviors they engage in.

Attachment theory began in the 1940s with John Bowlby's theory of infant attachment to a primary caregiver. Bowlby claimed that infants naturally form a bonded connection, or *attachment,* to the person who provides them with the most care. As the infant grows, this primary caregiver serves as a secure base from which the child begins to experience and explore the world. Then, in times of distress, the child returns to the caregiver as a safe haven and provider of comfort. Over time the quality of these interactions and the responses of the caregiver lead to the development of internal working models of the self and others. These models serve as an original baseline perspective of oneself, others, and how to relate with others (Cassidy & Shaver, 2008).

Mary Ainsworth and colleagues continued Bowlby's work in the Strange Situation experiment, in which they examined how infants and their caregivers responded to each other when distress was caused by temporary separation. The researchers categorized their observations into distinct attachment styles, or categories of relational behaviors. They originally conceptualized three attachment styles: secure, avoidant, and ambivalent (Ainsworth, Blehar, Waters & Wall, 1978). Main and Solomon (1990) later added the classification of disorganized attachment by reviewing tapes of the experiment.

One of Bowlby's original postulations of attachment theory is that childhood attachment would continue to influence and be influenced by relationships throughout life (Cassidy & Shaver, 2008). This was later supported in a longitudinal study by Fraley and colleagues (Fraley, Roisman, Booth-LaForce, Owen & Holland, 2013). Researchers have attempted to create self-report measures of adult attachment using attachment style

classifications that parallel Ainsworth et al. and Main and Solomon's categories. Hazen and Shaver (1987) were the first to do so with a measure that attempted to classify three categories of adult romantic attachment.

Bartholomew and Horowitz (1991) took this further, describing a four-category model of adult attachment styles not limited to romance. They used information from self-reports, friend-reports, and the Adult Attachment Interview (a longer, narrative interview created for the assessment of adult attachment through behavior provocation and observation). The researchers labeled their four categories secure, preoccupied, dismissing, and fearful (Bartholomew & Horowitz, 1991).

The Secure style was characterized by higher social warmth, greater involvement in romantic relationships, balanced power and control in friendships, appropriate self-disclosure, and greater self-confidence, for the people who fell into that category. The Preoccupied style reflected the clinginess seen in Ainsworth's ambivalent type, and was characterized by excessive emotional expressiveness, reliance on others, and romantic involvement; less control within friendships; and lower self-confidence. The Dismissing style was less likely to feel comfortable relying on others as a secure base, and was characterized by limited emotional expressiveness, social warmth, and self-disclosure; less involvement in romantic relationships and friendships; and unusually high relational control and self-confidence. Finally, the Fearful style was characterized by lower features of both self- and other-relating constructs: lower warmth, expressiveness, and self-disclosure; less relational involvement and comfort in relying on others; and unusually low balance of relational power and self-confidence (Bartholomew & Horowitz, 1991).

More recent research has described adult attachment as a 'location' across two dimensions: anxiety, and avoidance. Questionnaires using this dimensional view of attachment can depict an individual's score on a two-axis plane, with a marker showing an individual's score in a region of greater or lesser anxiety and avoidance (Mikulincer, Shaver & Pereg, 2003). This way of conceptualizing attachment does away with strict categories, and is thought to conceptually allow for 'movement' across regions. In other words, it embraces a more life-long approach to attachment, allowing for the possibility that attachment is impressionable and able to shift over time. The location of an individual's attachment may still be referred to in a categorical way, using the dimensional regions. These descriptions correspond to Bartholomew & Horowitz's attachment styles, i.e.: anxious (preoccupied), avoidant (dismissive), and anxious-avoidant (fearful). This conceptualization of quality of adult attachment bond is used for this study.

Relationship between posttraumatic stress and insecure attachment. There is now a well-established theoretical prediction that childhood trauma, particularly in the form of child abuse, creates insecure attachment patterns which result in pathological neurodevelopment (Perry, Pollard, Blaicley, Baker & Vigilante, 1995; Bremner, Narayan, Staib, Southwick, McGlashan & Charney, 1999; Schore, 2001; Creeden, 2009). The anxious-avoidant attachment style especially has been associated with the experience of trauma and the prevalence and severity of posttraumatic symptoms throughout life (Schore, 2001; O'Connor & Elkit, 2008; Creeden, 2009; Halpern, Maunder, Schwartz & Gurevich, 2012). Again, the limbic system plays a central part. Schore (2001, p. 209) notes that, "The limbic system has been suggested to be the site of developmental

changes associated with the rise of attachment behaviors and to be centrally involved in the capacity to [learn and adapt]." Creeden refers to these neurodevelopmental changes as *limbic irritability* and describes their effect on the brain's capacity to relate to others:

> Attachment patterns which cannot integrate affective responses from the limbic system and lower brain… create obstacles for individuals in recognizing and/or adapting to changes in the context of day-to-day living situations and different relationships…. One of the ramifications of trauma may be the development of neurological obstacles to creating and sustaining secure attachment relationships (Creeden, 2009, p.267).

It is easier to understand how repeated trauma would lead to "neurological obstacles" involved in the development of both insecure attachment behaviors and posttraumatic stress symptoms in children. Because their brains are still developing, children are more open to experience-dependent learning. Karl et al. (2006) note that limbic irregularities are present in both trauma-exposed adults and minors, although not the same irregularities. They suggest that the differences are developmental in nature, first occurring during childhood trauma and changing with maturation. This developmental perspective acknowledges that neurons, the synaptic building cells of the brain, develop in response to all experiences, but those that are reinforced by repeated experience (including repeated trauma) are kept and strengthened.

The process of developing, culling, and strengthening neuronal networks through repeated experience provides a neurological foundation for Bowlby's original concept of internal working models. As children have repeated interactions with a primary caregiver, their brains develop in response, creating an internal representation of what the world is

like. This includes their attachment, or representation of how social relationships function.

Children are likely more vulnerable to traumatization because their brains are less developed and more receptive to the shaping impact of repeated harmful experiences; however, because adults retain some neural plasticity, they may also be affected by trauma through experience-dependent learning and sensitization. Sensitization is a process by which the intensity of a specific repeated experience makes a neuronal network more reactive to similar external experiences. According to Perry et al. (1995, p. 275), "Once sensitized, the same neural activation can be elicited by decreasingly intense external stimuli…. The result is that full-blown response patterns (e.g., hyperarousal, dissociation) can be elicited by apparently minor stressors".

Researcher Kathryn Basham has recognized similar phenomena in individuals whose traumatic events occurred during adulthood. In her overview of the state of attachment research in military couples, Basham (2008) explains that the experience of living in an environment with constant threats to safety (military deployment to a combat zone) shifts people's paradigm about the safety of relating to others. Traumatized service members can fear re-traumatization, as well as be triggered by external stimuli, which lead them to be incorrectly mistrustful. They may suspect or perceive threats where there are none, resulting in trauma symptoms such as re-experiencing intense trauma-specific emotions (e.g. shame, fear); avoidance through emotional suppression/numbing; and hyperarousal through anxiety or anger (Basham, 2008).

In addition to reinforcing neurological changes, the combination of insecure attachment and posttraumatic stress may catalyze potent relational processes that

reinforce emotion dysregulation, perceived isolation, and mistrust of others. Such symptoms make vital attachment behaviors such as receptiveness to care from others, caregiving, and empathy difficult to act out in relationships and may incite others to respond negatively instead of with nurturance. Dr. Sue Johnson, creator of Emotionally Focused Therapy (EFT), recommends it for couples work with clients experiencing posttraumatic stress primarily because attachment theory is foundational to its method. In her words,

> Attachment theory also suggests that individuals whose caregivers respond inconsistently to their cries for help or who actively abuse them will come to perceive the world as a dangerous place. …It becomes clear that perceived lack of emotional support would make a bad situation worse for traumatized individuals. …Perceptions of isolation and abandonment tend to characterize their experiences both inside and outside of their relationships with romantic partners (Greenman & Johnson, 2012, p.562).

Individuals with insecure attachment already have internal working models representing relationships as unsafe and/or unreliable sources of comfort. This perception can make them even more likely to socially withdraw, for longer periods of time, in the face of a personal crisis (Halpern et al., 2012). Alternatively, attempts to seek interpersonal comfort are done confusingly in ways that are dismissive, aggressive, or fearful, and often contribute to stress in potential social supporters (i.e. friends, family, and partners). Ein-Dor, Doron, Mikulincer, Solomon & Shaver (2010) found that when veteran prisoners of war had insecure attachment, the dyadic processes in their marriages

contributed to not only the severity of their own PTSD, but their spouses' secondary traumatic stress as well.

The gestalt of the reviewed literature exploring attachment security and posttraumatic stress provides rational, empirical support that trauma and insecure attachment may have a reciprocal association. Neurological changes to the limbic system through experience-dependent strengthening of synapses and sensitization of neural networks; experiences that lead the individual to develop a fearful approach to relationships; and negative dyadic processes that reinforce symptoms, suggest that posttraumatic stress and insecure attachment are very likely associated and mutually reinforcing.

Emotion regulation. Emotion regulation and dysregulation have proven to be quite tricky to accurately and consistently define through research. Many pieces of the construct have been studied individually and included in assessments, only to be pointed out by other researchers as not capturing the full picture of what it means to manage feelings in a healthy, adaptive way. Current definitions of emotion regulation in the literature are often borrowed from research by James Gross. In 1998, Gross provided this more generic definition: "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions''. More recently Gross and other researchers have described emotion regulation in terms of the awareness or recognition of emotions, the acceptance of emotions felt, and the use of goal-directed behaviors to manage them (Gyurak, Gross, & Etkin, 2011; Goodall, Trejnowska, & Darling, 2012; Pepping, Davis, & O'Donovan, 2013). The confusing array of factors covered by only these two definitions (influence or control over the

experience and timing of emotions; metacognitive processing of emotional experiences; outward expression of emotions; intrapersonal awareness; acceptance of emotions; and goal-directed behavior) represents a larger struggle in the field of emotion studies to define this construct.

To date, one of the most comprehensive and clear definitions of emotional regulation and dysregulation is provided by Gratz & Roemer (2004), who identify six "dimensions of emotion regulation wherein difficulties may occur" including awareness, clarity (understanding exactly what emotion is being felt), acceptance, access to regulation strategies perceived to be effective, impulse control, and goal-directed management behaviors. For its completeness and attention to previous literary findings, this is the definition used in this study. It is also important to note here that emotion dysregulation should not be confused with mood dysregulation. Chronically negative moods and fatalistic thinking (such as in depression) or dramatic shifts in pervasive affect (such as in bipolar disorder) represent struggles in a person's broader experience of moods across time and situational contexts. Emotion regulation refers more specifically to how an individual experiences, processes, and manages emotions as they arise.

As mentioned previously, difficulty with emotion regulation is a feature of both posttraumatic stress and attachment insecurity. Emotion dysregulation impairs one's capacity to relate and interact with others. In a sample of 313 veterans of the Iraq war, Erbes and colleagues (2012) found that emotional numbing and general avoidance (a part of a dysphoric PTSD symptoms) were most the predictive of lower levels of relationship functioning longitudinally. More specifically: individuals experiencing intense emotional reactions have a hard time relating to others and viewing the world rationally in the

moment. According to Pepping et al. (2013, p.454), "much evidence attests to a relationship between attachment and emotion regulation abilities. Securely attached individuals… are less likely to be overwhelmed by difficult emotions associated with abandonment [or to suppress emotions]".

The connection may be even deeper than similar or shared features of pathology. Multiple authors have theorized in the past decade that emotion dysregulation could be an essential variable connecting PTSD with insecure attachment. For example, Goodall and colleagues (2012) have suggested that "attachment and emotion regulation may develop interdependently". Lilly and Lim (2013), who found strong correlational associations between emotion dysregulation, symptoms of PTSD and depression, and insecure attachment, offered a hypothetical explanation that emotion dysregulation is part of pathogenesis for posttraumatic mental health outcomes, either as an individual vulnerability factor or a result of failed early attachment. Schore (2002) presents an intricately detailed theoretical expansion of this concept, claiming that insecure attachment leads to pathological neurodevelopment of the right brain, therefore increasing risk for pathogenesis of trauma-related and dissociative disorders.

Exactly how this connection might work is still unknown, as research has not yet caught up with theoretical proposals. Unfortunately, very few studies have attempted to directly study proposed processes of association between all three constructs of emotion regulation, trauma, and attachment. Very recently, Benoit, Bouthillier, Moss, Rousseau & Brunet's (2010) study found statistically significant support for a mediational model hypothesis which suggested that emotion regulation mediates the relationship between PTSD symptoms and level of attachment security. To date, this is the only study I am

aware of which tests this relationship directly. Benoit and colleagues used the Adult Attachment Projective Interview (AAP) as a more stringent method for assessment of adult attachment security. Their findings met all four of Baron & Kenny's criterion for correlational testing of a mediation model, with attachment security explaining less than 2% of PTSD symptom variance and the previous correlation no longer having significance after emotion dysregulation was accounted for (Benoit et al., 2010, p.110).

Mindfulness in Therapy

Mindfulness has existed as an important element of Buddhist philosophy and meditation for thousands of years. The English word 'mindfulness' is translated from the Pali word 'sati' or Sanskrit 'smrti'. Original Buddhist descriptions of mindfulness are found in texts such as the *Satipatthana Sutta*, in which the Buddha describes it as present-state awareness during meditation which allows the individual to clearly observe, comprehend, and contemplate "the body in the body… feelings in feelings… mind in mind… and phenomena in phenomena" without interference from personal desire or dissatisfaction (Bodhi, 2011, p.21). The minutiae of translation, philosophical definitions, and departures from traditional Buddhist understanding of mindfulness are still discussed in the literature, especially with regard to honing the operational definition (Rapgay & Bystrisky, 2009; Bodhi, 2011). Currently the generally accepted definition of mindfulness as used in current western psychology comes from John Kabat-Zinn. Mindfulness is "the effort to intentionally pay attention, nonjudgmentally, to present-moment experience and sustain this attention over time… to cultivate a stable and nonreactive present awareness." (Miller et al., 1995, p.193).

Kabat-Zinn is credited with being the first to adapt mindfulness therapeutically with the development of Mindfulness Based Stress Reduction (MBSR) therapy (Kabat-Zinn et al., 1992; Miller et al., 1995). He developed MBSR as a potential treatment for anxiety. Since its advent, MBSR has been used to successfully reduce symptoms of generalized anxiety disorder, panic disorder, depression, chronic pain and symptoms of PTSD (Miller, et al. 1995; Price, McBride, Hyerle & Kivlahan, 2007; Kimbrough, Magyari, Langenberg, Chesney & Berman 2010; Kearney et al., 2012).

Mindfulness as used in therapy today can be broken into three broad categories: mindfulness-based therapies, therapies incorporating mindfulness, and mindfulness-based interventions. Mindfulness-based therapies are structured therapies that have been specifically designed around the core concepts of mindfulness, and use it as the main modality of treatment and intervention. These include mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), mindful awareness in body-oriented therapy (MABT), and relapse prevention (RP) (Baer, 2003; Rees, 2011). By contrast, therapies incorporating mindfulness make use of, but are not solely based upon, mindfulness concepts and practices. Two therapies commonly suggested to have integrated mindful characteristics are Acceptance and Commitment Therapy (ACT) and Dialectical Behavioral Therapy (DBT) (Baer, 2003). Finally, mindfulness-based interventions are not whole therapeutic approaches. Rather, they are specific interventions for use during sessions or as therapeutic homework, which may be used in conjunction with other techniques or therapies. Brown, Marquis & Guiffrida (2013) provide a review of how therapists might use a few mindfulness-based interventions

without using a mindfulness-based therapy. Mindfulness-based interventions have the least amount of research examining their prevalence and effectiveness.

For this study I am concerned with how therapists use mindfulness in trauma treatment. Goodman & Calderon (2012) provide an example of how this could be done with their proposal of using mindfulness to help trauma clients become aware of body sensations and thoughts accompanying hyperarousal. Researchers have also recognized personal awareness and acceptance of emotional experiences as important features of emotion regulation, which are essential aspects of mindfulness by definition (Gratz & Roemer, 2004; Gyurak et al., 2011). Finally, the successful use of MBSR and MBCT to treat anxiety disorders and DBT to treat borderline personality disorder (which is commonly associated with trauma history), further substantiates the use of mindfulness-based treatments for emotion regulation in trauma therapy.

There is neurological evidence for the therapeutic use of mindfulness as well. Mindfulness meditation practices activate the prefrontal cortex (PFC) and the anterior cingulate cortex (ACC) in the brain, while simultaneously reducing activation of the amygdala (Corrigan, 2002; Chiesa et al., 2010). Banks, Eddy, Angstadt, Nathan & Phan (2007) saw this same pattern of brain activity while subjects used other methods of emotion regulation. Given their individual processes, it makes sense that these areas of the brain would behave in an orchestrated way during emotion regulation. The PFC and ACC respectively control attention, problem solving, and judgment; and error detection, conflict negotiation, empathy, and consciousness. The amygdala is responsible for emotion production, fear response, and memory modulation. In essence, mindfulness meditation allows a person to practice increased activation and use of areas of their brain

which are essential to emotion regulation (the PFC and ACC), while simultaneously reducing activation of areas associated with trauma symptoms and excess emotional reactivity (the amygdala).

Gaps in the Research

Since emotion regulation has been found to mediate the predictive association between attachment security and posttraumatic stress symptoms, and mindfulness has been supported as a method for learning emotion regulation, mindfulness could be a powerful therapeutic tool in treating trauma-affected clients. Mindfulness could be used during therapy to treat posttraumatic symptoms and improve clients' ability to regulate emotion, especially by focusing on specific posttraumatic symptoms, recognizing emotional triggers in relationships, and memory processing issues. Research on trauma so far has mostly considered the effects of mindfulness and attachment separately; there has been a lack of research examining the potential interaction of these constructs in understanding and treating trauma. There has been even less on understanding how mindfulness has been applied in the field for the treatment of trauma.

Purpose of the Study

The literature expresses that posttraumatic stress has negative effects on trauma survivors' mental health, emotional control, and ability to relate to others in a healthy way. It also suggests that mindfulness could be useful in addressing these three common complaints of trauma survivors. However, are therapists using mindfulness interventions and mindfulness-based therapies to treat all three issues? What influences drive their decisions for the use of mindfulness in trauma treatment? Answers to these questions would provide an understanding of how the advent of mindfulness in mental health is

impacting therapy for trauma survivors. Therapists have to constantly determine what treatments they think will be effective for a particular case and why. It is my hope that using this study to identify common themes in the use of mindfulness for trauma treatment will provide a platform from which the mental health field can refine the way in which we train therapists and treat clients, and perhaps open new paths for the use of mindfulness in unexpected ways. The study attempts to answer these questions about the use of mindfulness as a treatment for trauma:

RQ1: How are therapists currently utilizing mindfulness interventions and therapies in the treatment of trauma, especially in regards to the major issues of attachment, emotion regulation, and post-traumatic stress symptoms?

RQ2: How do therapists make decisions regarding the use of mindfulness-based methods for trauma; i.e., whether to use it at all, and which therapies or interventions to use?

Researcher as Instrument

Ethical Considerations: Bracketing

This study used a psychological phenomenological approach, essentially taking a more structured design approach to answer questions that are still open-ended: how do therapists use mindfulness to treat trauma in the field today? And what is it that prompts or influences their decisions in the mindfulness-based treatments they choose? In the tradition of phenomenological research, the primary role of the researcher is as a research instrument. This means that my role in this study was as a tool of both collecting and analyzing the data.

To function as a tool that gathers and analyzes phenomenological meaning takes precision in understanding and executing interviewing techniques that create space for what is expressed by informants, as well as expansive self-awareness of one's own influence on that information. Phenomenology suggests that it is best for researchers to disclaim and form awareness of their own preconceptions, so that we can avoid biasing the research and tinting participants' true experiences with the lens of our own perspectives as much as possible (Field & Morse, 1985; Creswell, 1998). Here, I bracket my own relevant experiences and preconceptions, and mentally prepare for how I can adjust my use of interviewing techniques to reduce bias:

Relevant Experiences of the Researcher

My investigative curiosity about the treatment of trauma and therapeutic mindfulness has been built slowly over the years, constructed out of a myriad of diverse life experiences. Viewing my past this way is like looking back down a cobbled brick road that one has traveled, and realizing that the masons used multiple kinds of brick to fashion it. The unevenness of the bricks highlight their distinct shapes and qualities. Sometimes the life experiences which influence my understanding of trauma and mindfulness feel "bumpy" in this way; they are qualitatively different enough that their integration is hardly smooth. Some have dark and intensely personal edges, and some stand out for their brightness and inspiration; some are pitted and textured with layers of clinical experience, and some are smooth with book knowledge and facts. Yet, cobbled together these experiences still create a pathway with purposeful direction.

One such facet of life experience can be clarified as *perspective*. My unique point of view, or perspective, on trauma and mindfulness is shaped by my experiences and

personal identity as a healer, researcher, and survivor. As a healer, I feel an innate calling to aid in healing the wounds that trauma leaves in its wake. I have worked and volunteered as a peer mediator, an after-school Girl Scouts program assistant for at-risk youth, a childcare provider at a crisis nursery, and a student therapist for individuals, couples and families coping with trauma. As a researcher, I am fascinated by the effects of trauma on neurology and emotion, and the process of how individuals overcome posttraumatic symptoms and pathology. I have composed literature reviews, papers, and research about trauma topics such as gender roles in domestic violence, military combat trauma, resiliency experiences in trauma-exposed youth, and trauma as related to attachment and mindfulness.

Finally, as a survivor I possess a more personal understanding of trauma and mindfulness. My personal trauma experiences pepper my life from childhood through young adulthood, when I was diagnosed with PTSD and started my own journey of healing. In my recovery, mindfulness played the essential role of helping to find a quiet place in a storm of emotions and fear. Learning that I could acknowledge pain, live and breathe through it, accept it, and move through it to healthy behaviors was empowering.

This triad-perspective as a healer, researcher, and survivor offers me both a blessing and an Achilles heel in my role as a researcher. As mentioned before, phenomenology posits that a main and vital role of the researcher is as the instrument through which data is collected. The identities as healer, researcher, and survivor considerably broaden the scope of my perspective. From a phenomenological perspective, this is a boon as it allows me to have a wider “mental net” so to speak with which to catch meaning while interviewing. Having broader experience provides a

broader, less restrictive range of phenomena that I have personal experience with or knowledge of. This potentially made me less likely to miss strands of meaning that might go unnoticed otherwise. However, the Achilles heel of my perspective is in the danger of assuming an "expert" position. It was essential during interviews to refrain from the assumption that I easily understood all meaning expressed by the informants, or that I was able to predict what they would tell me. This highlights the importance of using requests for clarification and reflective summarizing during the interview process as I enacted the role of research instrument.

Finally, I should also take the time to bracket the influence of my *location.* Were I a dot on a map, then aspects such as my socioeconomic status (SES), race, culture, education level, and gender would be revealing coordinates for my position. I am Caucasian, and grew up in a fairly racially homogenous small town with a majority Caucasian population. My parents were divorced, and I grew up with one lower-class parent who struggled with occasional poverty and one middle-class parent who was able to maintain financial stability. Today, I enjoy the comfort of an upper-middle class lifestyle which was greatly contributed to by my college education and marriage to a man with no debt and steady income. My perspective as a researcher was heavily shaped by this education, and my definition of and experiences of trauma are shaped by American medicine and culture respectively. Some of my own trauma experiences and my position as a feminist also make me quite self-aware of my female sex and gender during interactions with other people.

These aspects of location influence the direction of my thoughts, and presented a risk of bias as I listened to informants. I was more attuned to cues and meaning that were

personally relevant to my location or salient to my experiences. Because of this, I made a greater effort to maintain a sense of open curiosity as I tracked with informants' meaning, and took care to phrase my probing questions in as neutral a way as I knew how. This was especially important for individuals whose sex and gender identity was different from mine, as well as for those with different socioeconomic backgrounds. I also attempted to be self-aware of my own mental and emotional reactions to informants' stories, and to be cautious to not let them block out or distort any phenomenological meaning to the best of my ability.

Method

Ethical Considerations: Methods of Rigor

I have used several strategies in this study to protect the ethicality of the work and support the credibility of the results. It is my aim to be explicit and clear in discussing both the strengths and weaknesses of the study procedures as they unfolded, so that readers may be clearly aware of how these strengths and weaknesses influence the results, and so that this information is readily available to any researchers interested in conducting similar research. For this reason I explain the methods of rigor that I used in the study method here. I have also described methods of rigor used during data analysis later in the text. Limitations are mentioned briefly throughout the text, and discussed in depth in the Discussion section. These methods are widely suggested for an interview-style study design by multiple researchers (Moustakas, 1994; Creswell, 1998; Chodhuri, Glauser & Peregoy, 2004; Shenton, 2004).

Member-checking. Member-checking my notes and understanding immediately after the interview provided immediate clarification and correction of misinterpreted

meaning. It also provided me another opportunity to bracket my own perspective. If this validation strategy had not been used, I could have painted my perspectives over the data even before informants had a chance to later "proof-read" my work through secondary member-checking (providing informants a summary of gleaned meaning after analysis is done). Member-checking at this stage ensures better purity of meaning and clarity of themes even before analysis.

Descriptiveness. In the Method section of this study I have attempted to transparently provide my reasoning behind choices such as sampling criteria and method, as well as detailed explanation of the interview procedure. An additional section is included regarding data security. Though not always discussed in studies, procedures for data security (especially electronic) are essential to respecting informants and protecting their well-being by guarding identifying information. It is my aim that the level of descriptiveness here offers credibility by extending thorough transparency.

Informants

I originally scheduled nine individuals for interviews; however, the data from one interview was not included in the final sample due to problems with technology. Amolto failed to record the interview, which was conducted over Skype, and the individual was too busy to reschedule. Thus the final sample had n = 8 informants. I collected a brief demographic survey from all informants before interviewing began, partially to be sure that they met inclusion criteria. Out of the informants whose data was included, six were female and two were male. Although an option for transgender identification was included in the demographics form, no informants identified themselves this way. Four (50%) of the participants were Caucasian; two (25%) were African American; one

(12.5%) was Middle Eastern; and one (12.5%) was Asian. The informants' number of years in practice ranged from 3–14yrs, and ages of clinicians ranged from 26-46yrs. They represented a diversity of mental health fields, including four psychologists, one counselor, two marriage and family therapists, and one clinical social worker. All informants were required to have used mindfulness interventions with at least four trauma clients within the past year. The actual number of clients meeting this qualification for each informant ranged from 4-7 in the past year.

Informant Demographics					
Pseudonym	**Gender**	**License**	**Ethnic Background**	**Age**	**Work Setting**
Juliette	Woman	Licensed Professional Counselor	Caucasian	27	Contracted to a private practice.
Christian	Man	Licensed Psychological Associate	Caucasian	34	Contracted to a private practice.
Maria	Woman	Marriage and Family Therapy Associate	Caucasian	26	State-provided mental health services- in-home therapy.
Gregory	Man	Licensed Marriage and Family Therapist	African-American	36	Equal partner in a group practice.
June	Woman	Licensed Clinical Social Worker	Asian	41	Contracted to a private practice. Part-time VA therapist.
Tessa	Woman	Licensed Psychologist	Caucasian	29	Contracted to a private practice.
Kathi	Woman	Licensed Psychologist	African-American	46	Private practice.
Adya	Woman	Licensed Psychologist	Middle Eastern	38	Private practice.

Table 4.1

In the interest of focusing the study more accurately on the chosen phenomena, I set inclusion criteria to only interview licensed therapists. All informants had licenses to practice mental health, though three had associate licenses in their respective fields and were still accruing practice hours towards full licensure. The other five were fully licensed. Unlicensed student practitioners or other mental health workers were not included because the phenomena of how they use mindfulness in trauma cases would likely be too different. I.e., the level of education for an unlicensed student therapist or type of experience for a psychiatric nurse could profoundly influence treatment perspectives, creating too heterogeneous of a study group to truly focus on targeted phenomena. In addition to being licensed, informants also had to have worked on at least four cases involving treatment of trauma symptoms in the past year, in which they had utilized mindfulness as part of the treatment.

Sampling

The primary sampling methods were purposive convenience and snowball sampling. I used convenience sampling to reach out to therapists that I was already familiar with through a local practice specializing in OCD and PTSD treatment. I selected this practice not only for convenience as a local resource of informants, but also its potential to provide sound, efficient leads for snowball sampling. The director of the clinic encourages and facilitates her staff to network with community resources and participate in community events and training related to OCD and PTSD treatment. Therapists at this clinic have relationships with a previous staff therapist now working at a VA center, and a local treatment center for survivors of torture.

I utilized snowball sampling by requesting that these therapists spread word-of-mouth about the study, and provide referral contact information to potential informants meeting the inclusion criteria. A $10.00 incentive was offered to all individuals who agreed to participate, in order to encourage motivation to schedule an interview.

Data Collection and Procedure

Once potential informants were identified, I scheduled a time and place with them to conduct the interview. I conducted most interviews in person and two online using Skype, a video-conferencing program. Preference was given to in-person meetings, to allow me to be more fully experientially present with the informants' responses and stories through nonverbal communication. I encouraged informants interviewed online to choose a meeting space that allowed them enough privacy to feel comfortable in speaking freely and honestly.

For each interview, I arranged an hour-long meeting time. None of the informants needed more than an hour to complete the initial interview. Each informant completed and signed an informed consent and a demographics questionnaire before beginning the interview. Within the informed consent, I obtained permission to contact the informants after the interview, for clarification of themes and member-checking. Additionally, I offered to discuss any questions they might have before beginning the interview, to ensure they understood the consent and to build rapport with each person.

After collecting and discussing any questions about the informed consent and demographics form, I began the semi-structured interview containing five basic questions. Informants were instructed that they could use anecdotes and case examples during the interview to provide extra detail, but also that they should protect the

confidentiality of all clients by not mentioning any identifying information such as names or detailed demographic information. Throughout the interview I prompted informants to describe or explain ambiguous statements, give case examples, or provide more details about an experience to evoke greater detail and richer description of potential themes.

The interviews were audio-recorded and I took notes of my own observations while interviewing. Once all five questions had been explored, I finished by asking informants if there was anything more they thought I should be aware of about their experience, but hadn't yet asked about. The intention behind this was to allow space for responses that were not prompted by questions which could have been influenced by my own preconceived ideas. I also requested that informants review my notes and listen to a summary of their experiences from me.

Confidentiality and Data Security

I transported the audio-recording device for the interviews in a locked box to which I had the only key and kept it in this box at all times when not in use. I also kept informed consent and demographics form documents in this box. When not in use, the box was kept in a set of locked drawers. After the interviews, I transcribed the audio using a laptop, into Microsoft Word documents. This laptop has a firewall and antivirus software. Access to the computer is password-protected, and only I have the password. During analysis, I de-identified information and combined it with information from other informants taking part in the study. The informants are not personally identifiable in analysis documents or the final written study. Since informants must be distinguishable from others in the written results, in order to compare quotes and/or thematic statements gleaned from their interviews, pseudonyms are used to protect their identities.

Measures

Demographics. I collected demographics were collected for each informant. Age, race, gender, sex, current state of residence, education level, and number of years in practice were collected. *(See Appendix A).*

Semi-structured interview. The semi-structured interview has six questions about therapists' familiarity with mindfulness interventions and their use of it for posttraumatic symptoms, emotion dysregulation, and trauma-relevant attachment issues. Because therapists must have had at least two trauma cases within the past year, their responses were both present and retrospective in nature. An example is provided in the appendices. *(See Appendix B).*

Analysis

The procedure for analysis followed Moustakas' 1994 modification of the Stevick-Colaizzi-Keen method which is used quite frequently in phenomenological research. This method requires a great deal of intuition and decision-making on the part of the researcher, as well as frequent consultation with others to guard ethics and guide the decisions made. I first discuss methods of rigor used to enhance credibility of the results. A full description of the analysis procedures follows.

Ethical Considerations: Methods of Rigor

Peer-review. Utilizing peer-review as a validation measure enhances the authenticity of meaning (Choudhuri et al., 2004; Creswell, 1998; Field & Morse, 1985). Peers have unique locations and perspectives, and therefore the ability to relate to, understand, and represent phenomenological meanings that I may be less in-touch with. Their help ensures that more informants' voices are heard more accurately.

Secondary member-checking. By requesting that informants review summarized threads of meaning from their interviews after initial analysis, and then revising summaries if needed, they are more included in the analysis process and more power is given to them to refine and bring out expressed meaning. In short, their voice is not cut off after the interview but welcomed. Shenton (2004) encourages this particular style of member-checking to increase credibility: "Another element of member checking should involve verification of the investigator's emerging theories and inferences as these were formed during the dialogues."

Visibility of analysis. "Validity in qualitative investigation is built on the foundation of visibility of process. It allows the reader to see the delineation between the informants' experience and the researchers' experience" (Choudhuri et al., 2004). In my analysis I will attempt to provide such transferability by detailing how interviews are analyzed into core meanings.

Clarity and thickness. In my analysis and especially my discussion of results, I will attempt to bring clarity to the phenomenological meaning(s) discovered with use of examples and explanation. I will also be cautious not to lose meaning by being overly curt in the presentation of results, but rather allow for thickness and richness through detail. Described by Shenton (2004) as "thick description of the phenomenon under scrutiny", this combination of clarity and detail in writing helps convey with exactness what was said during interviews, and the context around the statements.

Horizonalization

After bracketing my own biases and experiences to increase my personal awareness, and collecting the data through semi-structured interviews, I transcribed the

audio-recordings of them into Microsoft Word documents. The next step was *horizanalization of the data* (Creswell, 1998); I reviewed the interviews line-by-line for statements that seemed weighted with meaning which conveyed essence of the experiential phenomena. Finding meaning in this way involves paying attention to indicators such as thick clarifications given by the informants, thick detail, emotive or precise language, and nonverbals such as tone, pauses, and remembered facial expressions. I chose to highlight words and phrases within each line that stood out as weighted with meaning.

Coding for Themes

After horizonalization, I pulled the highlighted meaning together into representative statements, or strands of meaning. During the first stages of coding, nine strands of meaning emerged that were commonly shared across at least 5 of the 8 the interviews:

learning sources (8 out of 8 interviews)

familiar interventions (8 out of 8)

uses for trauma (8 out of 8)

uses for attachment (8 out of 8)

visualization exercises (7 out of 8)

barriers to use (6 out of 8)

experience with attachment work (6 out of 8)

additional uses (5 out of 8)

regret/guilt/discomfort with use of mindfulness (5 out of 8)

Listing the strands allowed me to consider them equally as they were reduced and refined into themes without overlap; that is, each theme needed to convey a unique element of meaning essential to understanding the phenomena.

At this stage, it was important for me to use methods to reduce bias in the data analysis. The list of statements from the interviews that I believe each carry a unique, non-redundant, non-overlapping element of the essential experience of how to choose and utilize mindfulness needed to be reviewed by others to reduce my personal influence. Member-checking allowed me to refine the list further. I emailed the statements to the informants and requested that they provide feedback about whether the statements were accurate to their experience, whether the meaning expressed was distinct enough to represent separate themes, and whether I had missed any meaning that could potentially represent a unique theme. Informants identified pairs of meaning which they felt overlapped enough to be combined into one theme, as well as providing clarification that allowed other strands to be absorbed as subthemes. For example, Adya and Gregory sent these replies:

> *Adya:* You asked whether the meaning "strands" were distinct enough from each other. Although I feel like you did capture everything I was trying to say, I'm not so sure that there was much of a difference between my experience with attachment and using mindfulness for attachment work. I felt that I talked about those at the same time during the interview.
>
> > *Researcher:* Hmm, okay. I'm thinking back to our interview. Do you mean that, when we talked about your experiences with attachment work,

it encompassed your use of mindfulness for attachment work? Would you suggest absorbing one strand into another?

Adya: Hmm, kind of, yeah. They just overlapped so much. Maybe more like combining them together, at least in my case.

Gregory: Not sure what you meant by "additional uses"… can you clarify?

Researcher: Yeah, sure. In my mind, "additional uses" was sort of a catchall for times when people mentioned using mindfulness without discussing trauma or attachment work specifically. In our conversation specifically, I was thinking of when you talked about helping clients with being mindful of sticking to consistency in their daily routines before starting to discuss deeper emotional wounds.

Gregory: Maybe I'm mincing but I think that's a part of the trauma work for me still. It's still part of mindfulness with the aim of becoming familiar with the practice of it, and what it feels like to be aware of their surroundings and actions in the moment. My intention is to help them create a sense of safety and stability in their lives that they can rely on later, when we start addressing those wounds. Does that make sense?

Researcher: Yes, it does! That makes it much clearer for me. Thank you for your feedback.

Based on these responses I subsequently combined the strands named “experience with attachment work” and “uses for attachment” into one theme. Other informants also clarified the strand named “additional uses” as a subtheme of trauma work, so I absorbed it into “uses for trauma”. I also absorbed the strand named “visualization exercises” as a potential subtheme of “familiar interventions”. Finally, I broadened the strand “regret/guilt/discomfort in use of mindfulness” to include any feelings identified about using mindfulness, which allowed a new theme to emerge. Outside review of the data identified another theme that was initially missed: Cues for Use.

Bias-Checking and Phenomena

I considered the possibility that this list of themes could actually be subthemes of greater themes of meaning, as some seemed to be more closely related to each other (i.e. cues and barriers to use). However, smaller and more specific strands of meaning already seemed to be emerging within these existing themes as I reviewed the data. Recognizing my own confusion and hesitancy, I began to seek out a peer-reviewer for additional input.

Unfortunately, I had difficulty finding an available peer to review the themes. Both student and professional researcher peers that I contacted either did not reply, or felt their understanding of qualitative methodology was too limited to be of use in peer-reviewing. I ultimately reached out to a university resource, consultation at an applied statistics laboratory, to have an independent peer review these themes and my perspectives on their meaning. It should be noted that this person had more experience in quantitative statistical research, and therefore was not an ideal peer-reviewer for a qualitative study. This should be taken into account while interpreting the results.

I asked her to suggest alternatives I may not have considered or themes I may have left out. In addition to identifying the theme Cues for Use, she suggested that my research question was broad, and that perhaps I was capturing more data than I had originally intended. This substantiated an earlier intuition that I might have been hearing about multiple phenomena from my informants during interviews. I allowed myself to step back and consider which other phenomena might have been represented during interviews or contained within my research question. This act of adjusting focus, similar to adjusting the lens on a microscope or stepping closer and further from a painting, allowed me to make fuller sense of the data.

Between my research question and the themes I saw three phenomena suspended: how informants had learned about mindfulness work, how they use it for trauma and attachment in current practice, and what influences their choices in using it. Most of the themes naturally fell under a phenomena, except for Personal Feelings about Use of Mindfulness. Further member-checking revealed that informants felt this theme was independent from any of these phenomena, but still a valuable aspect of their experience. When asked if they felt it should be included in the results, a majority said yes, mainly because they felt it reflected a problem or weaknesses with the use of mindfulness in mental health. Further detail is included in the study results.

Coding for Subthemes

Finally, I explored subthemes by comparing the identified themes with content that was originally highlighted for meaning during horizonalization, to find details which were relevant or specific to each theme and provided a thicker understanding of their meaning. This was done within each interview separately first. Afterwards, I conducted

between-subjects coding by comparing these relevant sub-details across interviews for each theme, and within-subjects coding by tallying the number of times that a sub-detail was uniquely mentioned within each interview. I categorized meaning as a subtheme if the sub-details were represented in a majority of the interviews in which their parent theme was present. For example, if a parent theme occurred in 5 interviews, then a subtheme was named if the detail occurred in at least 3 of those interviews. A large number of subthemes (25) emerged between-subjects, mostly concentrated under Uses for Trauma. Only a few (4) subthemes emerged within-subjects.

Results

Phenomena, Major Themes, and Subthemes

For the most part themes organized neatly under three phenomena: learning about mindfulness, the use of mindfulness in current practice, and choices in applying mindfulness. Each phenomenon housed two major themes, and another major theme was independent from any of the phenomena. Subthemes were present for all major themes, although the number of subthemes per major theme varied. The final list of identified themes was:

<u>Learning about Mindfulness</u>

Sources of Learning

*No Formal Training

*Not Graduate Classes

*Supervisors & Peers

Familiar Interventions

*Grounding

*Mindful Breathing

*Mindfulness Meditation

*Requesting Mindful Presence

Use of Mindfulness in Current Practice

Uses for Trauma

*PTSD criterion symptoms (hyperarousal, intrusion, and avoidance)

*Other common trauma symptoms (dissociation, emotion dysregulation)

*Recognizing Triggers

*Skill Building

Uses for Trauma-relevant Attachment Injuries

*Risk-Reassessment

*Interpersonal Mindfulness

Choices in Applying Mindfulness

Cues for Use

*Recognizing Symptoms

Barriers for Use

*Not Enough Knowledge

*Client Characteristics

*Work Setting

Feelings of Doubt

Following is textual and structural description of each theme grouping, discussing what was experienced and how the informants experienced it. The number of informants that

applied to a specific theme or subtheme out of the total is listed in parentheses. For example, (7 out of 8) means that the theme described was brought up by 7 of the informants, out of n = 8. Alternatively, (5 out of 7) means that a *subtheme* was brought up by 5 of those informants who endorsed the major theme.

Learning about Mindfulness

Sources of learning. Three subthemes emerged from Sources of Learning: not having received any formal training in mindfulness; not learning enough about it in graduate school; and learning what mindfulness is and getting advisement in using it from postgraduate supervisors and peers. All the informants discussed how they had learned about mindfulness (8 out of 8 informants).

No formal training. All of the informants (8 out of 8), regardless of their level of familiarity and knowledge with mindfulness, were quick to point out that they had "no formal training" (8 out of 8). Juliette's experience was common: "Nobody has ever really sat down with me and said like, hey, here are interventions for mindfulness. It was more like I just picked up interventions from different people at random." Gregory's reply nearly mirrored hers: "You know, I can't say that I've ever sat in a class or had formal teaching where an expert or professor sat me down to explain mindfulness. It was more something I've picked up a little at a time, as it became more popular."

Only one informant (June) had thoroughly studied mindfulness, in a graduate class about coping skills for addictions treatment. Kathi and Tessa had some more thorough training from a conference seminar and supervisor training, respectively, but did not consider these to be formal training:

Kathi: Well I know just a little about it because I have some colleagues who are interested in mindfulness, and I've picked some things up at conference presentations and things. I have no formal training, though, in mindfulness-based therapies.

Tessa: And then a lot of my practicums were with trauma clients, so a lot of the therapists and supervisors that I worked with taught me… now that I'm thinking back… things such as grounding techniques, focusing on what's going on around them… like if a client's dissociating or having a really hard time going over their trauma narrative. But I think at the time I didn't REALLY realize what it was- that it was specifically mindfulness.

Little or no mindfulness education in graduate school. Most informants (7 out of 8) expressed that their graduate education about mindfulness was simply too brief and limited to make an impact on them. When trying to recall if she had ever learned a definition of mindfulness in graduate classes, Maria stated "I feel like… I know there was one in that theories book from grad school. But I couldn't give you one now, so it didn't stick!" Considering the same question, Adya explained "No, it just wasn't quite as popular when I was in graduate school- or at least not with my professors, so I didn't learn it." Tessa, who had the most knowledge and technical understanding of mindfulness therapies, expressed her difficulty in being able to connect any of her current knowledge back to her PsyD program:

Tessa: I didn't have a lot of training for mindfulness in grad school… actually I don't think we ever really talked about DBT. I know there's others, clearly there's other therapies that use mindfulness and acceptance of emotions, and relaxation

techniques, but… I can't really think of anything specifically in grad school, that we learned about. Nope.

Supervisors & peers as sources of knowledge. Most informants (7 out of 8) identified post-graduate supervision and peer consultation as their most useful and memorable sources for learning about mindfulness. Many of them recalled very specific techniques taught to them by supervisors or suggested by peers. They noted that this kind of learning was highly experiential and often done on the fly: peers and supervisors offered up interventions and brief explanations during times of need, such as when they felt at a loss for how to address particular symptoms. Maria clarified to me what she called her "piecemeal learning" with the following explanation: "My supervisor now walks me through how she tends to use mindfulness techniques, but honestly at this point I feel like I can do a couple of sessions and then I hit a wall. It's like, my knowledge of what else to add or how to expand on it goes away." Gregory recalls that supervisors and peers would suggest interventions, but only when he was specifically seeking out help: "Never the therapies, no, but mindfulness interventions I'd get- other colleagues or supervisors would suggest from time to time a technique to try if I was already asking for advice on a case." Another informant, whose entire knowledge about mindfulness had come from observation and asking questions of his peers, described the connection to his feelings of uncertainty and confusion when utilizing mindfulness:

Interviewer: … how much do you know about mindfulness therapies and interventions?

Christian: Um, probably very little in comparison with someone who's actually been trained in mindfulness work. So even thinking back to my cases, I have used

mindfulness, but heaven knows if I've done it correctly. Probably the safe answer would be, I have experience using it, but very little technical knowledge.

Interventions familiar to informants. In addition to explaining how they had learned mindfulness, all of the informants (8 out of 8) also talked at length about what specific interventions they were the most familiar with and how they were used to utilizing them in therapy sessions. A few interventions emerged as familiar to most informants: grounding exercises, mindful breathing exercises, and simply requesting present-moment awareness and nonjudgmental acceptance from clients.

Grounding and mindful breathing. All informants used grounding exercises flexibly and for a wide variety of trauma symptoms (8 out of 8). June tells about using mindfulness to help calm clients feeling emotionally dysregulated: "And so, mindfulness sometimes is a way to help them with grounding a little bit, and learning coping techniques. … they get caught up and wrapped up in their emotions so I think mindfulness helps them to be grounded from that a little bit." They mainly used breathing exercises as a prevention or treatment for hyperventilation (6 out of 8). Adya stated, "I find the breathing helpful when people are getting physiologically aroused from anxiety-most clients can recognize sensations of chest tightness or a hard time breathing, so it's an easy way to get them to practice awareness. And help stop panic attacks!" Sensory grounding, in which the therapist guides the client to use awareness of the five senses to focus their attention to the present, was especially popular (5 out of 8). Christian described this technique:

Christian:… you have the client point to five things in the room they can see, four things they can feel, three things they can hear, two things they can smell, and one

thing they can taste. And so, it's a grounding technique that helps people reorient to the moment, and come back to their bodies, and so they can be aware of what's happening in the present moment.

Meditation. Most clinicians (5 out of 8) were familiar with meditation exercises, but not comfortable with them, and did not use them frequently. Tessa explained to me how meditation is used in DBT to help clients center themselves and engage present awareness before starting a session, but admitted she hadn't ever used this intervention with her own clients.

Tessa: And also DBT talks a lot about meditation, and using that as a way for clients to take the time to notice what's going on in the present. I have never done that one specifically with my clients, so… I've never actually had a client come in and do a mindfulness meditation in the beginning of the session. Which I know is recommended in DBT. So I think that's something that could be important to incorporate, I just- haven't. Not with my own clients.

Kathi had experience learning about compassion meditation in a therapy training seminar, but felt that it clashed too much with her style and theoretical orientation to feel comfortable with it.

Kathi: The meditation… you know, it didn't seem like something I would use with my clients because it was just… so different? I mean it was nice but seemed kind of weird and just not… not my style, definitely not my usual style, so. And it kind of seemed maybe more… artistic or spiritual, and less scientific.

Requesting mindful presence. Most informants (7 out of 8) communicated the most comfort and familiarity in simply requesting mindfulness from their clients, by

asking them to focus on present-moment awareness and nonjudgmental acceptance of their current experiences. Informants tended to relax and speak with more confidence when describing their familiarity with this most basic, no-frills approach. Juliette described the simple, direct wording she frequently uses with clients during this intervention: “you’re feeling what you’re feeling, and you’re allowed to have that feeling, and you can stay with it now”. Maria expressed the importance of asking her clients to give themselves permission to notice thoughts connected to feelings of shame by “Just allowing them to come and not forcing them away before they’ve had a chance... many times, [my client] pushed them away, the ones she didn’t like. So they would always come back again.” Kathi described her process of walking clients through mindfulness by requesting awareness first, then moving on to acceptance.

> *Kathi:* I encourage them to acknowledge those symptoms, acknowledge the feeling, maybe step back from it. If they think of it as a negative feeling, then accepting and acknowledging that they’re having a feeling which seems negative to them, and seeing that they’re feelings, so they’ll come, they’ll go, but they won’t stay forever.

Use of Mindfulness in Current Practice

Uses for trauma. Unexpectedly, the most subthemes emerged for uses of mindfulness for trauma. All informants endorsed using mindfulness to treat trauma, which was expected as this was part of the inclusion criterion (8 out of 8) Descriptions are given below.

PTSD criterion symptoms: hyperarousal, intrusion, and avoidance. Despite describing their piecemeal learning process, and sometimes feeling less certainty about

using mindfulness “the right way”, all the informants consistently used mindfulness to treat three of the four major symptom categories of PTSD, including hyperarousal symptoms, avoidance symptoms, and intrusive symptoms (8 out of 8). No clients endorsed using mindfulness for the fourth symptom criterion of PTSD, changes in mood and cognition (0 out of 8). Their use of mindfulness for PTSD symptoms seemed especially focused on helping clients practice awareness of ‘knee-jerk’, automatic symptoms and then using acceptance to reassess the situations that triggered them. June spoke about helping a child client understand where his behavior came from, so that he could learn to self-soothe.

> *June:* I’ve used it with him because he gets really hypervigilant, really fidgety and hyper, particularly when he’s talking about the trauma that he’s experienced with dad. And so a lot of times when he gets like that I have to ground him and just say, “Okay, let’s go to our happy place for a minute.”

Maria discussed using mindfulness to help a mother cope with flashbacks in the midst of family time

> *Maria:* … another client who has experienced severe domestic violence… occasionally she’s sitting in her living room watching a triggering TV show, and then all of a sudden she feels the fear as if [her abusive ex-partner] is standing right there on the porch. And with her we’ve focused more on the acceptance aspect, trying to accept the feelings and know that she can be scared, and it doesn’t make her a bad mom to simply feel that way, when her kids are present.

Juliette told a story about using mindfulness to help a client become aware of her avoidance behaviors of avoiding eye contact and slipping into a flat affect to internally avoid emotion while discussing her trauma and its effects on her life.

> *Juliette:* In my most recent case, I found out that during her therapy she was avoiding emotionally while talking about her trauma. So in that instance I implemented the mindfulness so that she would be able to be more aware of the story she was telling and how she was telling it, so she could reduce and stop doing those avoidance behaviors. Because that sort of, emotional blunting, was preventing her from being able to heal. It was keeping her emotions buried.

Dissociation and emotion dysregulation. Another subtheme was using mindfulness to address symptoms of dissociation and emotion dysregulation in clients (6 out of 8). Although these are also common symptoms of trauma, informants spoke about them distinctly from using mindfulness for PTSD symptoms, describing these experiences during other parts of the interview. Informants generally recognized that when a client was dissociating or felt emotionally out of control, they were in a state of "fight or flight" and couldn't move forward unless they had a chance to relieve the stress causing it. They taught mindfulness to clients as a coping tool to help regulate the autonomic fear response, so that clients could relax enough to engage in other important tasks in and out of session.

Adya told me about using mindful body awareness for a client who had been making great progress, but suddenly got 'stuck' and began dissociating to the point of having difficulty speaking.

Adya: She was finally making some strides, but she came back after a session, and told me that it had been very helpful, but, also, brought up flashbacks over the week. … she struggled so much, back and forth, crying and shutting down- like staring silently kind of checked out, you know? She was finally able to tell me she desperately wanted to describe the flashbacks but felt frozen and like she couldn't talk each time she tried. We'd already done some somatic therapy, so the mindful body awareness made sense to her, and we did it VERY slowly, walking through each sensation of frozen-ness, and then each emotion about telling me, and practicing acceptance until she could finally get to that memory and say it out loud.

Maria taught a client mindfulness to help her through the experience of creating a recording of her trauma experience as evidence for the client's court case against her abuser:

Maria: So we've been working on moving through her story… when she starts to get too flooded, using the grounding techniques to help her come back down and stop dissociating… we've used mindfulness to help her be aware of, when are you starting to feel that way, how can you ground yourself to bring yourself back down, and how do you feel that makes you know you're calmed down enough to keep going with the story?

Kathi described teaching clients mindfulness as a way to manage their own intense emotional reactions to other people's behaviors:

Kathi: I think I might tend to use it when, for example, when someone is having a lot of anger… towards something that someone else is doing. Especially in situations where, you know, they don't really have control over the other person. But they're

> getting very worked up, and physiologically aroused by it, and so I encourage them to sort of like, you know, step back, and accept that the other person is going to do what they do, and we don't have control over that.

Tessa had used mindfulness in her past work with teens who had difficulty with emotional outbursts and acting-out behaviors due to trauma:

> *Tessa:* So kind of helping- I mean a lot of teenagers have a hard time with emotion regulation anyways, so you add in the trauma piece, and there's more difficulties there. So a lot of their behaviors are suicidal gesturing, self-harm, and a lot of kids now do choking games or develop disordered eating. So how to regulate your emotions, and how emotions aren't necessarily scary, and you can be accepting of them and non-judgmental of them, and… the mindful relaxation training, is especially important with those kinds of kids.

Recognizing triggers. Teaching clients how to become mindful of triggers that affected them throughout the day was another subtheme of use for trauma (5 out of 8). Especially for clients that had a solid grasp on the concepts of mindfulness, informants asked them to practice noticing situations that were triggering and the symptoms or feelings that followed. Christian told a story about a client whose traumatic combat experiences were triggered by watching the nightly news: "We will talk about things like… a story that came on the news that was difficult for him to watch… and I'll periodically ask him what thoughts, feelings, and even body sensations he is aware of as we talk." Gregory reported that multiple clients experiencing pervasive irritability and anxiety had great success with this homework exercise:

> *Gregory:* I will have them take an entire day. And their homework is to spend the day being aware of times they feel triggered. They have to practice being aware of those sudden feelings of fear, aggression, whatever. They don't have to change it. At first, I want to get them used to just noticing and accepting that those things are happing for them all the time on a day-to-day basis.

Skill-building. In this subtheme, informants imparted the importance of giving attention to treatment planning as well as treating symptoms (5 out of 8). They frequently noticed that clients who were more severely traumatized were not always ready to delve right into deeper therapeutic exploration of trauma memories and schemas. According to Adya, "Baby steps, they're important, sometimes I have to spend lots of time helping someone just learn to cope with life before they're stable enough to do other work." Others reflected her perspective with stories about clients who were not ready for certain aspects of treatment. Tessa and Christian, who had experience using exposure therapies, recounted situations where they had used mindfulness interventions to help more severely affected clients build skills in emotion regulation and awareness before using traditional prolonged exposure:

> *Tessa:* Prolonged Exposure- it's difficult in any case, clients have a hard time tolerating the reliving of those experiences and often they fall back into the trauma when they're first learning so, knowing that there's some Borderline traits going on I often think, okay, there's going to be additional work and we'll have to augment the traditional PE treatment to include some emotional regulation skills and tools, and maybe we won't be able to even do any PE until we can get them more stable.

Christian: So a lot of what we're working to do, since he can't do those traditional PE interventions yet like imaginal or in-vivo exposure work, or talking through the trauma narrative, is just helping him manage that daily hyperarousal.

Uses for trauma-relevant attachment injury. Overall, informants did not feel that mindfulness interventions and therapies were as useful for attachment issues as they were for posttraumatic stress symptoms (6 out of 8). They offered several different reasons for this. Three informants explained it by noting that attachment issues were something they didn't always encounter in their trauma clients, especially when the trauma did not occur within a relational context (for example: work equipment accidents and natural disasters). In other words, they did not choose to frequently use mindfulness in treating attachment issues because attachment issues were not a common problem for their clients. Other reasons included a tendency to choose interpersonal therapies instead; an intuitive feeling that mindfulness and attachment theory were "apples and oranges" and simply didn't go together; and a lack of knowledge about attachment theory.

Despite finding mindfulness to be less useful for trauma-relevant attachment issues, two subthemes still emerged for this theme: helping clients to re-assess relational risk, and teaching clients to be interpersonally mindful.

Risk-reassessment. Regardless of their knowledge about attachment theory, informants attended to the fact that their trauma-affected clients could be very interpersonally fearful and sensitive (4 out of 6). They also commonly conveyed awareness that trust was a basic necessity for their clients to be able to relate to both them as therapists, and other important people in their lives. In a variety of ways, they frequently asked their clients to become presently aware of their immediate environment

and the therapist, in order to search for realistic risks. They also asked them to be accepting of the dissonance between their feelings of fear and vulnerability, and the lack of actual interpersonal danger. Juliette reflected, "But with fear, having them ground themselves in their environment, realizing, what are any real risks in the environment? What's actually going on in your environment? I do that a little bit."

Adya presented an eloquent example of what this sounds like during her therapy sessions:

> *Adya:* So it was important in our work that they realized they could trust me … if they started freaking out I'd stop them and say, take a look at the data around you right now. What does my face look like? How scary am I right now? Is there anything dangerous in this room? Based on your past experiences *with me,* what can you guess about how *I* will react?

Interpersonal mindfulness. The second subtheme of attachment issues was teaching clients mindfulness as a way to become aware of how their feelings and behaviors influenced their relationships, and vice versa (5 out of 6). Informants frequently used their own therapeutic relationship or examples from the clients' lives as ways to draw their attention to attachment issues that might be affecting them. Juliette described this use with a young woman who had been abused by her parents and romantic partners, and had generalized those attachment experiences to most new relationships, including therapy:

> *Juliette:* I ask her, you know, how are we playing out your dynamics in session right now? She does not trust me! (laughs) So, her trust goes off and on. …So just pointing that out and drawing her attention to a lot of the different things that are happening between us in the moment, I do a lot of that with her.

Tessa went into greater depth about using the acceptance aspect of mindfulness to help clients manage conflicting feelings about interpersonal reactions. She noted that many of her clients feel guilt or self-directed anger upon realizing that they want to connect to others, but are hampered by their fear: “Validating that for them, and showing them that it’s okay to feel however they’re feeling. To be accepting of how they feel in that experience. Even if it’s different from how other people might feel during a normal interaction.”

Choices in Applying Mindfulness

The final phenomenon encountered in the interviews was about how informants made choices about using mindfulness therapies and interventions. Themes for this phenomenon were: cues that catalyzed the use of mindfulness interventions in session; and commonly experienced barriers that prevented informants from using mindfulness interventions and therapies.

Cues for use. All informants stated that they were far more likely to make the decision to use mindfulness interventions during their sessions, rather than as a part of treatment planning or case conceptualization outside session (8 out of 8). They frequently described the decision to use mindfulness as being unplanned, and a reaction to something that was happening during the session (6 out of 8). Juliette, Christian, June, and Maria all defined their choices to use mindfulness interventions as “gut decisions”.

Recognizing symptoms. Witnessing trauma symptoms was the single common subtheme for what prompted informants to make the choice to use mindfulness therapeutically (6 out of 8). When asked what it was that made them “reach into their metaphorical therapy bag and pull out a mindfulness intervention” during a session, they

frequently cited examples or stories in which they had watched a client begin to behave symptomatically, recognized the behavior as a symptom of trauma, and then responded with a mindfulness intervention.

> *June:* So for, for example if he's talking about something that he's getting really agitated and irritable about, watching that change in his behavior.
>
> *Juliette:* Well, if I find out that they're, um, like that one client I told you about who was avoiding… her way of keeping calm was to imagine herself somewhere else. And so if I heard that from another client, right away I would think, 'mindfulness!'
>
> *Adya:* Just, seeing that they were triggered or maybe having a flashback or some other symptom... Working with trauma long enough you can see it as it happens, people's facial expressions will change, they freeze up, they get emotional zero to sixty. Seeing those things lets me know.

Barriers for use. Though mindfulness interventions were used, no informant ever described using a mindfulness therapy as the main mode of treatment for their clients. When asked about why this was, most of them brought up outside variables that influenced their choices, and were not purely due to personal preference (6 out of 8). Three subthemes emerged as things that prevented them from using more mindfulness with their trauma-affected clients.

Not enough knowledge. Lacking knowledge about mindfulness-based therapies was the most commonly given reason for why informants didn't use them (5 out of 6). Even informants who could identify specific mindfulness-based therapies had usually not received formal training or read manuals or books for them. June had learned a great

overview of mindfulness in a class about strategies for treating addiction, but not about mindfulness-based therapies: “Ah, well, I wouldn’t say that I have a really good understanding of [mindfulness therapies], but I know interventions well enough.” For Maria, this topic evoked exasperation as she described her experience of a pervasive lack of specific knowledge in her workplace:

> *Maria:* … everyone talks about it, but I feel like a lot of us are flying pretty blind, myself included. I find myself going to older clinicians and asking pretty specific questions. Like, I have heard this term mindfulness thrown around a lot and I think that everyone sort of expects each other to know what it means but no one really talks specifically about how to use it, and when it is or isn’t appropriate.

Client characteristics. Similar to the subtheme recognizing symptoms, this subtheme also pertains to in-session decision-making. Informants did not identify any single characteristic that they consistently watched for to determine that mindfulness was contraindicated. Rather, they described their own unique experiences of coming across various client characteristics which generally stopped them from using mindfulness (4 out of 6).

> *June:* In my experience in the VA, mindfulness definitely isn’t useful if someone is really activated from some kind of episode. Like being in a manic episode, or psychotic, or maybe under the influence of some kind of substance. I don’t think those are appropriate times to use them.
>
> *Gregory:* I tried, but he didn’t even have the language for it, so he couldn’t identify what it was that he was feeling when I asked him to be present. He didn’t

have the emotional vocabulary at all and it was just too frustrating for him. Now I look for that in others.

Adya: … some people just find it too new-agey. They think I'm going to make them sit down and say "ohmmmmmm, ohmmmm" over and over. Even when you educate them that it doesn't have to be like that, some clients just don't feel it. It's too different for them.

Work setting. Work setting was the final subtheme that emerged for barriers to using mindfulness in trauma treatment (3 out of 6). Informants talked about restrictions they had to deal with in their work settings that narrowed the treatment options they felt were available for use. Gregory, who currently uses mindfulness interventions regularly, had once worked in a practice where mindfulness was looked down upon by his boss. He recalled the delicacy of the situation, and that even though he was not banned from using mindfulness, he felt a pressure to choose between using it or maintaining peace with his boss: "In the end it was her practice, and she didn't like mindfulness. At the time it didn't feel worth it to argue. I needed that job."

Juliette felt a different kind of pressure. Her workplace strongly encouraged learning and using a specific therapy that she was still in the process of becoming familiar with. This influence steered her to stop using any other therapies, in favor of learning the new one: "… I have that manual. It's so in my head, I'm like, Gotta follow that manual! Gotta follow the session plan! So I don't veer that far from it right now."

Maria explained that while she had the freedom to choose any interventions she wished in her work setting, the nature of her clients' common presenting issues often prevented her from picking mindfulness:

Maria: So I'm generally given clients who are multi-underpriviledged. They're usually poor, usually have some sort of abuse or bad, painful, traumatic background. They all have children. They're usually also young, and very under-educated. So all of these different challenges. And the biggest constraint in working with them is sometimes the practical issues of life simply trump deeper therapeutic issues.

Independent Theme: Feelings of Doubt

Finally, one theme of meaning was independent from each of the specific phenomena. Although it does not neatly fit under any of the above-described phenomena, it was impossible to eliminate this theme without mis-conveying the essence of the informants' experiences. Informants became deeply reflective at the end of interviews, and many of them contemplated out loud their personal feelings and revelations about their use of mindfulness in treating trauma (7 out of 8). They expressed feelings of doubt and a lack of self-confidence in their use of mindfulness interventions. Despite having thoroughly described their use of mindfulness interventions with clients and why they made their decisions, many still doubted that they were using mindfulness in the best way for their clients. This feeling was often, but not always, attached to the experience of lacking knowledge or formal education about mindfulness.

Tessa: … I guess too in some ways I've always been afraid to do relaxation and mindfulness in a session, because I don't feel confident, or our time is limited, and because of payment issues.

Juliette: Yeah… just realizing, that I treat my clients and interact with them a lot differently at both sites… I think I'm compensating a bit for feeling restricted in my practice.

Christian: No, I would be happy to say I am… you know I'm certainly not anyone's expert at anything at all. And I love to learn about techniques and execute them with real effectiveness. But I make no assumption that I'm doing that now. Maybe I'm doing mindfulness wrong. That's all.

Maria: I end up feeling kind of silly, because I know the word, and related words like 'grounding'. But as far as how and when would you recommend this treatment for a specific case, how you would differentiate between when you should and shouldn't use it with a specific client, that's not really discussed when I ask people about it.

Discussion

This study sought to examine the experiential essence of how therapists put mindfulness to use in the treatment of trauma-affected clients. Specifically, I asked the research questions "How are therapists currently utilizing mindfulness interventions and therapies in the treatment of trauma, especially in regards to the major issues of attachment, emotion regulation, and post-traumatic stress symptoms?" and "How do therapists make decisions regarding the use of mindfulness-based methods for trauma; i.e., whether to use it at all, and which therapies or interventions to use?" These questions were broad, and ultimately led to the exploration of three unique phenomena: how therapists learn about mindfulness interventions and therapies; how therapists utilize mindfulness in the treatment of trauma; and how therapists make choices in applying mindfulness therapeutically.

Overall, informants felt that they learned the most about mindfulness-based interventions and therapies in their post-graduate work, from peers and supervisors. They described four familiar interventions, three of which were commonly used. Informants also shared common experiences about how they used mindfulness interventions to treat trauma, and trauma-relevant attachment issues. They unanimously stated their strongest cue to using mindfulness was noticing symptoms as they happened in-session, and discussed barriers to using mindfulness such as client characteristics and workplace restrictions.

How Therapists Learn about Mindfulness Interventions and Therapies

In asking the above research questions, I did not expect to hear about where and how the informants had originally learned about mindfulness. Yet, they invariably turned to these memories when I asked about their knowledge base ("how much do you know about mindfulness interventions and therapies?"). Informants described their learning process as having interventions "given" or "handed down" to them by supervisors or peers. They learned about mindfulness informally, without a lot of attention given to it in formal education or training. Informants did not identify this type of training as ineffective or unhelpful to their work, but most did struggle to effectively explain their familiarity with mindfulness beyond telling which "hand-me-down" interventions they were mimicking. Only one informant, Juliette, gave a theoretical description of what she understood mindfulness to be before moving on to a description of interventions she was familiar with.

This seems to reflect a quick-fire style of learning for most informants, in which they were given only a little direction and information about mindfulness before being

expected to put it into clinical practice. Towns & Ashby (2014), in their study of practical application of occupational therapy theory in practicum settings, noted that supervisors could have a profound effect on their students' use of theory-based practice because they were in the role of translator. When supervisors failed to explain therapy process with theoretical language and concepts, students tended to give up on theory as a guiding principle and focus on an eclectic use of interventions in practice instead. This phenomenon could potentially explain the informants' common experience of identifying supervisors as a primary source of learning, but not endorsing any formal training, and expressing limited familiarity with specific mindfulness therapies or theory.

How Therapists Utilize Mindfulness in the Treatment of Trauma

This study's results provide some self-report evidence that therapists' experiences using mindfulness with clients are confirming suggestions for its use that come out of neuro-psychological research. The most frequently endorsed utility for mindfulness by informants was using singular interventions to mitigate or treat trauma symptoms, especially when they presented during the session. The symptoms most frequently mentioned were ones related to fight-or-flight activation and emotion regulation difficulties (hyperarousal, intrusive symptoms, avoidance, dissociation, and emotion dysregulation). Informants did not feel mindfulness was useful to treat trauma symptoms related to changes in mood, cognition, and beliefs about the world, self and others.

This pattern of use supports previous research suggesting that mindfulness is therapeutically useful for relieving symptoms associated with amygdala response such as fight or flight and intrusive memories by activating the prefrontal cortex and anterior cingulate cortex (Banks et al., 2007; Corrigan, 2002; Chiesa et al., 2010). It also bears

similarities to the case example and consequential perception of Goodman & Calderon (2012) that physiological and memory-related symptom relief is an initial task of trauma therapy which mindfulness is very useful for, because it provides clients not only symptom reduction, but also an increased sense of control over these symptoms. This makes sense, given that the pre-frontal and anterior cingulate cortices are responsible for decision-making and regulation of emotions (Banks et. al., 2007)

Some informants also found mindfulness useful for helping clients increase awareness and nonjudgement of interpersonal behaviors and feelings, though most did not feel this use was as valuable as using mindfulness to address trauma symptoms. This is surprising, given that a number of prominent mindfulness researchers have written books on the topic of mindfulness benefits for socio-emotional awareness and development for both children and adults (Solomon & Siegel, 2003; Lantieri & Goleman, 2008, Kabat-Zinn & Kabat-Zinn, 2009; Miller, Richo, Welwood, Branch & Nhat Hanh, 2011). The most likely explanation for this shared feeling is the one pointed out by a few informants: not all of their clients dealing with trauma symptoms also struggled with attachment issues, and so they did not feel it was important to focus on attachment-relevant interpersonal behaviors. It is also possible that, given the lack of formal education on mindfulness for most informants, they paid less attention to attachment issues because they were simply unaware of any connection between mindfulness and socio-emotional processes. When clients did struggle with both, however, mindfulness was used as a way to draw clients' attention to reassessing relational risk and interpersonal behaviors that played out in the therapeutic relationship. In this case, the focus was less on evaluating the behaviors as healthy or unhealthy, but rather

acknowledging and accepting the survival-based impulses behind them (fighting, fleeing, freezing) as understandable, albeit inappropriately timed.

How Therapists Make Choices in Applying Mindfulness Therapeutically

No one took a planned approach in utilizing mindfulness to treat trauma-affected clients. Rather than selecting mindfulness-based therapies as a treatment approach or planning to incorporate interventions eclectically and selecting them beforehand, clinicians made the choice to use mindfulness interventions in-the-moment. These choices were made in situations where clinicians recognized an immediate need to address symptoms that were interfering with the client's ability to attend to other therapeutic tasks. Decisions to use mindfulness were quick, intuitive, "gut decisions". They might have been influenced by some of the other themes stated in interviews, such as some of the mentioned barriers to use (lack of knowledge, constraints within work settings, and client characteristics).

Another explanation is that the informants were utilizing procedural knowledge to quickly and efficiently select an appropriate intervention during a stressful moment in therapy. Coren (2014) describes the necessity of having a balance between declarative and procedural knowledge as a therapist:

> When we learn something new we need to combine declarative knowledge (…theory), with procedural knowledge (the application of that theory i.e. clinical practice). These are two forms of knowing – we need both. The central dilemma in clinical trainings is how to avoid declarative knowledge becoming inert, in the sense that trainees become burdened with theoretical knowledge and become hamstrung

about how it can be applied in a clinical setting. Procedural knowledge involves knowing what to do when we are in a real clinical encounter.

Since informants had generally not had formal training or learning experiences about mindfulness, it is probably that they suffered the opposite deficit of not having the necessary declarative knowledge to incorporate mindfulness theory into a treatment plan, or consciously select a mindfulness-based therapy. Rather, their main exposure to mindfulness had been through brief, example-based learning that was often shown or demonstrated, rather than theoretically explained, by supervisors and peers. By learning about mindfulness through witnessing or sometimes experiencing the taught interventions, informants likely learned procedurally and were then primed to use the interventions reactively, instead of in a way that required conscious forethought.

The dissonance created from using mindfulness for appropriate symptoms, but not having the theoretical knowledge to really understand why it worked, could have contributed to the common feelings of self-doubt that informants expressed about their use of the interventions. Alternatively, the self-doubt could have been due to a genuine lack of competence in mindfulness skills. Stauffer & Pehrsson (2012) surveyed published experts in mindfulness to determine a set of competency skills necessary to teach clients mindfulness. Some of the most strongly supported skills involved having a strong foundation of declarative knowledge about mindfulness (distinguishing it from other psychological processes, knowing a broad variety of methods & therapies for application), regularly seeking continuing education, and engaging in self-practice of mindfulness. By these standards, the therapists' feelings of self-doubt might have been an accurate reflections that they were not proficient in using mindfulness with clients.

Although informants were not asked about self-practice, none volunteered any information, memories, or experiences about personal use of mindfulness. Only Kathi described a continuing education experience (attending a conference training) but she also stated that she did not use the meditative intervention she had learned because it seemed contrary to her therapeutic style.

Clinical Implications

The results of this study highlight a need for continued formal training for therapists in specialized topics that relate to their work. Although informants did use mindfulness interventions, they made clear to me that they did not have formal training and often questioned the accuracy and effectiveness of their use. Though supervision and peer sharing were the main access point for informants to learn about mindfulness, this method felt haphazard and uncoordinated to them, which contributed to their lack of confidence. While post-graduate supervisors may have greater responsibility to monitor issues such as ethicality and liability in their supervisee's work, informants' responses suggest that these people still have a great impact on clinical practice, even years after post-graduate supervision is no longer used. Because of this unique point of influence, post-graduate supervisors have the potential to increase the credibility and effectiveness of mindfulness interventions and therapies by directing young therapists to accurate, well-researched learning resources. These may include landmark studies, manuals or guiding texts for mindfulness therapies, books about mindfulness application in different mental health traditions, and regional or national trainings. See Table 2 for a list of written resources that may be useful for clinicians in educating themselves or others

about mindfulness, therapeutic mindfulness interventions, and therapies utilizing mindfulness.

Resources for Further Reading		
Title	**Author Last Names**	**Type of Resource**
Teaching Mindfulness: A Practical Guide for Clinicians and Educators	McCown, Reibel & Micozzi	Teaching Guidebook
Clinical Handbook of Mindfulness	Didonna (Ed.)	Textbook & Clinical Guidebook
Mindfulness-Based Cognitive Therapy for Depression, 2nd Ed.	Segal, Williams & Teasdale	Clinical Guidebook for a Specific Therapy
Acceptance and Commitment Therapy, Second Edition: The Process and Practice of Mindful Change	Hayes, Strosahl & Wilson	Clinical Guidebook for a Specific Therapy
A Mindfulness-Based Stress Reduction Workbook	Stahl & Goldstein	Self-Help & Group Therapy Guidebook
Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications	Baer	Clinical Intervention & Research Guidebook
The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance	McKay, Wood & Brantley	Clinical Intervention Guidebook
Mindfulness-Oriented Interventions for Trauma	Follette, Briere, Rozelle & Hopper	Clinical Intervention Guidebook
		Table 7.1

Limitations

As with all research, this study has limitations, and results should be interpreted with these in mind. One limitation of this study is that all the informants were recruited within one city, and some of them worked in the same local clinic. Of those who worked in the same clinic, most of them also worked part time seeing clients at other sites as well, such as a local VA, or a residential treatment center. However, their similarity of experience working in the same city and some in the same clinic limits the generalizability of the results and allows for potential regional bias.

Another limitation of the study was the broad nature of the research questions. Although unintentional, the scope of the research questions and having more than one research question ultimately led to data that addressed more than one phenomenon. While it is not inherently negative to analyze more than one phenomenon, it is more difficult to do with a phenomenological approach, which seeks to capture and understand the condensed essence of a phenomenon. Adjustments in the study design and/or qualitative research approach could have either limited the number of phenomena studied, or made it easier to examine multiple phenomena.

A final minor limitation of the study was the use of technology to conduct one of the interviews. Because preference was given to scheduling face-to-face meetings, only two of the original interviews were conducted via Skype using Amolto to record audio. However, the data from one interview could not be included because the audio was not properly recorded. It is unknown whether this error was due to a malfunction with the program Amolto, or a malfunction of the laptop used to run that program. Regardless,

this error eliminated data that was otherwise sound and would have been a valuable addition to the study.

Suggestions for Future Research

These suggestions address the above limitations and provide advice for researchers interested in similar studies and topics. Firstly, it is highly recommended that researchers take advantage of professional connections and resources to take a team approach to conducting the research. Utilizing a team approach reduces the risk of individual bias, given that a greater number of perspectives and backgrounds are present (although having a multiplicity of perspectives would not eliminate the need for bracketing). Working on a research team also provides greater access to resources such as available interviewers, and potentially access to more geographical areas for data collection.

More research is necessary to determine whether these themes are generalizable, given the small sample size, and whether this style of use is effective for clients, especially since these therapists did not meet the competency standards suggested in another study. Additionally, future research aiming to reproduce these results or follow a similar study design should carefully consider the desired amount of data. If the aim is to use a phenomenological approach, then researchers should narrow and refine a single research question before proceeding with method design. Attention should also be given to the number and specificity of interview questions, so that the amount and phenomenological topic of the data is precisely relative to the research question. Alternatively, if the aim is to explore a phenomena that is not well researched and understood, a different qualitative method may be more appropriate.

If technology is used as a tool for data collection, it should be thoroughly tested, practiced and well-understood by any researcher or assistant before using it in the field. Software such as Amolto should be installed on hardware that operates well and has a low risk of malfunction. As always, researchers should carefully select technology that attends to the confidentiality and privacy needs of their participants.

Conclusion

Using a phenomenological approach, this study explored the experiences of 8 therapists' use of mindfulness interventions with traumatized clients. Despite some homogeneity in familiar interventions and their application, the therapists used mindfulness interventions in an unplanned and reactive way. The phenomenological essence of their shared experience seems to be that they both learned and applied mindfulness interventions responsively, rising to meet occasions when their clients displayed symptoms of intense distress or were generally unable to focus on other tasks due to persistent distress. This suggests a use of mindfulness which is both intuitively responsive, yet intentional in what is responded to. They also experienced self-doubt about the efficacy and accuracy of their use of mindfulness interventions.

APPENDIX A

Demographics Questionnaire

For the following questions, please provide a number.

1. **What is your age? _____**

2. **How many years have you been practicing? _____**

For the following questions, please choose one answer which most accurately describes you.

3. **Are you:**

    - Male
    - Female
    - Transgender

4. **Which racial or ethnic category do you identify with the most?**

    - Asian
    - African American
    - Latino
    - Pacific Islander
    - Caucasian
    - Multiracial
    - Other: _____
    - Prefer not to say

5. **What is your certification or licensure to practice mental health work?**

    Fill in the Blank:_____

6. **In the past year, how many cases have you had in which you used mindfulness-based interventions or therapy to treat trauma (*see examples listed below)*?**

   Number of Cases:_____

Mindfulness-based Interventions:

- Requesting present awareness, nonjudgment, and acceptance of experiences from a client.
- Mindfulness meditation
- Compassion meditation *(also known as Metta, loving-kindness meditation, or self-acceptance meditation)*
- Body-awareness exercises
- Grounding techniques
- Mindful-breathing exercises
- Cognitive defusion
- Mindful awareness through exercise

Mindfulness-based Therapies:

- Mindfulness-Based Stress Reduction (MBSR)
- Mindfulness-Based Cognitive Therapy (MBCT)
- Mindful-Awareness Body-Oriented Therapy (MABT)
- Relapse Prevention Therapy
- Acceptance and Commitment Therapy
- Dialectical Behavior Therapy

APPENDIX B

Semi-Structured Interview

1. How much do you know about mindfulness interventions and therapies? Can you tell me about the interventions and techniques you are familiar with?

2. Do you use any mindfulness interventions or therapies to treat trauma symptoms directly? If so, how do you use them?

3. Do you use any mindfulness interventions or therapies to treat emotion dysregulation issues for trauma-affected clients? If so, how do you use them?

4. Do you consider attachment issues in your treatment of trauma-affected clients?

5. Do you use any mindfulness interventions or therapies to treat attachment issues for trauma-affected clients? If so, how do you use them?

6. Is there anything I haven't asked about that you think would be useful for me to know about using mindfulness to treat trauma?

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