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# Buddhist Concepts in the Practice of Psychotherapy: A Qualitative Study

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## Abstract

The purpose of this study was to clarify and accurately investigate specific Buddhist concepts utilized by mental health clinicians professing to integrate Buddhist ideology into clinical practice. A theoretical structure was sought in order to organize and conceptualize these concepts, thus providing an accessible clinical model that informs practitioners of these methods. Additionally, information is provided regarding how psychologists identify and resolve apparent philosophical differences in conceptualization and treatment from a Buddhist perspective with the ethical and professional norms of clinical psychology.

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BUDDHIST CONCEPTS IN THE PRACTICE OF  
PSYCHOTHERAPY: A QUALITATIVE STUDY

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

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REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

July 23, 2010

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## **Abstract**

The purpose of this study was to clarify and accurately investigate specific Buddhist concepts utilized by mental health clinicians professing to integrate Buddhist ideology into clinical practice. A theoretical structure was sought in order to organize and conceptualize these concepts, thus providing an accessible clinical model that informs practitioners of these methods. Additionally, information is provided regarding how psychologists identify and resolve apparent philosophical differences in conceptualization and treatment from a Buddhist perspective with the ethical and professional norms of clinical psychology.

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This dissertation is dedicated to my wife, Kerry and son Finnley, who have both, by way of single parenting and an absent father, generously provided time and support for this process. May we continue to give it all away before it is taken from us.

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## **Introduction**

Since the inception of psychological practice, psychotherapists have been confronted with the unique problem of integrating personal belief systems, especially religious, into the arena of clinical practice (Freud, S., 1927; Jung, C., 1933). The potential for conflict between one's individual ideology and those instilled by association with a profession have become compounded by a progressively more global and multicultural world. At this epoch of human development, mental health professionals are now more than ever integrating theoretical concepts and beliefs from a wide range of disparate cultural and ideological sources.

For mental health professionals, one of the great intellectual developments of our time is the rapid integration of Eastern and Western cultural paradigms. An estimated ten million people in the United States alone and some hundreds of millions worldwide are practitioners of meditation (Stein, 2003). Meditation has become one of the planet's most commonly practiced, lasting, and researched psychological disciplines (Deurr, 2004). In recent years the integration of Buddhist thought via the construct of mindfulness has been readily accepted into the discipline of modern Western psychology (DBT, MBCT, MBSR, ACT, etc.). Hundreds of research studies over the last four decades have been undertaken to empirically validate mindfulness-based practices as a recognized treatment modality (Kabat-Zinn, 1982, 1990; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn, Lipworth, Burney, & Sellers, 1987; Linehan, 1993; Segal, Williams, & Teasdale, 2002; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; etc.). It is widely understood that Buddhist thought is the catalyst behind the mindfulness movement; however, little research has explored the possible complications, conflicts, or strengths of integrating a fuller understanding of Buddhist ideology into therapy practice.

Specifically, two central questions are salient: ‘How are Buddhist-based concepts being integrated into clinical practice?’ and ‘Do conflicts arise in the process of integration?’ I suspect that given the intensity and focus on this area of study in recent years, numerous mental health professionals are using Buddhist-based mindfulness modalities outside of the protocol identified in well-researched manualized treatment modalities. Further, information regarding how mental health professionals identify and resolve emergent philosophical differences in conceptualizing treatment from a Buddhist perspective within the ethical and professional norms of clinical psychology may provide beneficial strategies for those practitioners undertaking similar work.

The purpose of this study is to explore the integration of Buddhist concepts in the practice of psychotherapy. First, I will review the literature on Buddhist ideology and its impact on Western psychotherapy, beginning with a description of core Buddhist concepts and concluding with a review of the principal figures seeking to integrate Buddhism and psychotherapy. Next, I will track the advent and emergence of mindfulness as a recognized and researched treatment modality. Lastly, I will use data collected from interviews with psychotherapists who report utilizing Buddhist concepts in their therapy practice, using a phenomenological methodology, to further understand the insights and complexities that arise from the integration of the Eastern and Western perspectives.

### **Review of the Literature**

The review of the literature will be organized into two major parts. In the first, an examination of core Buddhist concepts is provided, with discussion presented as to their relationship to Western psychology. In the second, the emergence of Buddhist

concepts in Western psychotherapy will be examined in two dimensions. First, a review of the history of this process and the individuals at the forefront of this discourse will be illuminated. Next, an examination of the construct of mindfulness as an accepted Western psychotherapy treatment modality is provided, with a focus on empirical outcome studies and a description of basic mindfulness techniques. This review will provide the reader with a broad context for the undertaken research and findings.

### **Core Buddhist Concepts**

Buddhism is both a religious and philosophical tradition, manifesting as a variety of beliefs and practices, largely based on teachings attributed to Siddhartha Gautama, commonly known as the Buddha, which translates in Pali/Sanskrit to "the awakened one." Most scholars believe that the Buddha lived and taught in what is today India and Nepal, sometime between the 6th and 4th centuries BCE. The teachings of Buddhism can be interpreted as astute phenomenological and psychological observations of the human experience, perhaps enabling the ease with which it has permeated and merged with the cultures it has come in contact with. In contrast to other major religions, Buddhism invokes no divine Creator or supreme Self, or Holy to whom followers might appeal for salvation. Instead, Buddhism asks that one rely on direct observation of one's personal experience and on honing certain skills in order to gain greater understanding and wisdom. Much of this wisdom can be distilled to what are known as the 'Three Marks of the Dharma' or 'Three Seals of Existence.' These are recognized as fundamental to all sects of Buddhism and offer a representation of core Buddhist concepts. The website of a prominent Buddhist group with 6.5 million active members states, "It is no overstatement to say that all the teachings of Buddhism are derived from these three laws (marks)" (Rissho Kosei-kai, 2010). Specifically, Buddhists believe that

the Buddha, upon his enlightenment, recognized that everything in the physical world, including mental activity and psychological experience, is marked with three characteristics – suffering, non-self, and impermanence. Seeing the world and the self in this way is considered a core element of the Buddha's teaching or *dharma* (Pali/Sanskrit "the way things are"). Buddhist thought posits that through examination and awareness of these three marks/seals of existence all of the Buddhist teachings become apparent. Thus, this paper will rely on the three core concepts of suffering, non-self, and impermanence as touchstones for what will be defined and investigated as Buddhist beliefs.

Finally, as Buddhism is a religion with strong ethical foundations, an exploration of the role of ethics will be considered as a potential point of conflict with Western psychotherapy. In the following sections, each of these core concepts (suffering, non-self, impermanence, and ethics) will be defined and examined with reference to potential paradigm differences between Buddhist ideology and Western psychology.

**Suffering.** To obtain a conceptual framework for understanding Buddhist thought it is crucial to understand what the Buddha diagnosed as the fundamental dynamic at work in the creation of human suffering. When the Buddha gave his first teaching, known as Setting in Motion the Wheel of Truth (*Dhammacakkappavattana Sutta*, Pali), he taught that there are Four Noble Truths that describe the basis of the Buddhist paradigm (Rahula, 1974). These concepts are at the heart of all Buddhist traditions and the foundation on which all further discourse rests. The Four Noble Truths state that: life contains suffering (e.g., birth, old age, sickness, death, as well as emotional and mental suffering); suffering is caused by attachment; suffering has a cause and

therefore can be ended; and lastly, the Eight-Fold Path can help to break ones habits of suffering.

In describing the First Noble Truth the Buddha proclaimed:

Birth is suffering, decay is suffering, disease is suffering, death is suffering, sorrow, lamentation, pain, grief and despair are suffering, to be united with the unpleasant is suffering, to be separate from the pleasant is suffering, not to get what one desires is suffering. In brief the five aggregates of attachment (the bases of the human personality) are suffering (Thera, 1973).

In this passage the Buddha is diagnosing the fundamental cause and maintenance of human suffering, or *dukkha* (Pali). *Dukkha* has been translated into English as ‘suffering’ or ‘dis-ease.’ However, this is misleading. Buddhist *dukkha* not only includes ordinary meanings such as ‘pain,’ ‘sorrow,’ ‘unhappiness,’ ‘sadness’ and ‘misery,’ but also deeper ideas such as ‘impermanence,’ ‘lack of freedom,’ ‘imperfection,’ and ‘dissatisfaction.’ Further, the Buddhist paradigm espouses that human suffering is caused by our attachment to a world in perpetual change. People can have attachments not only to objects but also to relationships with other people or even to ideas or opinions (Rahula, 1974). Attachments can take the form of the desire to have something or the desire to be free of something that one has but does not want (e.g., pain or disability).

Western psychology may agree with some of these assertions intellectually, however, from a cultural perspective this discipline is far from embracing a way of life free from attachments and accepting a world that is entirely penetrated and tainted by universal suffering. Conflict between paradigms is possible based on the noted philosophic underpinnings of a Buddhist perspective and Western culture’s focus on personal happiness, attainment, and consumption.

**Non-Self.** From a Buddhist perspective, the “self” is not a separate entity but rather an interdependent process that is in constant change and flux. The Buddha expounded upon the principle of *annata* (Pali), “non-self,” by explaining that what we embrace as an inherent and separate self is little more than the rising and passing of bodily and mental phenomena. The Buddha taught that our experience of being in the world is dictated by our attachment to the five *skandhas* (Pali), or aggregates. The *skandhas* are the five groupings of impermanent physical and mental forces that give the illusion of a permanent self. These groups are: form/matter, feelings, perceptions, formations/thoughts, and consciousness (Titmuss, 1998). The teaching of “non-self” is established via the fact that a permanent self can never be fully grasped due to the nature of constant change.

The Buddha taught that each of these *skandhas* or relational modes are impermanent and therefore can never represent an inherent, separate self. This leaves the observer unable to triangulate a fixed independent identity from these arising and disintegrating modes of perception. Consciousness arises out of the causes and conditions by which it is created. Therefore, it has no inherent existence of its own. As the Buddha explained, “Consciousness is named according to whatever condition through which it arises” (Rahula, 1974, p. 24), meaning that on account of the eye and visible forms arises a visual consciousness. On account of the ear and sound, a sound consciousness arises; this is true of smell, taste, touch, etc.

Within Buddhist literature there is a parable that deconstructs some of the underlying assumptions of the West’s view of the Self.

Nagasena says that names are just denotations which may not represent an actual entity, Milinda expresses his skepticism of this idea and so Nagasena asks him how he had come to their meeting. The king said he had come by chariot. “Show

me a chariot” asked Nagasena. “Is the pole the chariot?” “No” said the king. “Is it the axle?” “No.” “Is it the wheels, the body, the flag-staff, the yoke, the reins or the goad?” and again Nagasena says no. “Then is the chariot something different from all these parts? The king replies “No” and is forced to admit that ‘chariot’ is a term for a collection of parts. (Stryk, 1994, p. 91-94)

This parable then illuminates one of the most conflictual aspects between Buddhist thought and traditional Western thought. Buddhism holds steadfast to the notion that individuals don't have a permanent or fixed Self. Discoveries within modern science continually point to and validate that phenomena, both on a micro- and macro-level, are in constant movement. However, this has been less accepted within the field of psychology, especially research into personality types, such as the Big-Five trait taxonomy (John & Srivastava, 1999).

Yet another difference between Buddhism and Western psychology is that Buddhism does not adhere to a traditionally dichotomist view of topics such as the relationship between the mind and body. Specifically, Buddhism would make a distinction between biological, situational, and psychological states. However, on a fundamental level these are all seen to be interpenetrating and dependent upon one another (Hall & Lindzey, 1978, p. 373). Traditionally, Western psychology has held to more of a Cartesian split between mind and body, and only recently have some schools of thought broadened the notion of mind to include the body.

**Impermanence.** *Anicca* (Pali for "inconstancy," usually translated as “impermanence”) is the last of the three marks of existence. The term expresses the Buddhist perception that all things and experiences are inconstant, unsteady, and impermanent. Everything we can experience through our senses is made up of parts, and its existence is dependent on external conditions. The Buddha explains:

Impermanency of things is the rising, passing and changing of things, or the

disappearance of things that have become or arisen. The meaning is that these things never persist in the same way, but that they are vanishing and dissolving from moment to moment (Nyanatiloka, 1970, p. 14).

The Buddha taught that everything is in constant flux, and so conditions and the thing itself are constantly changing. Further, things are constantly coming into being, and ceasing to be. Since nothing lasts, there is no inherent or fixed nature to any object or experience. This is a challenging concept for the scientific community, as the established scientific method of inquiry is based on gathering observable, empirical, and measureable evidence subject to specific principles of reason and repetition. Although these challenges are well noted within psychological research, where the label ‘soft-science’ is often applied due to the difficulty of defining and researching intangible things, there is still a strong movement to in Western psychology to develop concrete and fixed models of the mind.

**Ethics.** Lastly, a review of Buddhist thought would not be complete without an exploration of the role of ethics. Both Buddhism and the practice psychotherapy have ethical foundations; however, potential conflicts arise when integrating a professional ethics code with those espoused by a religion. The renowned Indologist, Rhys Davids writes, “... Buddhist philosophy is ethical first and last. This, is beyond dispute” (2003). Religion has commonly been defined as, "any specific system of belief and worship, often involving a code of ethics and a philosophy"(Webster’s Dictionary, 1998, p.1134). Buddhism contains within its organization of thought: components of a belief system, a code of ethics, and a clearly established philosophy. The role of worship, although not central to early Buddhist teachings, is common throughout Buddhist countries.

Regardless of the role of worship, the role of ethical behavior is fundamental to a greater understanding of Buddhist thought. Buddhist teaching offers five central precepts

that form the basic ethical guidelines of a Buddhist life. The Five Precepts are commitments to abstain from killing, stealing, sexual misconduct, lying and intoxication. Undertaking the five precepts is part of both lay Buddhist initiation and regular lay Buddhist devotional practices. They are not formulated as imperatives, but as training rules that laypeople undertake voluntarily to facilitate practice.

The ethical dimensions of Buddhist thought are also echoed in the last of the Four Noble Truths. The fourth Noble Truth lays out an Eightfold path that specifies how to become free from suffering and contains some particular directives on ethical behavior. These eight guidelines are:

1. Right Understanding, or working to see the true nature of life: suffering, impermanence, and lack of self.
2. Right Thoughts, or keeping away from the hypocrisies of this world and to direct our minds toward Truth and Positive Attitudes and Action.
3. Right Speech means to refrain from pointless and harmful talk and to speak kindly and courteously to all.
4. Right Action means to see that our deeds are peaceable, benevolent, compassionate and pure.
5. Right Livelihood means to earn our living in such a way as to entail no bad consequences, such as dealing in poisons or weapons.
6. Right Effort means to direct our efforts continually to the overcoming of ignorance and craving desires.
7. Right Mindfulness means to cherish good and pure thoughts, recognizing that all we say and do arises from our cognitions.
8. Right Concentration means to focus on the interconnectedness of all phenomena (Epstein, 1995).

The Buddha professed that by following these trainings of mind and behavior, an individual would be on a path toward freedom from suffering. The behavioral categories of Right Speech, Right Action, and Right Livelihood are the ethical foundations; Right Effort, Right Concentration and Right Mindfulness are the meditative foundations associated with mental discipline; and Right Understanding and Thoughts are sometimes bundled under the category of Right View or philosophical foundations (Epstein, 1995).

The discussion thus far in this paper has focused on the meditative foundations of the Eightfold Path where much of the research and debate has been stimulated for Western academics. However, Buddhist teachings proclaim that each of the eight foundational components is necessary for suffering to have full cessation, not just the meditative components. Specifically, from a Buddhist paradigm, one's ethical behavior is essential for mental wellbeing. This focus on ethical behavior may be at odds with some Western psychological paradigms, where the focus on ethics is at times left to the domain of religion or viewed as primarily separate from the examination of one's mind.

Buddhists emphasize the practice of meditation as a means of understanding the impact of ethical behavior in their lives. In particular, it is believed that an understanding of the concept of non-self gives rise to an inherent sense of ethical imperative. When taken to its fullest dimension, a Buddhist practitioner is thought to perceive that one's behavior impacts all other beings and the self that one perceives to be indivisible is actually interdependent and interrelated with all other beings. On a fundamental level, Buddhists believe that one's individual wellbeing is not separate from the wellbeing of all. Thus the behavioral, meditative and philosophical foundations cannot be separated from any attempts to relieve human suffering, a paradigm significantly different from the Western model of mental health.

As Buddhism is a religion with a clear ethical code, the potential for conflict between personal ethics and professional ethics becomes feasible. Researchers in the field of spiritual and psychological integration state, "a value-free or value-neutral approach to psychotherapy has become untenable, and is being supplanted by a more open and more complete value-informed perspective" (Bergin, Payne, & Richards, 1996, p. 297). A

post-modern analysis would support that any attempt to completely bracket off a therapist's values in the therapy room is impossible.

In less general terms, Bergin, et al, point out that professional guidelines (American Psychological Association [APA], 2002) prescribe standards which endorse certain values over others, and that this almost invariably creates the potential for morally conflicting situations for religious people—clients or clinicians (1996). In areas considered socially controversial, such as abortion or sexual preference, individuals who adhere to a fundamentally religious moral paradigm may experience significant conflict between their religious values and identities as mental health professionals. Given the potential for this, a question worth investigating is: 'Do clinicians who utilize Buddhist ideology in their clinical practice also integrate ethical behavior into their clinical conceptualization and, if they do, have they noticed any conflicts arising related to this?'

### **Buddhism and Psychotherapy**

During the course of reviewing the literature of Buddhist concepts in Western psychology, two general categories emerged: Buddhism as a philosophic and religious construct and the later adaptation of mindfulness. This writer will first illuminate the emergence of Buddhist concepts in Western psychotherapy through a review of the history of this process and the individuals at the forefront of this discourse. Second, an examination of the construct of mindfulness as an accepted Western psychotherapy construct is provided, with a focus on empirical outcome studies and a description of basic mindfulness techniques.

**Philosophic and Religious Constructs.** During the early and middle 19<sup>th</sup> century the germination of Eastern philosophy could be felt strongly among many Western intellectuals (e.g., the writings of Arthur Schopenhauer, Theosophical Society,

Transcendentalists). Among the many British intellectuals influenced by colonial India, Caroline Rhys Davids is recognized as conducting some of the earliest Western research on Buddhist psychology with her seminal translation of the *Abhidhamma* (classical Buddhist psychological teachings) in 1900 (Rhys Davids, (1900) 2003). In early psychoanalytic circles, an interest in Eastern thought was common and many of Freud's early colleagues, and indeed Freud himself, were conversant with ideas about Eastern mysticism and attempted to address it from a psychoanalytic perspective (e.g., Ernest Jones, Otto Rank, Sandor Ferenczi, Franz Alexander, Lou Andreas-Salome, and Carl Jung) (Epstein, 1995). However, as Freud's psychology became established and remained at the forefront of the West's understanding of the dynamics of the mind, Buddhist ideas were relegated to the periphery of academic thought or to the works of the Beat Generation writers of the late 1950's (e.g., Jack Kerouac, Allen Ginsberg, Gary Snyder).

An interest in merging Buddhism concepts and contemporary Western psychotherapy practice grew steadily in the 1960's, especially with the publication of *Zen Buddhism and Psychoanalysis* (1960), the collaborative effort of the psychologist Erich Fromm (1900-1980) and the Buddhist scholar D.T. Suzuki (1870-1966). This was followed soon after by Alan Watts' (1915-1973) publication of *Psychotherapy East and West*. Both of these literary efforts sought to compare and create a dialog between the two Eastern and Western traditions. Not long after, Chogyam Trungpa (1939-1987), a prominent teacher of Tibetan Buddhism, founded Naropa University in Boulder, Colorado. Naropa University began to offer degrees in "contemplative psychology" as early as 1975 and provided a meeting ground for many Western intellectuals seeking to integrate Eastern and Western knowledge. Of these individuals, Joseph Goldstein, Jack Kornfield, and Sharon Salzberg have continued to be at the forefront of this movement.

They began teaching insight meditation retreats in 1974 and cofounded the Insight Meditation Society in Barre, Massachusetts. In 1989, together with several other teachers and students of insight meditation, they helped establish the Barre Center for Buddhist Studies. Goldstein, Kornfield and Salzberg have all published numerous books and articles generally focusing on teaching Buddhism and meditation practices (e.g., Goldstein, 1983, 1993, 2002, 2007; Kornfield, 1993, 2001, 2008, 2008; Salzberg, 1999, 2003, 2008, 2008).

Kornfield, who trained as a clinical psychologist, writes of the complementary nature of utilizing both meditation and psychotherapy as separate modalities of healing. He acknowledges the limitations of meditation to heal deep emotional wounds and the risk that a “spiritual practice can easily be used to suppress and avoid feeling or to escape from difficult areas of our lives” (2010). Kornfield (1993) writes that,

When we have not completed the basic developmental tasks of our emotional lives or are still quite unconscious in relation to our parents and families, we will find that we are unable to deepen in our spiritual practice. Without dealing with these issues, we will not be able to concentrate during meditation, or we will find ourselves unable to bring what we have learned in meditation into our interaction with others (p. 249).

Kornfield (1993) notes that Western psychotherapy can help deepen or free a ‘stuck’ spiritual practice. He observes that a skilled psychotherapist can offer specific practices and tools for addressing the common patterns, the specific developmental processes, and unhealthy defenses that create much of the suffering in our Western culture.

Kornfield’s most recent book, *The Wise Heart: A Guide to the Universal Teachings of Buddhist Psychology* (2008) offers insight into the utility of Buddhist psychological practices, specifically, meditation, cognitive strategies, ethical trainings, and practices that foster inner transformation. To do this Kornfield provides a number of

practices to support individuals connecting with the underlying goodness of oneself and others. For example, he asks his students to shift the frame of time and to see others as small children, still young and innocent or visualize the person at the end of life, open and vulnerable. Kornfield also explicates unhealthy mental states (grasping, aversion, and delusion) and healthy mental states (wisdom, love, and generosity) by revealing the tactic of letting go of those states which cause sorrow and fostering those that create joy. Kornfield's work provides less of a structure of how to do 'Buddhist psychotherapy' and more of a discussion of and expansion on various principles of Buddhist psychology as applied to a Western mindset.

Another mental health professional influenced by the founding of Naropa University is Mark Epstein, a psychiatrist and student of Kornfield and Goldstein. Epstein has written extensively about the integration of Buddhist thought and psychotherapy, specifically psychoanalysis (e.g., 1995, 1998, 2005, 2008a, 2008b). In his work he does not offer a manual for a new form of psychotherapy but rather explores the relationship between psychoanalytic theory and Buddhism. Much of his writing works to translate Buddhist psychology into twentieth-century psychoanalytic language, to integrate a Buddhist understanding of mind into this Western system of thought, and to describe the paradigm shifts evoked by the existing intersections of Buddhism and Western culture. Epstein, over the course of many books, has pointed out the benefits of achieving a shift in balance, away from self-identification towards self-observation through an exploration of the Buddhist concept of non-self (2008).

Epstein (1995) also applies the concept of "bare attention," a phrase used in meditation to indicate a state of acceptance and awareness of one's thoughts, to the therapeutic process. He points out that "bare attention" may also be used to reflect an

ideal therapeutic state where therapist and patient are actively working together on specific problems but are open and receptive to unexpected, often hidden aspects that enter the therapeutic frame. He emphasizes how critical it is for therapists to be open and accepting and not promoting their own agenda.

Also amongst those seeking an integrated view of Buddhism and psychotherapy is Tara Brach, a clinical psychologist, lecturer, and workshop leader, as well as the founder and senior teacher of the Insight Meditation Community of Washington, D. C. Brach (2004) describes that much of our suffering in the West is based in self-aversion, what Brach calls the "the trance of unworthiness." She explicates that our happiness, contentment, and awakening must come through a full and loving acceptance of who we are now, opposed to trying to escape from, avoid, or transcend our fears, desires, and longings. Brach describes this concept as 'Radical Acceptance' (2009). She promotes utilizing a compendium of spiritual practices that can serve as a counterbalance to long established feelings of neglect, judging others and ourselves harshly, and living in either the past or the future. Brach also puts forward the importance of acknowledging our innate goodness.

Another prominent thinker within the dialog between Buddhism and psychotherapy is John Welwood, a clinical psychologist, associate editor of the Journal of Transpersonal Psychology, and author of a number of books and articles focusing on the integration of spirituality and psychology. Welwood acknowledges Buddhism as a guiding influence of his academic work and personal spiritual practice (2010a). His work examines inner spiritual transformation, the process of spiritual bypassing (i.e., using spiritual practice to avoid psychological wounds), and the capacity to accept our experience (2002). In an article entitled, *Embodying Your Realization: Psychological*

*Work in the Service of Spiritual Development*, Welwood (2010b) works to explicate the complications of integrating Buddhist non-dualistic thinking into a psychotherapy practice.

Yet another therapist working to integrate Buddhism and psychotherapy is Thomas Bien, author of *Mindful therapy: a guide for therapist and helping professionals* (2006) and leader of workshops such as *The Buddhist Way: Ancient Wisdom for Modern Times*. Bien offers a number of useful therapy techniques that align with or embody Buddhist concepts: allowing silence, reflective listening, attending to the body and giving it a voice, empty chair work, visualization, dwelling with a phrase, insight, or image, mood monitoring, process comments, and a personal mindfulness practice. Each of these will be investigated as to its applicability to individual practice.

Bien notes that a therapist's comfort with silence works to help free the therapy space from empty small talk and allows for inner contemplation and awareness to develop. He states that reflective listening, the "heart of mindful therapy," works by increasing awareness of the patient's experience via the re-circulation of therapy content by the therapist (p. 224). The process of reflective listening works by facilitating greater attention to these dialog processes, since the patient formulates and then expresses a perception, then hears it reflected and summarized. Another method of helping patients digest challenging information is described as dwelling with a phrase, insight, or image. A client is asked to breath in and out while holding the key phrase, insight or image in awareness. He notes that the goal here is not necessarily more verbal processing but to help the patient slow down and bring deeper mindfulness to the subject. Similarly, the use of process comments can help bring awareness to a client's manner of being via observation and comment on the nature of present moment interactions.

Another method described by Bien is helping patients attend to and be mindful of their bodies, the first of the four foundations of mindfulness in Buddhism. He notes that one simple method of doing this is to ask patients to attend to the physical sensations that accompany a particular issue and then ask them to “give it a voice.” He acknowledges that this technique has its roots in Gestalt therapy. Another Gestalt technique identified by Bien is the ‘empty chair’ exercise, which helps to bring neutral awareness to both sides of an internal conflict, by spatial and verbal role-playing.

Yet another method proposed by Bien is the use of visualization as a means of exploring an experience in greater depth and for imagining possibilities for positive change. He also includes the classical cognitive behavioral therapy technique of mood monitoring in order to bring mindfulness to emotional states outside of the therapy room. Lastly and possibly most importantly, Bien describes what he calls a personal mindfulness practice. He encourages therapists and, if appropriate, patients to have a solid meditative practice of their own in order to fully gain the benefits of mindfulness therapy. He warns against making meditation just another task to accomplish and instead promotes the concept of bringing mindfulness into all aspects of daily living.

In sum, it appears that a number of common themes emerged from this review of literature by Western mental health practitioners working from a Buddhist perspective, specifically: self-acceptance, utilizing and staying in the present moment, seeing the underlying goodness of oneself and others, moving from self-identification towards self-observation, awareness of the process of spiritual bypass, and the overall capacity to accepting our experience as it is.

**Mindfulness.** From a research perspective the integration of Buddhist concepts did not gain footing in the scientific community until the introduction of mindfulness in

psychotherapy. A review of PsycINFO utilizing the keyword 'mindfulness' produces 1025 results. The available literature currently provides many comprehensive literature reviews of mindfulness (e.g., Delmonte, 1985; Baer, 2003; Allen, 2006), thus this review will only seek to provide an overview of the salient terms and empirically reviewed studies.

The term mindfulness entered English as a translation of the Eastern words *smrit* (Sanskrit), *sati* (Pali) and *dran-pa* (Tibetan) (Shapiro, Oman, & Thoresen, 2008). In the simplest of terms, mindfulness is a way of paying attention that originated in Asian meditation practices, particularly Buddhist. It has been described as "bringing one's complete attention to the present experience on a moment-to-moment basis" (Marlatt & Kristeller, 1999, p.68).

The construct of mindfulness is complicated and multi-dimensional, with a complex history dating back more than 2500 years. The origins of mindfulness practice can be traced back to the Pali Canon (the earliest written and only completely surviving Buddhist records) in which the Buddha's discourse on the "Foundations of Mindfulness" (*Satipatthana Sutta*, Pali) were recorded (Batchelor, 1997). Common to all traditions of Buddhism and thought to be one of the most important discourses, it describes the four areas of life to which mindful awareness may be applied: body, feelings (i.e., pleasant, unpleasant, and neutral), emotions (i.e., mad, happy, sad, etc.), and *Dharma* (translated as religious teachings or "the way things are") (Trungpa, 1991).

Bhikkhu Bodhi, a monk in the Theravada tradition of Buddhism describes mindfulness further:

The mind is deliberately kept at the level of bare attention, a detached observation of what is happening within us and around us in the present moment. In the practice of right mindfulness the mind is trained to remain in the present, open, quiet, and alert, contemplating the present event. All judgments and interpretations have to be suspended, or if they occur, just registered and dropped (1985, p. 308-311)

The capability to focus one's awareness in this way has traditionally been developed through the practice of meditation, which has been defined as the deliberate self-regulation of attention from moment to moment (Goleman & Schwartz, 1976; Kabat-Zinn, 1982). Mindfulness prescribes attending to the internal experiences occurring in each moment, such as bodily sensations, thoughts, and emotions or attention to aspects of the environment, such as sights and sounds (Kabat-Zinn, 1994; Linehan, 1993). The quality of awareness sought by mindfulness practice includes openness or receptiveness, curiosity and a non-judgmental attitude (Kabat-Zinn, 1994). An emphasis is placed on seeing and accepting things as they are without trying to change them. That is, phenomena that enter the individual's awareness during mindfulness practice are to be observed carefully but are not evaluated as positive or negative, genuine or fictitious, or significant or inconsequential (Marlatt & Kristeller, 1999). In this way, mindfulness may be conceptualized as the observation of present moment internal and external stimuli, in a manner that passes no judgment nor moves to change what arises.

Recent efforts to clarify the definition of mindfulness by authors Shapiro, Carlson, Astin, and Freedman (2006) have posited three fundamental components: intention, attention, and attitude. Intention, they propose, involves understanding why one is paying attention. It requires motivation for one's actions via a conscious direction and rationale. Attention involves the direct, moment-to-moment knowing of what is occurring as it is really happening. The mind is trained to direct, aim, and maintain awareness. Lastly, attitude describes the quality of attention, specifically a position of acceptance, compassion, and openness that encapsulates the experience of mindfulness.

One of the most prominent researchers and advocates of mindfulness interventions has been Jon Kabat-Zinn. A prolific author, Associate Professor of Medicine at the University of Massachusetts Medical School, the founder of the Center for Mindfulness in Medicine, Health Care, and Society, and the developer of a manualized treatment program entitled Mindfulness-Based Stress Reduction (MBSR), Kabat-Zinn has worked to promote mindfulness based techniques for both patients and caregivers for over 27 years (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth & Burney, 1985; Kabat-Zinn, Lipworth, Burney & Sellers, 1987). Kabat-Zinn defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1990, p. 4).

One of the most basic and traditional practices is sitting meditation, a central component of MBSR. The patient maintains an upright sitting posture, either in a chair or cross-legged on the floor, and attempts to maintain attention on the somatic sensations of his or her own breathing. Whenever attention wanders from the breath to the inevitable thoughts and feelings that arise, the patient will simply take notice of them and then let them go as attention is returned to the breath. This process is repeated each time that attention wanders away. As sitting meditation is practiced, an emphasis is placed on simply taking notice of whatever the mind happens to experience and accepting each arising thought and feeling without judgment, elaboration, or action (Kabat-Zinn, 1990; Segal, Z., Williams, J. & Teasdale, J., 2002). The client is also encouraged to use the same mindfulness skills whenever possible during the course of their day by bringing awareness back to the present moment via the anchor of the breath. Mindfulness theorists propound that using the breath as a touchstone provides a consistent source of

information regarding the patient's present moment experience and can work as a constant and reliable mechanism of emotional regulation.

Kabat-Zinn's work with MBSR is among the earliest empirical studies evaluating the efficacy of meditation exercises including sitting meditations and hatha yoga techniques in the treatment of chronic pain. A number of these studies have shown statistically significant improvement in ratings of pain and general psychological symptoms, with follow-up evaluations indicating that these gains have been maintained over time (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn et al., 1987).

The use of mindfulness via the MBSR approach has been found affective in working with both the psychological and physical aspects of some medical conditions such as cancer and multiple sclerosis (Specia, Carlson, Goodey, & Angen, 2000; Mills & Allen, 2000). Additional studies using MBSR with varied diagnoses found significant improvements in both medical and psychological symptoms (Reibel, Greeson, Brainard, & Rosenzweig, 2001). In addition to diminishing symptoms in clinical samples, mindfulness practice has been established to improve wellbeing in some community-based samples. For example, student populations completing MBSR programs reported considerable improvements in psychological symptoms, empathy ratings and spiritual experiences (Astin, 1997; Shapiro, Schwartz, & Bonner, 1998).

Further research with MBSR has show that it can be effectively incorporated into interventions treating a variety of mental health disorders. Specifically, a number of studies have shown improvement in individuals with anxiety disorders (Kutz, Borysenko, & Benson, 1985; Kabat-Zinn, Massion, Kristeller, Peterson, Fletcher, Pbert, L., et al 1992). MBSR has also been investigated with bulimic adults and shown to have

statistically significant positive results (Kristeller & Hallett, 1999). In a more contemporary study, MBSR has been shown to significantly reduce ruminative tendencies in patients with recurrent mood disorders (Ramel, Goldin, Carmona, & McQuaid, 2004).

Mindfulness-Based Cognitive Therapy (MBCT) grew out of Kabat-Zinn's MBSR program and works to combine training in mindfulness meditation with cognitive therapy (Segal, Williams, & Teasdale, 2002). A large multi-site randomized controlled trial has shown that this combined approach can significantly reduce the rate of relapse in recurrent major depression, partly through teaching participants to disengage from dysphoria-activated negative rumination (Teasdale *et al*, 2000). These findings have recently been confirmed by a replication study by Ma and Teasdale (2004). Another pilot study indicates that modified MBSR techniques may hold promise as an intervention to assuage stress in patients with schizophrenia, although the authors warn that further research is warranted due to the small sample size and risks inherent with this population (Davis, Strasburger, & Brown, 2007).

Well-known researcher Marsha Linehan has implemented mindfulness-based activities into the well-validated treatment protocol of Dialectical Behavior Therapy (DBT) (Linehan, 1993a). DBT has been shown to be effective with hard-to-treat Borderline Personality Disordered clients by utilizing mindfulness as one of its four central skill components. Linehan admittedly draws heavily from the practice of Zen Buddhism in her utilization of meditative techniques and accredits Zen master Thich Nhat Hanh in a number of the activities promoting mindfulness in the DBT workbook that she authored (Linehan, 1993b). In DBT, patients are taught mindfulness skills to help facilitate a switch in frame from "emotional mind" to "wise mind." Despite strong

empirical support for DBT, the mindfulness skills have not been partitioned out and incrementally investigated separate from the entire treatment package.

Similarly, ACT (Acceptance and Commitment Therapy) is an experiential treatment utilizing mindfulness interventions as part of a comprehensive treatment package designed to imbue psychological flexibility. Mindfulness in ACT is designed to foster acceptance, diffusion from literal interpretation, self as context, and contact with the present moment (Fletcher & Hayes, 2005). ACT has empirical support for a wide array of disorders and conditions (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004), but like DBT, has not had mindfulness separated from the larger treatment protocol.

In summary, there is strong research supporting the component of mindfulness as an important feature of a number of empirically validated treatments (e.g., ACT, DBT, MBSR, MBCT) and it is widely understood that Buddhist thought is the catalyst behind the mindfulness movement; however, little research has explored the possible complications, conflicts, or strengths of integrating a fuller understanding of Buddhist ideology into therapy practice. As noted previously, two central questions are salient: ‘How are Buddhist-based concepts being integrated into clinical practice?’ and ‘Do conflicts arise in the process of integration?’ At this time it is unknown if clinicians are encountering challenges integrating core Buddhist concepts into their clinical work. Further, information regarding how psychologists identify and resolve emergent philosophical differences in conceptualizing treatment from a Buddhist perspective within the ethical and professional norms of clinical psychology may provide beneficial strategies for those practitioners undertaking similar work.

## **Methods**

### **Rationale for a Qualitative Study**

Essentially there are two major research paradigms available for researchers in the field of psychology (Creswell, 1998). The qualitative research method seeks to maintain the form and essence of human behavior and to examine its qualities, whereas the quantitative research paradigm utilizes methods of statistical analysis to interpret mathematical data points (Lindlof, 1995). Further, many quantitative research perspectives hold that there is a solitary, impartial reality, which is quantifiable through deductive procedures, while qualitative research is based on the assumption that the world is not an objective one, but exists in multiple realities or multiple facets (Merriam, 1988).

A qualitative study was chosen as the research method for this study because of the interest of the researcher to elucidate the lived experience of mental health professionals practicing in the field. The multiplicity of experience is especially applicable in the mental health clinician's office, where successful therapy is the result of complex human interaction and individual perception. Moustakeas promotes qualitative studies as useful to,

...determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions general or universal meanings are derived, in other words, the essences of structures of the experience. (1994, p. 13)

Additionally, a qualitative research method was employed due to the confidential nature of therapy and the inherent challenges in observing or quantitatively measuring the individual style or methodology of a particular therapist. Many professionals adhere to a

clinical style that attempts to prevent personal beliefs from overtly influencing the clinical dynamic or strategically refrain from informing patients of personal beliefs due to potential ideological conflicts (e.g., a Buddhist therapist working with an Evangelical Christian client) thus making the influence of these beliefs statistically challenging to measure by observation.

## **Procedure**

**Interview.** An interview is a common approach for data collection in qualitative research. A qualitative interview is an interaction between the researcher and the interviewees through conversation, which is a basic mode of human interaction and the heart of “talk therapy.” Through interviews, the researcher can enter into another person’s perspective and understand how people make sense of their world and experiences. Further, it allows the researcher to experience the clinicians within their own environment, generally in that clinician’s therapy office, enabling increased depth of phenomenological experience.

Interviews constituted a major part of data collection in this research. The interviews conducted in this study were designed as semi-structured interviews in which the interviewer asks predefined questions but also tries to leave more freedom for the interviewee to talk. The lived experience and insights of the interviewees are hopefully released through the interview, and the interviewer tries to gain access to the world of the subject and his/her perspective (Rubin & Rubin, 1995). In this case, the participants had varied experiences and attitudes toward Buddhist ideas and identity and the researcher wanted detailed depictions of their experiences. Thus, a semi-structured interview, rather than a structured interview, was considered best for this research.

**Interviewee selection.** Prior to data collection, the researcher obtained approval from Pacific University's Institutional Review Board (IRB). Purposeful participant selection is a key element of qualitative research (Creswell, 1998). This researcher utilized criterion sampling and "snowball"/chain referral to recruit participants. Criterion sampling requires that all participants meet some specific criteria. Thus, all interviewees met the following criteria: a) they had completed graduate training in the mental health field, b) they currently had a clinical practice in the Portland, Oregon metropolitan area, c) they identified themselves as individuals who utilized Buddhist ideas in their clinical practices, d) they were English-speaking, e) they were willing, and open to sharing their knowledge and experience.

When considering how many interviews to undertake in a phenomenological study, Polkinghorne (1989) recommends that researchers interview between 5-25 individuals who have experienced the phenomenon. For this study, ten interviews were completed. This number was chosen primarily due to the limited availability of interview candidates, not saturation of content; however, upon post-hoc analysis, it appeared that that saturation occurred given the significant overlap and recurrence of interviewee response themes or 'meaning clusters.'

Many interviewees were identified by their participation in the Portland Mindfulness Collective (PMC). This researcher was referred to the group by a co-worker at Portland State University. A contact list of group members was provided upon membership to the PMC and from this list eight of the ten interviewees were identified. The remaining two interviewees were identified by their website which noted their utilization of mindfulness techniques in clinical practice. Following an initial phone screening to identify group members utilizing Buddhist concepts in clinical practice, ten

individuals were selected as fitting the participant criteria. Upon confirmation, face-to-face interviews were scheduled.

In terms of demographics, all individuals were Caucasian and between the ages of 30 and 60. The participant pool consisted of eight men and two women. Participants in this study included six clinical psychologists, four of which had a Ph.D. and two of which had a Psy.D. All were licensed psychologists practicing in the State of Oregon except one Psy. D., who was completing a residency in private practice. Additional participants included two social workers, one with LCSW licensure and the other an MSW degree. Lastly, the participant pool included an Oregon licensed marriage and family therapist and an Oregon licensed school psychologist with an Ed.S. degree.

**Informed consent.** All participants in the survey read and signed an informed consent statement provided by the researcher (See appendix C). The statement of confidentiality explained that limited identifying information would be used on the survey. This was important since participants were answering questions about personal beliefs, some of which might be unpalatable to their consumers. By signing the informed consent, they agreed to let the researcher use the audio recording from the interview for the purposes of the dissertation only. As a means of protecting the identities of individual clinician, all the names of the participants will be identified solely by their degree and a number. Participants will be noted as such: Ph.D.-1, Ph.D.-2, Ph.D.-3, Ph.D.-4, Psy.D.-1, Psy.D.-2, LCSW-1, MSW-1, LMFT-1, Ed.S.-1.

**Interview Questions.** Prior to recruiting participants, I completed a literature review that helped to elucidate the general topics supporting this research. The interview protocol (see appendix A) contained a total of ten questions. The first three questions pertained to the participant's biographical information. The next five questions focused

on how therapists are integrating core Buddhist concepts, as identified in the literature review, into their therapy practice. The remaining two questions focused on potential paradigm conflicts between Eastern and Western perspectives and the perceived efficacy of utilizing Buddhist concepts in clinical practice.

**Data Collection.** All interviews were conducted at a place of the interviewees' choice, either their office, home, or in one case the local Zen Center residence. All interviews were recorded digitally and lasted under one hour. The audio recordings in the form of a MP3 files were sent to a professional transcription service that provided Word formatted text of the interviews to the researcher. Transcriptions of the interviews were then emailed back to the interviewees to ensure validity of content and enable additions, deletions, or clarifying statements to be added. Five participants responded with edits and comments.

**Data Analysis.** Phenomenological analysis involves attempting to bracket ones personal experience from distorting the experience of what one is seeking to understand. This is also the primary reliability concern, specifically, whether or not I, as the researcher, was a consistent and dependable reporter and interpreter both during and after the interviews. Thus, an accurate assessment of the biases, values and experiences of the researcher is of utmost importance. In this case, the researcher is a male Caucasian doctoral student in clinical psychology and a Buddhist practitioner of 15 years. It became evident during the interview process that the manner in which I asked questions, the choice of follow up questions, my reaction both verbal and physical, and even my own physical presence had a significant influence on the data I was collecting. Some of these factors are unavoidable within the context of human interaction, whereas others became a conscious choice as the interviews progressed. Specifically, I chose not to hide my

enthusiasm and interest in the topic and on the whole found that the process of active engagement and dialog enriched the interviews. Although true phenomenological assessment is challenging in any interactive environment, the validity of this type of research could be jeopardized or biased by this kind of engagement. In qualitative studies researchers must seek to protect the integrity of their data by interpreting what happened objectively and actively working to overcome any bias. To minimize this, I implemented the following techniques designed to increase validity and reliability:

1. *Cross Case Analysis.* Cross case analysis involves collecting and analyzing data from several individuals. This type of analysis can “lead to categories, themes, or typologies that conceptualize the data from all the cases; or it can result in building substantive theory offering an integrated framework covering multiple cases”(Merriam, 1998, p. 195).
2. *Member Checking.* Taking the data back to the informants ensures that the data collected are objective and represent them and their ideas accurately (Glesne, 1999). In this research, the interview transcripts were emailed back to each interviewee for their feedback. Five of the interviewees chose to reinterpret, delete, or add clarification to their interview statements.
3. *Interview Quotations.* Utilizing direct quotes from research participants further served to anchor my interpretations to participants’ direct experiences and thereby reduced the chances of straying too far from the interview data.
4. *Non-researcher transcription.* Utilizing an outsourced professional transcription service decreased the risk of the researcher “hearing what I want to hear” from the interview responses.

When all ten initial interviews were completed and the audio was transcribed, I began to analyze the data in a format outlined by Creswell (1998) and Moustakas (1994). The first step in the analysis of the transcripts was horizontalization, or the division of transcription data into relevant equal-value statements (Creswell, 1998). I did this for each of the ten questions, concurrently editing from the transcriptions all duplicate statements. Next, for each question a list of quotes supporting similar themes was reorganized into emergent ‘meaning clusters’ (Creswell, 1998). These clusters were derived by linking individual responses that appeared similar in content and meaning. This organizational strategy allowed me to develop a pool of common response themes that were then arranged by their associated question.

At this point, I reviewed each ‘meaning cluster’ and worked to develop appropriate language to describe and categorize them. I then highlighted each unit with a particular font color, which served to clearly identify it, as I worked to develop a coherent thematic response pattern. Specifically, the emergent ‘meaning clusters’ were generated by organizing the responses from each question according to similarity of meaning. For example, when answering question 9 (Role of Ethics), interviewee’s responses generally fell into two categories: those focusing on the natural arising of ethical behavior when mindfulness is utilized and those related to orienting clients toward their own personal values. Next, I worked to create labels for each ‘meaning cluster.’ In this case, “Mindfulness as ethical” and “Activation of personal values” were generated and became the titles under which each theme or ‘meaning cluster’ was organized and explicated.

The presentation of results was derived directly from these reorganized transcriptions and largely follows the progression of topics and questions found in the Interview Protocol (see appendix A). Four global topics emerged organically from the

interview questions and are utilized for organizational purposes: Participants Biographies (Questions 1, 2, 3), Impact of Buddhist Ideology on Clinical Practice (Questions 4, 5, 6, 7, 8), Paradigm Conflicts (Question 9), and Perceived Efficacy (Question 10). This organizational structure is depicted in the charts entitled ‘Global Topics, Research Generated Interview Questions, and Emergent Meaning Clusters’ (see appendix B). Within the text of the Results section each emergent ‘meaning cluster’ will be identified by the signifier (MC).

## **Results**

In this section I present the results of in-depth interviews conducted with the ten participating clinicians. Interviews were transcribed, and then coded for analysis in accordance with methods outlined in the previous section. Results of this analysis are presented here in narrative form with supporting quotations taken directly from interviews. Research participants personally reviewed all transcriptions to insure accuracy.

Again, the two core questions guiding this research are as follows: 1) ‘How are Buddhist-based concepts being integrated into clinical practice?’, and 2) ‘Do conflicts arise in the process of integration?’ Although these remain the two key questions of concern, at times participants, during interviews, voiced their personal perspectives and ideology in ways that are not easily classified within the semi-structured interview protocol. When relevant, this type of material has been included as a source of both valuable insight into the larger topic of Buddhist-oriented psychotherapy and important supporting context for the primary research questions.

The progression of this section reflects the general course of the interview protocol (see Appendix A) and then is further organized by guiding subsections created from four researcher-generated topics (Participants Biographies, Impact of Buddhist Ideology on Clinical Practice, Paradigm Conflicts, and Perceived Efficacy) (see Appendix B). The first topic represents participants' biographies, with particular emphasis on how they identify themselves from a theoretical orientation perspective, their background in Buddhist practice, and their current self-identification. The second topic highlights the impact of Buddhist ideology on clinical practice. The third topic relates to conflicts arising between Buddhist teachings and the practice of psychology. The last topic illuminates what interviewees perceive to be the most effective aspect of Buddhist/mindfulness approach. Within each topic, the emergent 'meaning clusters' will be explored. Important responses and their implications are then given further consideration in the discussion section.

### **Participants Biographies**

**What is your theoretical orientation toward psychotherapy?** When participants were asked to identify their theoretical orientation to psychotherapy, four reported to work from a person-centered or interpersonal approach, two reported to work primarily from an Acceptance and Commitment Therapy (ACT) approach, two stated a psychodynamic/psychoanalytic approach, one reported utilizing Mindfulness-based Cognitive Therapy (MBCT), and one noted not having an orientation at all.

**What is your background/training in Buddhist Mindfulness techniques, both professionally and personally?** All participants identified themselves as having had Buddhist teachers or practice of some kind. Two identified as currently practicing with the Vajrayana/Tantric Buddhist tradition or the Shambhala lineage, six identified as

currently practicing from a Zen tradition, and two reported practicing from “secularized practice drawn from contemplative traditions” (LCSW-1, personal communication, March 25, 2010).

**Did you begin integrating Buddhist ideas from a personal/spiritual practice or from an academic/professional perspective or both?** All participants indicated becoming interested in Buddhist practice for personal/spiritual reasons first and then later integrating these concepts into their clinical practice. Each participant had a unique story of personal and spiritual discovery related to their coming into contact with varied Eastern spiritual traditions. However, these personal explications are beyond the scope of this dissertation and will not be reviewed in the results portion of this paper.

### **Impact of Buddhist Ideology on Clinical Practice**

**Do the ‘Four Noble Truths’ impact your conceptualization and treatment of clients? Specifically, the understanding that attachment is the root cause of suffering?** This question produced many rich and differing responses from the interviewees. This writer was able to identify three emergent meaning clusters from the responses: the cause of suffering, the difference between pain and suffering, and the functionality of suffering.

*The cause of suffering (MC).* Nearly all of the interviewees reported some resonance with the ‘Four Noble Truths’ put forth by the Buddha. Specifically, that human suffering is largely caused by our desire to have something or get rid of something. Ph.D-1 describes suffering to be caused by “either positive or negative fixation. It’s the wanting. It’s the craving; for things to be a way they’re not” (personal communication, January 29, 2010). She aptly notes that attachment or fixation can be either positive or negative. This is further elucidated by MSW-1, who notes, “the flipside of the coin of

attachment is aversion . . . the attachment to not having certain experiences, so we push them away” (personal communication, January 22, 2010).

This understanding is further explicated by Psy.D-1, who describes the cause of suffering to be,

. . . when we want something even if it’s wanting to get rid of something, when we want something, when we have a desire, that creates a lack in us. You know, I want something means I don’t have it. There’s kind of an emptiness and we feel something that we interpret as a hole in us lacking. That and the sense that there’s something wrong with me, that I’m unlovable or unworthy or inadequate or stupid . . . we all have that as a kind of a core sense that there might be something wrong with me (personal communication, January 22, 2010).

Psy.D-1 offers a clear conceptualization of the function of attachment/fixation and its relationship to suffering. He notes the correlation between want and lack and how this relationship is the primary mechanism for creating psychological suffering.

Another perspective was offered by Ph.D.-2 who describes the universality and inevitability of suffering as,

Even our having and happiness in attaining something is often said to be a form of veiled suffering because at some point you’ll have loss. But it goes back to suffering being a sense of I’m incomplete. So everybody can work on this sense of incomplete. And for the original kind of Buddhist teaching is that part of what makes it hard for us to deal with our suffering is that we want it to be otherwise. We grasp and we try to get rid of all the things that in some way don’t feel good to us and then try to get the things that are good (personal communication, February 1, 2010).

This explication offers further insight into how suffering is an inevitable aspect of human experience. He notes that even within our successful having/attaining there is the inevitable impermanence of that experience that will eventually transform into loss of that attainment.

*Two types of suffering (MC).* Many of the interviewees provided descriptions of the difference between the unavoidable pain associated with life and the suffering that is created by our rejection of that experience. Psy.D.-1 offers a description of these two

types of suffering, “One is just the inevitable difficulties in life that we’re all going to lose loved ones. We’re all going to lose our health, our selves. We lose our jobs. We lose a lot of stuff. We get sick, we make mistakes. Life is just one suffering after another” (personal communication, January 23, 2010). This is differentiated from the suffering that is applied to these inevitable experiences by our resistance to them. MSW-1 explains, “we will feel pain and we will feel pleasure. Those qualities will pass in and out of our life. The suffering is created when I resist it” (personal communication, January 23, 2010). Ph.D.-2 further explains suffering as, “I want things to be different is really kind of at the core of suffering. And that’s really kind of a desire, isn’t it? I don’t want things to be this way. I think desire and want is really at the core of all of human suffering” (personal communication, February 1, 2010).

LCSW-1 offers an algorithm to describe this dynamic, saying “suffering equals pain times resistance, which I think is a pretty neat way of kind of summarizing the Four Noble Truths” (personal communication, Dec. 16, 2009). Generally pain was described as a fundamental and unavoidable component of human experience, whereas suffering is the psychological experience of that pain created by our desire for it to be otherwise. LMFT-1 offered a simple explanation of the distress many of his clients experience as a function of a belief that “they think life should be without pain” (personal communication, March 7, 2010).

LCSW-1 further described this phenomena by distinguishing the

. . . qualitative and quantitative difference between suffering and pain. And pain comes in many forms, painful feelings in the body, painful thoughts in the mind, painful mental images. So we talk about pain and our reactions to pain and how our resistance and contraction and response to painful events determines whether or not it becomes suffering or it is something that we can have a complete experience [with] (personal communication, Dec. 16, 2009).

MSW-1 elucidates clearly the difference between the pain inherent to life and the suffering that is created when we long for a different world through an example related to experiencing grief. He states:

But if we really let the grief pass through us, we feel it. It's painful. We don't like the feeling. I mean, we have aversion to the feeling of grief, but it also, if we're really with it, we notice there's a sweetness to it, there's a wholesomeness to it, and the quality of grief is appropriate for what's happening. And so it can be brought in. This is full acceptance of what life is. The grief will pass through and it's just like "Yeah, I have an aversion to it. But at the same time, when I can really be with it, it has a rightness to it." If my spouse dies, she deserves my grief. I'm supposed to be upset, but I'm not taking it that other step where I'm trapped in an idea of that, or in a tightness that says this isn't the way it's supposed to be. To me that's suffering. That's when I'm in aversion from that experience (personal communication, Jan. 22, 2010).

***Functionality of suffering (MC).*** A number of interviewees offered explications of the utility of human suffering for both clinicians and for clients. These responses generally fell into two categories: suffering as a motivator toward change, and suffering as a mechanism for greater compassion.

The first is elucidated by Ed.S.-1 in the following statement:

Suffering is the cause of enlightenment, it's what moves us forward, and so to have some equanimity about the fact that I'm not really trying to take suffering away from people; I'm trying to help them work with it. I personally-- and this is my practice-- I'm not trying to get rid of my suffering. I don't know where I'd be without it, but to try and learn with what it is that I get (personal communication, Jan. 30, 2010).

Ed.S.-1 further states that by accepting suffering as inevitable and functional, "It's the fuel for the fire. It's what is existence. It's what turns the wheel. It is what opens the lotus. And if you don't have the wood, you're not going to be able to burn it, you're not

going to be able to grapple with your existence and the wheel is not going to turn”  
(personal communication, Jan. 30, 2010).

Ph.D.-2 offers insight into how our pain has a utility and functionality in guiding change and orienting individuals toward what needs to be changed. He describes this by observing:

People want to get rid of their humanness, get rid of their anger, their sadness. But actually where does it start? Is there a human that can cut out their anger and throw it away? Is there a human that can cut out emotion and toss it? Pain; if we don't have signals for pain, we won't know when to start. It's part of our wonderful system to say, “Hey don't do this. Do that.” In some ways, that's why there's a difference between this kind of basic suffering of you're thirsty so take a drink and this suffering that feels like it's a bigger off balance, off centered quality (personal communication, Feb. 1, 2010).

A number of interviewees described how understanding the ‘Four Noble Truths’ deepened their own capacity to be more present with others’ suffering. One interviewee offered a very simple explanation, “Understanding the continuity of suffering equals compassion” (Psy.D.-2, personal communication, Jan. 22, 2010). Another described that her Buddhist practice allows her to be present with others who are “deeply suffering in a way that I find a lot of my peers become so broken hearted that they turn away from it, and they can't continue to be open hearted ... because it's too painful. It's too painful to open yourself to their pain” (Ed.S. -1, personal communication, Jan. 30, 2010). Ed.S.-1 further describes her understanding that the universality and functionality of suffering allows that “pain is held differently. It's seen differently. And so, there's a great deal more equanimity about it because you're going to develop more self-forgiveness or other forgiveness, for the process of why we're here and what it is that we've picked up to work with in this lifetime” (personal communication, Jan. 30, 2010). One interviewee described how his own meditation practice functioned to enlarge his capacity for

compassion. He states, “having to sit with my own discomfort in a meditation practice gave me great compassion for the suffering of others and I could see the connectedness that lies there” (LCSW-1, personal communication, Dec. 16, 2009).

Many other interviewees echoed these thoughts. Ph.D.-3 states that,

. . . just deeply getting the universality of suffering and the way that that can help me be more empathic with patients and really resonate with and tune into their suffering. So that is one key piece, and I think that that also informs my motivation to be a therapist. I think that is just a core piece of why I feel drawn into the field (personal communication, Feb. 12, 2010).

In sum, many clinicians reported the activation of greater compassion as a response to the universality of suffering within the human experience. The perception of suffering to be an activating and motivating agent of change appears to be integrated into many clinicians’ conceptualization of the therapy process.

**Do you integrate the concept of non-self into clinical practice? If so, how?**

This question produced responses from the interviewees that either focused on the experience of the clinician or the client. The concept of non-self as applied to the client produced two general response themes: cause of suffering and relief of suffering. This writer was able to identify two emergent themes as related to the clinician perspective, which are transference and attitude of optimism.

*Client: cause of suffering (MC).* A number of interviewees diagnosed the experience of a separate and fixed self as a core component of human suffering. This was elucidated by Psy.D.-1 in his observation that, “. . . oftentimes people cling to this

really painful, inadequate, narrow sense of themselves out of fear” (personal communication, Jan. 22, 2010). He further extrapolates:

I think it all does circle around this core idea that I’m a separate self and I’m lacking . . . Because of impermanence we sort of know in the back of our mind that our self is sort of shaky and being constructed out of paper-mâché all the time, and so there’s this sense that I’m not stable and I’m not okay and I’ve got almost this anxiety to try to shore myself up all the time. So starting that sense of I’m lacking is almost endemic to just this belief that we have a separate self (personal communication, Jan. 22, 2010).

Psy.D.-1 was able to articulate how the concept of non-self is interwoven with ideas of impermanence and suffering. He notes how clients often seek a solid sense of self but experience anxiety related to never fully being able to “shore” one up due a self that is ever-changing and fundamentally dependent upon and connected to external stimuli.

*Client: relief of suffering (MC).* The theme of developing an objective experience of the self was resonant within many interview responses. Interviewees utilized different language with similar function (e.g., soften, dis-identify, creating distance, de-identify, etc). On a fundamental level many interviewees stated that one of the primary goals of the therapeutic work was to support clients begin to have an objective experience of their emotions and thoughts. Ph.D.-3 outlines his approach, “The first step is helping folks see that they are not the emotion. Because I think oftentimes when folks are emotionally flooded there's this sense that they are anger, their whole world is anger. So it's just giving them that distance to say, ‘Here is this observing self, there is the emotion’” (personal communication, Feb. 12, 2010). Psy.D.-2 states that he works to help “people dis-identify with their thoughts. And also in healthy ways, dis-identify with rigid self-concepts” (personal communication, Jan. 22, 2010).

Many interviewees identified how the process of objectively experiencing emotions or thoughts allowed for greater freedom and less suffering. Specifically, MSW-1 describes his approach with clients as,

. . . you're looking are they ossifying, are they becoming rigid around this central idea of who they are rather than being somebody who's an essence . . . or who's continually in process, continually in flow. And so to help soften, you talk about defenses within their self, so they're clinging to "This is who I am," and to soften that in order to . . . [have an] experience of freedom (personal communication, Jan. 22, 2010).

MSW-1 describes the suffering that arises from experiencing an inflexible sense of identity and the freedom that arises from the recognition that the self is an 'essence' that is in perpetual movement. He utilizes the concept of 'softening' his clients' attachment to a rigid self-identity. Ph.D.-3 echoed this description of 'softening' and further acknowledged that by loosening attachments to who we think we are or should be allows for natural growth. He describes it thus:

Loosening attachments to a certain-self image. And that can mean— very often it might mean somebody is trying to push away, resisting and fighting a image of their self or that they're attached to a image of their self, either one. And that those attachments to that certain way of being in the world to that sense of self keeps them static, keeps them in a static pattern. And I really trust the human growth process and I feel like when there's not something keeping the human growth process static, growth is going to occur, particularly in the context of awareness. But that when you have a crystallized sense of self, it can shut the whole thing down. And so softening that sense of self allows for . . . the dynamic flow that I see is the human growth process (personal communication, Feb. 12, 2010).

Ph.D-3 further expanded this by offering a method of utilizing present moment stimuli to reorient and support clients in emotional regulation. He states:

. . . as far as emotional regulation goes, once you are de-identified, stopping the thought processes that are feeding that emotional dis-regulation and potentially tuning into other grounding sensory stimuli, like the steering wheel or your breath or your body, so that as well as all of those stimuli that are creating those emotions, be it tightness in the chest or the thoughts you're having or whatever, you're counterbalancing them with stimuli like— calming stimuli like the breath or your feet on the ground or whatever that might be (Ph.D-3, personal communication, Feb. 12, 2010).

When asked to describe how this functions with clients, Psy.D-1, elucidated the flexibility that arises from not attaching to a fixed, solid and separate self. He notes that when clients loosen their restricted sense of self, a natural expansion and acceptance arise. Specifically, he stated:

Well, for one thing, just starting to see that who you are, how you feel, the different parts of yourself are so multifaceted and so different, dependent on who you are with and what's coming up for you and what you think and all of that stuff-- that you start to expand, just stretch out a little bit their comfortability of multiple selves, of change, of impermanence, not so fixed on being a solid and separate self (personal communication, Jan. 22, 2010).

LMFT-1 offered a description of the function of a client experiencing a perceptual shift from a solid sense of self to a neutral observer from a selfless/non-self context. He noted:

...People tend to take their sense of self from whatever they're thinking in the moment or whatever they're feeling in the moment. So clinically if you can-- what I'm discovering is if you can help a client start to discover that sense of selfless context, what we would call in Buddhist meditation practices, the observer, then all of a sudden their world gets a lot bigger because there's the observer, there's the thoughts, then there's the context of the world they're in and suddenly things are not so serious, right, because it's-- to get a client from the point where they are like this client, from being a depressed person to being a person who experiences

depression. That's a fundamental shift because now there's a-- because selfless context, that observer is neutral (personal communication, March 7, 2010).

*Clinician: transference (MC).* A number of interviewees noted the implications of a personal understanding of the concept of non-self on themselves as clinicians.

LMFT-1 described the experience of being able to depersonalize emotional reactivity arising in the therapy room, sometimes described as ‘transference.’ He noted:

For me, as a clinician, it's almost always information about something that's going on for the client, if I'm going to see that not as a real manifestation but as a manifestation of a grasping on to something that doesn't exist. And it's also true that there's- you just can't take things personally, because it not personal. There's nothing to hold onto, and it creates a kind of groundlessness that helps keep us in the present moment. So, non-self and present moment awareness are really related (personal communication, March 7, 2010).

This statement was further supported by MSW-1, who noted that he creates an enlarged emotional space for his clients by experiencing himself as fluid and unfixed. He stated:

So first from a personal perspective, I can be in this place where I have a lot of space because my personality, my ego doesn't get involved and then I actually see all these options for movement. It's not just a solid [therapist] sitting here having to deal with a client who's sitting across from me. But it's really just a realm of creative possibilities and I can be whoever it's most appropriate to be in that moment with the client. So since there's no solid self here, it gives me a lot of freedom to be a clinician (personal communication, Jan. 22, 2010).

Ph.D.-1 noted that experiencing herself with some objectivity and distance has facilitated a number of helpful therapeutic attributes:

I think it has helped me a couple of ways. With the tolerance, you know, I can sit with a lot, without having to externalize any reactivity. It doesn't mean I'm not having internal sort of things are happening. I'm not saying I get into a no self place here. I'm just saying I can get a lot of distance on my own sensory experience because of practicing a lot and . . . I'm aware of when I'm having images or talk or feel about what they're saying or about me or about-- or I'm having associations. I mean I can feel it quickly. I think that's a helpful (personal communication, Jan. 29, 2010).

*Clinician: optimism (MC).* A number of interviewees reported a sense of optimism and open-ended possibility for their clients related to the concept of non-self. LMFT-1 stated, “from my perspective and watching other clinicians who worked with an idea of impermanence and non-self, it's much more optimistic” (personal communication, March 7, 2010). He notes that, “people come in and are convinced that they're broken. And from a worldview that has a soul that can be damaged, from a worldview that sees things as- that it fuses label with the thing it describes. But from my perspective, they're an appearance, a manifestation, and their context is flexible” (personal communication, March 7, 2010).

LMFT-1 further describes this fixed sense of self with a clinical description of a client. “His identity in that label and set of qualities was fused together. And his possibility was frozen. And from my perspective, that's a label that, whatever the self is, it's not that and that none of it, none of it is frozen (personal communication, March 7, 2010). Another interviewee described the freedom and optimism that accompanies experiencing a client as a non-self simply by stating, “all things are possible at every moment” (Ed.S.-1, personal communication, Jan. 30, 2010).

In sum, the concept of non-self appears to influence clinician's conceptualization and experience of themselves and their clients. Interviewees identified that a limited,

fixed, and restricted sense of self can be a central agent in the cause of suffering. They also noted that working to help people expand that sense of restriction opened their clients up to greater freedom and possibility. Some interviewees noted that their own understanding of non-self allowed them to create a more open environment and ability to recognize transference in the therapy process. Lastly, they noted that they experienced greater optimism related toward their client's ability to change.

**Do you integrate the concept of impermanence into clinical practice? If so, how?** This question produced responses from the interviewees that focused on both the experience of the clinician and the client. The concept of impermanence as applied to the client produced the general theme of 'this too shall pass.' This writer was able to identify two emergent themes as related to the clinician perspective: greater self-awareness and clinical flexibility.

*Client impermanence (MC).* A majority of clinicians reported an enlarged sense of perspective toward their clients when working from the perspective of impermanence. Ph.D.-2 reported that clients "have a better clue of 'this too shall pass.' They have a bigger picture" (personal communication, Feb. 1, 2010). This was echoed by Ph.D.-3 who noted the relief related to, "being able to say 'This too shall pass,' and also to not take it so personally whatever comes up, but just kind of have curiosity and say, you know, 'It's okay'" (personal communication, Feb. 12, 2010).

MSW-1 reported an increased sense of self-efficacy in being able to work with clients who are suffering and offering a maxim based on his personal belief in impermanence:

I can say with confidence . . . "This won't always be this way." . . . it will not always be the way it is right now and I can guarantee that. The emotion believes it's gonna go on forever, so a client will say "I don't wanna feel this 'cause it feels

like I'll never stop." So I guarantee you, you won't always have a solution . . . [but] I can say that with confidence, that it won't always be that way (personal communication, Jan. 22, 2010).

MSW-1 explicated the notion that clients fear and avoid certain emotional experiences due to the belief that they will continue indefinitely. He appears to utilize the concept of impermanence to encourage clients to approach emotional experiences with the confidence that they will eventually change.

Ph.D.-3 notes that when clients experience a sense of impermanence related to their self-identification, it has the potential to decrease a client's sense of attachment to a fixed and rigid self. He stated:

So often there's a temporal aspect to those attachments or counter-identifications or pushing away from aspects of self. And again, it feels like that that will be forever. And so starting to not— not just conceptually understand but experientially believe and feel the reality that these different states are just shifting and temporally limited really helps with that non-identific— with not having a crystallized sense of self and not having an attachment to them (personal communication, Feb. 12, 2010).

This understanding is further explicated by LCSW-1, who offered an example of how he integrates the concept of impermanence into the therapy process as it relates to physical sensations:

I talk about flow and change, and vanishing and gone. I talk about change, and, as they notice these sensations . . . when we're doing practices here in session, I'll ask them to pay attention to the sensation, and notice changes in the intensity of the sensation, notice changes in the position or the location of the sensation. Does it start here, but seem to suddenly spread somewhere else? Is it like a splash and a ripple kind of an effect, where they notice it more intensely here, but it seems to radiate out somewhere else? So I

really try and get them to relate to the sensations, relate to their body as a three dimensional space, and to relate to the sensations as events that are occurring in the space. And so tracking those changes, and I don't use the term impermanence, but they see how the distress [changes] (personal communication, Dec. 16, 2010).

LCSW-1 describes the use of the body as one method of teaching clients about the impermanence both physical sensations and the accompanying mental distress. He proposes that by building greater awareness of the quality of sensation and tracking the subtleties associated with the changing of those sensations, clients begin to develop a sense of objectivity and learned sense of impermanence.

*Therapist impermanence (MC).* Ph.D.-3 acknowledged that the nature of impermanence has utility for clinicians as well. He stated, “One last thought I have about impermanence would be not having attachment to gains or success. And sometimes I'll see patients doing well and they get that sense of like ‘Oh, it's all better now. Struggle’s over.’ And seeing that this too shall pass. And so, holding lightly even therapeutic gains” (personal communication, Feb. 12, 2010). Psy.D.-2 offered a different perspective, noting that applying the concept of impermanence onto a clinician’s own experience can aid the therapy process. He states, “I hope that it makes me a little bit more sensitive to my own states of mind and how they're part of the situation and being able to work with those states of mind in a way that is beneficial to my patients. And also see my states of mind as impermanence, providing information but not necessarily real” (personal communication, Jan. 22, 2010).

MSW-1 notes that when a therapist is oriented to an ever-changing self, client, and world they are more likely to approach a client and treatment plan with more flexibility and present moment awareness. He describes this experience as follows:

I think also the concept of impermanence helps me as a clinician in recognizing that I don't need to have a rigid treatment plan or a rigid idea of what's happening with my client, that actually I could be very fluid because my client is changing and this part of no-self as well. But my client changes over the time we're together, maybe from moment to moment and the engagement needs to be different every time that I see that client (personal communication, Jan. 22, 2010).

In sum, the utility of integrating the concept of impermanence appears to manifest as important and functional for both clients and clinicians. A number of interviewees reported that the sense that "this too shall pass" encouraged them in authentically supporting clients in experiencing unwanted emotional states, as well as working to release a client from an inflexible sense of self-identity. Further, interviewees described a greater self-awareness and clinical flexibility when approaching their own experiences in the therapy room and in treatment planning.

**What do you see as the importance of 'ethical behavior' in the process of psychotherapy, specifically: the five precepts, refrain from: killing, stealing, lying, misusing sexuality, and use of intoxicants?** This writer identified two emergent meaning clusters arising from interviewee's integrated responses. First, a number of clinicians identified the concept of a 'natural' or 'innate' ethical sense manifesting from a mindfulness practice, primarily as a function of paying attention to the 'cause and effect' of one's actions/behaviors. Second, a common theme of supporting a client in the process of building awareness around and activating behaviors related to their own personal values emerged.

*Mindfulness as ethical (MC)*. Although an overwhelming majority of interviewees reported not explicitly discussing ethical behavior in the therapy room, many noted that it was inherently integrated into working from a mindfulness perspective. Ph.D.-2 noted: “In some ways, if you’re awake and being really authentic and open then you naturally are ethical. . . The Buddhist assumption is that at the core, we are naturally ethical. We are naturally ethical beings. And so this awake quality leads itself to that” (personal communication, Feb. 1, 2010). He further extrapolated that, “When we’re awake in this moment, when we’re wholly ourselves, we tend to be already ethical and don’t need extra rules from the outside” (personal communication, Feb. 1, 2010). These thoughts were echoed by MSW-1 who noted, “I think that when you look at ethics, the mindfulness practice is to look deeply into the ethics. Is this skillful living?” (personal communication, Jan. 22, 2010).

A number of interviewees described supporting a client’s ability to identify the relationship of cause and effect in their lives. LMFT-1 stated, “I let my clients tell me what their suffering is. . . . I can look at those and say, ‘Those are causing suffering.’ But I don’t look at them as ethical breaches. I just, again, just, ‘Here’s the behavior. Here’s the result. How’s it working?’” (personal communication, Jan. 22, 2010). Further expanding on the concept, LCSW-1 described how he implicitly integrated ethical behavior into his practice: “In an implicit sense, yes, . . . in the cause and effect, and looking at their behavior and looking at their values, and looking at their intentions (personal communication, Dec. 16, 2009).

The utilization of implicit integration was echoed by Psy.D.-1, who noted that although he does not think of the ethical precepts explicitly, he engages in the process of

building awareness around the cause and effect of both positive and negative outcomes.

He states:

I haven't really thought of it as explicitly but . . . these things, they cause suffering, to lie and to steal and they cause restrictions and anxieties and fears, and a sense of self as not okay. So just to help people start to see that, "oh yeah, that causes suffering." And when you do live a more ethical life, not only don't you have that suffering, but life is more enjoyable. You can accomplish more. You can engage more. You don't have to hold yourself back from relationships and from engaging in your life more fully (personal communication, Jan. 22, 2010).

Some clinicians noted that the law of cause and effect was integral to Buddhist teachings. Specifically, the Third Noble Truth of Buddhism states that because suffering has a cause it also must have an end. This rationale appeared to have influenced clinicians to supported clients in building awareness around the relationship between actions/beliefs and their consequences.

*Activation of personal values (MC).* A number of clinicians reported working to orient a client to their own personal values as a means of activating change. MSW-1 noted the importance of this being a personal and individually-relative process. He stated, "I want to make clear that it's not that I see them as commandments and certainly don't expect every client to follow all these precepts, especially in private practice... [The question] is where are you at and what are you working on" (personal communication, Jan. 22, 2010). LMFT-1 added, "from a Buddhist perspective, it always comes back to this really pragmatic criteria of truth, which is relative, contextual and what works for the first client that walks in my office will not work for the second, except if it does" (personal communication, March 7, 2010).

Ph.D.-1 stated that ethical issues arise when a clinician explores the relationship between current behavior and personal values aspired to by an individual. She summarized:

. . . [ethics] come up in the sense of people's behavior has an impact on them. And this is where ACT is really good, that kind of being able to [ask] what is your value and what is your goal here and is this working to get you there because when you're behaving unethically or when you have some of those precepts being violated routinely, it typically means you're not making it to your goal if you have a value that's in there (personal communication, Jan. 29, 2010).

LCSW-1 noted that values work as aspirations or guides for behavior as well as function to relieve suffering. He described, "I do talk a lot about values with a client. I tell them that, you know, there's kind of the two wings, and not in the traditional sense, but like one aspect of this work has to do with the suffering, the other has to do with their aspirations. Who do you want to be? What kind of life do you want to have?" (personal communication, Dec. 16, 2010). He further extrapolated the function of integrating values and behavior:

I've spent a lot of time with clients, trying to get them to talk about their values about relationship, their values about career, their values about spirituality, their values about community, what would constitute a meaningful purposeful life . . . And begin to move toward behavioral activation, when you get down to concrete kinds of steps of kind of voting with your hands and feet, you know, moving towards, making more, kind of translating those intentions, or taking those aspirations and making them intentions, and then looking at how they can kind of bring those into their daily life (LCSW-1, personal communication, Dec. 16, 2010).

In sum, when asked to describe how ethics are integrated into clinical practice, clinicians described a multi-stage process: first, orienting a client toward awareness of a personalized value set, followed by building mindfulness related to the impact of behaviors outside of that valued set (i.e., cause and effect), and then finally, supporting behavioral activations in alignment with those stated values had the effect of creating ethical behavior and relieving suffering.

## **Beyond mindfulness are any of the other aspects of the Eight Fold Path**

**useful in therapy practice?** Most interviewees denied utilizing the Buddhist Eight Fold Path in the conceptualization and treatment of clients. However, one interviewee noted that that the practice of psychology was very much in alignment with the Eight Fold Path. In reference to the Eight Fold Path, she stated,

. . . it seems to me that this is really what psychology is doing all the time anyway, like Buddha was the first psychologist that there was . . . first one to articulate in such a familiar way. You know, so right speech. . . we have psychological like systems for communication . . . don't use provocative language, use I statements. I mean that's one form of that. So I feel like even if I had come through it completely, psychologically, you could be using these because they're so fundamental (Ph.D.-1, personal communication, Jan. 29, 2010).

MSW-1 was able to articulate how he conceptualized integrating the Eight Fold Path, specifically:

**Right thoughts** -- I mean, that's cognitive behavioral therapy. . . So is this a helpful thought or is it not a helpful thought? I mean, you could just put that out. Is it a skillful thought or not? Try thinking this thought and see what helps. . .

**Right speech** -- I do a lot of work helping people recognize how their speech is causing them problems in life. So, how are you expressing yourself, how are you speaking to your wife or your husband, and is this really the most skillful way for you to get your needs met.

**Right action** is behavioral change. Are you doing the actions, the acts, the things that you need to do in order to have the happy life that you want? So addictions is right action. Are you going to meetings? Are you calling your sponsors? If you just do those things, your life will start to improve. It's just right there.

**Right livelihood** -- I mean, people come and they're struggling with their work. Employment isn't really meaningful and we help them, or I help them get down to their desires more.

**Right effort** -- I think about a lot of clients who are really hard on themselves and beating themselves up, or the other clients who are just like not wanting to really do any work and both of those are like wrong effort. One is too hard and one is too soft. And really helping clients to find a way-- When I have a client who's really hard on themselves and just beat themselves and not give themselves a break, and I try to help them move over, they become really scared that they'll

become so soft, that they won't pay their bills, that their life will fall apart -- I say "If you were on this side over here, and you weren't willing to do it, I'd be telling you a whole different message. It's really about getting you to a place where you can function the best."

**Right mindfulness** is that you just had awareness of what's happening and being able to watch what's happening in the right moment, as I mentioned earlier.

**Concentration** is probably the one that comes up the least, and there is a lotta resistance to people wanting to increase their ability to concentrate. But I think that one thing that happens in the therapeutic session is 50 minutes of concentration. Then you think about it and like somebody who's not in that mode all week and they come and they go "Okay," and it's an intense hour (MSW-1, personal communication, Jan. 22, 2010).

## **Paradigm Conflicts**

**Have you experienced any conflicts between Buddhist teachings and the practice of psychology?** Two meaning clusters emerged from the interview content.

First, a number of interviewees acknowledged avoiding Buddhist terminology, even if employing specific Buddhist techniques in attempts to remain secular. Second, a meaning cluster related to divergent conceptualizations of mental illness was generated.

*Avoidance of Buddhist terms (MC).* A number of interviewees noted the avoidance of utilizing Buddhist nomenclature in their clinical practices. Ph.D.-2 described this,

I stay away from any of the kind of classical terms. It's off-putting to some people. They're fearful that I'm trying to kind of enlist them into Buddhism, or that I'm being insensitive to their religious spiritual beliefs, so I really try to avoid any kind of direct references to Buddhism, and I try to maintain a very secular terminology and orientation to practices (personal communication, Feb. 1, 2010).

This was echoed by LCSW-1, who stated, "I never use that term with clients. You know, unless I'm dealing with a client who has a self-described practice as a Buddhist, I don't use those terms" (personal communication, Dec. 16, 2009). A number

of interviewees noted the importance of employing non-Buddhist language to discuss phenomena described by the Buddha. For example, some clinicians stated avoiding the words ‘impermanence’ and ‘attachment’ and substituting words such as ‘change’ and ‘fixation.’ It appeared that generally the purpose of this relabeling was in the service of enlarging the palatability of Buddhist concepts to non-Buddhist consumers.

*Conflict with the Western medical model (MC).* A number of interviewees described conflict arising between how mental illness is perceived from a Buddhist paradigm relative to a Western medical model paradigm. Three specific challenges were identified. First, the challenge of working to change something that might not need to be fixed but rather accepted. Second, the challenge of working with a self that is interconnected, fluid, and in constant change. Lastly, differences between spiritual aspirations and accepted models of mental health.

Ph.D.-2 described a number of these differences succinctly:

Western psychology generally has the existence of self that needs to be fixed. And Buddhist path it's more how can you fix one being and not all at the same time. It's no way to separate out an element of the world as if there was a vacuum. Here's the self and it's not attached to all these things. So, no-self in the sense of being we're constantly fluid through time. We're constantly fluid through space. Without all the things going on in the entire world at this moment exactly as they are, we would be different. So each moment, a whole new world pops up and we're different in entirety with all of it (personal communication, Feb. 1, 2010).

Ph.D.-2 noted the challenge of fixing something that is fundamentally interconnected to and in constant change. This was echoed by Ph.D.-1 who noted the limitations of the Western medical model's inability to integrate ambiguity and the reality that things are in constant change. She described it as follows:

Well, the medical model is not acknowledging this reality we're talking about, about things aren't so fixed. Things aren't so absolute as it's this way and you do that. It's a process and sometimes, you know, the medical model wouldn't like. And well, sometimes, you shouldn't make them do effort and sometimes you should tell them to let go. Well, which is it, make effort or let go, you know? Which is the vaccine? (personal communication, Jan. 29, 2010)

Ed. S.-1 described the limits of the Western conception of mental health and pathology when relating to a spiritual practice. She noted a fundamental conflict between spiritual or transcendent aspirations and those required to function 'in the world.' Ed.S.-1 stated:

. . . for psychology, the end point is to have a functioning human being. In Buddhism, it's much more to become transpersonal and becoming a fully functioning human being is just one place on the continuum. It's not the ending place. So to me, psychology stops way short of us realizing our potential as Buddhists. You know, the Buddha was not a fully functioning adult. He was a transpersonal being with his connection with, you know, all the different levels of reality in the universe. That goes way beyond the definition. I mean he'd be considered psychotic in psychology. He would not be considered a fully functioning human being (personal communication, Jan. 30, 2010).

Psy.D.-2, noted the Western conceptualization that individuals suffering from mental health problems need to be fixed. He described this as divergent from a Buddhist perspective. He stated:

. . . [the medical model implies] people are broken. They need to be fixed. But if people are whole, with experiences that have hurt them and confused them, they need rehabilitation in a sense just like rehab where they need exercise skills to strengthen weaknesses. They need to unlearn difficult, painful habits, habits that cause them difficulty and learn ones that are more functional. So then people are lopsided more than broken (personal communication, Jan. 22, 2010).

Lastly, Ph.D.-3 noted that within the model of something that needs fixing is the implied promise that mental health professionals can work to increase happiness in a

client's life. He described how this might be at odds with a Buddhist conception of suffering as inherent to the human experience (i.e., The First Noble Truth):

And also this implicit promise of happiness that is never necessarily explicitly made, but seems like sometimes if you read between the lines, like "If you do our therapy, you're most likely going to be happy." And just feeling like "Well, that's not really how life works." And from my understanding of what Buddhism says, that's not necessarily in the cards (personal communication, Feb. 12, 2010).

Ph.D.-3 acknowledged that managing client expectations that therapy may quickly assuage suffering and increase happiness is important to address.

### **Perceived Efficacy**

#### **What do you believe is the most effective aspect of a Buddhist approach?**

**(i.e., what aspect activates healing and relieves suffering?)** Nearly all interviewees

generated the meaning cluster of acceptance as the most effective component of a

Buddhist approach to psychotherapy. Ph.D.-2 offered this description, "Letting go,

acceptance. The hallmarks of what you get in meditation and on this path are being a part

of, not separate from, embracing death, embracing suffering. Not in a negative way like

nihilism. But, more not seeing it separate from oneself" (personal communication, Feb.

1, 2010).

Psy.D.-1 described the importance of building acceptance by means of supporting

awareness of the impermanence of unpleasant experiences. He stated that relief of

suffering is often achieved by:

. . . not necessarily avoiding that kind of pain and suffering. It's being able to sort of be with it and accept it. So mindfulness really I think is a tool to just help us get through those kinds of sufferings. Accept it and be with it to deal with some affect tolerance, you know, stuff comes up with us, thoughts, urges, depressions, anxieties that we all go through. Just start to be with that and see it not necessarily as identified as me, but stuff that's going through me (personal communication, Jan. 22, 2010).

Also embedded in Psy.D.-1's statement is the acknowledgement that by increasing objectivity around thoughts and feelings, a client may experience a sense of de-identification and spaciousness around uncomfortable experiences. These concepts are expanded on by MSW-1, who reported that freedom from suffering is paradoxically related to the ability to experience suffering. He described working from the perspective that pain is fundamental to the human experience and influences his therapeutic approach. He described doing this by:

. . . increasing people's tolerance for those uncomfortable feelings so that they're not feeling aversive to the human experience. If they have aversion to experiences and their attachments to pleasurable experiences—[I] invite them to really be with that experience and why they were resisting it. And once the ability to stay with that experience creates space for that experience, they learn that they have the capacity to be with the unpleasant experience and to let it move in and out of their lives from a larger space to experience the freedom from the suffering. So when you can't rid of the grief, even some of the traumatic wounds will stay with us, but they create more space (MSW-1, personal communication, Jan. 22, 2010).

In sum, the interviewees generally described acceptance as the fundamental element to relieving suffering. They utilized, in various ways, the three identified Buddhist concepts (i.e., suffering as inherent to the human experience, insubstantiality of self, and impermanence) as methods of supporting clients in accepting rather than resisting moments experienced as unpleasant. Paradoxically, many clinicians described that by decreasing resistance to perceived suffering and/or increasing a sense of acceptance of the present moment, suffering in their clients decreased.



## **Discussion**

In this section, I will summarize the results of this study and present information regarding the relationship of the present research to the previous literature. Then, I will discuss the limitations of the study; particularly those related to participant and researcher factors. Finally, I will propose suggestions for future research.

### **Summary of Results**

The purpose of this study was to clarify and accurately identify specific Buddhist concepts utilized by mental health clinicians professing to integrate Buddhist ideology into clinical practice, as well as to explore the possible complications, conflicts, or strengths of this integration. To lay a frame work for this exploration, selected literature on Buddhist ideology and its impact on Western psychotherapy was reviewed. This review included a description of core Buddhist concepts, the work of the principal figures seeking to integrate Buddhism and psychotherapy, and lastly, tracing the advent and emergence of mindfulness as a recognized and researched treatment modality.

The literature review of Buddhist ideology revealed four concepts that appeared to represent universal elements within Buddhist thinking, specifically: suffering, non-self, impermanence, and ethical behavior. A review of literature by Western mental health practitioners working from a Buddhist orientation provided a multitude of complex and diverse perspectives. A number of common themes emerged from this review, specifically: self-acceptance, utilizing and staying in the present moment, seeing the underlying goodness of oneself and others, moving from self-identification towards self-

observation, awareness of the process of spiritual bypass, and the overall capacity to accepting experience as it is. Lastly, a review of the empirically validated mindfulness literature provided an overview of how Buddhist derived concepts have entered into mainstream psychotherapy practice, particularly as a means of decreasing distress by increasing awareness of the present moment without judgment.

As discussed in the methods section, this study used data collected from ten interviews with psychotherapists who reported utilizing Buddhist concepts in their therapy practice. The interviews were conducted utilizing a phenomenological methodology with the aim of elucidating the lived experience of mental health professionals who integrate Eastern and Western paradigms. A semi-structured interview protocol explored the concepts identified from the literature review as representative of Buddhist ideology. The concepts of suffering, non-self, impermanence, and ethical behavior were presented to interviewees with the intention of exploring if, how, and when these concepts manifest in their clinical psychotherapy practices and if conflicts arose from this integration. In the following section, I will review each identified Buddhist concept and explore the emergent meaning clusters arising from the integrated interviewee responses, as well as discuss potential paradigm conflicts and perceived efficacy of integrating Buddhist thought with a psychotherapy practice. Further, I will work to integrate the previously reviewed literature, seeking to establish a broader context for the results.

**Human suffering.** Three emergent ‘meaning clusters’ were identified from the integrated interview responses: the cause of suffering, the difference between pain and suffering, and the functionality of suffering. Among the interviewees there was consensus that human suffering is largely caused by our desire to have something or get rid of

something. Many interviewees noted that this attachment or fixation could be either positive or negative, meaning it could be a movement towards or away from something. Either way, it was a desire for things to be different from what 'is.' This was further explicated via the construct of two types of suffering. Pain being differentiated from suffering by pain being the unavoidable experience of being a human being (i.e., sickness, old age, and ultimately, death), while suffering being the emotional response or rejection of these fundamental human experiences. This description is at the heart of MBSR, ACT, and elements of DBT treatment protocols, albeit without the Buddhist languaging.

Many interviewees offered an explanation of suffering that described it from a positive or functional perspective, specifically, as a motivator toward change and as a mechanism for greater compassion. As many therapists know, it is often a client's suffering that inspires help seeking and to contemplate change in their behavior or perspective. Experiencing suffering as a functional element in the change process may afford clinicians a greater capacity for experiencing client's distress without 'burnout' or compassion fatigue (e.g., Figley, 1995; Leiter 1997).

Amongst the reviewed Buddhist psychotherapy literature, a number of individuals have written extensively about cultivating compassion for oneself and others (e.g., Kornfield, Goldstein, Brach, etc.). This was echoed by a significant number of interviewees, who reported the activation of greater compassion as a response to the universality of suffering within the human experience. I suspect that the intentional cultivation of compassion is similar to the well-researched construct of empathy (Mearns & Thorne, 1988; Rogers, 1951). Empathy is generally understood as enabling the therapist to get inside the client's frame of reference, enabling the therapist to understand,

sense, and share what the client is feeling, thinking, and experiencing. Although compassion has its roots in the empathic response, it commonly moves one step further and activates a desire to alleviate another's suffering. Buddhist literature states that the appropriate practical response to observation and perception of the 'three marks of existence' (i.e., suffering, impermanent, and non-self) is compassion (American Academy of Religion, 1995); however, the construct of compassion is not clearly defined in psychological literature. Further research, well beyond the scope of this paper, would need to be undertaken to examine the differences between an empathic and a compassionate response within the therapy context.

**Non-self.** Two overarching categories were identified from interviewee responses in relation to the Buddhist concept of non-self, those focusing on the client and those centered on the clinician. The concept of non-self as applied to the client produced two general response themes: cause of suffering and relief of suffering. This writer was able to identify two emergent themes as related to the clinician perspective: transference and attitude of optimism.

In terms of the client experience, interviewees identified that a limited, fixed, and restricted sense of self can be a central agent in the cause of suffering. They also noted that working to help people expand that sense of restriction opened their clients to greater freedom and possibility. This response theme was consistent with reviewed Buddhist psychotherapy literature, particularly the work of Tara Brach, who promotes 'Radical Acceptance' or the concept that our happiness, contentment, and awakening must come through a full and loving acceptance of who we are now, opposed to trying to escape from, avoid, or transcend our fears, desire, and longings.

When the concept of non-self was applied to the experience of the therapist a

number of interviewees noted that their own understanding of non-self allowed them to create a more open environment and heightened the ability to recognize transference in the therapy process. These responses appear consistent with what Epstein (1995) describes as “bare attention,” a phrase used in meditation to indicate a state of acceptance and awareness of ones’ thoughts and to the therapeutic room. This was echoed by Bien (2006), who advocates that therapists practice a personal meditation practice with the purpose of achieving greater clarity and accuracy toward ones own thoughts and feelings.

Lastly, a number of interviewees noted that they experienced greater optimism about their client’s ability to change when applying Buddhist concepts. As Buddhist thought has entered the Western psychological discourse, the concepts of suffering, impermanence, and non-self have, at times, been misunderstood as promoting a pessimistic paradigm. Conversely, all the literature reviewed for this paper and the interview responses collectively indicate a posture of optimism, usually focused around celebrating the present moment without anxiety related to potentially oppressive concepts of past and future.

This construct of optimism can be taken further with an examination of the archetype/model of the Buddha himself. Buddhism offers the relief from suffering and an identified sense of freedom, significantly beyond what psychology has traditionally offered. Sigmund Freud’s famous quip that the aim of therapy is ‘replacing neurotic suffering with ordinary human misery’ aligns well with the Buddhist posture that as long attachment exists then suffering is inevitable; however, Buddhism moves one step further by positing a radically optimistic construct of an end to suffering and moment of enlightenment. The construct of enlightenment or awakening may provide Buddhist oriented therapists a sense that radical change within an individual is possible, thereby

supporting an optimistic posture toward therapeutic transformation. The utility of the enlightenment construct on clinician optimism is an area that may benefit from future research.

**Impermanence.** The identified emergent themes produced on the subject of impermanence offered insight into both the experience of the clinician and the client. The concept of impermanence as applied to the client produced the general theme of ‘this too shall pass.’ This writer was able to identify two emergent themes as related to the clinician perspective: greater self-awareness and clinical flexibility.

A number of interviewees reported that the sense that “this too shall pass” encouraged them in authentically supporting clients in experiencing unwanted emotional states, as well as working to release a client from an inflexible sense of self-identity. This is a central component of DBT’s distress tolerance treatment model as well as, MBSR’s pain/stress management model. A majority of the reviewed Buddhist oriented literature supported the utility of recognizing the temporal nature of the human experience (e.g., Goldstein, 2007; Kornfield, 2008; Epstein, 1995; Brach, 2004). The concept of impermanence also has resonance within the mindfulness movement, where clients are instructed to bring awareness to the experience of change, particularly: emotional, cognitive, and physical states (Kabat-Zinn, 1990; Segal, Z., Williams, J., & Teasdale, J., 2002).

Interviewees described a greater self-awareness and clinical flexibility when approaching their own experiences in the therapy room and in treatment planning. Epstein (1995) describes “bare attention,” as supportive of an ideal therapeutic state, where therapist and patient are actively working together on specific problems but are open to engage with whatever arises without expectations. He particularly emphasizes

how critical it is for therapists to be open and accepting of their present moment experience with wariness to the potential of promoting ones own agenda.

**Ethics.** Two emergent themes were identified arising from interviewee's integrated responses related to the topic of ethics. First, a number of significant number of interviewee's identified the concept of a 'natural' or 'innate' ethical sense manifesting from a Buddhist practice, primarily as a function of paying attention to the 'cause and effect' of one's actions/behaviors. Second, a common theme of supporting a client in the process of building awareness around and activating behaviors related to their own personal values emerged.

The concept of an innate ethical sense differs sharply from a drive or instinctual based human behavior model traditionally accepted in psychological circles. Buddhism promotes the concept that human beings are fundamentally moral but become deluded/poisoned by challenging states of mind (i.e., greed, anger, and ignorance). This view of ethics was supported in the literature, especially in the writings of Brach and Kornfield, who both provide a number of practices to support individuals connecting with the underlying goodness of oneself and others (Kornfield, 2008; Brach, 2004).

Lastly, the integrated interview responses generated a multi-stage model for implicitly engaging clients to investigate ethical behavior. The steps are: first, orienting a client toward awareness of a personalized value set; second, building mindfulness related to the impact of behaviors outside of that valued set (i.e., cause and effect); and third, supporting behavioral activations in alignment with those stated values had the effect of creating ethical behavior and relieving suffering. This model has similarities to ACT, which, among other things, works to clarify what the client values for his or her own sake (i.e., what gives life meaning?). The goal is to help clients understand the distinction

between a value and a goal, choose and declare their values, and set behavioral tasks linked to these values (Fletcher & Hayes, 2005).

**Paradigm Conflicts.** Two themes emerged from the interview content related to therapist perceived challenges with integrating Buddhist concepts into psychotherapy practice. First, a number of interviewees acknowledged avoiding Buddhist terminology, even if employing specific Buddhist techniques, in attempts to remain secular. A number of interviewees noted the importance of employing non-Buddhist language to describe phenomena described by the Buddha. For example, some clinicians stated avoiding the words ‘impermanence’ and ‘attachment’ and substituting words, such as, ‘change’ and ‘fixation.’ It appeared that generally the purpose of this relabeling was in the service of enlarging the palatability of Buddhist concepts to non-Buddhist consumers. This appears to be the tact utilized primarily by the practitioners associated with the mindfulness movement in psychotherapy (e.g., MBSR, DBT, ACT, etc.), where Buddhist concepts are generally utilized outside the religious structure of Buddhism. Conversely, a number of individuals who are both Buddhist teachers and psychotherapists (e.g., Brach, Epstein, Kornfield & Welwood) fluently employ Buddhist terminology within their writing and lectures.

Second, a theme related to divergent conceptualizations of mental illness was generated from the collective interview content. Three specific challenges were identified: first, the difficulty of working to change something that might not need to be fixed but rather accepted; second, the challenge of working with a self that is interconnected, fluid, and in constant change; and lastly, differences between spiritual aspirations and accepted models of mental health. This topic was less supported within the reviewed literature, indicating an area that may benefit from further research.

**Perceived Efficacy.** An overwhelming majority of interviewees generated the theme of acceptance as the most effective component of a Buddhist approach to psychotherapy. They utilized, in various ways, the three identified Buddhist concepts (i.e., suffering as inherent to the human experience, insubstantiality of self, and impermanence) as methods of supporting clients in accepting rather than resisting moments experienced as unpleasant. Paradoxically, many clinicians described that by decreasing resistance to perceived suffering and/or increasing a sense of acceptance of the present moment, suffering in their clients decreased. This perspective was generally supported by the available literature, most notably by ACT, a treatment model utilizing the therapeutic strategies of acceptance and mindfulness together with commitment and behavior change strategies to increase psychological flexibility (Fletcher & Hayes, 2005).

#### **Limitations of the Study.**

This study has several limitations that may affect its generalizability. As this study was limited to ten mental health professions, their experiences and attitudes cannot represent all mental health professional utilizing Buddhist concepts in clinical practice. Additionally, qualitative research is subjective; when the researcher conducted this study, he may not have addressed the issue of subjectivity and inter-subjectivity as extensively as possible, resulting in a potential pollution of the data, which, in turn, might result in research bias. Further, the research participants were all located in Portland, Oregon metropolitan area, and, thus, may not represent the conditions and experience in other practitioners in differing geographic locations. Additionally, the lack of gender equity in the study may pose another challenge to generalizability. A majority of the participants

were men (8 men and 2 women), potentially skewing the results from a male oriented perspective.

Lastly, within the ever-changing discipline of psychology, today's research might not explain the phenomenon of tomorrow's situation very well, so this research can only explain the phenomenon in this specific case, at this particular time and place. If future researchers use these research results, they need be aware of all these factors to maintain the objectivity of their studies.

### **Future Recommendations**

There is considerable potential for future investigations of clinician's utilizing Buddhist concepts in clinical practice, in part because of the generally broad range of application and expression of these concepts. The following suggestions are informed by the limitations of this study as well as gaps in existing research.

First, to address the diversity issues that may have limited the results of this study (location and male bias), future researchers should increase the sample size and the demographic diversity of participants to verify the broader relevance of current findings. The research may benefit from bringing greater awareness to creating gender balance within the participant pool and seeking to draw participants from differing geographic locations.

Additionally, it would be fruitful to include participants from a greater variety of types of Buddhist training and orientation. For example, it is challenging given the limitations of this study to examine the difference in orientation and perspective a Zen Buddhist might experience verses an individual who has studied in the Vajrayana/Tantric Buddhism schools of Buddhism. Examining and placing the views and experience of

these individuals in context should advance our understanding of how these differences influence the variability of Buddhist concepts expressed in clinical practice.

Further, I would suggest that additional research be conducted exploring the experience of clients who receive therapy that utilizes Buddhist concepts. As much research has established the effects of confirmation bias (e.g., Darley & Paget, 2000; Nickerson & Raymond, 1998; White et al., 1993) or the inclination to favor information that confirms ones preconceptions or hypotheses, it would be important to seek alternative perspectives regarding the efficacy of Buddhist oriented psychotherapy. Interviewing willing clients and phenomenologically evaluating their therapy experience, may offer a fuller perspective as to the utility of these methods and work to diminish the effects of confirmation bias.

A number of topics for future research were generated within the discussion section of this paper. First, research exploring the difference between spiritual aspirations and accepted models of mental health was limited within the reviewed literature, indicating an area that may benefit from further research. Second, the construct of enlightenment or awakening as generating an optimistic posture toward therapeutic transformation for Buddhist oriented therapists may be an area worth of investigation. Lastly, further research to examine the differences between an empathic and a compassionate response within the therapy context may benefit therapists working to integrate Buddhist concepts into their therapy practice.

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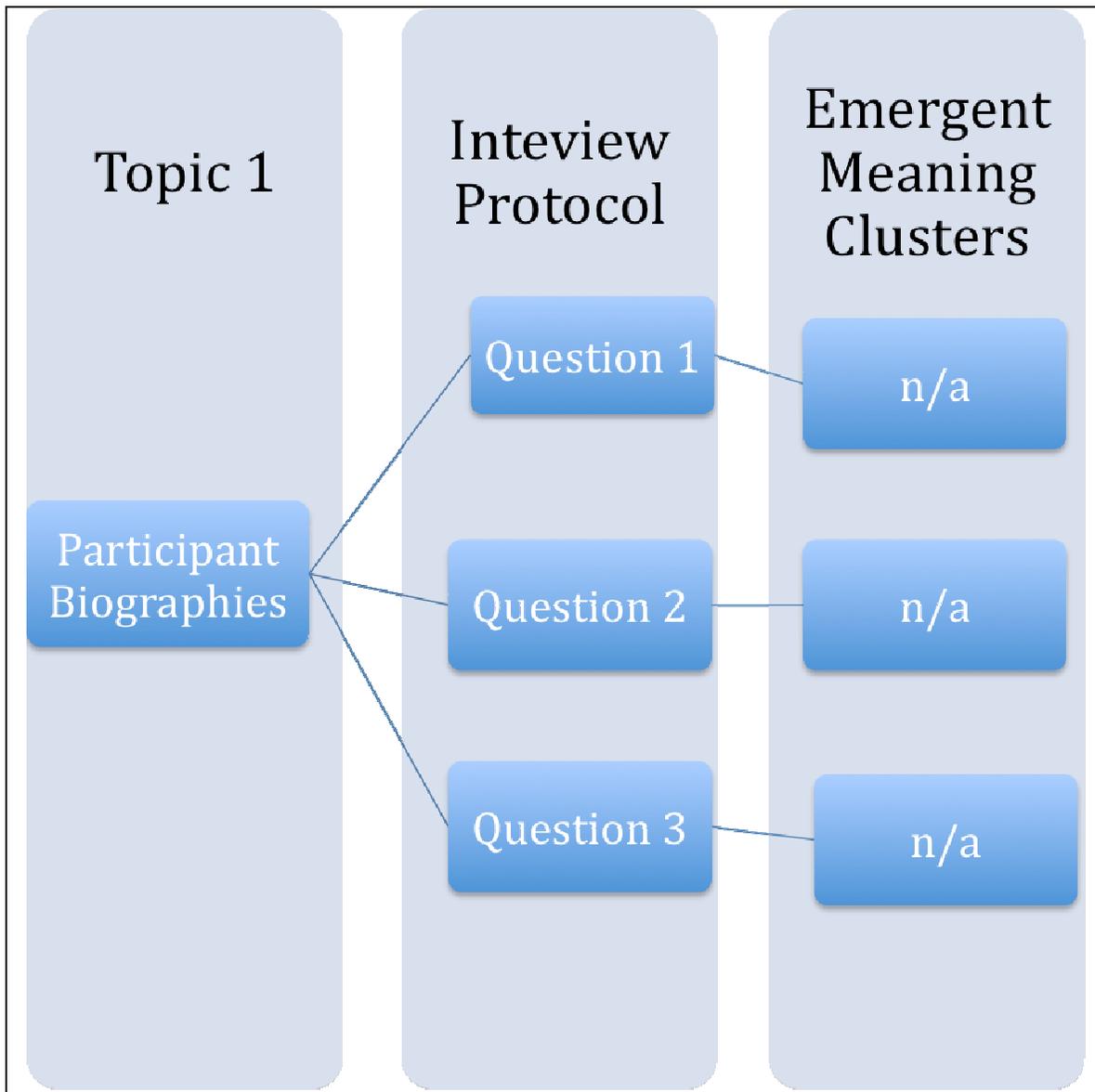
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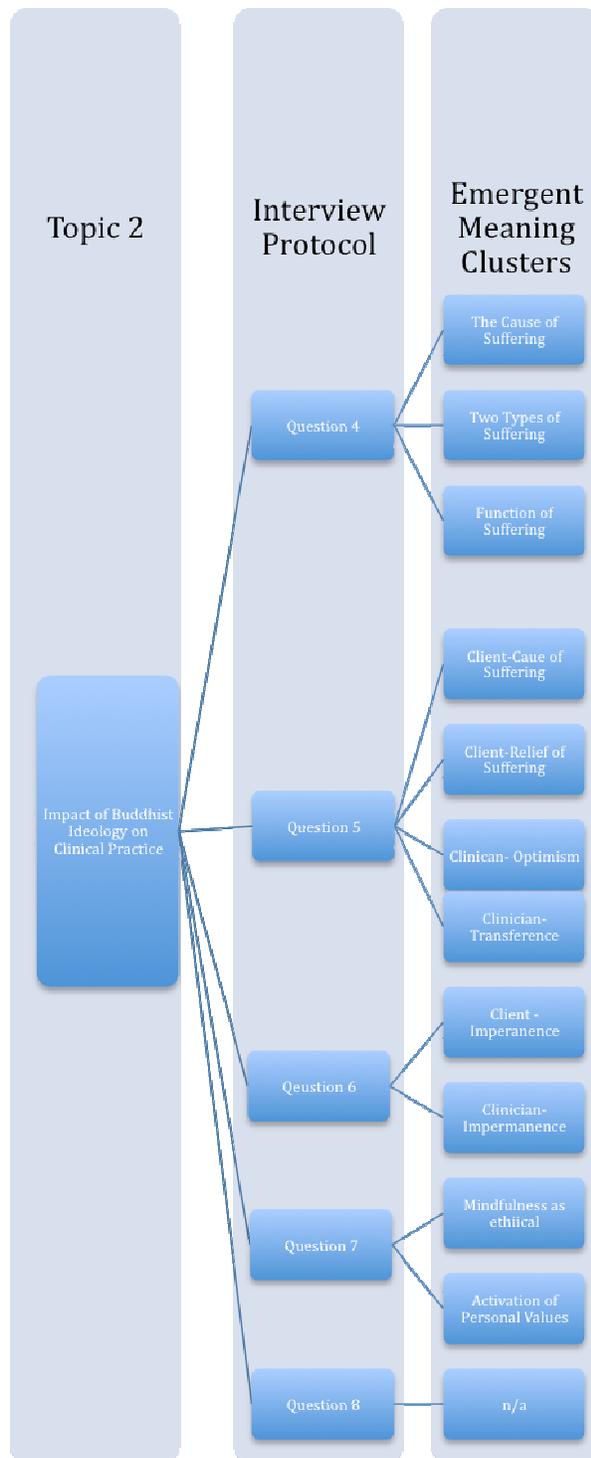
## **Appendix A**

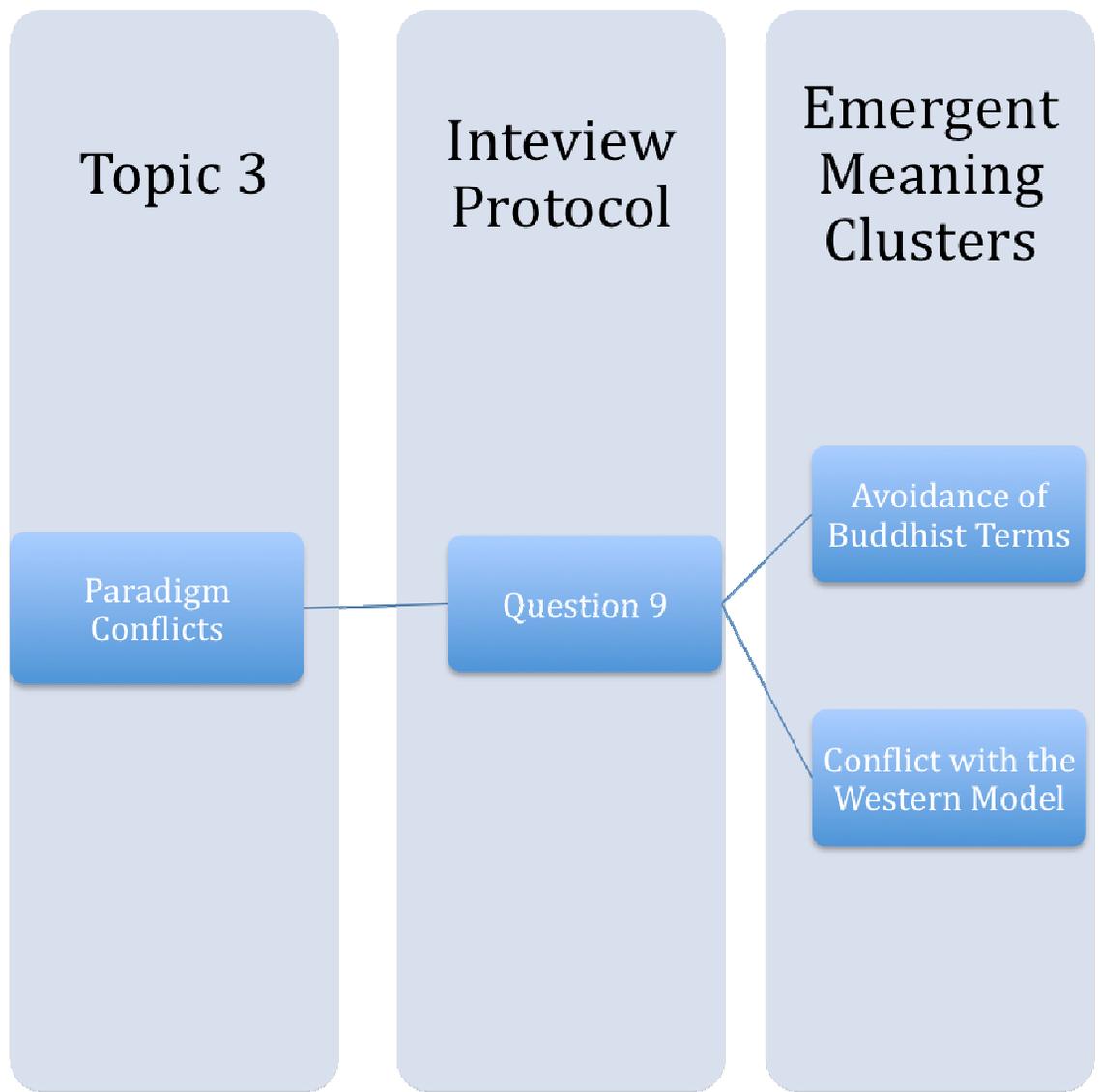
### **Interview Protocol**

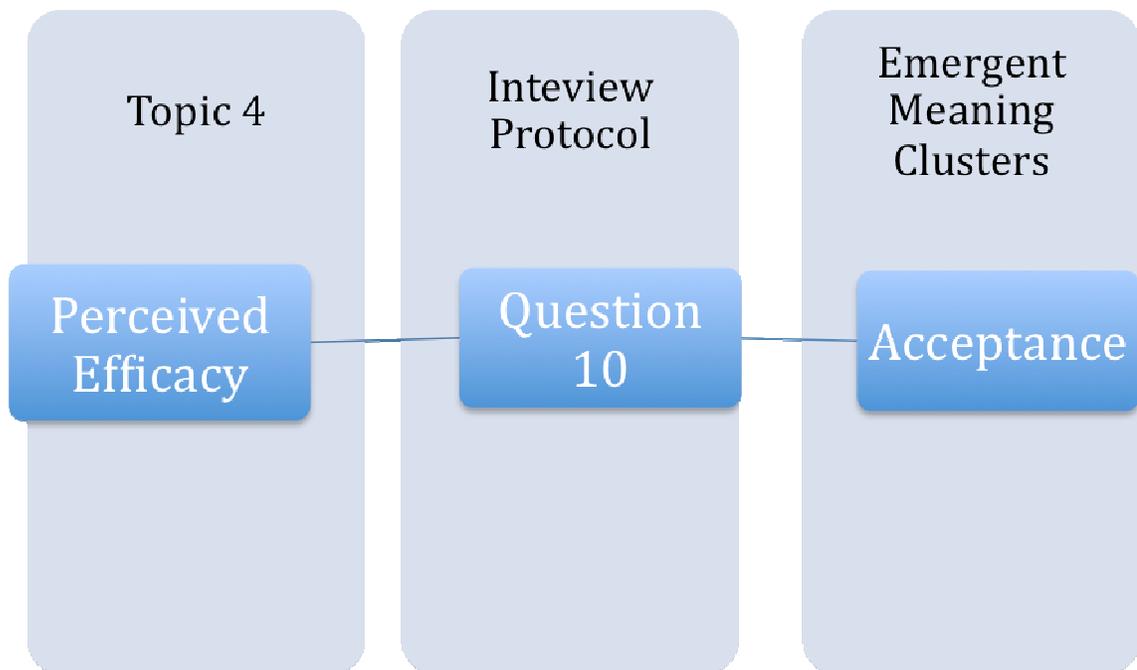
1. What is your theoretical orientation toward psychotherapy?
2. What is your background/training in Buddhist Mindfulness techniques, both professionally and personally?
3. Did you begin integrating Buddhist ideas from a personal/spiritual practice or from an academic/professional perspective or both?
4. Do the 4 Noble Truths impact your conceptualization and treatment of clients? Specifically, the understanding that attachment is the root cause of suffering?
5. Do you integrate the concept of non-self into clinical practice? If so, how?
6. Do you integrate the concept of impermanence into clinical practice? If so, how?
7. What do you see as the importance of '*ethical behavior*' in the process of psychotherapy, specifically: 5 precepts, refrain from: killing, stealing, lying, misusing sexuality, and or use of intoxicants.
8. Beyond mindfulness are any of the other aspects of the 8 Fold Path useful in therapy practice?
9. Have you experienced any conflicts between Buddhist teachings and the practice of psychology?
10. What do you believe is the most effective aspect of a Buddhist approach? (i.e., what aspect activates healing and relieves suffering?)

**Appendix B**  
**Global Topics, Research Generated Interview Questions, & Emergent Meaning Clusters**









**Appendix C**  
**Informed Consent Form**

**Informed Consent Form**

**1. Study Title**

BUDDHIST BELIEF SYSTEMS AND TECHNIQUES IN THE PRACTICE OF  
CLINICAL PSYCHOLOGY: A PHENOMENOLOGICAL STUDY.

**2. Study Personnel**

	Principal Investigator	Faculty Advisor	Reader
<b>Name</b>	William Banjo Weymouth, M.S.	Jon Frew, Ph.D.	Eva Gold, Psy.D.
<b>Institution</b>	Pacific University	Pacific University	Pacific University
<b>Program</b>	School of Professional Psychology	School of Professional Psychology	School of Professional Psychology
<b>Email</b>			
<b>Telephone</b>			

**3. Study Location and Dates**

This study will be completed by the end of 2011 and take place primarily in the Portland Metropolitan area.

**4. Study Invitation and Purpose**

You are invited to participate in a study seeking to clarify and accurately identify specific Buddhist therapeutic techniques that are currently being utilized by mental health clinicians professing to integrate mindfulness or other Buddhist concepts into clinical practice. A theoretical structure is sought in order to organize and conceptualize these methods, thus providing an accessible clinical model that informs practitioners of these interventions. The results of the study will be used to complete the requirements of a doctoral dissertation in clinical psychology.

**5. Study Materials and Procedures**

This study will involve a semi-structured interview that will last one hour or less, either in person or via telephone. An outline of interview questions will be forwarded to the interviewees to aid in preparation. Informed consent will be completed and individuals will be given the opportunity to have their identities remain confidential in the bound and completed dissertation by checking a box on the last page of this form. The data will

consist of 10 digitally recorded interviews and that will be transcribed into text and stored on a password-protected computer. I will then perform an analysis of the qualitative data and identify prominent emerging themes. These themes will then be transformed into clusters of meanings expressing identifiable psychological and Buddhist concepts. These groupings will then be used to both identify the essential experiences and methods of practice, as well as identify any conflicts reported in integrating Buddhist ideology with clinical psychology. These findings will then be compared and contrasted to existing literature in the field. Limitations to the study will be noted and suggestions for further research will be made.

#### **6. Participant Characteristics and Exclusionary Criteria**

Individuals must have completed at least a master's degree in the field of mental health and have a currently active license to practice.

#### **7. Anticipated Risks and Steps Taken to Avoid Them**

The primary risk is the possible publication of information that is potentially damaging to the professional reputation of the interviewee. All possible steps will be taken to avoid such risks. Interviewees will have the opportunity to withdraw from the interview process at any time and have all recorded or written documentation destroyed. Further, interviewees will be given the opportunity to have their identities remain confidential in the completed and bound form of the dissertation by checking a box on the last page of this form. Opportunities for confidentiality will be presented verbally during the informed consent process and again after the interview is complete. Interviewees choosing confidentiality will have their names substituted in the completed dissertation (e.g., "Clinician 1, Ph.D.", "Clinician 2, MSW", etc.).

#### **8. Anticipated Direct Benefits to Participants**

There is no direct benefit to participants.

#### **9. Clinical Alternatives (i.e., alternative to the proposed procedure) that may be advantageous to participants**

Not applicable.

#### **10. Participant Payment**

No compensation is given.

#### **11. Medical Care and Compensation In the Event of Accidental Injury**

During your participation in this project it is important to understand that you are not a Pacific University clinic patient or client, nor will you be receiving complete mental health care as a result of your participation in this study. If you are injured during your participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study.

## **12. Adverse Event Reporting Plan**

Should an unexpected or adverse reaction occur during the interview process, interviewees will have the opportunity to withdraw from the interview process and have all recorded or written documentation destroyed. The IRB will be informed of all adverse events, generally by the next regular business day.

## **13. Promise of Privacy**

Any records associated with this study will be kept private through vigorous confidentiality efforts, including but not limited to the utilization of a password-protected computer and a locked cabinet for all non-digital data. All participants will be given the opportunity to have their identities remain confidential in the completed and bound form of the dissertation by checking a box on the last page of the consent form. Opportunities for confidentiality will be presented verbally during the informed consent process and again after the interview is complete. Interviewees choosing confidentiality will have their names substituted in the completed dissertation (e.g., “Clinician 1, Ph.D.”, “Clinician 2, MSW”, etc.). Further, electronic data will be deleted after transcription, an event that will take place no longer than one month after the interview process. Lastly, confidentiality will be maintained in any presentation or publication that is derived from the dissertation.

## **14. Voluntary Nature of the Study**

Your decision whether or not to participate will not affect your current or future relations with Pacific University. If you decide to participate, you are free to not answer any question or to withdraw at any time without prejudice or negative consequences. You have the right to withdraw at any time from this study.

## **15. Contacts and Questions**

The researcher will be happy to answer any questions you may have at any time during the course of the study. Complete contact information for the researchers is noted on the first page of this form. If the study in question is a student project, please contact the faculty advisor. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352 – 2112 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

**16. Statement of Consent**

I have read and understand the above. All my questions have been answered. I am 18 years of age or over and agree to participate in the study. I have been offered a copy of this form to keep for my records.

\_\_\_\_\_  
Participant's Signature  
Date

\_\_\_\_\_  
Investigator's Signature  
Date

Please check this box if you would like your identity to remain confidential in the bound and completed form of this dissertation.

**17. Participant contact information**

This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish.

Would you like to have a summary of the results after the study is completed? \_\_\_ Yes  
\_\_\_ No

Participant's name: (Please Print) \_\_\_\_\_

Street address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

