A BUDDHIST-INFORMED CONCEPTUAL FRAMEWORK FOR APPROACHING DIFFICULT EMOTIONS IN PSYCHOTHERAPY

By

Pamela A. Szczygiel

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Dedication

"Little do ye know your own blessedness for to travel hopefully is a better thing than to arrive; the true success is to labor."

- Robert Louis Stevenson

I dedicate this dissertation to my friend and mentor, Michael Montanaro, who died suddenly this year while travelling to a beautiful destination. A true practitioner of mindfulness, Mike found deep love and joy in sitting with his clients. In turn, his clients were able to sit with their own pain and experience unfathomable healing. Thank you, Mike, for your guidance along the way.

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Abstract

Clients often enter psychotherapy with struggles and concerns related to their *direct* experience of emotion. Though most of the major psychotherapy theories in the West address the general issue of emotion, very few have developed a framework or theory for supporting clients in their direct encounters with difficult feeling states. Since Buddhism is highly experiential and Buddhist philosophy is mainly concerned with the issue of human suffering, its relevance to maneuvering difficult emotions in a clinical context is profound. While the use of Buddhist concepts and practices in mental health treatment in the West has proliferated in recent years, the clinical use of Buddhist material has often bypassed the larger philosophical framework of Buddhism. This secular, decontextualized use of Buddhist material has limited the potential value of Buddhist philosophy in mental health treatment. This dissertation offers a conceptual framework for approaching difficult emotions that is grounded in the wisdom of Buddhism. Zen Buddhism is especially relied upon in the development of the following themes: *Sitting With, Middle Path, Healthy Interdependency,* and *Compassion*. Further, clinical composite case vignettes are presented to demonstrate how the themes can be worked with in a therapeutic context.

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Introduction

Clients often enter psychotherapy with struggles and concerns related to their *direct* experience of emotion: "What do I do with my grief?" "My anger consumes me." "I'm overwhelmed with sadness." "When will this pain end?" Though most of the major psychotherapy modalities in the West address the general issue of emotion, they seldom address clients' struggles, concerns, and questions regarding their direct encounters with internal feeling states. Further, very few of them (Greenberg, 2004) have developed a theory or framework that focuses on the emotional life of clients. In some cases, Buddhist concepts and practices have been incorporated into already existing theoretical frameworks to assist clients with various aspects of emotion (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; McCracken & Keogh, 2009; Segal, Williams, & Teasdale, 2002).

In recent years, the use of Buddhist-based practices such as mindfulness, to address an array of mental and physical health issues, has proliferated (deVibe, Bjorndal, Tipton, Hammerstrom, & Kowalski, 2012). Mindfulness, in particular, has been the focal point of various stress reduction programs (Kabat-Zinn, 1990). In most cases, the clinical use of Buddhist practices, in the West, has bypassed the larger Buddhist framework. Although the use of mindfulness as a secular, decontextualized intervention is yielding positive outcomes in quantitative studies (deVibe et al., 2012), one must question whether the use of Buddhist practices as *intervention*, which necessitates their removal from the Buddhist context, distorts their meaning and thereby reduces their potential value to both clients and clinicians. Since Buddhism is mainly concerned with the issue

of human suffering, its relevance to the process of working through emotional difficulty is profound.

This dissertation will explore the development of a clinical framework for maneuvering difficult emotions that is heavily informed by Buddhist philosophy. Chapter One will explore emotion in a broad sense: how various theorists have come to understand what emotion *is*, the difficulty of arriving at a clear definition of emotion, and the ways that various theories of psychotherapy have dealt with emotion. In Chapter Two, I will examine emotion within the Buddhist framework, paying close attention to the ethical and spiritual dimensions of emotion within Buddhism. Chapter Three will focus on the construction of Buddhist-informed themes for use in approaching difficult emotions. Lastly, in Chapter Four, I will apply the themes to composite case vignettes, demonstrating their value in a clinical context.

It is important to note that emotion in the context of this paper will generally be understood through the lens of the client. That is, emotion is the client's encounter with his/her inner sensations and feeling states. Thus, the terms emotion, feelings, feeling states, inner sensations/experiences are used interchangeably in this paper. Here, the intention is to provide an approach that attends to the unique and direct experience of the client.

Chapter 1: Emotion in the West

Introduction

The task of defining emotion is not an easy one. Psychotherapists, philosophers, neuroscientists and the like have explored what emotion *is*. LeDoux (1995) discussed the abounding controversy over defining emotion: "scientists...have not been able to reach a consensus about what emotion is and what place emotion should have in a theory of mind and behavior" (p. 209). With regard to psychotherapy, what produces emotion as well as what compels an individual to repeat emotional patterns again and again, is of central interest (Tantam, 2003).

Definitions and theories of emotion are variable and seem to be limitless. Tantam (2003) explored that emotion is sometimes considered to be an "alerting mechanism" and at other times "can dictate some of our highest aspirations" (p. 25). Further, he explored that emotions may be understood as "both true and false guides of conduct" (p. 25). Thus, some may consider that ongoing, disruptive emotions indicate some sort of emotional disorder. At the same time, "it is also a kind of disorder to be without emotion" (Tantam, 2003, p. 25).

Since emotion has been defined and conceptualized in so many ways by different theorists from varying disciplines, one may consider if cultivating a definition of emotion is possible. One's definition of emotion seems to depend on one's theoretical lens and/or personal experience with emotions. The following chapter will provide insight into the realm of emotion by first, providing an overview of how various theorists understand emotional experience, and second, by investigating how major Western theories of psychotherapy have conceptualized emotion. To this latter point, this chapter will

illuminate the priority (or lack thereof) that various Western theoretical frameworks have given to the issue of emotion, as well as how such frameworks *work with* emotion within the context of psychotherapy.

As mentioned in Ekman, Davidson, Ricard, and Wallace (2005), Aristotle conceived that all emotions are healthy and thus are integral components of virtue and ethics. For example, in the *Nicomachian Ethics,* Aristotle (c. 322 B.C.E./1962) claimed that virtue and happiness are closely related. In the dialogue *Phaedrus* in *The Collected Dialogues of Plato* (1961), Plato used the metaphor of the charioteer and horses to describe the relationship between emotion and reason. The charioteer (reason) uses his reigns to pull back on the wild, unpredictable force of the horses (emotion). Leahy (2007) offered a notable interpretation of Plato's metaphor: "although one can view this as the Platonic view that reason should rule emotion, the metaphor also carries with it the realization that you are not going anywhere without the horses" (p. 353). The ancient Greek recognition regarding the relationship between emotion and reason continues to dominate theories about emotion today, especially within cognitive frameworks.

Emotion theorists have explored various aspects of emotion such as emotion causation, the psychoevolution of emotion, and the expression of emotion, affect. I will consider such aspects more closely in the following section *only* as a means to introduce the complexity involved in understanding emotion.

Several theorists have taken up the issue of identifying *what causes emotion*. Moors (2010) presented several classical theories of emotion causation and noted that emotion theorists "not only disagree about the components that they include in the emotional episode, but also about the component(s) that they include in or identify with

emotion" (p. 3). For example, the William James theory (1890) states that bodily sensations precede emotional experience, e.g. one touches a hot stove and *then* feels the emotion of fear. The Schachter theory (1964) is slightly more complex, proposing that an input stimulus first occurs, followed by a cognitive process that interprets the input. An example of this is a person who is initially aroused by a tap on the shoulder. Upon turning around, the person who is greeted by a friend is pleasantly surprised. If one is greeted by an angry individual holding a handgun, one becomes terrified. In other words, according to Schachter, emotional experience involves an interpretation of the physiological arousal. Moors (2010) noted that both the James and Schachter theories "equate emotion with emotional experience" (p. 12).

Other emotion causation theorists are classified as "appraisal theorists." Appraisal theorists agree with Schachter (1964) that emotions occur after cognition though they would include that "much of the cognitive work involved in the elicitation of emotion is unconscious or otherwise automatic" (Moors, 2010, p. 13). Those who adopt an appraisal theory of emotion accept a more dynamic, complex view of emotion causation. That is, they argue that an emotion like sadness can be provoked in a number of different circumstances and that what provokes sadness in one person will not necessarily elicit sadness in another. For example, a person saying goodbye may provoke sadness in one person but anger and fear in another.

Appraisal theory is an integrative approach to understanding emotion. According to Tantam (2003):

> Emotions, therefore, are influenced by hereditary temperament, are affected by early experience, such as attachment, and involve cognitive appraisal. Appraisal is mediated by language, by the verbal descriptions that a person gives to emotional stimuli (p. 24).

One may consider that many Western theories of psychotherapy adopt an appraisal theory of emotion causation. Greenberg (2004), a developer of emotion-focused therapy (EFT), provides the following definition of emotion: "Emotions... are biologically-based relational action tendencies that result from the appraisal of the situation based on these goals/needs/concerns" (p. 3).

The concept of *emotion narratives* also fits within appraisal theory. This is the idea that "emotions are usually closely coupled to beliefs and values which constitute a 'script'" (Tantam, 2003, p. 25). Tantam (2003) discussed that such *scripts* are of particular interest to psychotherapists. In particular, narrative and existential therapists conceive emotion in this way (Frankl, 1963; Madigan, 2010; Zinker, 1977).

The above is only a sampling of theories that explore emotion causation. The issue of emotion causation is a science in and of itself and thus its complexity exceeds the confines of this paper. Other emotion theorists focus on the evolutionary purpose of emotion in human life. One such theorist, Robert Plutchik (1990), proposed a psychoevolutionary theory of emotion with six key postulates: The first postulate states that emotions "are communication and survival mechanisms" (p. 4). The second postulate encompasses Darwin's belief that emotions have a genetic basis. That is, one can detect similar emotions among a variety of species and also within a species, from one generation to the next. Third, emotions are "inferences based on various classes of evidence" (p. 6). In other words, emotions must be understood within a certain context, or rather with certain "knowledge of an organism's behavior in a variety of settings" (p.6). The fourth postulate maintains that emotions are complex events. Together, the fifth and six postulates discuss that some emotions are primary and others are secondary,

derived from primary emotions. Plutchik (1990) offered the following example of primary and secondary emotions: "Hostility has been judged to be composed of anger and disgust, sociability is a blend of joy and acceptance, and guilt is a combination of pleasure plus fear" (p. 7).

McGuire and Troisi (1990) explored an evolutionary perspective of anger. They discuss how anger and aggression serve the need to protect oneself, loved ones, and property. Essentially, theorists that take an evolutionary view of emotion focus on how emotions have been adaptive throughout history (Ekman et al., 2005).

Other theorists focus on affect, the experience or expression of emotion. How a feeling "shows up" in an individual's facial expression is an example of affect. The regulation of affect is a primary concern for attachment theorists. The second main postulate of attachment theory, according to Slade (2000), is that an infant will do whatever is necessary to stay connected with his/her primary caretaker. An unhealthy, chaotic and/or disruptive primary attachment can lead to the infant's inability to regulate affect (Slade, 2000). According to attachment theorists, the regulation of affect occurs within a relational context. The parent and the infant regulate one another's affective displays. In psychotherapy, the client and therapist may do the same thing.

Emotion in Western Theories of Psychotherapy

In this next section, I will explore how affect and emotion are conceived within various Western theories of psychotherapy. The investigation will start with a more thorough examination of emotion within attachment theory and interpersonal neurobiology. Other theoretical views of emotion have been placed within the following categories: psychoanalytic/psychodynamic, cognitive-behavioral, existential/humanistic, and systems approaches. This inquiry is by no means exhaustive; however, it provides a broad and varied overview of emotion across some of the most integral Western approaches to psychotherapy.

Interpersonal Neurobiology and Attachment Theory

As this paper moves from a general study of emotion to a more detailed analysis of emotion within Western psychotherapy theories, it is fitting to begin with an investigation of modern attachment theory and interpersonal neurobiology. Attachment theory and interpersonal neurobiology bridge the gap between *purely biological* understandings of emotion causation and conceptions of emotion based in psychotherapy theory. Cozolino (2002) explored the interface of neuroscience and psychotherapy. Essentially, one's "neural architecture" is uniquely shaped through relationships with others (pp. 15-16).

Research in the field of neurobiology has bolstered the importance of attachment theory in the West. The basic premise of attachment theory suggests:

> ...present modes of perceiving and dealing with emotionally significant persons, including the therapist, may be influenced and perhaps seriously distorted by the experiences which he (one) had with his (one's) parents during the years of his childhood...(Bowlby, 1977, p. 202).

Specifically, with regard to emotion, Bowlby (1977) posited that emotions are a reflection of a person's *affectional bonds*. Schore and Schore (2008) argued that any contemporary theory of psychotherapy should include "psychobiological findings regarding precisely how early emotional transactions with the primary object (caregiver) impact the development of psychic structure..." (p. 9). Such psychobiological findings, according to Schore and Schore (2008), have "shifted attachment theory to a regulation theory" (p. 9).

Essentially, through relationship and communication, regulation of emotion and affect occurs. Cozolino (2002) explored the process through which psychotherapy, like parenting or caregiving early on in life, changes the brain. Schore and Schore (2002) offered the example of a mother who is attuned to her infant's changing needs for attention: "the more she attends to his reinitiating cues for reengagement, the more synchronized their interaction" (p. 11). This synchronization allows for certain neural activity to occur. Essentially, healthy and attuned interactions will create a secure experience within the infant. With regard to emotion, attachment theory suggests that emotions are *initially* regulated by caregivers or close others (Schore & Schore, 2002).

Attachment theory offers a frame through which to view the dynamic nature of emotional experience. Interpersonal neurobiology hones in on the science within attachment theory. Optimal functioning involves the integration of neural networks for behavior, cognition, emotion, and sensation (Cozolino, 2002). Consequently, individuals with unresolved trauma often suffer from abnormalities in regions of the brain that are vital to neural network integration (Cozolino, 2002).

According to attachment theorists, psychotherapy may help to restore neural network integration (Applegate & Shapiro, 2005; Cozolino, 2002; Schore & Schore, 2008). Cozolino (2002) offered a cogent overview of the role of psychotherapy in neural network integration. He suggested that psychotherapy assists with neural growth and integration in several ways: the development of trusting relationships, acquisition of new cognitive, emotional, and sensory information, the alternation of stress with periods of calm, and integration of "conceptual knowledge with emotional and bodily experience through narratives co-constructed with the therapist" (p. 27).

The field of interpersonal neurobiology offers a compelling argument for psychotherapists to receive training in brain biology. As noted by Cozolino (2002): "Although psychotherapists do not generally think in 'neuroscientific' terms, I believe this is essentially what we do, regardless of our theoretical orientation" (p. 27).

Emotion in Psychoanalytic/Psychodynamic Theory

Though I have chosen to separate attachment theory and interpersonal neurobiology from psychoanalytic theory in this exploration of emotion, they are intimately related. John Bowlby's research on attachment was influenced by earlier object relations theory. In turn, Bowlby's work has been a main contributor to modern psychoanalytic relational theories. Further, Freud began his work in the field of neurobiology. It wasn't until Freud came into contact with Josef Breuer in the late 1880s that he abandoned his focus on neurobiology and began to take an interest in "talk therapy" as a means to releasing difficult and destruction emotions (Berzoff, 2008).

Primary to Freud's theory is the role of the unconscious. It is here that intense instincts, drives, and urges are imbedded within each human being. According to Freud,

pathological symptoms are manifestations of intense material stored in the unconscious that is much too intolerable for our consciousness to bear. Freud (1896) wrote:

> In every case a number of pathological symptoms, habits and phobias are only to be accounted for by going back to these experiences in childhood, and the logical structure of those neurotic manifestations makes it impossible to reject these faithfully preserved memories which emerge from childhood life. True, it would be useless to try to elicit these childhood traumas from a hysteric by questioning him outside psycho-analysis; their traces are never present in conscious memory, only in the symptoms of illness (p. 166).

Though many forms of psychoanalysis share the common goal of making unconscious material *available* to consciousness, the theory and methods used to achieve this goal vary from theorist to theorist. The following overview will consider the variations within psychoanalytic theory, paying close attention to how emotion is *worked with* and approached within the different schools.

At the root of classical Freudian psychoanalytic theory, the pathological symptoms of depression and anxiety are a result of deeply imbedded unconscious conflicts. Freud's drive theory accounts for the tension surrounding one's difficulty in satisfying one's urges. Here, unconscious sexual and aggressive drives, impulses, and instincts underlie the symptoms of illness identifiable in conscious life. With regard to emotion, ongoing feelings of sadness, fear, or rage are conceived as manifestations of unconscious drives. Freud believed that, through the use of free association, his patients could gain access to their unconscious urges and drives. By gaining access to such material, patients were able to verbalize their conflicts and find relief in their symptoms. It is important to note that Freud's drive theory was heavily influenced by the social norms of his time, which involved culturally imbedded sexual repression (Berzoff, 2008).

Freud established the sexual and aggressive drives as biologically based and universal to all. The Oedipus complex is a prime example. Here, Freud posited that *all* children have the desire to possess the opposite sex parent and successful resolution to this stage of development involves the child's identification with the same sex parent. As discussed in Berzoff (2008), Freud's theories were complex and were influenced by a variety of disciplines: art, architecture, literature, physics; they had an unbelievable depth, a mysterious quality that was often misinterpreted by the medical model that adopted them.

In tracking the psychoanalytic theories that followed Freud, it is fitting to begin with object relations theory. The emphasis on endogenous drives is still apparent in early object relations theory, though the drives are understood to be directed toward objects (people). Flanagan (2008) explained:

> Object relations theory is based on the belief that all people have within them an internal, often unconscious world of relationships that is different and in many ways more powerful and compelling than what is going on in their external world of interactions with "real" and present people (p. 122).

Similar to Freud, Melanie Klein (1952), the proclaimed "mother" of object relations theory, focused on unmanageable aggressive urges and instincts that arise endogenously. In contrast to Freud, Klein emphasized early infancy experiences, suggesting that infants have an internal world of *representations* of their relationships and acquire defenses to guard them from fears and insecurities that result from such representations (Klein, 1952). The mother-infant dyad takes center stage in Kleinian theory. For example, feeding between mother and infant yields unconscious aggressive *phantasies* (Klein, 1952).

Klein postulated that anxieties stemming from such early *internalized object relations* create the foundation for one's mental health (Flanagan, 2008). Here, emotional difficulty may result from disruptive internalized object relations. As discussed in Flanagan (2008), Klein referred to two basic positions: the paranoid-schizoid position and the depressive position. The paranoid-schizoid position is the earliest position, referring to "terrifying moments in the neonatal period that can be filled with feelings of fragmentation, surprise and fear," where the baby may be stimulated by scary "shadows and pieces, of noise and light, of moments that feel blissful and moments of great fear" (p. 135). The depressive position occurs as the young toddler begins to manage simultaneous feelings of love and frustration toward the caregiver: "the good person who feeds and nuzzles him...and the bad person who sometimes puts him down harshly and keeps him waiting" (Flanagan, 2008, p. 136).

Even the earliest object relations theorists prefigure the need for healthy attachment. Winnicott (1960) further explored the mother-infant dyad, focusing on the need for both attachment and separateness in development. Significant to healthy infant development (and for healthy emotional development), is a "good enough" mother (also understood as a "good enough" holding environment) who protects but does not overwhelm the infant (Winnicott, 1960). In contrast to Klein who focused on *internalized representations* of object relations, Winnicott emphasizes actual, real relations between mother and infant. Further, with regard to the clinical relationship between psychotherapist and client, a healthy clinical encounter involves the clinician being able to tolerate or "hold" the client's difficult expressions or behaviors (Winnicott, 1971). For Winnicott, the relationship that occurs between client and therapist or

between infant and caregiver creates a "potential space" where the "developing child (or client)" can "find his or her own means of self soothing" (Applegate, 1990).

Other notable Freudian revisionists that emphasized the role of relationships include Harry Stack Sullivan and Karen Horney. Sullivan (1953) was critical of drive theory as the explanation for pathology and posited that relationships play a significant role in pathology. According to Sullivan (1953), anxiety is the result of disruptive, unhealthy relationships and that all individuals seek to manage anxiety by seeking out comfort and safety in relationships. Both Sullivan (1953) and Karen Horney (1924) had difficulty relating to Freud's deterministic framework, which many have deemed to be pessimistic. Horney also focused on the basic pursuit of safety. Her model posited that lack of security and safety in childhood could lead to feelings of helplessness and isolation, which could then create neurotic conflicts that lead to an individual seeking treatment (Seligman, 2006A). In addition, Horney (1924) focused on the patriarchal societal influences imbedded with Freud's theory, challenging many Freudian concepts such as "penis envy."

Sullivan named his theory interpersonal psychoanalysis. Emotions, within this framework, can be understood as expressions of the quality of one's relationships, especially early childhood relationships. Pathology results from deficits- lack of security- in personal relationships and the primary role of the therapist in interpersonal theory is to help the client experience security through empathy, deep respect for the client, and an optimistic stance (Sullivan, 1953).

Another form of psychoanalysis, ego psychology, focuses primarily on the functioning of the ego. Here, the ego is not just a "puppet" controlled by the urges of the

id and the expectations of the superego; rather, it has important characteristics, roles, and strengths (Schames & Shilkret, 2008). Schamess and Shilkret (2008) outlined the major functions of the ego: reality testing, judgment, modulating and controlling impulses, modulating affect, object relations, self-esteem regulation, and mastery. Of these roles, it is significant in this discussion of emotion to explore how ego psychologists conceptualize the ego's role in modulating and controlling impulses and affect. Anna Freud (1966) conceived the goal of psychoanalysis as exploring the contents, boundaries, and functions of the ego "and to trace the history of its dependence on the outside world, the id, and the superego" (p. 5).

Mainly, defense mechanisms protect the ego from unacceptable and/or intolerable unconscious urges and deep-seated fears/anxieties. Defense mechanisms help to shield individuals from emotions that are too painful to experience or acknowledge. As noted in Schamess and Shilkret (2008), for classical analysts as well as for ego psychologists, the emergence of anxiety is significant in that it signals that something intolerable is lodged in the unconscious. Defense mechanisms are employed to settle this anxiety by keeping the repressed material at bay (Schamess & Shilkret, 2008). Repression is perhaps the most commonly discussed defense mechanism as repression shields the individual from anything too painful or intolerable for consciousness to bear.

Whereas object relations theorists focus on the internalized experience of the mother/caregiver and ego psychology develops the role of the ego as mediator, Heinz Kohut's self psychology focuses on the self as a cohesive whole. Wolf (1988) discussed that the self requires more than just an innate tendency to organize experience; it requires the presence of others. Others **"**provide certain types of experiences that will evoke the

emergence and maintenance of the self" (Wolf, 1988, p. 11). Such experiences are termed selfobjects. Further, according to Wolf (1988), healthy selfobject experiences lead to cohesion of the self, while unhealthy experiences may lead to fragmentation.

A distinct difference between Kohut's theory and the theories discussed previously is Kohut's emphasis on empathy, rather than insight, as a primary therapeutic tool and the means through which the self can be understood within the context of psychotherapy (Flanagan, 2008). Thus, certain *empathetic failures* create self-pathologies. Kohut and Wolf (1978) made the distinction between the overstimulated self and the overburdened self.

> In the overstimulated self, "people are subject to being flooded by unrealistic, archaic greatness fantasies which produce painful tension and anxiety... they will try to avoid situations in which they could become the center of attention...the overburdened self is a self that had not been provided with the opportunity to merge with the calmness of an omnipotent selfobject. The overburdened self, in other words, is a self that had suffered the trauma of unshared emotionality" (p. 420).

Kohut and Wolf (1978) discussed that even the most traumatized and vulnerable individuals can begin to cope if "embedded in healthy supportive milieu" (p. 417).

Painful or difficult emotional experiences can be seen, within self-psychology, as the result of a needs deficit. In other words, the need for an empathetic response, somewhere along the line, was unmet. Relational theorists draw on the ideas of both self psychology and object relations. In relational theory, it becomes much more clear that the process between the client and therapist is *key* in working through the client's presenting issues. Benjamin (1995) provided the following definition of relational theory: "What these approaches share is the belief that the human mind is interactive rather than monadic, that the psychoanalytic process should be understood as occurring

between subjects rather that within the individual" (p. 28). Moreover, Benjamin (1995) noted that relational theories take Kohut's theory around empathy a bit further.

Intersubjective or relational theories focus on "the connections between the interpersonal and intrapsychic dynamics within situational, social, and historical contexts" (Hadley, 2008, p. 225). The back and forth dialogue and process between client and therapist is key. It is here that problems, symptoms, pathologies, and difficult emotional states are dealt with. Benjamin (1995) explored the thoughts of Beebe and Lachman (1988) who posited that continuous harmony is not the goal, rather the goal is "continuous disruption and repair" (p. 47).

Emotion in Cognitive Behavioral Theory (CBT)

Simply stated, CBT is a basic term for psychotherapies that include both cognitive and behavioral interventions. CBT clinicians adopt the belief that "symptomatic change follows cognitive change" (Brewin, 1996, p. 34). Zettle (2007) offers an overview of the "three waves" of behavioral therapy.

The first generation, originating in the 1920s, focused on modifying problematic behavior "by the application of basic principles of classical/respondent conditioning a la Pavlov" (Zettle, 2007, p. 5). The second wave involved a merger of both cognitive and behavioral interventions and was based, in large, on the work of Aaron Beck (1967). Zettle (2007) explained that the first and second generations dealt with "*first order change*, that is, attempting to alter the form, frequency, and/or content of abnormal behavior" (p. 5). With regard to the second wave, the only real difference is that it seeks to alter both behavior and cognitions. The third generation of cognitive behavioral therapies emphasizes a "*second order change* agenda in which focus is shifted away from

the altering form or content of abnormal behavior to the context in which it occurs" (p. 6). The following section will illuminate how emotion is approached within the second and third waves of cognitive behavioral theory, as these are the most commonly practiced by psychotherapists today.

In second wave CBT, problematic emotions and emotional disorders are approached and treated by altering "maladaptive cognitive organizations or 'schemas' that have a strong impact on affective and behavioral responses" (Greenberg & Beck, 1990). Greenberg and Beck (1990) noted that this is not a unidirectional process; rather, emotion and behavior may affect cognitions, which may then lead to a dysfunctional dynamic. For example, a depressed person believes that she is unworthy of love. In response, she may begin to avoid contact with family and friends. As a result, her support network withdraws from her. Consequently, her depressive thinking becomes solidified. Though emotion is acknowledged within cognitive behavioral therapy, thoughts and behaviors are the focal points for intervention.

The focus on behaviors and thoughts in CBT makes sense, as cognitive behavioral therapy is heavily influenced by learning theory. Brewin (1996) explained: "prior learning is currently having maladaptive consequences, and ... the purpose of therapy is to reduce distress or unwanted behavior by undoing this learning or by providing new, more adaptive learning experiences" (p. 34). Classical CBT (which this author has been identifying as second wave) is not the only form of treatment that values this premise. Branches of CBT, like mindfulness-based CBT (MBCT), acceptance and commitment therapy (ACT), and dialectical behavior therapy (DBT) also share this basic position. These "branches" are a part of the third generation of cognitive behavioral therapies.

As noted in Fennel and Segal (2011), "mindfulness-based cognitive therapy creates an unlikely partnership, between the ancient tradition of mindfulness meditation rooted in Buddhist thought and the much more recent and essentially Western tradition of cognitive and clinical science" (p. 125). Further, the authors went on to discuss the origin of mindfulness-based cognitive therapy (MBCT), which is grounded in the recognition that depression tends to be recurrent: "Depressed mood leads to gloomy, pessimistic ruminations which, in turn, reinforce and deepen it, encouraging withdrawal from others and from everyday activities that might otherwise offer a sense of pleasure or accomplishment" (p.126).

Segal, Williams, and Teasdale (2002) developed MBCT. The developers of MBCT based the mindfulness component of the intervention on the seminal work of Kabat-Zinn and colleagues (1990), the originators of Mindfulness-Based Stress Reduction (MBSR) programming. MBSR is an eight-week program situated around the concept of mindfulness. Throughout the eight weeks, participants practice sitting and walking mindfulness meditation, yoga and breathing exercises, both in class and at home. Mindfulness, according to Kabat-Zinn (1990), is defined as purposefully paying attention, to the present moment, without judgment. In MBCT, participants are encouraged to become more aware of their thinking patterns and other experiences. They are encouraged to practice acceptance rather than judgment when having such experiences: "Rather than backing off or becoming entangled in 'thinking about' the difficulty, participants practice exploring it in the body, with an attitude of curiosity and compassion" (Fennell & Segal, 2011, p. 131).

Emotions, within the context of MBCT, are like other sensations; they are experiences *to be noticed*. Participants in MBCT programs are encouraged to observe emotions, without judgment. Emotions, in particular, are not a focal point for intervention. The intervention in MBCT, rather, is changing one's response to experiences. Whether the experience is an emotion, a thought, or a bodily sensation, the intervention is the same: observe experiences without judgment in order to limit becoming *entangled*. As mentioned previously, getting entangled in thoughts, feelings, and other sensations can lead to patterns of negative rumination that often hallmark depression and other mental health problems (Fennell & Segal, 2011).

Both CBT and MBCT share a similar distrust of feelings and thoughts in that both claim the dysfunctional aspect of becoming *too attached* to thoughts and feelings, especially negative ones. The marriage of mindfulness with cognitive therapy in MBCT has created controversy in both the cognitive behavioral and mindfulness camps (Fennell and Segal, 2011).

Some authors have been critical of interventions like MBCT because in such programs mindfulness is utilized as technique rather than a way of being (Grossman & Van Dam, 2011; Khong, 2009). Grossman and Van Dam (2011) pointed out that mindfulness is often misinterpreted in the West. They discuss that, in Buddhism, mindfulness is a practice and a process that involves several components. In contrast, in the West, mindfulness is "a relatively stable trait in a manner that takes little account of the developmental and contextual aspects inherent in the Buddhist formulation" (Grossman & Van Dam, 2011, p. 221).

Further, Fennell and Segal (2011) noted some stark differences between cognitive theory and the Buddhist concept of mindfulness in terms of goal-orientation, methodology, and language. They discuss that cognitive theory seeks change while mindfulness seeks acceptance. Furthermore, while cognitive theory "utilizes an extensive repertoire of treatment methods designed to help patients to discover that it is in their power to change," mindfulness-based interventions use "intensive mindfulness meditation…as the prime vehicle for nurturing insight and a steadier, more spacious perspective" (Fennell & Segal, 2011, p. 134).

As mentioned previously, in cognitive behavioral forms of treatment, emotions are *dealt with* indirectly, by changing one's thoughts and actions around a particular problem or issue. In MBCT, emotions are approached more directly in that individuals receiving MBCT are encouraged to become aware of all their experiences- thoughts, emotions, body sensations- and to approach such experiences with compassionate, nonjudgmental observation (Segal et al., 2002). Mindfulness serves to alleviate distress by fostering a nonreactive approach to experiences that previously worsened one's distress level. In Buddhism, mindfulness is a life long practice that promotes well-being. Mindfulness is a form of mental hygiene that leads to further insight into life (Khong, 2009). In this way, becoming more mindful of emotional experiences can enhance overall insight into one's self. The issue of how the West has adapted the Buddhist concept of mindfulness for use in psychotherapy will be examined more closely later in this paper. For now, it is important to bring this issue up in a broad sense, only to discuss the ways in which Western approaches have assimilated Buddhist concepts into clinical

theory and how this assimilation has led to changes in the classical theory (in this case, how the assimilation of mindfulness changes CBT into branches like MBCT).

Another cognitive behavioral form of treatment that utilizes mindfulness is Dialectical Behavioral Therapy (DBT). DBT utilizes individual therapy, skills training, and as needed consultations between therapy sessions to assist individuals, especially those with borderline personality disorder (Rizvi, Steffel, & Carson-Wong, 2013). In addition to CBT principles, the theoretical basis for DBT is biosocial theory and dialectical theory. As discussed in Rizvi et al. (2013), the emotional dysregulation that hallmarks individuals with borderline personality disorder "stems from a transaction over time between a biological dysfunction in the emotional regulation system and an invalidating environment" (p. 74). Further, the same authors note the definition of dialectical theory: "reality is interrelated and connected, made of opposing forces, and always changing" (p. 74). Aspects of Zen Buddhism, such as mindfulness, are also incorporated into DBT as a means to assist individuals with approaching difficult emotional states less reactively.

Since DBT focuses on assisting individuals who are often considered to be extremely emotionally reactive, it deals with emotions more directly than other forms of CBT. Though DBT supports emotional regulation through the use of cognitive and behavioral changes, the mindfulness aspects imbedded within DBT are meant to support individuals in their *direct* experience of emotions. The mindfulness component of DBT is derived from Zen Buddhist principles and encourages "becoming 'one' with current experience, without judgment or any effort to change *what is*" (Lynch et al., 2006). Further, in comparison to other behavior-focused therapies, the mindfulness component

of DBT encourages acceptance and oneness with experience *in addition to* striving to change, fix or alter an experience (Lynch et al., 2006). This is a big divergence from more classical forms of CBT. An individual receiving DBT is encouraged to "sit with" difficult emotional experiences rather than react to emotions. Essentially, within the context of DBT, this type of approach to emotions is meant to support the emotional regulation process. On the other hand, the behavioral and cognitive components of DBT encourage change. True to the nature of dialectics, DBT encourages both change and acceptance.

Yet another form of CBT is Acceptance and Commitment Therapy (ACT). ACT is partially rooted in Relational Frame Theory (RFT), which is an extension of B.F. Skinner's work and posits that learning takes place within a specific context and environment (Montgomery, Kim, & Franklin, 2011). Zettle (2007) notes that relational frame theory attempts to reconcile some of the weaknesses of the first two generations of cognitive behavioral therapies. RFT supports the main goal of ACT, which is to promote psychological flexibility (Zettle, 2007). Zettle (2007) highlighted the six core processes that contribute to psychological flexibility: "Self as context, Defusion, Acceptance, Contact with the present moment, Values, and Committed action" (p. 11). Montgomery et al. (2011) note that the mechanism for change in ACT is not to change thoughts or feelings but rather to change one's response/relationship to their internal processes. In contrast to DBT, ACT is not a *manualized* treatment approach. It aims to foster psychological flexibility in clients and the originators of ACT encourage therapists to meet the individual needs of each client (Montgomery, Kim, & Franklin , 2011).

With regard to emotion and other experiences, clients receiving ACT are encouraged to practice both *acceptance of* and *distance from* their emotions (Montgomery et al., 2011). For example, a client that normally avoids anxiety feelings will be supported in maintaining awareness of the negative feelings and to accept the presence of such feelings in his/her life. This same client will also be encouraged to contact his/her transcendent self. The transcendent self can observe, with distance, the difficult thoughts and emotions and not become tangled in them (Montgomery et al., 2011). Whereas DBT fosters both acceptance and change with regard to difficult experiences, ACT promotes acceptance as a means to develop more flexibility around one's emotional and mental pain.

Emotion in Humanistic and Existential Theory

According to Sartre (1962), emotion "is not a pure ineffable quality like brick-red or the pure feeling of pain- as it would have to be according to James's theory. It has a meaning, it *signifies something in my psychic life*" (p. 91). The humanistic/existential school accepts emotion as integral to human experience. This section will explore key figures within the existential/humanistic framework, focusing on how various treatment modalities within this framework approach emotional experience.

> Seligman (2006B) explored the tenets of humanism:
> Humanism is phenomenological, focusing on people's own frames of reference and the personal meaning of their experiences. It optimistically promotes wellness, personal growth, and achievement of one's potential...It emphasizes qualities such as choice, freedom, values, and goals (p. 172).

Carl Rogers' (1951) person-centered counseling is grounded in humanist values. At the time when Rogers was developing person-centered therapy, behaviorism and psychoanalytic approaches to treatment prevailed. Rogers was critical of the way in

which psychoanalysis and behaviorism bolstered the clinician as the expert, while ignoring the wisdom and capability of the client.

A key Rogerian concept is *unconditional positive regard*, whereby the therapist has a deep but non-possessive caring for the client (Rogers, 1957). According to Rogers (1957), the therapist's warmth toward the client is necessary for the development of a therapeutic relationship and for subsequent growth and change to occur.

Phenomenology is a key aspect in the humanistic/existential approach. Some use the terms existentialism and phenomenology interchangeably, yet Clarkson (1989) explores the subtle differences: "The phenomenological method, which pays total attention to the phenomenon (person, experience, object) as it presents itself, becomes the method of choice in the counseling approach" (p. 15). Existentialism and phenomenology are very closely related, though some argue that phenomenology seems to pay closer attention to one's immediate experience (Clarkson, 1989).

To summarize, humanism is a movement that centralizes human *experience*. Existentialism and phenomenology are means through which to explore the human experience. Within the context of psychotherapy, existential therapists posit that certain human experiences often contribute to emotional difficulty- death, isolation, meaninglessness, and responsibility, to name a few. Frankl's (1969) *logotherapy* is a prime example of existential therapy. Logotherapy was born out of Frankl's three-year imprisonment in a Nazi concentration camp during World War II. Frankl (1969) concluded that creating meaning and purpose is a prime motivator in human life:

> If there is meaning in life at all, then there must be meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete (p. 106).

The acceptance of *inevitable* human sufferings like death and isolation, coupled with the belief that creating meaning is integral to humanity, gives existential therapists a unique perspective on emotion. That is, difficult emotion is often conceived of as a natural part of human experience. For example, existential therapists make a distinction between *existential* and *neurotic* anxiety. Existential anxiety is characterized by the uneasiness *most* individuals feel about issues like death or, for some, the discomfort associated with realizing that there is no inherent meaning or purpose to life (Frankl, 1969). On the other hand, neurotic anxiety manifests when individuals do not explore that larger meaning of their lives and thus feel distress and low self worth regarding existential issues, which can then lead to increased fear and anxiety about routine life issues/problems (Seligman, 2006C).

Gestalt therapists prioritize emotion in that emotion is a significant part of the entire human experience. Gestalt is the German word for wholeness. According to Gestalt, "man is a whole who is (rather than has) a body, emotions, thoughts, sensations, and perceptions..." (Passons, 1975, p. 14). Thus, gestalt therapists encourage individuals to stay in contact with their mental, emotional, and bodily experiences, as they exist in the *here and now* (Clarkson, 1989). It is through this type of self-awareness of emotions, thoughts, and bodily sensations that empowerment and growth can occur. An example of a gestalt technique would be to ask a client to identify and express the felt emotion, locate the emotion within the body, and then engage in a conversation with that emotion. Shepard (1975) discussed that hints of psychodrama can be detected within gestalt, which is no surprise given that the founder of gestalt therapy, Fritz Perls, studied theater prior to becoming a psychiatrist and psychotherapist. Though Perls initially trained as a

psychoanalyst, he became increasingly critical of the focus on past trauma inherent in psychoanalytic theory (Shepard, 1975). Perls saw the *here and now* as the key to growth.

Further, the focus on wholeness within gestalt elevates the importance of all physical and emotional experiences. In gestalt, one is encouraged to adopt a holistic view of their experiences, not to separate thought from emotion or emotion from body. Threads of Zen Buddhism can be detected in Gestalt's emphasis on wholeness (Lindblade, 2011).

Another form of treatment that arguably fits into the existential/humanistic category due to its phenomenological emphasis is Emotion-Focused Therapy (EFT). They key tenet of EFT is that "emotion is foundational in the construction of the self and is a key determinant of self organization" (Greenberg, 2004). Greenberg (2004) notes that emotions are integral in that they help to regulate the individual as well as others surrounding the individual, thereby giving further meaning to life. In other words, a felt emotion may indicate a particular need. A feeling of being overwhelmed triggers someone to take better care of him/herself. Or, the feeling of anger causes an individual to confront someone.

EFT is grounded in neuroscience research and refutes outdated, classical theories of emotion. As mentioned earlier, classic theories of emotion causation claim that cognition precedes emotion. Emotion-focused theorists argue that emotions may be pre or post cognitive and that emotion causation and processing is much more complex and dynamic than previously thought (Greenberg, 2004). Further, EFT theorists claim that emotions are integral in the processing of human experience (Elliott & Greenberg, 2007). This claim is congruent with interpersonal neurobiology research regarding the

significance of *dealing with* emotions within the context of psychotherapy (Applegate & Shapiro, 2005; Cozolino, 2002).

An important theoretical component of EFT is the dialectical-constructivist view of human functioning: "personal meaning emerges by the self-organization and explication of one's own emotional experience and optimal adaptation involves an integration of reason and emotion" (Greenberg, 2004, p. 4). Greenberg (2004) offered the following example: "overtime the innate response of joy at a human facial configuration becomes differentiated into feelings of pleasure with a specific caretaker and contributes to the development to basic trust" (p. 5).

Emotion-focused therapists make a distinction between more traditional cognitive and insight oriented forms of psychotherapy that utilize a *top-down* approach to emotions and the preferred *bottom-up* approach associated with EFT (Greenberg, 2004). As noted by Greenberg (2004), top-down intervention models teach individuals that certain emotional reactions are "erroneous interpretations of what is occurring or belong to the past and are now irrelevant" (p. 6). Although such approaches may give clients a model for understanding their difficulties as arising from past experiences, they are "unlikely to reconfigure the alarm systems of the brain, or the emotion schematic networks that have been organized from them" (Greenberg, 2004, p. 6). In contrast, bottom-up approaches like EFT seek to alter *automatic emotional responding* by asking clients to become acutely *in tune* with the sensorimotor processes within the body (Greenberg, 2004). Individuals are encouraged to practice mindfulness of their internal experience (Greenberg, 2004; Elliott & Greenberg, 2007).

Further, EFT is grounded in *process-experiential emotion theory*, which states that emotion is adaptive and is a central aspect of human functioning and change. Therapists utilizing EFT continuously balance emotional experiencing with more cognitive self-reflective tasks (Elliott & Greenberg, 2007). It is the emotional *experiencing* aspect of EFT that sets it apart from many contemporary psychotherapy theories that focus on short-term interventions aimed at changing thoughts and behaviors, with or without some elements of mindfulness and/or experiencing included. According to EFT, experiencing emotion is *the central* task. Similar to Plutchik's (1990) psychoevolutionary theory of emotion, EFT makes a distinction between *primary adaptive* emotions and *secondary reactive* emotions:

> *Primary adaptive* emotions are the person's most direct, useful responses to a situation; therefore, it is best for these to be accessed and allowed to shape adaptive action. *Secondary reactive* emotions are the response to another more primary emotion; they thus require empathetic exploration of more adaptive emotions that may underlie the emotion presented (Elliott & Greenberg, 2007, p. 244).

In sum, becoming more emotionally aware promotes self-reflection, which, in turn, promotes the creation of new meanings or new narratives (Greenberg, 2004).

Narrative therapy, another form of therapy, which arguably fits into a humanistic/existential framework, shares some common ground with EFT. While narrative therapy does not prioritize emotion and emotional experiencing, it does emphasize personal narratives and meaning. Presenting problems and issues, within the context of narrative therapy, are intimately linked to one's personal narrative about oneself, which is comprised of one's socio-cultural and political context (Madigan, 2011).

Narrative therapy views therapeutic issues as created by social, cultural and political forces rather than being inherent within the individual. Madigan (2011) explains: "Narrative therapy places the site of the problem within the relational action of person/culture/power and, as a result, not inside the person's body" (p. 65). With regard to the discussion on emotion, narrative therapy offers a unique perspective. On one level, narrative therapy does not deal with emotions at all insofar as emotions are experienced subjectively, *within the individual*. Narrative therapy is theoretically grounded in social constructionism. Social constructionist theory asserts that there are no subjects without objects. It follows, then, that an individual's emotional experience (or any other "subjective" experience for that matter) cannot be separated from their environmental context (social, cultural, political, etc...). On another level, one can argue that emotions, within the context of narrative therapy, *are* dealt with insofar as emotions are creations of the subject coming into contact with socio-cultural and political "objects." Emotions, like diagnoses, issues, and problems, are born out of a unique interaction with the larger environmental framework.

An example may help to illuminate how narrative therapy approaches a clinical issue. Madigan (2011) discussed the problem of anorexia: "Narrative therapy questions...the process of how and through what means mental health invented anorexia as a pathology to be placed inside the bodies of the women afflicted" (p. 61). Further, the narrative therapist does not believe that anorexia arises *within* the person who suffers from it. Rather, narrative therapy posits that the disorder was created from the *outside in*. That is, the structural-societal belief system influences the emergence of symptoms within the individual.

Emotion within Systems Approaches

In this section I will group systems theory, eco-systems theory, and the ecological perspective in the same category, referring to all as "systems approaches," as all prioritize the *interaction* of the individual with his/her environment. Because this investigation is mainly concerned with how emotion is *worked with* in various theoretical frameworks, it is enough to focus on the interactional component inherent in all three.

Systems approaches are often criticized as clinical theories, as their concepts are sometimes considered to be too abstract (Grief & Lynch, 1983). Nevertheless, the theories are integral to social work practice as they serve to illuminate the person-in-environment perspective celebrated by the field. With regard to the current discussion about emotion, systems approaches offer a frame through which to understand the complexity inherent in human struggle, pain and healing, and resiliency.

Systems approaches adopt the language of ecology- boundaries, transactions, temporal dimension, resilience, homeostasis- and make use of such language when conceptualizing clinical issues (Bronfenbrenner, 1995). Grief and Lynch (1983) explored that the main contribution of general systems theory in clinical contexts is the shift away from linear causality to a "multidimensional view of systemic causality" (p. 51). In this way, one is encouraged to consider that both the *origins of* and *solutions to* clinical issues must be understood within the web of phenomena occurring in each individual's life. Werner, Altman, Oxley, and Haggard (1987) explained:

> Psychological phenomena are best understood as holistic events composed of inseparable and mutually defining psychological processes, physical environments and social environments, and temporal qualities. There are no separate actors in an event; the actions of one person are understood in relation to the actions of other people, and in relation to spatial, situational and temporal circumstances in which the actors are embedded. These different aspects of an

> event are so intermeshed that understanding one aspect requires simultaneous inclusion of other aspects in the analysis" (p. 244).

The above quote illuminates how the clinical issues of one client are, at least in part, connected to the larger socio-cultural frame. The example of how a narrative therapist approaches working with an anorexic client fits here.

Going back to the exploration of how emotion is conceived within clinical theory, the systems theorist seems to posit that emotional phenomena is a part of the complex weaving that constructs one's self. Within this approach, the health or well-being of one's self is related to the "*perceived level of fit* between their personal and environmental resources" (Mizrahi & Davis, 2008, p. 2). As Mizhari and Davis (2008) explained, emotional stress is related to a *poor fit* between an individual's "perceptions of environmental resources and their needs, aspirations, and capacities" (p. 2).

A clear clinical use of the systems approach is structural family therapy, where the interactions and processes among family members and between the family and their environment, are the focal points of intervention. Germain (1981) discussed how the ecosystemic therapist considers "who or what can be added to the life space so that transactions will be improved" (p. 328). Further, Germain (1981) provided the example of Salvador Minuchin's decision to use an adolescent as a co-therapist in a family therapy session, to teach "the family much about issues involved in adolescent autonomy" (p. 328).

Systems theory provides a framework for understanding how peoples' *perceptions* of what is available to them in the way of help or resources may affect their sense of well-being. This is a primary concern of social workers. It offers a unique clinical perspective that situates emotions within a larger contextual framework, which

includes interpersonal relationships as well as dynamic interactions among social, economic, political, and cultural spheres.

Summary

Clients often begin psychotherapy with the goal of coping with emotional pain and discomfort. How this pain in dealt with in psychotherapy depends on the theoretical lens of the clinician. This chapter has explored Western definitions and conceptions of emotion, paying close attention to how emotion is *worked with* in the context of various psychotherapy theories. Interpersonal neurobiology and attachment theory explore the role of relationships in changing emotional patterns as well as the circuitry within the brain. Psychoanalytic and psychodynamic approaches account for the role of the unconscious in our emotional experiences, patterns, and expressions. Cognitive behavioral theories emphasize the role of thoughts and behaviors in changing destructive emotional patterns. Existential/humanistic theory prioritizes *here and now* experiencing as well as the development of a sense of meaning as primary to overcoming emotional obstacles. Lastly, within systems approaches, emotional issues are situated within a complex web of person-in-environment interactions.

Chapter 2: *Emotion* in Buddhism

Buddhism provides yet another lens through which to explore the complex world of emotion. In essence, Buddhism is concerned with suffering: how individuals suffer, the origin of suffering, and the path to eliminate suffering. Though there is no generic term for *emotion* in Buddhism, Buddhist philosophy offers a framework for understanding the role of mental activity (emotions are included here) in human suffering and pain.

One cannot begin to discern *how* Buddhism approaches emotion without understanding the main tenets of Buddhism. To this point, this chapter will offer an overview of Buddha's main teachings as well as provide a discussion on the Buddhist concepts of *self* and *emptiness*, which further illuminate Buddhist ontology. In addition, this chapter will explore the ethical and spiritual dimensions of emotion within Buddhism. Lastly, I will examine how the Buddhist concept of mindfulness has been adopted in the West. This examination highlights the implications of using Buddhist concepts outside of the larger Buddhist framework.

Buddhism: Historical and Cultural Considerations

Buddhism is a complex religion with historical roots that are even more complex. There are various sects of Buddhism and often a variety of interpretations of Buddhist concepts within each sect. Though it is beyond the scope of this chapter to delineate all the nuances within Buddhism and the various sects of Buddhism, I will offer a brief overview of historical and cultural considerations for two reasons: 1. Since Buddhism has been understood within various contexts, it is important to clarify the context in

which Buddhism will be understood within this paper. 2. Exploring how emotion is approached within Buddhism necessitates the delineation of Buddhist ontology.

Buddha's teachings were passed down orally for approximately four hundred years following his death. It has been discussed that the only monk who fully memorized Buddha's teachings was quite arrogant and that several others made grave mistakes in their attempts to explain Buddha's teachings (Hanh, 1998). Thus, the teachings were distorted even before they were written down (Batchelor, 2011). Further, by the time Buddha's teachings were written down in the Pali language, there were about twenty schools of Buddhism already formed. Though the earliest written recordings were in Pali and Sanskrit, Buddha spoke neither of these languages (Hanh, 1998). Many scholars consider the Pali canon as containing the closest account of Buddha's teachings (Batchelor, 2011; Watts, 1999). Even so, as Batchelor (2011) noted: "The Pali Canon is a vast patchwork of thousands of pages of text, woven and sewn together over many generations" (p. 101).

It is important to acknowledge the cultural and religious backdrop against which Buddhism was formed. Hindu cosmology is tightly wound into Buddhist texts. The strong influence of Hindu culture on Buddhism (beliefs in gods and angels, reincarnation, and karma, for example) cannot be ignored. This influence has provided some sects of Buddhism with more dogmatic elements. Further, Batchelor (2011) explained that it is nearly impossible to completely discern what Buddha *actually* said. Watts (1999) discussed this same point. In addition, he noted that Buddhism carries with it a specific set of beliefs that vary drastically from Hinduism:

> The crucial issue wherein Buddhism differs from Hinduism is that is doesn't say who you are... Buddhism is not interested in concepts, it is interested in direct experience only (p. 6).

Theravada and Mahayana are the two main schools of Buddhism recognized today. Theravada means "the way of the elders" and is generally considered to be a very strict form of Buddhism; it is mainly practiced in places like Thailand, Cambodia and other regions in South Asia. Theravada is considered to be the Buddhism of monks. Theravada practices, generally speaking, include a sort of distancing from the world of desires. Theravada monks traditionally follow the scriptures in the Pali language (Watts, 1999).

Mahayana means "great vehicle" and is typically practiced in northern India, Tibet, China, and Japan. Mahayana Buddhists often challenge the strictness of the Theravada and focus on awakening oneself within the material world. In other words, for the Mahayana, it is important to be able to connect with others in the material world as well as to assist others in their efforts to become bodhisattvas (ideal humans). The Mahayana school has traditionally followed the scriptures in Sanskrit (Watts, 1999). As stated previously, it is important to acknowledge that there are many nuances within the various sects of Buddhism. For example, though Zen and Tibetan schools of Buddhism fall under the Mahayana category, many notable scholars within these schools follow the Pali Canon as a guide to Buddha's teachings.

In this terse exploration of the culture and history of Buddhism, it is significant to discuss the *type of* religion that Buddhism is. Many practicing Buddhists, especially in the West, describe themselves as secular, agnostic, or atheist Buddhists. Watts (1999) pointed out that the religions of the Far East (Hinduism, Buddhism, Taoism) do not

require a belief in anything in particular. He discussed that such religions do not require adherence to specific commandments and/or rituals in the same way that a religion like Christianity does. Watts (1999) explained: "Their objective is not ideas or doctrines, but rather a method for the transformation of consciousness, and our sensation of self" (p. 19). Olendzki (2010) discussed that systems like Buddhism and Hinduism call the individual to look inward rather than outward for wisdom and inspiration. Further, many Buddhist scholars note that the *Dharma* (loosely translated as "teachings") of Buddha is not meant to be a type of law or revelation in and of itself. To this point, Hanh (1998) included a statement uttered by the Buddha on several occasions: "My teaching is like a finger pointing to the moon. Do not mistake the finger for the moon" (p. 17).

Buddha's Teaching

The Four Noble Truths are central to Buddha's teachings. Batchelor (2011) envisioned the Four Truths as "injunctions to do something rather than claims to be believed or disbelieved" (p. 153). Following Batchelor's interpretation, one may understand the truths as a means through which humans can approach and minimize suffering in their lives. Hanh (1998) discussed the Chinese translation of the Four Truths, "The Four Wonderful Truths or Four Holy Truths," and offered the following interpretation: "Our suffering is holy if we embrace it and look deeply into it" (p. 9). In this way, The Four Truths offer guidance and support as the individual digs deep into his/her suffering.

The First Noble Truth is suffering (*dukkha*). Young-Eisendrath (2008) pointed out that, in English, the word *dukkha* is often translated into "Life is Suffering," which has led many Westerners to identify Buddhism as a "morbid religion" (p. 543). Further,

Young-Eisendrath (2008) suggested that the word encapsulates what it means to be human. That is, humans are guaranteed to experience inevitable sufferings or "unsatisfactoriness," losses, decline, and death (p. 543). Batchelor (2011) posited that the First Truth is a challenge given to individuals to become fully aware of their suffering. According to Buddhism, suffering is a universal human experience.

The Second Truth is the origin or cause of suffering (*samudaya*), delusive desire (Okumura, 2012). Here, delusive desire refers to the *Klesas*, which are "the hindrances, troubles, defilements, or passions that drive us toward unwholesome action" (Okumura, 2012, p. 17). The definition of the word *Klesas* may vary from one school of Buddhism to the next. Okumura (2012) identified the four *klesas* as "ignorance, egocentric view, arrogance, and self-attachment" (p. 17).

The Third Truth is the cessation (*nirodha*) of suffering. Hanh (1998) proposed that this is a hopeful path, as the Buddha's teaching focused *both* on how to acknowledge suffering in our lives *and* how to lessen it. Thus, Hanh (1998) declared: "The Third Truth is that healing is possible" (p. 11). The Fourth Noble Truth is the path (*marga*) that leads to the cessation *(nirodha*) of suffering. This path is called the Noble Eightfold Path (*arya ashtangika marga*): Right View, Right Thinking, Right Speech, Right Action, Right Livelihood, Right Effort, Right Mindfulness, and Right Meditation (Okumura, 2012).

To have Right View presupposes that one has an understanding of the Four Truths. When one has Right View, he/she has a commitment to well-being, or rather, a commitment to the elimination of suffering. It also involves an "ability to distinguish wholesome roots from unwholesome roots" (Hanh, 1998, p. 51). Thus, one understands

for him/herself what is healthy and what is not and makes a commitment to move toward wholesomeness. Essentially, all humans have tendencies toward actions that assist in their flourishing as well as tendencies toward actions that produce further suffering. According to Hanh (1998), the seeds of everything are within us and what we grow into depends on which seeds we water.

The next step along the path is Right Thinking. It is important to note that the steps are not meant to be linear. For example, it is not as if *mastering* Right View then leads to Right Thinking. Right Thinking (*samyak samkalpa*) assumes that one is also practicing Right View. In turn, Right View also implies that one is practicing Right Thinking as well as the other steps along the path. As Hanh (1998) explained, the steps of the Eightfold Path as well as The Four Truths have *interbeing* with one another. Right Thinking is the acknowledgment that human thought tends to be tainted. Often, the human mind is full of thoughts that have nothing to do with the present moment, with what is *actually* happening. An example of this is an individual who, upon having an interaction with a friend that felt uncomfortable, begins to tell him/herself a story about that discomfort: "Oh, she must be mad at me because I didn't call her last week when I said I would." Right Thinking speaks to this "weaving of tales" that occurs in our minds when we don't understand something. One who follows Right Thinking can conclude: the individual felt uncomfortable in the presence of a friend and didn't know why, plain and simple.

As mentioned previously, Right Speech (*samyag vac*) is based on Right Thinking and Right View. Practicing Right Speech means that one is aware of the way in which speech either reflects the wholesome or unwholesome seeds within. It is really a

direct extension of Right Thinking in that speaking is thinking aloud (Hanh, 1998). A main component of Right Speech is practicing mindful listening.

It makes sense to explore Right Action (*samyak karmanta*), Right Livelihood (*samyag ajiva*), and Right Effort/Diligence (*samyak pradhana*) together, as they all have to do with a nonviolent approach to life (Hanh, 1998). Right Action entails paying close attention (being mindful) to all of one's interactions in the world and evaluating whether or not actions *create* or *alleviate* harm and suffering. Right Effort means that one puts his/her energy and emphasis into those activities that promote a wholesome, fulfilling life. This includes the energy put into one's meditation and mindfulness practice (such practices will be explored later). Thus, an individual putting energy and effort into gambling to the extent that he/she loses his/her home, family, and job is an example of "wrong" effort. Though, it is important to point out that even seemingly *right* activities can become examples of *wrong* effort. An example of this is trying to deepen one's meditation practice by forcing oneself into painful mediation postures for several hours a day, all the while being driven by an attitude of disgust toward one's self. Much like Right Effort and Right Action, Right Livelihood has to do with whether or not one's life activities are helpful, neutral, or promote further suffering in the world. Altogether, these three concepts assume a commitment to mindfulness.

All of the steps along the Eightfold Path interrelate with one another and Right Mindfulness (*samyak smriti*) can be understood as the thread that ties them all together. Hanh (1998) referred to Right Mindfulness as the "heart of the Buddha's teachings" and discussed that the term mindfulness means remembering to come back to the present moment (p. 64). With mindfulness, one can discern how one's thoughts, actions, and

work in the world either lead to further fulfillment or further suffering. Essentially, it is the acknowledgment that one's attention is always placed on something. That something can be the present moment or it can be random thoughts that occupy the mind.

Every aspect of one's humanity- thinking, speech, intention, action- is integral in the development of well-being. Batchelor (2011) explained:

> The challenge of Gotama's (Buddha's) Eightfold Path is, as I understand it, to live in this world in a way that allows every aspect of one's existence to flourish...Each area of life calls for a specific way of practicing the Dhamma. Meditation and mindfulness alone are not enough (p. 240).

The significance of the concept of mindfulness in Buddhism as well as within Western frameworks will be explored in greater detail later in this chapter.

Middle Way

The Middle Way (Path) is a major aspect of Buddha's teachings. As discussed, the path of cessation from suffering requires that one follow the Eightfold Path. The Middle Way is a guiding light through the Noble Path. In this teaching, Buddha urges those who follow his path to find a middle road between asceticism and indulgence in sensual pleasures (Hanh, 1998). Epstein (1995) pointed out that a contemporary understanding of this principle is the avoidance of two extremes: denial and idealization. Idealization (often occurring in the ascetic life) leads to a denial of one's sensual pleasures (Epstein, 1995). The Middle Way guides one to fully experience human life in the here and now, to experience the sensual world. At the same time, it also guides one to avoid becoming attached or reliant on sense pleasures as a means to happiness. Again, enduring happiness is a trait cultivated from within, through mindfully experiencing and practicing the Noble Path. Further, the Middle Way encourages one to cultivate this enduring happiness, without relying on an external deity (Okumura, 2012). With regard

to emotion, the Middle Way offers valuable insight into cultivating a balance between denying emotional experience and dwelling in it too deeply. Chapter Three will explore the use of the concept Middle Way (Path) in a clinical context.

Enlightenment

Batchelor (2011) noted that Buddha compared himself to a doctor offering treatment/therapy: "To embark on such therapy is not designed to bring one any closer to 'the Truth' but to enable one's life to flourish here and now..." (p. 154). In this light, the Eightfold Path is a therapeutic route to a more fulfilling, healthier human life. Here, Batchelor posited that the Noble Eightfold Path is meant to be practiced *not* for the attainment of something else (like a hidden Truth) but rather in the service of understanding and limiting human suffering. Such a path *may or may not* lead to enlightenment. Thus, the concepts *Truth* and *enlightenmen*t are not interchangeable. Enlightenment is freedom from suffering: the causes of suffering and suffering itself.

There are many ways to interpret enlightenment. Later Mahayana Buddhist traditions, such as Zen, focus on the concept of emptiness as a means to further explain enlightenment (Okumura, 2012). Within this tradition, enlightenment involves seeing the *emptiness of the self*. Regardless of whether one subscribes to this definition of enlightenment, the exploration of *self* and *emptiness* in Buddhism captures some of the main ontological differences between Buddhism and Western psychological theory. Zen Buddhist Okumura (2012) provided a deep explanation of emptiness, a concept that will be explored in the following section.

Self and *Emptiness* in Buddhism

The Buddhist concept *emptiness* has been discussed and interpreted by many Eastern and Western thinkers. The concept is integral to grasping Buddhism, especially in understanding how *the self* is conceived in Buddhism. This section will explore the concept of emptiness and self in Buddhism on the way to exploring how Buddhism deals with the topic of emotion.

Some have explored the negative connotations, misunderstandings, and uneasiness around the concept of emptiness in the West (Epstein, 1998; Magid, 2005). Marc Epstein (1998) discussed that, while emptiness is at the core of Buddhist psychology, the concept in the West seems to yield a "feeling of distress, an absence of reality, a sense of being not quite real enough, of disconnection" (p. 13). Further, Barry Magid (2005) explored that the concept in Western psychoanalytic literature often points to a *failure* in cultivating a cohesive self.

Emptiness is not a hollow pit of despair. Rather, emptiness in Buddhism refers to the impermanent quality of things. In Buddhism, it is a fact of nature. When one does not accept impermanence, then one can suffer immensely. If one does not accept the transient nature of human existence, one may never come to accept the death of a significant other, for example. When one cannot accept transience, one is denying the nature of things and can therefore suffer immensely. If one likes the bloom of new flowers in the spring, one must accept the rain responsible for the blooms. The Buddhist concept *dependent arising* explains impermanence. Emptiness means more than just transience in Buddhism. It means that things exist in relation to other things. David Demoss (2011) examined the role of modern theories of *extended self* in shedding new

light on the tenets of Buddhism. He highlighted that "the impermanent identity that we do have is spread out in a matrix of interdependent relations with lots of other empty things" (p. 312). Batchelor's (1997) explanation of dependent arising illuminates this point:

> There is no essential me that exists apart from (a) unique configuration of biological and cultural processes...I am who I am not because of an essential self hidden away in the core of my being but because of the unprecedented and unrepeatable matrix of conditions that have formed me (pp. 78-79).

Using the above interpretations of the Buddhist concept of emptiness, one can deduce that emptiness is not a lonely place. It explains how all things exist in the world.

The Mahayana Buddhist *Heart Sutra* sheds further light on the concept of emptiness. The Heart Sutra is arguably the most widely read and discussed Buddhist *sutra* (loosely translated as *sermon* or *teaching*). Okumura (2012) stated that the *Heart Sutra* is "about the wisdom that sees emptiness" (p. 134). Needless to say, one could write volumes about this sutra alone. The Heart Sutra also explains that nothing exists *except* in relation to other things. Okumura (2012) summarized: "The *Heart Sutra* says there are no eyes, no ears, no nose, no tongue, no anything. Because they are not independent, they work together as one... The whole body becomes an eye in the darkness" (p. 146). The sutra is very complicated and explores the even more complicated relationship between form and emptiness. In terms of the current investigation, I offer the Heart Sutra as an example to illustrate the depth of the concept of emptiness.

According to the Heart Sutra, emptiness *even* involves the negation of the earliest Buddhist teachings, The Four Truths. As Okumura (2012) explained, enlightenment involves becoming free from all views, even the Buddha's teachings: "If we take the

Buddha's teaching as an opinion or view, it's no different from the preconceptions we have about other things" (p. 161). Here, one may recall the quote about Buddha pointing to the moon, urging his followers not to mistaken his finger for the moon. In this way, sitting in meditation with the goal of enlightenment presents problems. Even the goal of becoming enlightened interrupts the path to freedom. In the Zen tradition, zazen (sitting meditation) is the route to freedom. In zazen, one sits, plain and simple. If thoughts arise, the individual notices them and tries not to become entangled in the mental chatter.

As stated earlier, emptiness does not imply a fragmented or lonely self. Okumura (2012) examined the relationship between form and emptiness. He discussed, for example, that the self is *both* separate from others *and* interdependent with others. There is no dualism here. For example, one may experience deep emotional pain following the death of a loved-one. Though others may empathize with this person's pain, others can never experience *exactly* what this person feels in the moment that he/she feels it. At the same time, the grieving person exists in relationship with human and nonhuman others. As such, he/she is never completely alone. With regard to human relationships, relying too much on oneself or too much on others may become problematic. Neither independence nor interdependence is better than the other. What matters is one's real world practice of each: Does the individual rely too much on independence or too much on interdependence? Can he/she rely on both in ways that are healthy? Zen practice supports insight that can assist one in finding a healthy balance between the two.

The relationship between interdependence and independence is examined in the following example. When I see someone suffer, because I understand what suffering is, I am drawn to help that person. Though I am separate from the person experiencing the

pain, I can relate to his/her suffering. Likewise, when I eat an apple, I am aware of the conditions that brought that apple into existence and into my hands: sun, rain, earth, human labor, etc. The apple cannot exist without these other conditions; however, the apple itself is neither the sun nor the rain. Again, in Buddhism, the concepts interdependence and independence are not understood dualistically.

Emptiness is not a feeling. It is useful to discuss the difference between the *felt experience* of emptiness and the Buddhist concept of emptiness. As mentioned previously, emptiness, in the West, is often understood as a *feeling* of being completely alone and/or unfulfilled. In Buddhism, the concept of emptiness is related to mindfulness. As Magid (2002) explained: "It is just a way of saying that this moment-to-moment experience is all there is" (p. 61). Thus, emptiness is not a type of *nothingness*, it is just the thing, thought, feeling, sensations, image, etc. that one encounters right here, in the present moment.

There is no *true* Self. The Buddhist notion of self is vastly different than the Western conception of the self. In Buddhism, there is no concrete, core, isolated self that is hidden away. Thus, there is no digging that needs to be done so that one can "get to the root" of one's problem. Magid (2005) explained the notion of self in Zen Buddhism: "The true self of Zen is *no self*: Simply the immediate, non-self-centered response to life as it is" (p. 83). Within a Buddhist framework, one becomes aware of one's problems by openly experiencing thoughts, emotions, sensations, and stories. Here, there is no emphasis on uncovering some type of secret treasure chest that will unlock the mysteries of an individual. This is quite a divergence from Western thinking. In Western models of psychotherapy, there is a tendency to fix, cure, release, and solve an individual's

problems and symptoms. Individuals often come into psychotherapy with a desire to fix a flaw that exists within the self. Western approaches to psychotherapy often assume the dualistic framework that is indicative of the medical model. Within this model, problems within the self are located, removed, and fixed. Alternatively, Buddhism does not seek to cure or fix anything. It seeks to experience and understand.

Western dualism has promoted the idea that an individual's self is separate from everything else around it. Here, the picture one may conjure is a bunch of separate selves, each within their own bubble or container, floating around. In Buddhism, there may be a lot floating around, though nothing has its own container. As Magid (2005) stated: "Our world is our self, rather than our self being our world" (p. 83).

Emotion in Buddhism: Ethical and Spiritual Dimensions

It is impossible to discuss emotion within the context of Buddhism without also discussing the spiritual and ethical teachings of Buddha. To grasp emotion within the Buddhist framework, one must understand how mental states, in general, are approached within the tradition (Ekman, Davidson, Ricard, & Wallace, 2005).

There is no term for emotion in Buddhism, rather emotions are considered to be a part of the general realm of mental activity (Ekman et al., 2005). Buddhism encourages deep awareness of one's mental states so that one may experience for him/herself which mental states encourage well-being and which do not. Though Buddha discussed common afflictions of the mind (*Klesas*), it is important to note that the individual's experience of his/her inner world is paramount in Buddhism. Thus, enduring happiness, *sukha*, can only be developed and sustained from within. This is in conflict with an ideology that promotes happiness obtained through *outward* activities- getting a better

job, earning more money, obtaining more possessions, etc. With the exception of Western Stoicism, which encourages focus on inner experience, one may argue that the West has a history of equating happiness with the accumulation of *outward* things. Olendzki noted that (2010), of the two basic strategies for achieving happiness- changing the external environment to meet one's needs or changing one's internal state to adapt better to the environment, the latter is arguably more efficient.

As discussed in Ekman et al. (2005), it is important to note that *sukha* is a *trait* that one cultivates and *not* an end state. One fosters and maintains this trait by engaging in the Eightfold Path. For example, through the use of Right Mindfulness and Right Concentration, one increases inner awareness. It is through this introspective monitoring that one can begin to distinguish wholesome and unwholesome mental states (Ekman et al., 2005). Furthermore, there is a stark difference between *sukha* and pleasure. Pleasure is a fleeting experience that comes and goes: the initial happiness of getting a long sought after job will eventually subside. *Sukha* is an enduring trait that comes from the cultivation of inner balance, which stems from engaging the Eightfold Path.

Buddhism encourages commitment to the Eightfold Path in every aspect of life. It is easy to get off track, even during meditation. Magid (2005) told a tale of two meditators. The first meditator had a deep experience of oneness while sitting one day. Since having this experience, he began to focus on this oneness every time he meditated and tried to re-create the feeling of oneness over and over again. He began to feel superior to others because of the deep experience that he had. The deep experience fed his ego and consequently separated him from the people around him. The second meditator practiced regularly as well. Although he never had a "religious" experience of

oneness during his practice, he stayed mindful of his breath and body in a manner that cultivated further insight and helped him feel more connected to the people around him.

Buddha distinguished between wholesome and unwholesome mental states. Non-craving (non-greed), non-hatred, and non-delusion are considered to be the roots of wholesome emotions (DeSilva, 2005). Though many have interpreted Buddha as saying that greed or craving is the source of all suffering, craving is actually one of many afflictions (*klesas*) of the mind. Craving is the first affliction mentioned on the list of *klesas* and, as such, is significant and worthy of further exploration.

Craving assumes a separation between self and other: one sees something that the other has, realizes that he/she wants it, and thus begins to covet the other's possession. An example of this is an individual who wishes that he/she could win the lottery "just like those people on TV did." Craving involves a type of ignorance or limited view of a situation. The person who wants to win the lottery "just like the people on TV" is making some faulty assumptions. First, the person is wrongly thinking that money will make them happier. Second, the person is coveting the other's money without knowing anything about that person's life. Perhaps that person has a miserable life and upon winning the lottery, life becomes much more complicated. Faulty assumptions may lead to hurt, pain, and unnecessary separation between the person and the other. Craving sets into motion all types of problems and may lead to more destructive thoughts and emotions.

In some ways, hatred is the reverse of craving in that it drives an individual to want to harm or destroy the other. As noted in Ekman et al. (2005), "hatred exaggerates the undesirable qualities of objects and deemphasizes their positive qualities" (p. 61).

Hatred obviously increases the divide between one's self and the rest of the world and, much like craving, causes further mental affliction.

Delusion involves clinging to the belief that one's self is concrete, fixed and separate from the rest of the world. This goes back to the discussion about emptiness and self earlier in this chapter. Essentially, the belief in one's separation from the rest of the world sets into motion a host of negative reactions that further serve the delusion of separateness. Although karma has not been explored in this paper, a secular interpretation of karma may serve to illuminate how delusion causes further suffering. One way to understand karma is that destructive, negative mental states set into motion further destruction and negativity. If one is jealous of the other for winning the lottery, the jealous person may choose to acknowledge and reflect on the feeling of jealousy in a way that encourages insight. Alternately, the jealous individual may wallow in the jealousy, which may lead to festering anger or hatred. Essentially, acts of delusion create further delusion.

In Buddhism, how one experiences and works through a difficult emotion such as anger or sadness is reflective of whether or not the person has conditioned the mind to be *wholesome* or *unwholesome*. In other words, if a person's mind is continuously afflicted by craving and hatred, this person may experience the emotion of anger quite differently than a person who practices non-craving, non-hatred, and non-delusion. When one is conditioned to respond to anger with non-craving, for example, one may be more likely to work through anger in a wholesome manner. It follows then, that one who accepts the impermanence of things, including the transience of thoughts and emotions, leads one to have a different experience of emotion than the person who *clings* to every thought and

emotion. One who understands that even very painful emotions will change, with time, will arguably be more equipped to address difficult emotional states.

Khong (2009) discussed the significance of Buddhist ontology, such as the belief in impermanence. She pointed out that Buddhism "encourages people to see that the nature of reality (the ontological) and the nature of the mind (ontic) are analogous" (p. 124). Thus, if one can become aware of and accept the changing nature of the mind, then one is also capable of accepting the changing nature of reality. In this way, understanding the nuances within one's own mind leads to a more nuanced understanding of reality and vice versa. Insights into one's own mental activity can have profound implications. To this last point, both Eastern and Western approaches agree. A point of divergence is that Buddhism encourages depth and insight as a way of life rather than as a means to address a particular pathology.

Meditation: The Route to Insight and Awareness

Insight meditation (*vipassana*) assists one in grasping the fleeting nature of the mind. In the Eightfold Path, two main types of meditation are discussed: *vipassana* and *samatha* (tranquility). *Vipassana* cultivates further insight into one's mind, body, and breath. In *vipassana*, the individual is encouraged to sit and pay "bare attention" to whatever surfaces in the mind and body (Khong, 2009, p. 121). Thus, if anger begins to surface during *vipassana*, one is encouraged to be aware of how this emotion manifests itself: perhaps by tightness in the chest and throat, shallow breathing, and/or through negative thoughts and mental images. *Vipassana* is a practice that helps to foster greater awareness of the "nature" of the mind. In conjunction with the rest of the Eightfold Path, insight meditation offers guidance on the path to reduce suffering. Wisdom, insight, and

understanding are core values in Buddhism. Mahayana Buddhism observes the Six *Paramitas* or "perfect realizations" which, in essence, are bridges toward well- being (Hanh, 1998). The sixth *paramita*, *prajna paramita*, is considered the highest form of insight and understanding. *Prajna paramita* refers to the perfection of wisdom (Okumura, 2012). The Heart Sutra, discussed earlier, is one of the key writings within the *prajna paramita*.

It is important to note that *vipassana* is the guiding principle of numerous mindfulness-based programs in the West. As explored in chapter one, Jon Kabat-Zinn (1990) grounded his entire eight-week mindfulness program around *vipassana*. Further, in the West, mindfulness has increasingly been incorporated into various psychotherapeutic modalities and/or has become a popular adjunct to psychotherapy. The next section of this chapter will explore the adoption of mindfulness as a *strategy* or *intervention* used to treat a variety of mental health issues. I will explore the potential pitfalls associated with using the concept outside of the larger Buddhist framework.

Mindfulness as *Intervention*

No one can deny the growing support for mindfulness as an evidenced-based practice for a variety of mental and physical health issues (deVibe et al., 2012). So many quantitative studies have looked at the benefits of mindfulness-based interventions on various health conditions that a recent systematic review suggested that quantitative studies on mindfulness for certain health conditions are no longer a priority (deVibe et al., 2012). Instead, the authors of this review recommend more qualitative studies, as it is still very unclear *how* and *why* mindfulness interventions work.

A meta-analysis that looked at the effect of mindfulness-based therapies found that the intervention was moderately effective for improving anxiety and mood symptoms (Hofman, Sawyer, Witt, & Oh, 2010). In this study, it was difficult to pinpoint why such mindfulness-based interventions were successful, given the variations among the mindfulness-based interventions that were analyzed. Depending on the type of intervention, mindfulness may include any number of elements or practices. Some mindfulness-based interventions include close attention to the breath and body whereas others include paying close attention to thoughts and feelings. Some may involve light movement or stretching. Many include all of the above. Further, some are attached to another therapeutic modality like cognitive therapy, existential therapy, or psychoanalytic, while some mindfulness interventions stand alone, as in the eight-week MBSR courses.

In addition to the widespread use of mindfulness-based interventions in empirical research as well as within the context of mental health treatment, there are a multitude of mindfulness-based trainings for the general public and for mental health clinicians. As a result, mental health clinicians are using mindfulness-based strategies in their work with clients and/or infiltrating mindfulness into their already existing preferred treatment modalities. Jon Kabat-Zinn's (1990) MBSR program is offered throughout the U.S. and abroad. In Pennsylvania alone, there are twenty-seven MBSR programs (www.umass.edu). Kabat-Zinn's MBSR programming is just a portion of existing mindfulness-based programs offered for both the treatment of health conditions as well as for professional training. MBSR and similar programs have been used in schools, prisons, mental health agencies, and hospitals.

Given the widespread use and acceptance of mindfulness-based strategies as tools for greater health and well- being, one might challenge any claims regarding the limitations of such programs. Although there are a select few for which mindfulness may be contraindicated (those with psychotic disorders, certain cognitive limitations, severe dissociative symptoms, to name a few), generally speaking, there are no categorical limitations to learning and/or practicing mindfulness (Dobkin, Irving, & Amar, 2012).

Due to the variation among mindfulness-based interventions and programs, it is difficult to discern *how* and *why* mindfulness works. Another complication in the quest to pinpoint how mindfulness is effective is that participants in studies will inevitably vary in terms of their commitment to and experience of mindfulness practice. For example, some interventions may include participant homework that will inevitably help some but not all participants deepen their experience of the intervention. Further, participants may or may not have familiarity with Eastern spirituality, a factor that may positively influence the effectiveness of the intervention for some.

Grossman and Van Dam (2011) explored the potential pitfalls of attempting to define mindfulness for empirical study. The authors discuss how the lack of agreement among researchers regarding the definition of mindfulness has distorted the meaning of mindfulness. They also note that some researchers have attempted to overcome this lack of clarity by promoting restrictive definitions of the practice. Further, they explained that the quest to pinpoint what mindfulness *is*, for the purpose of research, has led to a devaluing of "the unique composition of multifarious interacting factors involved in the Buddhist construct" (Grossman & Van Dam, 2011, p. 223). The authors also discussed

that mindfulness needs to be discussed in unison with other key elements of Buddhism (like the Eightfold Path) in order to be fully grasped.

To this last point, given the burgeoning use of mindfulness as a therapeutic intervention, it is important to discuss possible implications of taking mindfulness out of its larger Buddhist context. First, there are some fundamental differences between Western and Buddhist ideology with regard to mental health. Buddhism is a system that promotes *sukha* (enduring happiness) while mental health treatment in the West has tended to focus on eliminating symptoms associated with certain diagnoses. As noted by Ekman et al. (2005), with the exception of Martin Seligman's (1998) work on positive psychology, mental health treatment in the West has been generally concerned with pathology. One may argue that, in the West, many individuals are initially introduced to mindfulness, meditation, yoga and other Eastern approaches to well-being as a means to address physical and mental stress/problems/symptoms. A potential pitfall of starting a mindfulness practice, with the intention to address a problem or a symptom, is that once the problem or symptom is gone, so is the practice. Within the Buddhist framework, mindfulness is a life-long practice. A Buddhist doesn't stop practicing just because a certain ailment is gone or he/she feels better. Further, practicing mindfulness during periods of happiness and joy, in addition to periods of pain and distress, may assist one in deepening his/her experience of positive mental states (Hanson, 2009, 2013).

Second, as discussed in Khong (2009), as Eastern-based interventions like mindfulness continue to increase in popularity, it is important to consider whether or not the interventionist (psychotherapist, medical professional, researcher) is an experienced practitioner of mindfulness. Though many psychotherapists are practicing Buddhists

and/or have received training in mindfulness, there is no experience or training requirement necessary to teach mindfulness to clients or patients. Further, though many mindfulness programs, such as MBSR, offer professional training for clinicians, the completion of training does not ensure a therapist's commitment to or knowledge of the practice. Again, whether mindfulness is used simply as a technique to eliminate a problem versus as a life-long practice, will depend entirely on the clinician's intention.

How a clinician utilizes the practice of mindfulness with his/her clients is partially dependent upon the clinician's theoretical orientation. Shorter-term, solution focused therapies such as those falling under the cognitive behavioral framework are, arguably, *more* likely to utilize mindfulness as an intervention. Longer-term, insight-focused therapies such as psychoanalysis and existential therapies have elements of mindfulness practice embedded into their frameworks. Claessens (2009) pointed out that both mindfulness practice and existential approaches to therapy involve a "phenomenological exploration of the individual's experience" (p. 113). Further, both Magid (2005, 2013) and Epstein (1995, 1998) have explored the compatibility of psychoanalysis and Buddhism: both approaches encourage openness, depth, and awareness.

This discussion is not meant to present one therapeutic approach as being an optimal one in which to incorporate Buddhist practice and philosophy; rather, it is meant to highlight the potential pitfalls of using or practicing mindfulness apart from the Buddhist context. To this point, the trend in psychotherapy practice in the West is shorter-term, evidenced-based practices. The reliance on shorter-term therapies necessitates the use of mindfulness as a technique or skill. On the one hand, mindfulness *is* rightfully identified as a technique that needs to be practiced. The Eight Fold Path

calls one to *practice* mindfulness of speech, action, thought, etc. On the other hand, mindfulness is one aspect of the much larger, more complex philosophy of Buddhism. One must consider if bypassing this larger framework limits the potential value of Buddhist practices and concepts in clinical contexts.

Mindfulness, in the Buddhist tradition, cannot be practiced for the alleviation of a problem and then put aside. Mindfulness is an ongoing approach to life and involves an ongoing commitment to insight and awareness. Through the practice of mindfulness, one is made aware of the subtleties of one's experiences. This is not to say that a short-term practice is not beneficial. For many, introductory courses in mindfulness may offer a significant and valuable entry point into thoughts, feelings, and sensations that were previously unnoticed. Further, even a very cursory introduction to mindfulness may lead to a reduction in painful symptoms. This begs the question: But, is this the point? Buddhism is concerned with *sukha*, enduring happiness (and not just the elimination of problems), which can only come from a deep understanding about the cause of and nature of suffering. *Sukha* is a life long practice.

Summary

This chapter explored emotion within the context of Buddhism. In particular, the spiritual and ethical teachings of Buddha were considered as primary to understanding emotion within the Buddhist framework. This inquiry revealed some key ontological differences between the Buddhist framework and Western conceptions of mental health. In particular, the Buddhist framework delineates *impermanence* and *interdependency* as facts of existence. Impermanence and interdependency, along with the Buddhist focus on direct experience, awareness, insight, and a never-ending movement toward enduring

happiness, has much to offer clinicians and clients in their efforts to maneuver distressing and painful emotional experiences. Essentially, Buddhism offers a framework for working through suffering.

The proliferation of mindfulness as a therapeutic intervention was also discussed as a means to identify the pitfalls of using Buddhist concepts and practices outside of the larger Buddhist context. This decontextualized use of Buddhist practices and principles limits the potential use of Buddhist wisdom in clinical contexts.

The next chapter will construct Buddhist-informed themes for approaching difficult emotion in the process of psychotherapy. Here, emotion is regarded as a *human* rather than a *pathological* experience that needs to be fixed or cured. Learning to maneuver emotional experiences is one of the greatest challenges that clients and clinicians face in psychotherapy. It is perhaps one of the greatest challenges of being human. Further, the inability to work through difficult emotion often creates further pain and suffering and is, therefore, an integral factor in well-being.

Chapter 3: Constructing Buddhist-Informed Themes for Approaching Difficult Emotions

Introduction

The following chapter will present Buddhist-informed themes for use in guiding both clients and clinicians through challenging emotional experiences in the psychotherapy room. The following themes will be explored: *Sitting With*, *Middle Path*, *Healthy Interdependency*, and *Compassion*.

I refer to the themes as Buddhist-informed, as they are heavily grounded in Buddhist philosophy, especially Zen Buddhism. Zen Buddhism has a particular bare-bones interest in direct experience (via sitting meditation) and, as such, offers value in the quest to develop a clinical approach for maneuvering emotion. I cannot say that the themes are *solely* based in Buddhism because I have relied, at times, on other theoretical lenses in the development of the themes. I have indicated these other influences accordingly. Further, as a Western clinician, it may be impossible for me to present Eastern concepts in pure sense. Having said this, I have intended to construct themes that tap into the wisdom inherent in Buddhist philosophy.

It is also important to note that the themes may be useful for clinicians of varying theoretical lenses. Though the themes may arguably fit more easily into some therapeutic frameworks more than others, the themes do not necessitate a specific theoretical lens. Further, altogether, the themes provide a conceptual framework. The framework serves as a *guide* rather than a *protocol* for working through difficult emotions. It is a guide insofar as it intends to offer direct support in the complex world

of emotion as well as assist clinicians in conceptualizing the challenging emotional experiences of their clients.

Sitting With Emotional Experience

Defining the Theme *Sitting With*

It is appropriate to begin with the theme *sitting with,* as it will be an integral part of all the themes discussed in this chapter. *Sitting with* simply means that one is able to be present with one's actual, direct emotional experience. This theme is closely related to the concept and practice of mindfulness. As mentioned previously, mindfulness, generally stated, is being present with one's moment-to-moment experience, without judgment (Kabat-Zinn, 1990). Since mindfulness broadly refers to paying close attention to a wide array of life experiences (such as other people, a sunset, certain other life tasks), I thought it necessary to make a distinction between one's direct attention to emotional experiences (*sitting with*) and the broader definition of mindfulness. This is not to say that mindfulness is not an optimal term but rather that, since the focal point of this paper is emotional difficulty, it is important to develop a term that more closely captures how to approach emotional experiences. *Sitting with*, thus, is mindfulness directed toward one's emotional experience.

The theme *sitting with* is derived from the practice of meditation, where one simply sits and holds awareness. In other words, the physical act of sitting is a model for being present with thoughts, emotions, and sensations (Magid, n.d.). Arguably, those who practice meditation on a regular basis may become more adept at noticing their inner responses to life. One study found that long-term meditation practice led to increased emotional stability by promoting acceptance and awareness of emotional states (Taylor,

Grant, Denault, Scavone, Breton, Roffe-Vidal, Courtemanche, Lavarenne, & Beauregard, 2011). In addition, Pagnoni and Cekic (2007) found that regular Zen meditation led to an increase in gray brain matter and had neuroprotective effects on the brain.

Zazen

In the previous chapter, the two major types of Buddhist meditation were discussed; however, meditation exists in many forms. In yogic traditions, for example, some use visualization, candle gazing, various breathing techniques, and/or chanting in meditation (Butera, 2012). The Zen Buddhist practice of zazen serves as a guide for the clinical theme *sitting with*. In zazen, one sits with one's experiences and sensations. If thoughts, feelings, and/or other sensations arise, one notices and tries not to become attached or to react to such sensations. Thus, if the thought "I'm bored" arises during zazen then one acknowledges the thought and attempts to let it go by not developing a storyline about the thought. Because it is the nature of the mind to be active, it is very easy for a thought like "I'm bored" to become "I'm bored...I shouldn't be bored...I should be paying attention...I'll be less bored when I get home and can talk to my friend...I'm terrible at meditation."

Zazen is a simple practice. When the practice of *sitting with* is applied to emotional experiences, it can have profound implications. By sitting with emotion, one may begin to recognize the nuances inherent in emotional experiences. In the beginning stages of psychotherapy, clients often enter therapy with general feelings and sensations of "being stuck," "overwhelmed," "tense," "depleted," etc. As the psychotherapist and client dig further into such general sensations, clients may uncover a variety of life experiences and emotional states that account for such general sensations. By quietly and

attentively sitting with these general sensations, clients gain further insight. For example, asking a client to sit for a few moments with the sensation of "being overwhelmed" often yields a lot more information: "I'm just going through the motions...I feel like a wave washed over me...I'm tired all the time...I feel like crying and pulling my hair out..." This information gives both the client and the therapist a better entry point into the client's difficulty. Further investigation may reveal that the client, for example, is extremely angry or sad that his/her significant other is distant and cold, or rather, a client may reveal that fears about not succeeding are holding him/her back from engaging fully in life and trying new things.

When one sits with anger, one may recognize that anger is a compilation of sensations: burning forehead, tension in the shoulders, difficulty breathing, dark thinking, urges to lash out, deep sadness. Through direct experience, one obtains greater insight into what is *actually* going on when one says: "I am angry."

Accepting Emotional Transience

By sitting with emotional experience, one may recognize the fleeting nature of mental and emotional experiences. One moment the person walking down the street feels bored and the next moment, upon running into a friend, feels joyful. One's experience often changes, moment to moment. The practice of *sitting with* helps one see the transient quality of human emotional experiences. When one recognizes this transience, may become less *stuck* in difficult emotions. The recognition of emotional transience may lead to greater affect tolerance (Magid, n.d.). That is, one who is experienced in noticing the natural flow of emotional states is arguably less sensitive and therefore less reactive to internal sensations. As discussed in Chapter Two, accepting the fleeting

nature of thoughts and emotions is a main tenet of Buddhism. It is also frequently discussed in many of the mindfulness-based therapies practiced in the West today (Fennell & Segal, 2011; Kabat-Zinn, 1990; Zettle, 2007).

The central Buddhist tenet, which states that grasping onto things that change is a main cause of suffering, was also discussed in Chapter Two. Okumura (2012) noted that a deeper translation of the First Noble Truth is that suffering is heavily related to impermanence. Humans try to cling to things that inevitably change and thus experience pain. If one has been planning a vacation for months and the vacation gets cancelled, one may feel very depressed. There are different forms and levels of loss, some more traumatic than others. Clearly, losing a loved one suddenly is different than having vacation plans cancelled. Most would agree that the traumatic loss of a loved one involves a much deeper level of pain. Perhaps the depressive feelings resulting from a missed vacation could be curtailed through the Buddhist practice of non-grasping. Though, one would need to carefully consider *how* and *to what extent* the role of non-grasping may be a useful guideline/practice for someone experiencing traumatic pain.

It is important to elaborate here that the practice of non-grasping does not mean that humans should never feel pain. The Buddhist principle of dependent co-arising explains that humans are interdependent (Okumura, 2012). Because of this interdependency, humans experience an array of emotions within relational contexts. Relationships produce joys and pains in life. The goal is *not* to use one's meditation practice to shield oneself from emotions. Further, zazen practice is not a method for walling oneself off from relationships. Magid (2005, 2013) noted several examples of long-term meditation practitioners and meditation teachers who fell victim to emotional

bypass in the service of enlightenment. In their attempts to "rise above" the human experience of emotion, these individuals cut themselves off from important emotional insights and, at times, wound up committing egregious acts of sexual misconduct. Supposed spiritual places such as Buddhist monasteries and yoga ashrams have not been immune to such scandals.

Truly sitting with one's emotional experience involves cultivating full awareness of complex emotional experiences as well as being on the lookout for emotional *blind spots*. By blind spots, I mean one's hidden agendas or motivations that may result from one's inability to look at the complexities inherent in human emotional life. Of course, weeding through human emotional complexity is a life long journey. Though it may be impossible to access all of one's blind spots, it is significant to recognize that they do exist.

Finding One's Middle Path

Defining the Middle Path

A brief overview of the Middle Path (Way) was given in Chapter Two. Here, I will explore the concept further, showing how the Middle Path can be used to approach emotional experiences. With regard to emotional experiences and sensations, the Middle Path encourages one to find a balance between *holding on* and *letting go* and rigidity and flexibility. Further, it involves the ability to call into question many of the false dichotomies- good or bad, positive or negative, individuals often use to label their emotions. In addition, the Middle Path may be useful in assisting one in developing insight into one's emotional reactions and responses to life situations.

Holding On and Letting Go

Depending on the individual and the experience, there are instances when one will need to *hold on* to one's emotion to get to know and understand it better. Likewise, there will be times when one will need to practice *letting go* so that the emotional experience does not become too overwhelming and/or toxic. Further, there is a vast difference between being able to fully recognize and experience one's emotions and *clinging* to them. Dwelling too heavily in emotion can lead to further pain and destruction. *Sitting with* emotion does not mean that one focuses on emotion to the point of not engaging fully in life. On the other hand, *letting go* of emotion prematurely may lead to further suffering as well. Another layer of this discussion is that holding on and letting go are not static practices. It is not as if one type of experience necessitates that one *hold on* while another necessitates that one *let go*. There may be a movement back and forth from one to the other.

It is important to say that the clinician has an important role in supporting the client in cultivating a Middle Path. That is, the clinician and client are a team in identifying the client's blind spots and tendencies to cling to or let go of emotion. The process of understanding one's emotional tendencies and finding balance can be difficult to discern on one's own. This is arguably why many find their way into the psychotherapy room. Likewise, in traditions like Zen Buddhism, students are encouraged to work closely with experienced teachers in order to deepen their practice.

Assisting clients in finding a middle ground between *holding on* and *letting go* of emotion is a key factor in psychotherapy. For example, when working with individuals who suffer from complex trauma, psychotherapists often rely heavily on the client's

subjective experience of emotional pain, using this as a guide for the treatment. As discussed in Courtois, Ford, and Cloitre (2014), best practices for clients with complex trauma involve attention to a client's individual needs within the context of treatment. This means that the therapist will need to pay close attention to the client's emotional experience and whether or not the client is processing his/her pain in a manner that is palatable. Too much focus on emotional pain can leave a client ungrounded and unsafe. Not enough focus on pain will inhibit the healing and growth process. Therapists who work with grieving clients can attest to the importance of helping a client find the middle ground between holding onto grief and letting go of it prematurely. Some clients cling more heavily to their pain while others have a tendency to let go and "move on" too quickly. It is important for both the therapist and the client to maintain awareness about the client's tendencies with regard to holding on and letting go.

One example of holding onto pain too tightly is a client who, following the death of a parent, stops engaging with friends and family and becomes very angry when she feels that others are moving on with life and therefore "forgetting" the lost parent. Reactions such as these can be common in the recent aftermath of a life challenge, though when they persist on for several months or years, the client is held back from experiencing life fully. The client's grief has spilled out into every area of his/her life and begins to take over in a way that is unhealthy.

It is important to note that finding a Middle Path between holding on and letting go is a complex matter. In cases, for example, where a client has experienced more pervasive emotional symptoms due to a diagnosis such as post-traumatic stress disorder (PTSD), many layers of clinical intervention may be necessary. A client with PTSD may

experience the following symptoms: hyperarousal, flashbacks, intense anxiety, to name a few (van der Kolk, 2007). Essentially, the client continues to re-experience the traumatic event, both within the body and mind, even though the event is no longer occurring. Evidenced-based psychotherapy practices for such symptoms include therapies that assist the client in integration (Courtois et al., 2014; van der Kolk, van der Hart, & Marmar, 2007). That is, clients are supported in processing their trauma, experiencing and naming the emotions and sensations associated with the event, locating the tension within their bodies, and working toward finding a place for the trauma so that the trauma becomes less intrusive to the client (Courtois et al., 2014). Because the themes discussed in this chapter do encourage mind-body integration, they may be particularly useful in working with traumatized clients; however, such clients may also need other types of medical treatment and evaluation.

Sometimes emotions are the result of something actually happening in the here and now, though many times they are not. For example, experiencing stark fear during a car accident is different than experiencing fear at the thought of getting into a car again several months after the car accident. Likewise, feeling deep sadness following the death of a loved one is different than feeling deep sadness every time a loved one leaves town for a few days. At times, emotion explains what is *actually* going on in the present and sometimes it accounts for a deep pain that occurred in the past. Sometimes, in the interest of getting to know one's emotional life better, one can begin to rely too heavily on emotional sensations as guides to action. Magid (2005) discussed the pitfalls of relying on *gut feelings* as life guides. Too often, one's gut feelings are comprised of layers and layers of one's past reactions to difficult life situations and, thus, are not useful guides in

current life situations. Discriminating among the various levels of emotion as well as where one's emotional responses are coming from is key. The Middle Path supports this type of discrimination.

In the previous section, emotional bypass was discussed. This is the flip side of holding on too tightly to emotional pain. This is a problem resulting from letting go of emotion before it was properly felt, acknowledged, and understood. Unfelt and uninvestigated emotions play havoc in an individual's life. Most therapists can attest to having clinical encounters with clients who have attempted to "move on" from pain and trauma too quickly. One example of this is a client that enters therapy with vague feelings of tension and anxiety. After several sessions of psychotherapy, the client begins to discuss unresolved grief at the loss of a loved one or painful memories of past abuse. Another common example is a client who, following a very recent and painful event, throws him/herself right back into work and life at full force and, upon beginning therapy, realizes that he/she never allowed him/herself time to feel what happened.

At times, moving on too fast from a painful experience or shielding oneself from feeling pain is the result of dissociation. Dissociation is a complex process and a thorough investigation of the topic far exceeds this paper; however, a brief discussion of dissociation is important, as it serves as yet another example of the complexity inherent in emotional experiences. One may dissociate during a traumatic event in order to shield oneself from full exposure to the pain (van der Kolk et al., 2007). At times, this can be a *helpful* process and needs to be respected as such. It is when this type of emotional "shielding" becomes embedded in an individual's lifestyle that it can become problematic. It takes a skilled clinician to identify and understand a client's process of

dissociation. Further, when I speak of holding on and letting go, I am assuming a clinical context where the clinician is fully trained to identify and understand processes such as dissociation. Without such an understanding, it may be possible to misread how a client is presenting in the therapy room. For example, when a client is in the middle of processing his/her trauma and suddenly changes his/her affect, pauses, or changes the subject entirely, this may be a clue that dissociation is happening. It is important for the therapist to be in tune with this as it may signal that the client needs to take a break from the trauma story, breathe, and/or do something else to ground him/her back to the present moment (van der Kolk, 2007).

Dissociation is a fragmenting experience. The Middle Path supports integration in that it guides the individual to sit with emotional sensations, to detect where such sensations are coming from, to discover when it is helpful to feel vs. let go, and to link difficult emotions back to the traumatic events from which they originated.

Finding one's Middle Path with regard to difficult emotions involves a dance between holding on and letting go. Hanh (2001) gave a poignant account on how to approach anger. He discussed how to approach anger with mindfulness, understanding, and tenderness. At the same time, he discussed the importance of letting go of the yearning for revenge. He drew an analogy between an angry person and a house on fire. If one's house is on fire, one needs to attend to it immediately and carefully. One needs to put the fire out, not run after the person who set it on fire. This is an example of the dance between holding on and letting go. In other words, the person holds on to their experience of anger, looks at it deeply and lets go of the yearning for revenge.

Discipline and Flexibility

By discipline and flexibility, I am referring to the way in which an individual generally approaches the various aspects of his/her life and whether the approach works for or against him/her in times of emotional difficulty. Does one run through life controlling everything to the point of not being able to enjoy a free moment? Can one accept imperfections within the self and others? Does one show up late for everything and perpetually procrastinate in personal and professional endeavors to the point of hurting the self and others? Can one tolerate his/her weaknesses and/or the weaknesses of others? In which areas of life is one too rigid/disciplined and in which areas is one too flexible/too loose? Neither flexibility nor discipline, in and of themselves, can be defined as good or bad qualities; rather, one's need for flexibility and/or discipline depends on the individual and the circumstance.

The dance between flexibility and discipline is significant in times of difficulty. Those with rigid or overly flexible personal styles may find it difficult to maneuver through emotional difficulty. It is useful to consider the individual's personal style during times of emotional difficulty. As Chodron (1991) explained: "Everybody's middle way is a different middle way" (p. 43). More specifically, with regard to discipline and flexibility, Chodron (1991) discussed that each person must cultivate an awareness of when it would be helpful to be more flexible and when it would be useful to have more discipline. It's a very personal journey. It makes sense for psychotherapists to support the client's awareness of how flexibility and discipline manifest in various aspects of the client's life. A clinical example of when discussing discipline and flexibility may be useful is when a client enters therapy troubled by feelings of loneliness

and isolation and reports that he/she has stopped socializing on the weekends and instead spends copious amounts of time at the office. Perhaps this client's pattern of discipline around work is keeping him/her from living fully and productively? Perhaps the client is not being disciplined enough with regard to his/her social life? There may be a few ways to frame the issue, though the point here is that the client's behavior is reinforcing the feelings of isolation.

Another clinical example that may shed light on this issue is common among clients with anxiety related problems. Leslie Farber (2000) conceptualized anxiety as distress resulting from attempts to control something that can never be controlled. In the effort to control uncomfortable anxiety feelings, some clients begin to avoid certain life situations and/or relationships. For example, in the effort to avoid something bad from happening, one may avoid driving long distances, a plane flight, dating, going somewhere alone, etc. Depending on the unique circumstances of the individual, avoidance of such things is not *always* a negative. Though, avoidance to the point of limiting life experiences for fear of something bad happening is an example of unhealthy discipline, rigidity. In times of emotional crisis it may be a form of healthy discipline for a client to begin (and commit to) psychotherapy. Here, the client recognizes the need to focus on and work through the problem, commits to the process, shows up for weekly sessions, and puts effort into getting better. An example of having too much flexibility is when one chronically puts the needs of others before one's own. When an individual is too accommodating in his/her personal life, saying yes to everything, he/she runs the risk of resentment and burnout. Clinicians often run the risk for burnout when they do not set

clear boundaries with clients around office hours, policies around clinician vacation time, as well as "on call" protocol.

In moments of emotional difficulty, the dance between discipline and flexibility can serve as a useful guide to clients and the clinicians who treat them. As Chodron (1991) declared: "Not too tight, not too loose" (p. 43). This dance is undoubtedly apart of learning how to maneuver the needs of self and others and will be explored more thoroughly in the next section.

Healthy Interdependency

Defining Healthy Interdependency

As explored in the previous chapter, according to Zen teacher Okumura (2012), there is no clear separation between the state of individuality and universality. Individuality and universality exist simultaneously. Okumura (2012) explained that focusing too much on individuality negates the community and vice versa. Generally speaking, I define healthy interdependency as the recognition of one's simultaneous individual and relational existence *and* as the practice of finding a healthy balance between the two. The recognition that a person contains both aspects means that, depending on the situation or circumstance, one may need to emphasize one's individuality above relationship or vice versa. Further, to nurture one's individuality does not negate the importance of relationship and to nurture relationship does not negate the importance of individuality. Both are key. A healthy life, in part, consists on constantly discriminating between individual and relational needs and experiences (Okumura, 2012).

Judith Jordan (2010), one of the founders of Relational-Cultural Therapy (RCT), discussed the "inevitable interdependence" of humans (p. 3). According to Jordan (2010) and other RCT practitioners, therapies that focus on separation and boundaries between the self and others do not capture the complexity of human relational existence. This does not mean that RCT denies the individual his/her own individuality or needs, but rather that the individual's relational existence cannot be denied. Thus, RCT prefers terms like "differentiation" and "articulation" to terms like "boundary" and "separation" (Jordan, 2010, p. 3). Both Okumura (2012) and Jordan's (2010) thoughts about interdependency inform the theme discussed in this section.

I have identified three components of healthy interdependency that serve to further define the concept: healthy recognition of one's distinct and relational aspects, recognition of the individual's connection to a larger context, and a cultivation of a healthy relationship with one's inner experiences. I will explore each component more fully and discuss their application to difficult emotional experiences.

The Recognition of One's Simultaneous Separate and Relational Aspects

Recognition that one is both *distinct from* and *in relationship with* others is key when maneuvering through difficult emotional experiences. No one lives an isolated life yet it is helpful to know where one begins and ends. Okumura (2012) used the example of an orchestra that illustrates this point: "Each person plays a different instrument. A violin is not a piano, and a piano is not a drum. They all make different sounds...yet when they work together, they make one musical whole" (pp. 227-228). Distinguishing one's self from harmful relationships and situations is a practice that psychotherapists of various modalities often recommend. On the other hand, creating connections with those

who provide us with healthy material for relational growth is life affirming. At times, it may be easy for the individual to see that unhealthy patterns are forming and thus set limits to preserve the needs of the individual. Other times, it may be quite difficult to do so.

Generally speaking, mindfulness can help one maneuver the dance between separateness and togetherness by assisting one in discriminating between what is healthy and unhealthy with regard to relationships. Interpersonal neurobiology research has demonstrated how relationships are conduits for emotional regulation and dysregulation (Cozolino, 2002; Schore & Schore, 2002, 2008). Healthy interdependence means that, although all beings always exist in a relational context, there are times when preserving one's individuality is healthier than becoming entangled in toxic environment. For example, when Victor Frankl (1969) faced the horrors of imprisonment in a concentration camp, he set the ultimate boundary between his individual self and the horrific context in which he existed. For Frankl, his livelihood depended on his ability, at least partially, to assert a mental boundary between himself and his oppressors. Frankl's experience serves as an extreme example of distinguishing one's self from one's context. A more common, less extreme example is one that occurs in many long- term romantic relationships where one or both partners, in the midst of doing many activities together, stop exploring their own interests/hobbies. This may lead to feelings of being bored, unfulfilled, tired, etc. When a partner is able to get his/her needs met through engaging in fulfilling activities, he/she may feel more energized as an individual, and consequently, may be able to give more to the partnership.

Some situations call the individual to set boundaries with a toxic environment while others call the individual to *open up* and connect. Chronic avoidance of relationships, perhaps in the service of protecting the individual from becoming hurt or disappointed, is isolating and may lead to feelings of loneliness and despair.

With regard to cultivating healthy interdependency, there are very few situations that contain clear answers. One may argue that Frankl's experience was clear-cut in that his ability to survive his deplorable circumstances necessitated a survival response that involved setting an extreme boundary. More commonplace examples involve the ability to distinguish the degree to which one is relying too much on one's self to point of ignoring community. Those who practice meditation, for example, become used to sitting alone each day. At the same time, many mediation practitioners attest to the importance of also finding a communal place to practice. It is important for the individual to sit alone with his/her experience *and* it is also important for the individual to share the experience of mediation practice with others. Both the individual and communal experience helps one deepen one's practice.

Cultivating a Healthy Relationship with One's Internal Life

Just as one needs to maneuver the dance of interdependency, one also has to maneuver one's relationship with internal feeling states. Cultivating a healthy relationship with one's internal experience involves, in part, learning to sit with emotional experiences directly, without judgment. It also involves being able to discern how to approach various feeling states. By sitting with difficult internal sensations, one may acquire greater awareness of certain emotional reactions and thus acquire the information necessary to choose healthier responses to emotional difficulty.

Building a healthy relationship with one's emotions involves curiosity, acceptance, and self-care. Instead of reacting to an uncomfortable emotion with bodily tension and overall aversion, one learns to approach emotions with curiosity and openness. When one has curiosity rather than aversion toward various feeling states, it is easier to *respond* rather than *react*. One takes a moment to pause, breathe, and then make a decision about how he/she will respond to the discomfort. This is different than reacting, which involves an automatic, "knee jerk response." So, when feeling deep disgust or frustration, one takes a moment to accept the feeling rather than acting it out on oneself or someone else.

Acceptance is a concept discussed frequently in Acceptance and Commitment Therapy (ACT) (Montogomery et al., 2011; Zettle, 2007) literature as well as in Kabat-Zinn's (1990) MBSR programming. Acceptance in the context of one's emotional life means that one is able to acknowledge feelings instead of dismissing them or wishing them away (Zettle, 2007). Acceptance involves curiosity, a willingness to be open to those experiences and sensations that exist within all humans. A bare-bones definition of acceptance is that it is simply allowing oneself to have an experience, putting all judgment and commentary aside (Magid, n. d.). Acceptance is a large component of having compassion, which will be explored in a later section. If one can accept one's own difficulty and discomfort, one may be more likely to accept the same in others. Sometimes the simple act of identifying and naming a feeling can be helpful. Thus, when a person holds a lot of bodily tension, has difficulty sleeping, and frequently lashes out at others, it can be liberating for him/her to identify and accept underlying emotions. For example, acknowledging, "I'm terribly sad and frustrated that I was overlooked for that

promotion at work," may lead to further insight and the ability for that person to respond rather than react to the situation.

Self-care refers to one's ability to nurture oneself in times of emotional discomfort and pain. Self-care refers to activities and practices that support the individual in his/her healing. Using the same example above, the frustrated individual can find some relief in the emotional pain by practicing better sleep hygiene, talking to trusted others about the job situation, and practicing other healthy forms of stress relief such as exercising, hobbies, reconfiguring career goals, etc. Likewise, a person experiencing deep sadness may find some relief in connecting with nature, journaling, talking with loved ones, etc. All are examples of self-care. Everyone's modes for self-care will be different.

Altogether, curiosity, acceptance, and self-care are compassionate responses to suffering and pain. One potential consequence of practicing compassion toward one's pain is a better relationship with one's internal life, which, in turn, may lead to greater self-acceptance overall.

All Life is Interconnected

There is no denying that all life is interconnected. This is a main principle of Buddhism though it's also a scientific fact. Humans need connection in order to survive, whether the connection is to a food source or another human other. With regard to difficult emotional experiences, recalling that all life is interconnected can be very helpful.

The experience of feeling deeply healed, soothed, or nurtured by nature is a common one. Nature, music, and animals are commonly used in psychotherapy to

provide clients with emotional support. Chodron (1991) offered the following interpretation of the Four Noble Truths: "I've always experienced these teachings as a tremendous affirmation that there is no need to resist being fully alive in this world, that we are in fact part of the web. All of life is interconnected" (p. 38). The recognition of interconnection can be helpful to those who suffer.

There are many common examples of how the recognition that all life is interconnected can be helpful to those who suffer. For those who experience intense loneliness after the loss of a loved one, it is very helpful to recall that all life goes through death and therefore one is never really alone in his/her suffering. When one feels the pain of disappointment due to other life changes such as the loss of a job or friendship, it is helpful to remember that change is inevitable and change is something that we all experience. In a moment of intense anger, it may be helpful to take a deep breath and recall the natural ebb and flow of emotional states. Of course, the acknowledgment of interconnection is not done in the service of bypassing emotional sensations; rather, it is done to support one in maneuvering the sensations of difficult emotions.

The recognition of interconnection can bring solace in difficult times but also has the potential to bring joy. Most can attest to having profound experiences in nature: witnessing an incredible sunrise or sunset, feeling the heat of the sun in the first days of spring following a gray, harsh winter, swimming in the ocean, etc. Hanh (1998) discussed that he wished psychotherapists would spend more time talking with their clients about joyful experiences. Hanson (2013) discussed the significance of absorbing positive life experiences and feeling states. He explained that the brain has a bias toward negativity; it is more susceptible to holding onto negative thoughts and emotions than

positive ones. Thus, mindfully absorbing positive, life affirming experiences as well as uplifting emotional states can help one overcome the tendency to dwell in negativity (Hanson, 2013). Hanson (2009) offered several examples of practices that may help overcome the brain's tendency toward storing negative memory: meditation, guided visualization, healthy diet and exercise, surrounding oneself with healthy relationships, to name a few.

Compassion

Defining Compassion

Buddhist writers and practitioners often discuss compassion. Tara Brach (2003) wrote about radical acceptance, which is a blend of compassion and mindfulness. For Brach, embracing the present moment with an acceptance for what is *actually* happening, leads to greater compassion for oneself and others. Hanh (1998) discussed the role of compassion in the recognition of suffering: "Our suffering is us, and we need to treat it with kindness and nonviolence. We need to embrace our fear, hatred, anguish, and anger" (p. 29). In Buddhism, compassion seems to be an obvious extension of the Buddhist tenet codependent arising. That is, if everything is interdependent, it makes sense to foster compassion for all. Olendzki (2010) explained:

> The world we inhabit is a vast network of interrelated systems...In such a world every action has far-ranging effects, and often influences things in ways that go well beyond what is immediately apparent (p. 43).

It is important to consider the difference between compassion that arises spontaneously through the practice of Buddhism versus compassion resulting from a concerted effort to be kind to all beings. *Metta* is a Buddhist concept that is closely related to compassion. Metta, which is loosely translated as loving kindness, is mental

attitude that one cultivates and sends to others (Chodron, 1991). It is an important distinction to make because compassion can be seen both as a *natural* extension of one's practice or as a cultivated attitude. The definition of compassion in this current investigation is best explained as a mix between the two. Here, I recognize that most who read this dissertation may not be long-term Buddhist practitioners and, as such, may have not had the experience of compassion that comes from insight related to long-term practice. Further, since this investigation is mainly concerned with the development of a clinical approach toward emotion, it necessitates a definition of compassion appropriate to the task at hand. At the same time, it is important to consider how the concepts in this paper may relate to the long-term practice of Buddhism.

Using the thoughts above, I define compassion as acceptance for what is occurring within oneself and within one's unique life circumstances, the cultivation of kindness and nurturing toward the suffering of oneself and the suffering of others, as well as the cultivation of insight regarding one's interdependency with the world. This may seem like a complicated definition for a term that seems to speak for itself; however, compassion has significant value for clinical contexts and, as such, is deserving of a thorough exploration.

Compassion, the Brain, and Neuroplasticity

Learning to respond compassionately to oneself in times of pain is not an easy task. The brain is wired to send alarm signals throughout the body when one is under physical and/or emotional distress (Hanson, 2009). The reactivity of the human nervous system is not overcome easily; however, there is mounting scientific evidence that neuroplasticity occurs (Hanson, 2009). Essentially, neuroplasticity is a term that

accounts for the brain's ability to change. As discussed in Chapter One, interpersonal neurobiology provides evidence that healthy relationships, such as those cultivated in a safe and helpful psychotherapeutic environment, can lead to positive changes in brain chemistry (Cozolino, 2002; Schore & Schore, 2002, 2008). Neuroplasiticty offers hope that, with time, patience, and practice, individuals can learn to *respond* rather than to *react* to personal difficulties.

As discussed previously, to respond means that one is able to sit with and acknowledge discomfort as well as make an informed decision about what to do (if anything) about the difficulty. With regard to emotional difficulty, many times there is nothing specific to be done other than to feel and understand one's pain. This seems simple but is often very challenging. For example, one may consider the incredible challenge faced by the parents of the Sandy Hook tragedy to sit with immense and unspeakable amounts of sadness, anger, and despair. The desire to protect and retaliate in times of great tragedy is strong. At times, it may seem downright counterintuitive not to do so.

When one is conditioned to react rather than respond to emotional experiences, such experiences often become more difficult. For example, researchers have coined the term "anxiety sensitivity." Anxiety sensitivity scales measure how one reacts to their felt anxiety (Peterson & Reiss, 1987). If one reacts to anxiety feelings with overall tension and fear, then one's anxiety may worsen. On the other hand, if one is able to pause and *sit with* the sensations of anxiety, without further fear and tension, anxiety may decrease with time (McCracken & Keogh, 2010). Learning to respond rather than react can make a big difference. Meditation programs in correctional facilities are examples of programs

designed to help individuals with a history of reactive, violent behavior learn to respond rather than react to internal discomfort (www.davidlynchfoundation.org/prisons; www.dhammabrothers.com). More empirical studies are needed to assess the efficacy of Buddhist-based programs for this population, though the success of Buddhist-based programs in an array of other settings may indicate hope for their success with emotionally reactive, incarcerated individuals (Shonin, Van Gordon, Slade, & Griffiths, 2013).

Learning to respond is an act of compassion. When one learns to sit with one's anger and rage, for example, one creates the time and space needed to make a healthy decision. A common example is being cut off by another car while driving. The simple act of pausing to take a deep breath can mean the difference between an act of road rage and the decision to let it go and focus on driving safely. Many relational-focused clinicians can attest to the difference between reacting defensively to difficult client behavior and tolerating the client's difficult behavior. Overtime, tolerating the client's attacks may translate into that client being able to establish trust in the therapeutic relationship. It may even translate into that client being able to tolerate his/her own internal difficulties with more ease. Through the acquisition of practice wisdom, clinicians often realize that the clients with the most defensive behaviors are often the clients with the least amount of compassion toward themselves. By tolerating the client's difficult behaviors the clinician is demonstrating compassion.

In Buddhism, compassion toward the self and compassion toward others is inextricably linked. The neuroscience behind attachment theory tells a similar story. Again, interpersonal neurobiology research has indicated the significance of relational

experiences on the brain (Cozolino, 2002; Schore & Schore, 2002, 2008). Healthy early attachments may generally suggest an individual's ability to re-create healthy attachments later in life (Applegate & Shapiro, 2005; Bowlby, 1977; Cozolino, 2002; Schore & Schore, 2002, 2008). Keeping in mind the Buddhist notion co-dependent arising as well as interpersonal neurobiology research, when one has been consistently treated with compassion, it follows that the person may become "wired" to respond more compassionately.

Compassion: The Larger Context

One cannot ignore the effects of an individual's social context on his/her general sense of well-being. Factors such as racism, socioeconomic status, exposure to community violence, for example, affect one's sense of security in the world. Such factors may contribute to trauma and trauma affects one's ability to form healthy attachments (Bloom & Farragher, 2011). The individual who has been a victim of racial profiling, inadequate education, and/or who hears gunshots several times a day has a drastically different experience in the world than the individual who has not directly experienced racism and who grows up in a relatively safe community with adequate education and resources. It is vital to acknowledge the effects of the larger social context on the individual's life. As compassion is considered as a clinical theme to assist individuals in working through difficult emotions, clinicians must acknowledge that trauma is often the result of larger structural and social inequalities. Compassion involves assisting the client in responding with care and kindness to his/her direct experience of suffering as well as acknowledging and responding to the larger social structures that sustain oppression.

Jordan (2010) noted that the social pain of oppression and exclusion shows up in the same area of the brain as physical trauma and pain. This gives further credence to a clinical approach that accounts for social inequalities. Thus, RCT focuses on the importance of relationship building for individuals who have faced isolation and pain in personal relationships and/or as a result of social oppression. Narrative therapy is another example of a treatment modality that focuses on the impact of social context on one's personal experience in the world (Madigan, 2011).

Extending the definition of clinical work to include the importance of a client's context- family unit, neighborhood, social and structural supports, socioeconomic factors, etc- is key. In the field of social work, micro-level (clinical and case work with individuals and small groups) and macro-level (policy level work) practice is intended to inform one another. For example, a clinical social worker who practices psychotherapy with an ex-offender with Post-Traumatic Stress Disorder (PTSD) is trained to pay attention not only to the client's individual needs with regard to their trauma but also to the client's need for a supportive context. In other words, if the ex-offender is returning to a community with violence, few resources, and little opportunity for growth, one must question the likelihood that the ex-offender will "rehab" with individual treatment alone. An individual in this situation will often need support from various community resources as well as support from healthy family or extended family relationships to successfully re-enter into society. Many times, the task of attending to a client's individual and social needs is daunting.

In theory, social work clinicians are trained to link "micro" and "macro" levels of practice; however, oftentimes micro-level practitioners find themselves in practice

settings where attending to both levels is overwhelming. This is also true for clinicians of varying disciplines. The clinical theme of compassion calls on micro level practitioners, such as psychotherapists, to maintain and foster connection with their community resources and to cultivate a network of other providers that may be helpful in meeting clients' needs. The theme of compassion also calls on the clinician to stay informed about the way in which a client's social context may contribute to or detract from their individual treatment. If a client experiences a job loss and financially can no longer continue with individual treatment, the clinician must be prepared to support the client in finding affordable or free services that will help the client continue with treatment. Likewise, if the client experiences the loss of a loved one, it is helpful for the clinician to be informed about community support groups for grief and loss.

Compassionate treatment also means that clinicians are able to envision the client as a whole person who is interdependent with a larger context and who has various levels of need: physical, mental, emotional, relational, societal and structural. Educating clients about various levels of need, from personal self-care to supportive community resources, is essential to a comprehensive treatment plan. Essentially, connection is key. The connection that happens within the psychotherapy room will be short-lived if it does not also translate into the client experiencing greater connection with others as well as with the community at large.

Summary

This chapter has explored the following Buddhist-informed themes: Sitting With, Middle Path, Healthy Interdependency, and Compassion. Further, the themes' relevance to approaching difficult emotion in clinical practice was discussed. The themes serve as guides, rather than fixed interventions, to maneuver difficult emotional terrain.

In the next chapter, I will demonstrate how the themes explored in this chapter can be used within a clinical context. I will show how the themes can be worked with to assist clients in their direct experience of emotional pain as well as support clinicians in their conceptualization of clients' emotional suffering.

Chapter 4: Using the Themes in Clinical Work

Introduction

The following chapter will explore the use of the Buddhist-informed themes in a clinical context. A variety of composite case vignettes are presented to illustrate the flexibility of the themes for use in psychotherapy. Each case will present the use of a different combination of the four themes. Since the themes are subtly woven into the clinical case material, I will follow each case presentation with a summary of how specific themes were emphasized in the clinical work as well as offer a commentary about what it was like to use the themes with each case example.

Case 1: Ann

Presenting Issues

Ann entered treatment with the following symptoms: inattentiveness, distractibility, low mood, and general feelings of guilt, being overwhelmed, moody, tense, and worried. She discussed that she had been to therapy for a short period of time in the past and that she was currently taking psychotropic medication to treat her depressive symptoms. She talked a lot about her recent endeavor to begin a graduate program and how others, including her husband and various members of her family of origin, though she was "crazy" for doing so. She acknowledged that academics never came easily for her and that she had frequent worries about whether or not she could handle the challenging coursework. Nevertheless, she enjoyed learning and really wanted to succeed in the program. She frequently worried about her three adult children, her family of origin (most of whom lived across the country), and a few close friends who had serious health issues. She wondered if she might have Attention Deficit

Disorder (ADD). She reported wanting to try psychotherapy before pursuing further medical intervention for possible ADD.

Demographic and Historical Information

Ann had a mixed racial and ethnic background: White, American Indian, and Latino. She was in her mid-forties at the time of treatment. She talked about growing up in a chaotic, economically disadvantaged household with an "out of control" mother. She discussed that her father was often emotionally and physically absent and that her mother was highly critical of all the kids. She described moving several times as a kid and the effects this had on her ability to learn in school and to form relationships with peers. Ann noted the advantages of being the youngest of seven children: she did not have as much responsibility as her older siblings and, as such, she was able to leave her house often and wonder off to spend time with her peers' families. She noted that her older siblings, especially her older sisters, were often expected to take care of everything.

She discussed several accounts of domestic violence in her childhood household. Her father left the home several times, sometimes for several months at a time. She described having a very strong bond with her two oldest sisters. Other relevant information includes Ann's school experience. She discussed showing up late and/or missing school frequently. As a result, Ann said that her teachers did not like her despite the fact that she was a good student when she actually attended school. She was frequently ill and suffered from migraine headaches. Ann also explored the loss of a close friend during her adolescence, which reportedly left Ann feeling "numb" and "lost" for several years.

When asked about history of mental illness and addiction in her family, she noted

that her oldest sister was diagnosed with schizophrenia several years ago and that her brother was diagnosed with bipolar I disorder. She suspected other family members had been treated for anxiety and depression issues. She also reported that her father was most likely an alcoholic.

Overwhelmed, Guilty, and Sad

For Ann, identifying and discussing her inner experiences came easily. Generally speaking, she had good insight and was well-versed in a variety of self-care activities (meditation, yoga, swimming, journaling, reading) that she identified as being helpful to her when she was experiencing distress. Although Ann explored a variety of difficult feeling states throughout the treatment, she discussed feeling *overwhelmed*, *sad*, and *guilty* most frequently. She often discussed feeling "stuck" in these emotions and they were the most challenging for her to maneuver.

A typical therapy session would consist of Ann describing how difficult it was to keep up with the demands of her graduate program. She would describe habits of procrastination and a tendency to distract herself from the task at hand. While exploring these habits, Ann would often become tearful and identify feeling overwhelmed. When gently asked to sit with the sensation of being overwhelmed, Ann would do so willingly. She would easily describe the sensation of drowning and the subsequent fear of not being able to breathe or to "keep up" with life.

She also explored the metaphor of being knocked over by a huge wave and the fear that she couldn't stand on her own two feet. As therapy ensued, Ann would use the wave metaphor as a way to describe various life circumstances that left her feeling overwhelmed. She began to relate her present sensation of being overwhelmed back to a

variety of childhood experiences that left her feeling the same way. She realized that the sensation of being knocked down by a wave had been with her for a very long time. Together we explored that, despite feeling knocked down again and again, Ann was able to work through some very difficult life events and wind up in a relatively healthy place: she had a healthy marriage, a career and children that she loved, and had taken on the challenge of furthering her education. She was indeed standing on her own two feet in many ways despite the internal sensation of drowning. She began to explore a middle path between clinging onto her distressing inner sensations and dismissing them entirely. She still had the feeling of being overwhelmed but it just didn't knock her down as much. As a result, Ann began to see her life more realistically. She could acknowledge her challenges but she was also beginning to see some of her accomplishments. Prior to exploring her sensation of being overwhelmed more deeply, Ann would often discount many of the positive things that had been occurring in her life. For example, she often discussed being way behind in school and feeling as though she didn't know what she was doing despite the fact that she often received positive feedback from her professors.

Ann's feelings of guilt and sadness had much to do with family of origin relational issues. Sadness and guilt were familiar feeling states for Ann. Exploring these feelings also took precedence in the therapy, as Ann had endured several losses in her life, some occurring during the time of treatment and some as a young child. She faced existential anxiety related to mortality, along with trauma resulting from having little support during the losses she endured as a child. As mentioned before, Ann's childhood was filled with chaos and uncertainty. There was no time or energy to focus on feelings. Ann hypothesized that being alone with so much sadness at such a young age created a

heavy burden for her. Over the years, her heavy burden of sadness, mixed with her inability to change her situation for herself or her family members, manifested into unbearable guilt. Her guilt often trapped her. She began to feel guilty for most of her life decisions. For example, if she considered moving far away from her family, she'd feel guilty for abandoning them. If she stayed in close proximity to them, she'd feel guilty for not doing enough to help them. She was in a no win situation. In therapy, we'd consider the fact that nothing specific (no particular action) was going to rid her of her uncomfortable guilty feelings; rather, such feelings were an intimate part of her life story and, through sitting with them in tolerable increments, Ann was practicing a form of acceptance. In other words, she was giving herself the space and time to acknowledge pains that she was not allowed to acknowledge as a younger person.

By acknowledging the painful, burdensome emotions that resulted from her experiences, Ann was able to develop some compassion. Whereas her guilt often coerced her into overextending herself to fix family problems that couldn't really be fixed, her growing compassion encouraged her to accept the fact that the family "wheel of chaos" was set into motion by a variety of forces, none of which she had the capability to fix or control. Ann's increased compassion gave her permission to take better care of herself. If she couldn't fix the myriad of family problems, she may as well take care of herself.

It is important to note here that Ann's growing compassion for herself did not involve an abandonment of her family nor did it magically annihilate her feelings of guilt. She continued to be involved with family relationships and problems, sometimes to her own detriment. Likewise, she continued to experience some guilt. At the same time, she was able to develop compassion for herself as she maneuvered the incredible

complexities in her life. Her greater capacity for compassion assisted her in becoming less stuck in difficult emotions such as guilt. Ann acquired greater acceptance for the complexity (within herself and in her relationships) inherent in her life. Thus, she felt less pressure to "get rid of" her painful feelings and developed a greater tolerance for holding them.

Ann's increased capacity for compassion also led to healthier interdependency in her relationships. She often fielded urgent phone calls from various family members who expected Ann to fix unfixable problems. On several occasions, Ann was asked to "talk some sense into" her younger brother who had gone off his medication and therefore was experiencing an acute manic episode. Such requests would throw Ann into a complete panic as she strived to fix the situation. She felt that, if she didn't "handle it," something terrible would happen and it would be her fault. Despite the fact that Ann lived hundreds of miles away and there was nothing magical she could do to fix the situation, she was called upon to fix it. In these moments, she experienced a frightening, heavy burden.

As Ann cultivated more compassion for her own situation, she could see that the expectation for her to fix this kind of situation was unrealistic and unfair. As a result, she began to frame the situation differently. She began to see that everyone in the situation was in pain: herself, her brother, and the rest of the family. No one person was going to solve the problem. While this acknowledgment did not lead to a magical solution to family problems, it kept Ann from continuously dwelling in guilt. Thus, overtime, Ann began to approach her guilt differently. She began to see accept that she had a long-term relationship with the emotion, due to several traumas and family issues. Previously, Ann would feel guilt and immediately have thoughts of being a "bad person" because she

wasn't "doing enough" for others. Now, she accepted the guilt as a compilation of difficult life experiences. This helped loosen her desire to fix everyone else's problems.

Sitting With, Healthy Interdependency, and Compassion

Since Ann practiced yoga and meditation frequently, sitting with her feelings, while difficult, made sense to her. It seemed easy for her to describe her inner life and she seemed to find the process of sitting with her feelings intrinsically worthwhile. Further, Ann was able to connect certain feelings back to events that occurred in her life, which helped her in the process of developing compassion for herself.

The theme compassion was a useful guide, especially in Ann's struggle with guilt and sadness. Many times, Ann felt guilt no matter what she did. If she decided to help others, she worried whether she was helping them enough. If she decided not to help others, of course she felt guilty then too. Ann was in a no win situation! The more she considered this, the more she was able to garner compassion for her situation. That is, she saw that there was no clear way out of her predicament, which led Ann to accept her situation. For Ann, acceptance and compassion went hand and hand.

Ann's increased compassion for herself also led to healthier interdependency with regard to her family. As she responded to the never ending requests for help from multiple family members, who often became angry with Ann no matter what she did to help them, Ann saw more clearly that her efforts to help often led to nothing more than self sacrifice. Her helping was just a band-aid that would never reach the family issues that festered beneath the surface. The more Ann considered this, the more she was able to find ways to support her family without continuously sacrificing herself.

Growing up in a chaotic home environment where Ann's needs were often

dismissed, Ann learned early on that she could not rely on others. Ann's experience in therapy meant that she no longer had to face challenges alone. By working through her pain with another person, she began to acquire self-compassion. That is, Ann began to legitimize her own needs. Previously, Ann sacrificed herself to save others. Now she was beginning to simultaneously experience healthy interdependency and compassion.

Case 2: Rebecca

Presenting Issues

Rebecca entered treatment with symptoms indicative of post-traumatic stress disorder (PTSD). She had frequent flashbacks and panic attacks. She had difficulty sleeping and was hyper-vigilant in stressful situations. In addition, she experienced moderate to severe depressive episodes, which sometimes interfered with her daily functioning. A new college student, Rebecca worried about her ability to manage her symptoms and keep up with class work. She was also struggling with a recent relationship break up and mentioned general concerns related to intimacy in close relationships, both romantic and friendships. She had few social contacts and reported that she wanted to make friends though often worried about getting "too close" to new people. At the time of intake, Rebecca had been taking psychotropic medication, prescribed by a psychiatrist. She received outpatient psychotherapy on two previous occasions. Her most recent psychotherapy experience was with a therapist who focused heavily on Rebecca's trauma narrative. Rebecca reported that the "heavy" focus on her trauma left her feeling drained and ill equipped to manage her schoolwork.

Rebecca's initial presentation was cheerful. As time went by, it became clear that her affect did not match her internal world. Rebecca discussed that she wanted assistance

in working through her PTSD symptoms, though she also emphasized wanting to develop a greater capacity for relationships as well as a greater capacity to focus on academics.

Demographic and Historical Information

Rebecca was a twenty-something first year college student. She was bi-racial: White and African American. She lived with extended family members while attending college. She described her family of origin as "low-income" and "very dysfunctional." Early on, she was hesitant to provide much detail about her family of origin. Rebecca endured several years of abuse, physical and sexual, by her uncle. The abuse went unacknowledged for several years until a family friend with suspicions made a report to the police. At the time of our meeting, Rebecca was also concerned about up coming court dates surrounding her abuse case. She was worried that the pending court case would distract her from her efforts to begin a new life in college. How was she to manage all the demands of school, peer relationships, and ongoing court dates? She felt stuck because she knew that she needed to continue with more intensive psychotherapy to work through her trauma, yet she also knew that the intensity of the trauma work left her too drained to focus on her academic responsibilities.

Fearful, Lonely, and Disconnected

Rebecca discussed fears about getting close to others. She desperately wanted to make friends, though she didn't feel ready to talk about her life story and she didn't know how close she could get without revealing the painful details of her life. She feared how others' would respond to hearing about her trauma. It took her several sessions before she could begin to verbalize the details of her abuse with me. I was a new person in her life and she feared that I would not be able to "handle it." For Rebecca, anger went hand

in hand with her fears. She discussed that a previous therapist cried when Rebecca told her story. In response, Rebecca immediately felt the urge to take care of the therapist and then felt angry and resentful for having to do so. On the other hand, Rebecca was fearful of receiving support from others. She was stuck in a difficult relational cycle that left her lonely and disconnected from the world.

Slowly, she began to reveal some of the painful details of her abuse. She did so with a nervous laugh and, often, with a smile on her face. Stories of her abuse were often interwoven with her worries about being able to make friends. Since she had been upfront with me about others' responses to her pain, I was careful not to redirect her back to her abuse story. I encouraged her to talk freely about her abuse details as well as her desire to make new friends. In previous therapy experiences, Rebecca felt that she wasn't "doing" therapy correctly unless she was constantly talking about the details of her abuse. The back and forth motion of discussing her abuse as well as her present day fears about relationships seemed to resonate with Rebecca. Rebecca was beginning to find her own middle path for working through her pain.

In time, I began to hear Rebecca speak about positive encounters she was having with others on campus. She was beginning to spend more time with others who seemed interesting to her. She would discuss these encounters in therapy, as well as her fears and insecurities about others finding out about her abuse. Fortunately, when Rebecca finally told one of her new friends about her abuse history, her friend listened and did not make a "big deal" of it. Within a few months, Rebecca was forming actual friendships. One day she came into therapy and told me that she had joined the campus sexual assault prevention task force. I was stunned. Though I wasn't sure she was ready for this kind

of experience, I was confident that we could deal with it if it was too much for her.

Again, Rebecca was fortunate in that others were responding non-judgmentally to her life story. This reassured her and assisted her in taking further "risks." She was beginning to feel safer, more accepted, and even, empowered. For Rebecca, fostering healthy interdependency began with a leap of faith. She stepped into the unknown when she decided to tell others about her story, thus walking straight into many of her fears. For years, her abuser threatened her not to tell anyone. To speak of the abuse would have put her in a very scary, vulnerable, and downright dangerous place. Now, she was beginning to learn that being vulnerable in relationships, though sometimes uncomfortable and scary, could actually lead to some good things, too. The experience of healthy interdependency for Rebecca involved not only opening up about her life to others but also her realization that publicly speaking about her abuse might have an influence on others.

For Rebecca, the recognition that telling her story could actually help others was huge. In the past, others were either not interested in her story because they didn't want to believe it, were trying to cover it up, and/or they had such a shock reaction to hearing it that, in response, Rebecca found herself feeling more alone and disconnected. Now, she was finding that others were actually interested in her story and thankful that she was telling it. As Rebecca began to experiment with her vulnerability, she began to experience vulnerability as a necessary aspect of healthy and meaningful relationships.

Middle Path and Healthy Interdependency

Due to Rebecca's PTSD symptoms, I was acutely aware that I needed to support her in finding a balance between too much exposure to trauma and traumatic feelings and

bypassing her trauma completely. In large, this awareness came from listening carefully to what she was telling me (both verbally and nonverbally). She wanted a way to work through her issues that did not leave her incapacitated. For Rebecca, being able to stay in school and meet new people was a great support and comfort to her. In Rebecca's case, engaging the middle path theme meant that we would need to find ways to explore Rebecca's difficult emotions without overwhelming her. Focusing more on issues in her current life, at least in the beginning stages of the therapy, offered Rebecca a more comfortable way to approach her pain. For example, working through issues related to fear and vulnerability in her current social life was also addressing her past trauma, albeit in a more palatable manner. It was especially useful in that much of Rebecca's presenting emotional pain was related to finding safe ways to be vulnerable. Initially, I had concerns that Rebecca's focus on being a good student and making friends was dismissive of her trauma; however, emotional themes directly related to her trauma were always present in our sessions, both explicitly and implicitly.

Middle Path and Healthy Interdependency went hand in hand in working with Rebecca. With regard to our relationship, Rebecca responded well to garnering support in her goals to manage current day relationships better. This helped her develop trust and a therapeutic rapport. The more risks she took, by telling others her story, the more capacity she developed for vulnerability. Consequently, her feelings of loneliness and disconnection were less troublesome. Her interest in joining the campus sexual assault prevention coalition was a means to further experiment with vulnerability as well as connect with others in a meaningful way. On one level, it was also a less scary way for Rebecca to process her abuse story.

The middle path theme helped to conceptualize Rebecca's struggles. Though Rebecca needed to acknowledge her trauma, she did not want to be defined by it. Though horrible things were done to her in the past, she could also create good things for herself in the present, as evidenced by her joining the campus coalition. One way to frame Rebecca's journey in therapy is that she was on a quest to develop agency in the world. This agency allowed her to experience healthier interdependency with others. She could now effect change in her world and in her relationships. Previously, she felt incapacitated by the horrors of what had been done to her in the past.

Case 3: Derek's Family

Presenting Issues

Derek was twelve at the beginning of treatment. He was recently diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) through a school evaluation. He was previously seen by a play therapist to address symptoms related to his ADHD; this previous therapist and Derek's teachers also had suspicions that he may be on the Autism Spectrum. Derek's mother was especially concerned about Derek's inattention, both at home and at school, his increased defiance at home, recent displays of aggressive behavior, as well as a recent drop in academic performance. Mom was hoping that Derek could learn some ways to work through his seemingly high frustration level. In addition, she hoped that Derek could improve his academic performance by learning techniques to focus his attention.

Demographic and Historical Information

Derek came from a White, middle-class home. He lived in a suburban neighborhood with his mother, stepfather, and two half siblings. Derek's father had been

incarcerated for several months. Derek spent much of his free time with his maternal grandmother and often reported wanting to live with her. Overall, there was significant family relational conflict. Derek's mother and grandmother did not get along. Derek's mom often relied on the grandmother for financial support and childcare, yet became very angry with the grandmother for becoming overly involved with the family. At the same time, Derek's grandmother would often incite conflict when she regularly confided in Derek about her dislike for the way Derek's mom handled things. Thus, Derek was often in the middle of disputes between his mother and grandmother. And, when Derek did become angry with his mother, he would align with his grandmother, which caused serious conflicts between the two. This also caused significant parent-child relational conflict between Derek and his mother.

In addition to Derek's relational issues with his mother, there were other underlying, historical family issues that surfaced throughout the treatment. Derek's mom disclosed that she was sexually abused as a child, an issue that her mother never acknowledged. In addition, Derek rarely saw his father due to his incarceration as well as some serious health issues. Derek's mother often expressed anger about the father's mistakes, which would negatively affect Derek. In turn, Derek would confide in his grandmother and his grandmother would form an alliance with Derek against his mother. Another layer to this family's issues was that Derek's mom wanted to make a big move across the country. Despite the fact that she was the only one that wanted to move (even her husband was wary of such a move), she began making serious plans to move the immediate family.

I should also mention here that, despite many obvious family relational problems,

Derek's mom really wanted Derek to have individual therapy to address his problem behaviors. Fortunately, I was able to have a few serious discussions with mom about the role of family conflict in Derek's acting out behaviors. She became open to me working with both Derek and his family.

Frustration and Sadness

Individually, Derek had difficulty engaging in talk therapy. He was very distractible and had difficulty verbalizing his feelings and talking directly about problems in the home. However, when he and I engaged in play therapy activities, Derek would often blurt out things such as "I'm not moving away," "I wish I could see my dad," or "I wish I didn't have ADHD." He would also mention how "tense" everyone in his home was, especially his mom. He would discuss how he thought he couldn't do anything right at home. He stated that he was angry and sad. It was becoming clearer that the relationship between mom and Derek needed further attention.

Though I had seen various family members together for family sessions, the work between Derek and his mom was essential in assisting Derek in working through his frustration and sadness. Fortunately, despite mom's heightened stress level due to the various layers of family conflict, mom was able to be warm and engaged in sessions with Derek. A main focus of these sessions was mom talking with Derek about the family's pending move. Derek would express his sadness about the move and I would support mom in sitting with Derek in his discomfort. She had a tendency to try to talk Derek out of his sadness, saying things like "It's fun to see new places." When this happened, I gently encouraged her to help Derek sit with his feelings. He would often cry.

At times, mom was able to overcome her tendency to talk Derek out of his

feelings and, instead, just give him a hug or pat his back. With all the tension in the home, it seemed to me that this type of warm exchange was probably not occurring; no one was taking time to actually check in with each other about their feelings related to this potentially big move. Essentially, everyone was overwhelmed and no had time to be compassionate to anyone else. Mom would occasionally ask me what she should do when Derek started crying. She came up with the idea that, in addition to just allowing him time to express his obvious sadness and frustration, she could tell him some stories about transitions in her life and the various emotions she had at such times. I supported mom in her idea and this led to a few poignant sessions where Derek would ask a lot of questions about mom's life. This process seemed to bring them closer together and helped to reduce some of the tension in the home.

With regard to Derek's frustration, mom and I discussed the effects of the tension between she and her mom on Derek. Mom acknowledged that Derek was caught in the middle and that she would often blame Derek for aligning with his grandmother. Mom became more aware of the emotional impact that her conflict with her mother had on Derek. A focus on healthy interdependency was key in working through the frustration that was felt by everyone in the family. I suggested that Derek's mom and grandmother have a few sessions together to address the issue. Together, they worked through some of the ways that their relational conflict affected others in the family, especially Derek. They acknowledged the many layers of their conflict, including the fact that Derek's grandmother never really acknowledged his mother's sexual abuse as a child. Generally, they both were able to confront the fact that it was unhealthy for Derek to be in the middle of both of them.

It was much healthier for the grandmother to support mom in her efforts in raising her kids and in the decisions she wanted to make for her family, including the decision to move. Of course, when Derek's grandmother started to support his mom more, Derek became angry at both of them and, of course, at me as well (for "making them" get along). Derek's frustration over this issue faded with time, as he realized that his mom and grandmother were now a more united front. Though Derek did not enjoy certain moments when both adults told him "no," he no longer had to be in the middle of his mom and grandmother, two people he loved very much. This undoubtedly reduced some level of burden for him.

Sitting With, Compassion, and Healthy Interdependency

When the individual therapy with Derek shifted from talk therapy to play therapy, Derek was better able to experience and verbalize his emotions. Perhaps the play alleviated some pressure on him and made it easier for Derek to connect with his own inner experience. For Derek, the play therapy was a form of Sitting With. It was through his play that I was able to better understand his emotional experience. Most important was the work between Derek and his mother. It was here that Derek expressed himself the most. It was also here that mom gave Derek permission to feel what he needed to feel. This did not come easily for mom; she and I met prior to these sessions to discuss the importance of Derek expressing his feelings to her. Nevertheless, mom supported Derek in expressing his sadness and frustration.

One byproduct of these sessions was that mom was also given time to sit with her own feelings. She and Derek helped one another. Though not explicitly discussed in Derek's case vignette, the sessions between mom and Derek fostered compassion. Prior

to these sessions, mom was not really enjoying her son. Because of his poor behavior at home, Derek often left her feeling exasperated. The quiet therapeutic space gave mom an opportunity to really listen to Derek's inner experiences. This helped her see her son in a very different light. She still disliked his disrespectful behaviors though she was beginning to understand that Derek was really struggling with the family chaos around him. She was developing compassion for him, because he was indeed in pain.

There were so many relational issues going on in this family that it's impossible to touch on all of them. The relational problems between mom and Derek and mom and her mother seemed most significant to me. Derek's mom and grandmother were always in conflict. The pending move deeply saddened Derek's grandmother, as she didn't want "to lose" her grandkids. Her sadness and fear about the move left her clinging to the present. She had difficulty accepting that her daughter was an adult and should be able to move her family, if she wished. Sessions between Derek's mom and grandmother focused on his grandmother working through her sadness and fear by letting go of her expectations that her daughter and grandchildren should always live near her.

Further, she began to acknowledge that the move could even be healthy for her daughter's family. She had been overextending herself to help her daughter out of fear that her daughter would withhold the kids from her. She began to consider that the move might be a way for her to establish new, healthier relational patterns with her daughter's family. I began to see the move as an opportunity for the family to establish healthier interdependency. I shared my thoughts with both Derek's mom and grandmother and both agreed that this was possible.

Derek's case contained multiple layers of complex dynamics. Initially, Derek's

caregivers saw his symptoms as imbedded within him. The therapy process allowed the caregivers to consider the way in which Derek's "issues" were symptomatic of unacknowledged past trauma and resulting unhealthy family dynamics. Progress in treatment required the caregivers' acknowledgement of their contribution to the unhealthy system and its subsequent impact on Derek. For example, the more Derek's mom could see Derek's behavior as symptomatic of unhealthy dynamics, the more she was able to sit with Derek in his pain, which helped her experience more compassion for his suffering. Compassion fueled healthier interdependency and vice versa.

Case 4: Paul

Presenting Issues

Paul entered outpatient psychotherapy immediately following his discharge from a psychiatric hospital due to a suicide attempt. Paul reported feeling down/sad a lot and had several worries related to personal and professional goals. He spoke about not knowing what he wanted to do with his life: Should he finish college despite the fact that he felt it wasn't a good fit for him? Should he enter a trade school? Should he find a job anywhere just to be productive? In addition, he reported constant worries about what others, especially his parents and close friends, thought about his recent suicide attempt and his ability to "get over" his depression and succeed. Though Paul was no longer suicidal, he reported general feelings of hopelessness and despair about his current situation as well as copious amounts of embarrassment and shame. He noted that he wanted to feel "normal" again. He shared that he wanted to make better decisions about school/career and to find ways to meet new people. He emphasized that he would never do anything again to land himself in a psychiatric hospital.

Paul presented as anxious and self-conscious. He avoided eye contact and gave a lot of one-word answers to questions. He sat far away from me in the session and would often comment on how "weird" it was to be in therapy.

Background Information

Paul came from a White, middle-class household. His parents divorced when he was very young and he saw them both regularly. He had three older siblings to whom he felt close. Paul described his family life as "pretty normal" and didn't identify any significant, traumatic events. Early on in treatment, he discussed that severe facial acne contributed to his low self-esteem and his difficulty looking at people when he spoke to them.

Paul was attending college at the time of his suicide attempt. He reported that he hated school and was afraid to let his parents know and, instead of confronting the issue directly, he took every opportunity to avoid the fact that he didn't like it and was failing some of his classes. As a result, Paul began to drink more heavily on the weekends and stopped going to class. Following a fight with his best friend and roommate, Paul ingested several pills with alcohol and woke up in the hospital.

Despair, Loneliness, and Confusion

At the time of his suicide attempt, Paul couldn't imagine a way out of his situation. By the time he began outpatient psychotherapy, Paul still couldn't imagine a way out of his situation, though he felt strongly that he wanted to live and feel better. The beginning stage of treatment mainly focused on Paul's experience at college, leading up to his attempt. As he sifted through the general feeling of despair, Paul recognized other underlying feelings such as loneliness and confusion. Sitting with emotions did not

come easily for Paul, as he was uncomfortable coming for therapy. He often hinted at wanting to get through the process of therapy as quickly as possible.

Paul acknowledged that he had been feeling lonely and confused for quite sometime, long before he started college. He began to explore such feelings more deeply as therapy ensued. As his other peers became increasingly excited about college, Paul began to feel distant from them. He was unsure about what he wanted to do and had many doubts about going to college. The increasing mental and emotional distance from his friends left Paul with a growing sense of confusion. He told himself many times that he needed to attend college because that was the obvious thing to do. Paul was ashamed of being different than his friends. He worried that his emerging thoughts and feelings about doing something other than college meant that there was something wrong with him.

As Paul developed his narrative about what happened to him over the last several months, I would often encourage him to pause and sit with what he was saying and feeling. He would often remark that he felt stupid for staying in school when it wasn't the right fit for him. I suggested that he might consider having some compassion for himself, for the predicament he had experienced. I asked him questions such as: How many of us have found ourselves in situations that didn't work for us and stayed in them because we were afraid to change? To such questions, he would often shrug and respond: "I guess." Overtime, Paul granted himself some compassion. He would reflect about how scared he was to change his situation, which meant that he would risk letting others (namely, his family) down. The more Paul allowed himself to sit with the painful feelings he had been experiencing for such a long time, the more he began to develop

some compassion for himself. He was beginning not only to acknowledge his pain, but also to develop insight about how his pain manifested. Namely, Paul began to see that he was attacking himself for having interests that were different than his friends'. Paul was shaming himself for being different.

As therapy progressed, Paul started to talk about his own thoughts and ideas about his future. Instead of labeling his internal thoughts, feelings, and experiences about his future as "wrong" and "stupid," Paul considered that he actually had some good ideas about his future. Prior to attending college, he thought about carpentry school. This thought stayed with him and he began to research this idea as well as other possible ideas. In the meantime he got a full time job, which helped him feel productive and the pay the bills while he continued to weigh various career options.

Using the Themes with Paul: Compassion, Sitting With, and Healthy Interdependency

Encouraging Paul to sit with his pain was difficult. He was quite ambivalent about therapy and wanted to rush through the process. The more Paul discussed the facts surrounding his situation, the easier it was to encourage him to pause and consider his predicament. He was feeling ashamed of his own developing thoughts and feelings about his future. Paul constantly compared himself to his peers. His shame manifested as a result of feeling different than his peers and therefore thinking that there must be something terribly wrong with him. He felt so ashamed that he began to attack himself. Once Paul acknowledged the ways in which he was hurting himself, he was able to consider having compassion for himself. His developing compassion made it easier for him to respect his individual needs and goals. For Paul, compassion led to an undoing of

shame. One way to frame Paul's therapy journey is that he began to see that his problems and differences did not necessarily alienate him from others. Rather, everyone has problems and everyone is different. Difficulties and problems are what everyone has in common. By trying to force himself to have the same experiences as many of his friends, he was limiting his growth and potential. The process of therapy was a means for Paul to experiment with exploring the wisdom of his individuality.

The irony of Paul's exploration of his individual thoughts and feelings was that it helped him develop healthier relationships. He went from a state of hopelessness to a state of curiosity about himself and others. This was evidenced by his interest in dating and in exploring other career prospects. This is not to say that Paul became free of emotional pain and problems. He continued to struggle with general self esteem issues and moments of depression, though he created more space in his life to dream about possibilities and to develop healthier relationships. He was dating and was also experimenting with getting to know people he was meeting through his job. Though he continued to socialize with his college friends, he accepted that their choices were different than his, at least for the moment, and that was okay.

Expanding the Use of the Themes: Broadening Conceptions about "Clinical" Practice

One cannot ignore the effects of the larger social context on the individual's life. Further, when the role of social context is acknowledged, one's conception about what clinical practice *is* inevitably changes. So far in the chapter , I have focused on the use of the Buddhist informed themes with difficult emotions in a traditional psychotherapy practice setting. While a growing number of clinical social workers practice in this type

of setting, a main tenet of the social work field is to attend to social and structural inequalities, for the sake of marginalized individuals and communities. As such, it is important to demonstrate how the themes may serve as useful guides when working with individuals and communities directly affected by structural inequalities. In this section, I will present a composite case vignette based on my time working as a mental health clinician in an inner-city school. I will show how the themes can be used in a broader sense to address trauma resulting from vulnerability due to economic, social, and educational inequality.

Tia's World

Tia is a ten year-old, biracial girl living in a housing project in North Philadelphia. Tia's fourth grade teacher referred her to the school-based mental health program because she exhibited "disturbing" behavioral problems such as hitting other students, throwing objects in the classroom, eloping from the classroom, and refusing to attend school on several occasions. Tia was referred to the school-based mental health program before but, due to health issues, Tia's grandmother (her caretaker) was unable to take Tia to the necessary initial appointments to enroll Tia in the program.

Tia's father is deceased and her mother infrequently visits Tia. Tia's grandmother is in remission from a cancer diagnosis two years ago. Tia's home environment is unsafe. Her apartment door lock has been broken for over a month. There are bullet holes in the elevator shaft and Tia routinely wakes up at night to the sounds of her neighbor's domestic disputes. Her grandmother has attempted to call the police a few times and no one shows up to settle the matter. Tia does not always make it to school in the morning because her grandmother often feels ill in the morning and is unable to walk

Tia to school; her grandmother is afraid to let Tia walk alone.

At school, Tia is far behind in reading. She reads at the first grade level. Because Tia has an Individual Education Plan (IEP) it is very difficult for her teachers to hold her back a grade so that Tia can catch up on necessary reading skills. Generally speaking, the culture of the school and the school district is to "push kids through" to the next grade. When asked to complete class assignments, Tia often becomes frustrated and throws a tantrum. Tia has a concerned and involved teacher who does the best she can to give Tia one on one attention, which seems to help Tia calm down and focus better. Tia excels in art class and has sufficient math skills, despite her truancy.

Tia's Treatment Plan

The school-based program necessitates that Tia receive the following: individual counseling, a psycho-education group with other children her age, one-on-one behavioral support in the classroom, and case management for Tia and her family to support them in following through with appointments necessary to keep Tia in the program.

Generally speaking, Tia responds well to her classroom behavioral support worker as well as to her individual counselor. She engages cheerfully except when redirected to do something that she does not want to do. In such cases, she often yells or throws objects in the classroom. Tia routinely elopes from her classroom. When found, she often sobs and yells for everyone to leave her alone. On one occasion, she sobbed for several minutes and was difficult to calm. Both her behavioral support worker and her counselor spent over an hour sitting next to her on the hallway floor, saying nothing. Eventually, Tia was able to be redirected and went back into her classroom.

Using the Themes with Tia

As I apply the themes to working with Tia, I will make the following assumptions: Tia's school-based program is fully staffed, there is good communication between the mental health program and the school in which it resides, Tia's treatment team clearly understands her treatment goals and everyone on the team is on the same page about how to respond to her needs, everyone on Tia's treatment team regularly receives clinical supervision. Many times, clinicians doing this type of work are in environments that lack the above conditions. This often results in workplace trauma and/or burnout for employees, which affects their ability to respond adequately to the needs of their clients (Bloom & Farragher, 2011). In Tia's case, I will assume that her clinical team is generally equipped to meet her needs.

Compassion. In order to respond to the difficult behaviors that Tia displays, her clinical team will need to have compassion for the various difficulties that Tia and her family face. Working with Tia necessitates a thorough assessment of her behaviors and symptoms as well as a thorough assessment of the socioeconomic and educational difficulties that she faces. I discussed previously that one aspect of compassion is the acknowledgment that emotional difficulty can result from structural inequalities that make certain individuals more vulnerable to trauma. When Tia's clinical team made the unified decision to sit with Tia, in her distress, in the hallway rather than reprimand her from running out of her classroom, they were responding with compassion. It should be noted that healthy discipline can also be a form of compassion, though in this particular situation, supporting Tia in her effort to self soothe was the more appropriate choice.

Sitting With. Her clinicians need to first "sit with" the realities of Tia's life. Tia's world

is unsafe. Her lack of safety is reinforced everyday: the violence on the street and in her apartment complex, her inability to lock her own door, her caretaker's message that Tia should not walk anywhere alone, her abandonment by her parents, her grandmother's health issues. Further, when Tia's clinicians sit with her while she experiences distress, they are modeling distress tolerance. The literal act of sitting with Tia on the hallway floor demonstrates their full acceptance of Tia and her world. In this clinical situation, sitting with offers a type of validation that behavioral change and redirection cannot.

Middle Path. The concept Middle Path is a valuable guide for approaching Tia's challenging symptoms and behaviors. Tia's acting out is often disruptive and potentially harmful to her and other students. In many situations, she will need to be redirected, removed from the classroom, and disciplined for such behaviors. While such behavioral strategies and interventions are often necessary, it is important that they be balanced with an approach that validates Tia's emotions. One may conclude that Tia's world is pretty invalidating. She may desire to feel safe when she goes home at the end of the day but violence surrounds her. She may desire to learn new things in school yet she has burdens that undoubtedly affect her ability to pay attention and absorb information. The moment when her clinicians sat with her in the hallway is an example of validation. Tia's individual counseling sessions may be a valuable opportunity to support Tia in feeling and exploring her emotions in a safe and validating environment.

Healthy Interdependency. As mentioned before, a main aspect of the clinical work with Tia is validating her emotional experience as well as intervening behaviorally so that she remains safe and secure in her classroom environment. While such clinical interventions are important, they are limited. At the end of the day, Tia will have fear as

she walks home from school and when she enters her home. The larger, structural inequalities that directly affect Tia cannot be solved through micro level clinical work alone. The effects of racism, classism, community violence, and an underfunded education system interfere with Tia's ability to cultivate a sense of healthy interdependency with the world around her. Some clients are able to internalize the healthy experiences they encounter in psychotherapy because the world they live in is generally safe and full of opportunities and various privileges. This is not the case for Tia. Tia's world requires her to overcome all sorts of inequities so that she may one day find herself in a situation with more privilege and opportunity. Social service agencies and mental health clinicians working with marginalized individuals and communities will need to find creative ways to attend to trauma that is the direct result of inequities. Perhaps this begins with more open, direct communication between policy makers and micro-level clinicians.

Summary

This chapter has demonstrated how Buddhist-informed themes may be used in various clinical contexts to aid clients in their encounters with difficult feeling states. The themes serve as useful guides rather than protocols for working with emotion. Further, the themes may assist clinicians in conceptualizing clients' emotional distress, thereby offering clinicians further support in understanding and working with the emotional pain of their clients. Lastly, this chapter showed how the themes are potentially useful in clinical contexts that involve emotional pain and trauma resulting from structural inequalities. To this last point, the importance of connecting micro level clinical practice with macro level practice was considered.

Conclusion

The use of Buddhist-based practices and principles in the mental health field has proliferated in recent years. In particular, the practice of mindfulness has been incorporated into various psychotherapeutic treatment modalities to assist clients and clinicians in approaching distressing symptoms. In most cases, the use of such Buddhist practices in clinical work has circumvented the larger framework of Buddhism. Because Buddhism is mainly concerned with the issue of human suffering, dismissing the theoretical and philosophical foundation of Buddhism in the service of secularizing Buddhist practices for the mainstream runs the risk of distorting the value inherent in such practices.

This dissertation has explored one possible clinical application of the larger Buddhist framework: supporting clients in their direct experience of difficult feeling states. Clients' *direct* experience of emotional pain is integral to the process of psychotherapy yet has been largely unacknowledged in major Western theories of psychotherapy. Buddhism is concerned with *direct*, *here and now* experiencing. As such it offers insight about the potential value of sitting with one's difficult internal sensations and experiences. In addition, the theoretical and philosophical underpinnings of Buddhism offer a pool of possibilities in the development of conceptual frameworks to address human pain and suffering.

In this dissertation, I have constructed a framework for approaching difficult emotional experiences in the context of psychotherapy that is heavily informed by Buddhist philosophy. I have done this, first, by demonstrating that human emotion is assuredly difficult to grasp and define. To this point, I took the liberty of defining

emotion through the lens of the client. That is, emotion is in the client's *direct* questioning and concerns about *here and now experiencing*: "When will this sadness end?" Though such questions relate to direct, here and now experiencing, they often carry stories of past pain. Second, I have offered a broad and general overview of the main tenets of Buddhism. This served to delineate the Buddhist ontology as well as describe the interrelated parts of Buddhist philosophy. Third, I used the philosophical framework of Buddhism in the construction of themes that, collectively, may serve as a conceptual framework and/or guide for clients and clinicians as they maneuver challenging emotional terrain in the psychotherapy room. Lastly, I presented case vignettes to demonstrate the use of this framework in therapeutic contexts.

The secularization of Buddhist concepts and practices for use as *intervention* has limited the possibilities of engaging the entire wisdom of Buddhism in clinical contexts. It has been my intention, in writing this dissertation, to *create* possibilities. When pain and suffering are seen as inextricable to the human experience, the way one approaches pain and suffering inevitably changes. Implicit in this dissertation is the belief that one's relationship with one's own pain is an integral aspect of the healing process.

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