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Mindfulness Meditation as a Self-Care Practice in Social Work

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Mindfulness Meditation as a Self-Care Practice in Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
Abstract

Self-care is an important aspect in social work practice, and mindfulness meditation can be used to reduce stress, provide a sense of calmness and increase awareness. Since the benefits of using mindfulness meditation as a form of self-care for social workers has been minimally studied, this research focused on whether mindfulness meditation could have a positive impact on self-care for social workers. This study used mixed methods of data collection and a single subject design methodology using the researchers as the subjects. Pre and post test data on self-care measures were analyzed following a 6 week mindfulness intervention period. Data suggests that mindfulness interventions did increase self-awareness and compassion satisfaction, as well as decreased the likelihood of burn out and secondary traumatic stress. This research suggests a number of implications for social work students who may benefit by incorporating mindfulness practices into their daily lives.
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Introduction

We often hear about self-care and how important it is for social workers to take care of themselves. We also hear quite a bit about mindfulness these days, and the benefits that come from it. However, the significance of mindfulness as a form of self-care for social workers has been studied sparingly. Mindfulness and mindfulness meditation are often mentioned in the clinical literature, but the use of mindfulness meditation to improve social workers’ self-care is an area of study that has not been fully developed.

Self-care is a professional responsibility for all practitioners regardless of their discipline. “You can’t pour from an empty cup” is a popular saying (author unknown) that directly applies to social workers and therapists alike. Obviously, we cannot effectively aid our clients if we ourselves are empty and have nothing to offer our clients. Self-care is a way for social workers to replenish our reserves so that we have something to give. Williams, Richardson, Moore, Gambrel, and Keeling (2010) make it clear, “professional associations recognize the need for self-care and address it in codes of conduct (p. 321)” specific to their professions. The National Association of Social Workers (NASW) code of ethics discusses how social workers need to deal with impairments as an ethical responsibility to clients. In other words, social workers have the obligation to themselves as well as their clients to provide the best services they can without harming the therapeutic relationship. Proper self-care by social workers can reduce the impairments they may face while working with clients. The ethical responsibility related to impairment is as follows:

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.
(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their
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professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (NASW, 2008).

The NASW Code of Ethics is clear that practicing self-care is an ethical duty if we are going to offer the best possible treatment to our clients. Since we can become distracted in our professional and academic lives when we are emotionally over connected with clients it is important to realize that practicing self-care is not indulging in a luxury activity, but is a purposeful and conscious element of our professional practice (Williams et al., 2010), as well as a personally beneficial one.

One way of addressing self-care is through mindfulness meditation. Mindfulness is a meditation practice that brings awareness into the present moment without judging or evaluating the experience (McCollum & Gehart, 2010). According to McCollum & Gehart (2010), mindfulness is composed of:

Intentional focus of attention on present experience, especially thoughts, feelings and physical sensations while taking a particular orientation toward those experiences, an orientation of curiosity, acceptance, and interested investigation. (p. 347)

Not only can the practice of mindfulness bring awareness to the therapist, it can also strengthen the therapeutic relationship between the client and therapist by helping the therapist be more curious, accepting, and fully present (Gehart, 2010).

The cross-cultural practices and principals of mindfulness originated from Asia more than 2,500 years ago and since then have manifested in many cultures around the world and are being studied for their relevance to mental and physical health in the fields of medicine, psychology, and neuroscience (Garland, 2013). Although mindfulness has existed and has been studied for years, there has been an increase in empirical studies related to its ability to treat a
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range of mental health conditions (Garland, 2013). Mindfulness is a fairly recent interest in social work practice. Its relevance has not been fully integrated into its purpose, professional knowledge base and frameworks for practice (Lynn and Mensinga, 2015). Therefore, the use of mindfulness by social workers in the therapeutic sense is fairly recent, and attention to it in the professional literature is somewhat limited.

The literature does suggest that mindfulness is an empirically supported and effective practice (Garland, 2013). It also suggests that self-care is important and necessary for mental health care professionals. What is missing is more in depth studies of whether mindfulness meditation practice can improve the personal lives and quality of self-care for social workers. Since the benefits derived from practicing good self-care are also needed for effective therapy and coincide by the requirements with the NASW Code of Ethics, understanding the personal self-care benefits to practitioners would be an important contribution to the literature.

Social workers have rarely been used as test subjects when evaluating self-care. The use of mindfulness and mindfulness meditation by social workers on themselves has also been rarely studied. In this exploratory research project, we use social work students as subjects to observe how the practice of mindfulness meditation impacts their self-care. Social work students face the stress of being a student along with work, clinical internships, family life, socializing and everyday life stressors. It can be difficult for students to practice self-care, especially if it is not a priority.

In order to explore whether or not the practice of mindfulness meditation can impact the self-care of social workers, a literature review focusing on self-care, mindfulness, and mindfulness meditation in self-care will first be presented. This will be followed by a chapter detailing the methods used in this project. Next is the research
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lenses chapter that discusses researcher the theoretical frameworks used in this project along with researchers’ professional and personal lenses. This is followed by the findings chapter where we report observational data, our experiences implementing the mindfulness interventions, and the impact of mindfulness on self-care. Finally, in the discussion chapter we interpret the findings of this research and suggests implications for social work practice and future research.
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Literature Review

Social work is a demanding profession. It is a career that requires trained professionals to put their hearts, souls, and minds into their work, often with little external appreciation. This can result in feelings of depletion, mental exhaustion, and job dissatisfaction. These are just a few of the problems that can arise for social workers if they neglect caring for themselves. In this review of the literature we first address the importance of self-care in general and how it can be used as a coping mechanism. We then go on to consider mindfulness meditation, its effectiveness in self-care, how it can contribute to wellness, and the potential benefits of social workers using mindfulness meditation as a method of self-care. Finally, we present a brief summary of literature on mindfulness and self-care in the workplace, and conclude this chapter with a summary and the research question for this project.

Self-care

Self-care is an abstract term used widely to reference ways in which professionals make caring for themselves a priority in order to live a well-balanced life. The literature does not provide a concise definition of self-care. How is it possible, then, for social workers to effectively practice self-care if they are not clear on what it means? Social workers need to have a better understanding of self-care in order to comprehend its importance in reducing burnout, preventing impairments in their professional judgment, and making sure they have adequate self-care practices.

According to Lee and Miller (2013) self-care is a pattern of behaviors that support health and well-being by promoting resilience in practitioners who work closely with death and bereavement, mental health, and trauma. They describe it as a process that promotes a sense of subjective well-being, a healthy lifestyle, stress relief, and activities that manage vital functions
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such as sleep, diet, exercise, and rest. They go on to say that it is more complex than simply remembering to take care of one’s self, and to fully engage in self-care, social workers need to implement approaches in physical, psychological and emotional, social, spiritual, leisure, and professional care (Lee & Miller, 2013).

In the social work profession we perform many roles and functions ranging from brokers, advocates, case managers, educators, facilitators, organizers, managers and mental health providers. The work hours can be very long and mentally exhausting. This section will explore the importance of self-care and how burn out may emerge from not practicing self-care.

**Importance of self-care.** McCadam and Brown (2014) imply the importance of self-care by noting a sort of naïve optimism upon entering the profession:

The social work career begins with excitement and enthusiasm, yet nothing fully prepares social workers for the reality of managing urgent personal situations while also working in a demanding career. If social workers knew what is required to maintain the balance between personal and professional life, how many would still choose the profession? (p.4)

Social workers often find themselves in helping roles and have unrealistic perceptions of how demanding their careers may actually be. This can obviously set them up for disappointment.

Social work has the reputation of being stressful and underappreciated (Collins, 2008). With licensed social workers reporting an increase in paperwork, severity of client problems, caseload size, long waitlist for services, a decline in reimbursement, a decrease in supervision availability, staffing opportunities, and accessibility of client services, it is not hard to see why self-care is getting more attention in the literature as an essential part of social work (Lee & Miller, 2013; Aronsson, Astvik, & Gustafson, 2014). The structure of an organization can also impact the social worker’s mental, emotional, physical, and spiritual state. Social workers can experience overload, burnout, compassion fatigue, excessive amounts of work, absence from
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family, and exposure to inhumane conditions (Warren, Klepper, Lambert, Nunez, & Williams 2011). The practice of self-care enables social workers to better cope with stressful work conditions, engage actively in advocating for structural changes in the organization, and become more inclined to stay in the career (Lee & Miller, 2013). Papia (2014) details benefits of self-care:

We become rejuvenated, energized, inspired, healed, restored, and happier. In doing so, we become increasing capable to continue to serve others, to give to others, to engage in giving and receiving in a manner and to the degree that honors our profession and the role of a professional helper. Self-care practices improve and enhance our human being-ness and our human performance. (p.29)

On the other hand, poor self-care practices can lead to emotional and energy depletion which can have negative impacts on the quality of services provided (Lee & Miller, 2013). The positive practice of self-care allows us to reflect on the reasons we entered the social work profession when times become difficult and we feel like throwing in the towel. The literature suggests that burn out is one result of not caring for the one’s self (Papia, 2014). There will be times when we are faced with burn out and job dissatisfaction to the point where we may consider changing professions.

**Burn out.** Just as self-care has many definitions, so does the term burn out. The state of burn out is described as “a state of physical, emotional, and mental exhaustion, the experience of being a failure, and feeling worn out” (Papia, 2014, p. 28). This definition is similar to the NASW professional care policy that describes burn out as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishments that can occur among individuals who do people work of some kind” (Papia, 2014, p. 28). Burn out arises from the stress of performing the demanding work of social work. However, what the bright eyed and excited graduate social work student does not realize is that social work is a career in which a lot of
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effort is expended with little formal recognition for a job well done. Social workers are on the front lines and are also behind the scene workers performing many functions that their clients are not aware of. You know they are present, performing many important tasks, but are often not valued to the same degree as the other counseling professions.

What causes social workers to feel burned out? The simple answer is stress. Marc and Osvat (2013) define stress as a “body-environment interactional configuration, in which the body is overloaded to the extent of its reserves of immediate reaction, risking their exhaustion” (p.122). Burn out is therefore the body’s response to prolonged stress. Conditions that may contribute to social work stress include excessive demands, repetitive work, physical danger, role conflict, role ambiguity, organizational structure, and struggles to maintain family and job balance (Marc & Osvat, 2013).

Burn out is not just limited to veteran workers; it also affects new social workers that become overwhelmed with all their duties. As difficult as the job can be at times, social workers do gain some satisfaction and enjoyment from their work. Job satisfaction often starts to go downhill when there is lack of formal recognition. Carmeli and Freund (2009) found “when employees believe outsiders appreciate or favorably evaluate their organization, the social workers tend to bask in the reflected glory of the organization and develop high levels of satisfaction and affective commitment toward their organization” (p.247). For social workers, this lack of recognition may be experienced as a lack of support and appreciation for coping with difficult cases (Marc & Osvat, 2013). The low pay, demanding work, and lack of recognition all contribute to feelings of burn out (Marc & Osvat, 2013). Collins (2008) states that social workers who practice healthy coping strategies such as self-care, receive support within the work setting, along with personal hardiness and resilience are less likely to burn out.
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The practice of self-care by social workers allows for self-awareness especially when they are beginning to feel burned out. Self-care encourages us to engage in activities that bring our mind and bodies back to a place of peace and homeostasis and one way to accomplish this is through the use of mindfulness meditation.

Mindfulness Meditation

An emerging approach to self-care is the practice of mindfulness meditation. Mindfulness meditation is deeply rooted in Buddhist traditions, values and beliefs. For more than 2,500 years it has been vital in attaining spiritual wellness (Nhát Hạnh, 1999). Buddha, which means enlightened being, refers to a being that accepts that suffering, misery and unhappiness are inevitable; however, not permanent (Nhát Hạnh, 1999). After the Buddha experienced his awakening, he began teaching the Four Noble Truths (Coomaraswamy, 1964; Nhát Hạnh, 1999). The Four Noble Truths are: suffering (dukkha) exists, origin (samudaya) of suffering, cessation (nirodha) suffering by letting go of attachments and striving, and path (marga) that leads to extinction of suffering; which also includes the Noble Eightfold Path (Coomaraswamy, 1964; Nhát Hạnh, 1999). This awakening manifests through mindfulness meditation.

While mindfulness meditation originated in the Buddhist tradition, in recent years, it has also become a more popular practice within Western culture. This section will differentiate between Eastern and Western philosophies behind mindfulness meditation. First, it will explore how mindfulness and meditation are distinct. Then the types of mindfulness will be discussed along with the benefits of mindfulness meditation and benefits of mindfulness meditation in social work. Next, explore self-care and mindfulness meditation and conclude with the challenges of mindfulness meditation.
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**Eastern Philosophy.** *Dhyana* is an ancient Sanskrit word that translates as meditation.

There are two facets of meditation: *shamatha* (calming) and *vipashyana* (seeing-through, insight, or transforming) (Thurman, 2006). Nhất Hạnh (1999) describes *shamatha*:

*Shamatha* is stopping. We run our whole life chasing after one idea of happiness or another. Stopping is to stop our running, our forgetfulness, our being caught in the past or the future. We come home to the present moment, where life is available. The present moment contains every moment. *Shamatha* is also the practice of concentrating, so we can live deeply each moment of our life and touch the deepest level of our being (p.209-210).

Similarly, Nhất Hạnh (1999) describes *vipashyana*:

*Vipashyana* is looking deeply to see the true nature of things. You look into the person you love and find out what kinds of suffering or difficulty she has within herself and what aspirations she holds. Understanding is a great gift, but your daily life conducted in mindfulness is also a great gift. Doing everything mindfully is the practice of meditation, as mindfulness always nourishes concentration and understanding (p. 209-210).

The more general term, mindfulness, is translated from a Pali word, “sati,” which can be translated as “awareness, attention, and remembering” (Didonna, 2009; Siegal, Germer, and Olendzki, 2009). In addition, the Pali words for mindfulness meditation are *vipassana bhavana* (Siegel et. al., 2009). During this meditation, one can choose to flow through several different practices, *sati* (mindfulness), *metta* (lovingkindness), *samatha* (concentration), or *vipassana* (mindfulness or insight), as needed (Siegel et. al, 2009, p.28).

**Western philosophy.** Mindfulness meditation was popularized in the United States by Jon Kabat-Zinn in the early 1990’s. He defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145).

Mindfulness meditation is cultivated by the following seven foundational attitudinal elements: non-judging, patience, beginner’s mind, trust, non-striving, acceptance, and letting go.
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(Wisniewski, 2008; Kabat-Zinn, 2013). Kabat-Zinn (2013) defines non-judging as being able to be with whatever arises in the moment in a gentle, kind, and encouraging manner. Patience is accepting your tangential mind and refocusing it back to the present. Beginner’s mind, on the other hand, is allowing yourself to approach each meditation as though it was your first. Trust is defined as being able to trust one’s own experience which includes feelings and intuition. Non-Striving is being malleable with expectations of mindfulness practice. Acceptance is defined as embracing yourself as is before you can expect to change. Finally, letting go is being able to let go of burdens or impediments (Kabat-Zinn, 2013).

It is a common misconception that mindfulness meditation is simply about increasing awareness, attentiveness, taming the monkey mind, and reducing stress (Siegel, Germer, and Olendzki, 2009); as a matter of fact, the level of consciousness deepens and provides clarity of life. In order to deal with the fallacy, the distinction between mindfulness and mindfulness meditation practices is discussed in the next section.

**Mindfulness and mindfulness meditation practices.** Though often used synonymously, mindfulness and mindfulness meditation practices are not the same thing. Mindfulness refers to paying attention, being present, having no conscious purpose, and feeling no judgment. Mindfulness has to do with working with the mind by knowing it, shaping it, freeing it, and paying attention to how life is experienced every moment (Warren et al, 2011; Kabat-Zinn, 2013). Meditation practices, on the other hand, are particular ways to acquire mindfulness through commitment to certain practices. Through both mindfulness and meditation practices, the habits of the mind are recognized and wellness is enhanced. Warren et al (2011) discusses the relationship between the two, as well as their importance in social work practice:

> With meditation, there is “no purpose,” only enhanced awareness and mindfulness. One way to quiet the mind is through mindfulness. Mindfulness is
enhanced through meditation-based practices. In social work, wellness practices are critical and can enable recognition of burnout, cynicism, or overload. Practicing breathing and contemplating our body, feelings, mind, and objects of mind, we practice peace in the present moment. This is living mindfully. (p. 140)

In other words mindfulness meditation is “a manner of being aware, an attitude of mind toward experience, and a mode of awareness that is paradoxically both intimately close and objectively removed” (Olendzki, 2009, p.42).

Types of mindfulness meditation. There are numerous mindfulness practices used to generate mindful states of awareness these include but are not limited to: sitting meditation, body scan, movement meditation, mindful eating. Kabat-Zinn (1990) describes sitting meditation as sitting upright in an erect posture and focusing on your body, sounds, thoughts and feelings, and acknowledging anything as it arises. He contrasts this with body scans, which in most cases involve lying on the floor while guided through a process which brings awareness and breath into each part of the body: beginning from the head and ending with the toes. Holding each area with awareness and acceptance simultaneously. He goes on to discuss movement meditation, also known as walking meditation or yoga, and these involve focusing on the movement and incorporating the awareness of breath (Kabat-Zinn, 1990). Yoga is similar in that it focuses attention on the breath, however it incorporates body movements to enhance mental and physical training, which have the potential to enhance physical health (Ancona & Mendelson, 2014)

Kabat-Zinn (1990) also discusses breathing meditation, which involves taking a deep breath in through your nose for 5 seconds then breathing out through the mouth for 10 seconds (if possible). Furthermore, breathing meditation encourages awareness to be brought to the body, emotions, and thoughts that occur in the present moment (Greenberg and Harris, 2012; Shapiro et. al., 2009; Kabat-Zinn, 1994).
Loving-kindness meditation practice focuses on keeping the mind and heart open.

Salzberg (2011) describes loving-kindness as:

A quality of the heart that recognizes how connected we all are. Sometimes it’s described as extending friendship to ourselves and others – not in the sense of liking everyone, or dispensing universal approval, but more as an inner knowing that all our lives are inextricably interconnected. (p.178)

Loving-kindness is a practice that can turn selfishness into generosity (Salzberg, 2011). These various styles of mindfulness practices provide a number of personal and professional benefits.

**Benefits of mindfulness meditation.** Research suggest that practicing mindfulness results in emotional, physical and professional benefits for clinicians in helping fields. (Gockel, 2010; Schure, Christopher and Christopher, 2008; Shapiro, Brown, and Biegel, 2007; Shapiro and Carlson, 2009). Various studies have established the effectiveness and efficacy of mindfulness practice for improved mental health and end emotional well-being among clinicians (Shapiro, Schwartz, & Bonner, 1998; Baer, 2003; Kabat-Zinn, 2003; Walsh & Shapiro, 2006; Lynn, 2010). These studies show that mindfulness leads to reduced psychosocial problems including: addiction, anxiety, depression, eating disorders, chronic pain, stress, and suicidality.

In addition, research suggests that mindfulness practices positively impact clinicians’ physical health as well. These studies found that mindfulness meditation practice increased participants’ perceived health-related quality of life (i.e. reduction in rates and symptoms of cancer, eating disorders, chronic pain, fibromyalgia), as well as their general health, sleep quality and immune function while decreasing psychological distress (Gockel, 2010; Schure, Campbell and Christopher, 2012; Wisneiwski, 2008).

Lastly, research proposes that mindfulness practices have a positive impact on clinicians’ ability to work effectively with clients. Turner (2009) proposes that mindfulness can assist the practitioner in developing attention, affect regulation, attunement, and empathy skills. Similarly,
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Shapiro and Carlson; Lynn, (2010) suggest that mindfulness meditation in social work helps develop the clinician’s resilience and well-being which improve clinician’s empathy, compassion, and effective listening. Graduate counseling students who took part in Mindfulness-Based Stress Reduction (MBSR) classes during their training reported a reduction in perceived stress, feelings of anxiety, rumination, and negative affect, while also reporting more positive effects, including self-compassion, and regulation of emotional states compared to the control group who did not take the MBSR course (Shapiro, Brown, and Biegel, 2007).

Since according to NASW, social workers are essential in providing mental health services in this country (Whitaker, Weismiller, Clark, & Wilson, 2006), these studies suggest that developing mindfulness might be a valuable component of and practice. Potentially then, mindfulness meditation practices could be beneficial for social workers.

**Benefits of mindfulness meditation in social work.** Through the use of mindfulness meditation, social workers are able to increase clinical effectiveness and emotional resiliency (Williams et al., 2010). Mindfulness meditation allows social workers to be aware of their own emotions, and in this way, they are also able to hold their clients pain without it creating compassion fatigue.

One benefit of practicing mindfulness meditation is that mindfulness meditation increases empathy in social workers. McCollum and Gehart (2010) states that empathy is increased because it reduces stress, increases self-compassion, and by loosening identification with personal subjective experiences which allow social workers to observe and welcome the experiences of others without judgment or defense.

Another way that mindfulness meditation benefits social workers is that it allows them to focus their awareness on the present. During a therapy session, the mind may wander leaving the
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therapist uninvested in their client. The increased awareness allows the therapist to remain attentive in therapy (McCollum and Gehart, 2010). Increased awareness also allows the therapist to become more comfortable with silence, which can be a very effective therapy tool.

Building the skill of self-compassion is critical in self-care for social workers. Compassion is “active caring” and fosters acceptance (Warren et al., 2011). Once social workers are able to apply this skill to themselves, it becomes second nature to be compassionate toward others. The Dalai Lama (1998) defines compassion as:

A state of mind that is nonviolent, nonharming, and nonaggressive. It is a mental attitude based on the wish for others to be free of their suffering and is associated with a sense of commitment, responsibility, and respect towards others (p.91).

Warren et al (2011) makes an important point that when we act out of compassion, we do not act out of duty; but out of love instead; they also note that when we act out of compassion “we view suffering with understanding eyes” (p.136).

The development of compassion can help social workers keep an open mind. Needless to say, an open mind can lead to an open heart. Warren et al (2011) discussed the correlation of the mind and heart:

The open mind means witnessing the realities of human despair and destruction without judgment. The advocate can feel peace, not attaching to what is absent and celebrating the safety, supportive relationship, and opportunity in this moment. Serving with an open and enlightened mind is the foundation for a compassionate heart (p.139).

Compassion is evidently a quality necessary for social workers to acquire through mindfulness meditation to enhance therapeutic relationships with clients.

The practice of mindfulness meditation by social workers benefits not only the clients, but also has a great impact on the overall health of the practitioner. Research shows that social workers report decreased stress, improved mood states, decreased ruminating and distracting
thoughts, increased immune function, and reduced symptoms related to a number of physical ailments such as chronic pain, hypertension, heart disease, and cancer when they use mindfulness meditation as a self-care practice (Wisniewski, 2008; Garland, 2013). Similarly, not only are these elements significant for mindfulness meditation but also self-care of social workers.

Self-Care and Mindfulness Meditation in the Workplace

According to Cox and Steiner (2013), high levels of employee stress are costly. “Stress is estimated to cost U.S. workplaces roughly $300 billion a year as a result of absenteeism, health care expenses, turnover, worker’ compensation awards, and reduced productivity” (p.137). Mindfulness education and training is beginning to be incorporated into organizations for stress reduction. There are also several therapy models which are cultivated in mindfulness meditation practice as a way to enrich therapy and client wellness. Jon Kabat-Zinn is the founder of Mindfulness-Based Stress Reduction (MBSR). Other multifaceted therapies which incorporate mindfulness are Dialectical Behavior Therapy (DBT); Mindfulness Based Cognitive Therapy (MBCT); and Acceptance and Commitment Therapy (ACT).

Figley and Figley (2007) used the analogy of airline travelers, “don’t forget to put the oxygen mask on yourself first” (p.8) to make the point that self-care is essential to be able to care for another person’s emotional and psychological needs. Mindfulness meditation can help practitioners be kind and loving to themselves so that they can work with clients in a kind, gentle, and non-judgmental way. The ways in which social workers view others are manifestations of how they view themselves (Gockel, 2010; Shapiro and Carlson, 2009). The premise is that if social workers are unkind and critical with themselves, it is difficult to be kind and gentle with others in an authentic manner.
Mindfulness meditation is a practice that manifests benefits in all areas of life. It can be so powerful that a transformational process occurs – mentally, emotionally, physically, and spiritually. A quote by Jill Bolte Taylor expresses it best, “To experience peace does not mean that your life is always blissful. It means that you are capable of tapping into a blissful state of mind amidst the normal chaos of a hectic life” (Baron 2012, p. 75). The chaos is referring to “lives are interrupted with distractions, complications, and demands. Time for renewal is needed to breathe, quiet the mind, be in solitude, and find beauty in life. Buddha purported that no one can attain wellness and enlightenment without practicing meditation” (Warren et. al., 2011, p.140). Furthermore, mindfulness meditation can be beneficial to social workers self-care. Mindfulness meditation can provide a holistic approach to living, interconnectedness between the mind, body and spirit. As already discussed, mindfulness meditation can allow a person to deal with an emotion or situation as it arises. The ability to recognize what is going on in the mind and/or feelings in the body allows one to first notice his or her thoughts and emotions. After the recognition occurs, one can allow him or herself to let it go. Allowing one the freedom of no judgement of him or herself, which in turn promotes wellness in spirit. Moffitt (2012) describes it best:

Mindfulness and wise intention is part science and part art, part psychology and part spirituality, part common sense and part envisioning. It is a science in that you objectively identify and develop the skills needed and an art because learning how to focus on your attention in the various moments of your life involves subjectivity and intuition. It is part psychology because you are develop in much healthier ego and understanding the subtleties of your mind and part spirituality because your core values are based on what you feel gives life meaning. It is common sense because you apply your mindfulness judiciously, not getting lost in overinterpreting what is occurring in the mind, and envisioning because you have to see the possibility that there is a genuine opportunity to change your life (p.11).

Nevertheless, just as there are many benefits to practicing mindfulness meditation there are challenges as well.
Challenges of mindfulness meditation. We live in a society where everything is fast paced and instant gratification is the norm. In this context it is hard to take time to evaluate ourselves. Although practicing mindfulness meditation eventually brings a calming effect, this is not the case for everyone, especially in the beginning. Individuals new to the practice of mindfulness meditation, often become more aware of the unrest in their minds instead of finding calmness and peace (Williams et al., 2010). The feelings of unrest do eventually fade as the beginner becomes more comfortable with the practice.

Perhaps the biggest challenge of practicing mindfulness meditation is that it can be hard for individuals to keep up with it in their daily lives (Williams et al., 2010; McCollum & Gehart, 2010). Self-care is something that is not prioritized by individuals especially those with busy lives such as social work students. Making time for self-care and practicing mindfulness meditation can be a challenge. One has to be mindful that they are taking the time to refuel their mind and body.

Those individuals who are able to incorporate mindfulness meditation in their daily lives may experience significant changes and/or isolation. Moffit (2012), offers this warning:

When you start to gain clarity through your values and intentions, don’t be surprised if you suddenly begin to contemplate a major life change. You may discover that your goals are not truly aligned with your values, or that you now have a new set of priorities for your life, or that you’ve been profoundly unhappy in some aspect of your life for a long time but were afraid to face it. You may find that your situation is no longer acceptable and that you must do something to change it (p.165).

This can be frightening for those who have not been self-reflective and become more keenly aware of issues dormant for years. In these cases, it may be necessary to get additional support in order to deal with the issues that may arise with increased awareness.
Lynn and Mesinger (2015), discuss lack of education as another challenge in the use of mindfulness meditation. Despite the recent rise of mindfulness meditation in social work, there is still a lack of adequate knowledge surrounding the theoretical understandings and mindfulness interventions (Lynn & Mesinger, 2015). In addition, the spiritual component of mindfulness meditation has lacked recognition. Education about mindfulness and mindfulness meditation is needed in order for the practice to be valued and taken more seriously. The more knowledgeable social workers are about mindfulness meditation, the more likely they are to incorporate it into their practice. More importantly, experienced meditation teachers need to provide the education, since many teachers are not skilled in mindfulness meditation (Wylie, 2015).

**Summary and Research Question**

Self-care and mindfulness meditation practices are both important in shaping an effective social worker. Given the documented benefits of mindfulness, the research question for this project is: How might the use of mindfulness meditation practices impact the self-care of social workers?
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Method

In order to answer our research question, How might the use of mindfulness meditation practices impact the self-care of social workers?, we used a mixed method research design. A mixed method design consists of collecting and analyzing both quantitative and qualitative data. The benefits of using this approach is that we were able to collect narrative and contextual data related to our experiences implementing mindfulness practices as well as its impact on a number of self-care items.

According to Di Noia and Tripodi (2008) quantitative methods can provide three levels of knowledge: descriptive, correlational, and causal (p. 90), and we were interested in both descriptive and correlational knowledge. We were interested in being able to describe our implementation of mindfulness interventions as well as to see if there was any correlation between the implementation of these practices and self-care variables. We also wanted to collect qualitative data so that we could explore “inside perspectives” more sensitively and capture the “lived experience” of what it was like to implement mindfulness meditation practices (Padgett, 2008). Collecting both kinds of data allowed us to capture our implementation experiences while also attempting to measure the impact of mindfulness on our self-care practices.

Specifically, we decided to use a single subject design for collecting both quantitative and qualitative data using ourselves as the research subjects. This method allowed us to collect implementation data on mindfulness practices and then assess the extent to which these practices impacted our self-care.

In order to describe the proposed methodology for this project, we address a number of issues. First we provide a brief overview of single subject design as a research method. Then we discuss our sample, instrumentation, interventions, data collection and data analysis procedures.
This chapter concludes with a brief discussion of the strengths and limitation of this research design.

**Single Subject Design**

Single subject designs are used to evaluate the effectiveness of an intervention and is measured repeatedly across time (Nugent, 2010). The single subject design consists of three phases: establishing baseline data, the intervention period, and the follow up phase. Our research focused on collecting baseline data related to self-care, the intervention period in which we each implemented certain mindfulness meditation practices, and measurements related to self-care following the intervention period. This focus allowed us to compare baseline data to our posttest results and explore the effectiveness of the mindfulness meditation practices as implemented. Ideally, there would be a follow-up phase to determine how long benefits lasted, but due to time constraints associated with this project we were not be able to have a follow-up phase and assess how long benefits lasted.

Our single subject method used an AB design that collected baseline data prior to the intervention, followed immediately by a treatment phase, and the collection of data again to determine if there were any changes (Nugent, 2010). We also collected both qualitative and quantitative data to document the implementation of mindfulness interventions. The primary purpose of this design was to measure the impact of mindfulness interventions on self-care, and the secondary purpose was to collect data related to experiences implementing mindfulness practices.

**Sampling**

As already mentioned, we used ourselves as research subjects. We used this purposive sample not only because of the ease and convenience it allowed, but also because of our own
experiences with mindfulness mediation. Aneesha has had some experience with mindfulness, having practiced for about 12 months, whereas Ifeoma practiced mindfulness in a few classes prior to this research. As two very different subjects, we were able to examine two different experiences of implementing mindfulness programs, describe our experiences implementing them, and what (if any impact) they had on our self-care. We understand that using ourselves as subjects complicated our design by blurring the roles of researcher and research subjects, but we were also able to provide certain “checks and balances” during the research process while also providing readers with a window into two implementations and their related implications. We discuss limitations later in this chapter and also provide more discussion about our subjectivities as researchers in the Lenses chapter.

Instrumentation

We used a number of instruments to collect data. These included journaling and daily logs to document our experiences of implementing our mindfulness interventions. We also used three scales, two of which measured levels of self-care and quality of life, and one measured levels of mindfulness before and after the intervention.

We used the Self-Care Assessment by Saakvitne, Pearlman, and Staff of TSI/CAAP (1996) to measure physical, psychological, emotional, spiritual, relationship, and workplace and professional self-care (Appendix A), the Professional Quality of Life Scale (PROQOL) by Stamm (2009) to measure quality of life variables based on compassion satisfaction, burnout, and secondary traumatic stress (Appendix B), and the Mindful Attention Awareness Scale (MAAS) by Baer (2004) to measure the levels of mindfulness before and after the intervention period (Appendix C). Each of these were self-administered just prior to the intervention period and immediately after it.
Mindfulness Meditation and Self-Care

Along with the formal instruments already noted, we also kept journals to document our reactions to implementing the interventions. We both completed an Emotional Checklist Log (Appendix D) daily in order to track the emotions that arose during the intervention period, and we also used the Daily Log (Appendix E) to document the extent to which we implemented our mindfulness interventions each day.

Mindfulness Interventions

Each of us had a six week intervention during which we both planned to practice breathing/sitting meditation, body scans, lovingkindness meditation (Appendix F), mindful eating (Appendix G) and meditation movement (walking or yoga). Following the completion of the daily practice set, we planned to record the actual duration of time spent implementing each of the interventions on the Daily Log. Since we were both in different stages of practice, we had different practice schedules designed to meet our needs. Our practice schedules are attached (Appendix H).

Aside from these practices, Ifeoma also completed an introduction to mindfulness course. This weekly introduction to mindfulness course was offered online for six weeks through Common Ground Meditation Center in Minnesota. The purpose of the course was to provide Ifeoma with a foundation to mindfulness meditation practice. She listened to one audio recording per week except for week five when no audio was available online.

Data Collection and Analysis Procedures

We each completed daily logs and emotional checklists. We also completed each of the assessments (MAAS, PROQOL and Self-Care Assessment) just before the intervention and immediately afterward. We did not review or attempt to analyze the data taken before the intervention until after the intervention had been completed and other data was collected.
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Descriptive statistics (ranges) for the emotional and daily logs were calculated and presented on bar graphs. Our pretests and posttest scores for the assessments were summarized in tables to show how our scores compare to each other’s and to document changes in mindfulness and self-care.

We also collected narrative data in the form of journal entries. We both used a qualitative data analysis technique to look for patterns in the data and identify emergent themes. After independently coding our journal entries and identifying themes, we crosschecked each other’s quotes to make sure they appropriately supported the intending theme. This was a quasi-measure of inter-rates reliability. In order to strengthen the rigor of this research, we also each reflect on our use of reflexivity in the Lenses chapter.

We identified two potential threats to validity that we address in this analysis: threats to internal validity and threats to external validity (Creswell, 2009). The threats to internal validity in this research were history, selection and testing. The threat of history are experiences that threaten our ability to draw correct inferences (Creswell, 2009). In this case, our intervention took place in January when we were out of school. This gave us time to indulge in other activities that may have impacted our self-care. To account for this we kept journals which provided a narrative of the experiences we had. The internal threat of selection arises by having participants who have similar characteristics. Since this was not a random sample and we are both similar in multiple ways, this threat was addressed by discussing our differences in the Lenses chapter and in the Findings chapter. The testing threat has to do with familiarity with the tests and tendency to score ourselves higher in order to get better results. To address this threat we did not score the pretest data until after the intervention period. We also committed ourselves to giving honest answers during the post-test.
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The threats to external validity were interaction of selection and treatment, interaction of setting and treatment, and interaction of history and treatment (Creswell, 2009). The interaction of selection and treatment threat arises if we were to generalize this research to individuals who do not share the same characteristics as us. The threat of interaction of setting and treatment may arise if we generalized this research to individuals in other settings. Lastly, the threat of interaction of history and treatment would arise if we generalized the results of this study to past or future situations. Our intervention took place in January, a time when school was out of session and we may have been less stressed. Given these threats, we do not claim that our results are generalizable. Since we were only studying ourselves in this research, we did not make inferences of how this study benefited the general population. However, we did make general observations and identify potential benefits, as well as challenges, for other social work students.

Strengths and Limitations

The first and most obvious limitation to this method is that there were only two subjects, and they also happened to be the researchers. Obviously our sample size was small and therefore results are not generalizable to other populations (Monette, Sullivan, & DeJong, 2011). Due to time constraints we were not able to conduct a follow up phase to determine how long the benefits lasted. Another limitation has to do with using ourselves as subjects and the bias that could have occurred in the qualitative data analysis. To account for this, we assisted in identifying proper documentation for themes in each other’s data. The final limitation had to do with the self-care assessment. The assessment did not provide a scoring guide which meant that we had to create a way to interpret our results.

There were also a number of strengths associated with our research design. One strength was that we were able to collect data that monitored our implementation of mindfulness practices
during the intervention period. We were able to determine whether our mindfulness practices were consistently implemented, what patterns we observed individually and how these patterns corresponded to what we wrote in our journals. We were able to measure the impact of implementing mindfulness practices on a number of self-care variables, comparing and contrasting our individual experiences. This design provided important preliminary data for social workers interested in the relationship between mindfulness practices and self-care.
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Research Lenses

As with many research studies, we have included a section that articulates a conceptual framework. This is important because researchers need to be able to organize their ideas or concepts in a manner that expresses a context for readers to understand. For the purposes of this research we are distinguishing the difference between professional and personal self-care.

Literature supports the variation between personal and professional components of self-care (Lee & Miller, 2013; NASW, 2009). We are using the two definitions of self-care operationalized by Lee & Miller (2013) as:

Personal self-care is defined as a process of purposeful engagement in practices that promote holistic health and well-being of self, whereas professional self-care is understood as the process of purposeful engagement in practices that promote effective and appropriate use of self in the professional role within the context of sustaining holistic health and well-being (p. 98).

In order to promote optimal self-care, it is necessary to demonstrate how the two are parallel.

Personal self-care can affect professional self-care and vice versa. This chapter discusses theoretical, professional, personal lenses, and how we used reflexivity in this research project.

Theoretical Lenses: Transpersonal Theory

Literature supports that transpersonal theory is related to spiritual experiences and heightened level of consciousness (Cowley, 1993; Cowley, 1999; Kasprow & Scotton, 1999). Cowley (1993) states “transpersonal psychology is used to describe levels of consciousness that allow access to the unitive self, or Real Self, and are “higher” on the ladder of being than the personal or “self-actualized levels (p. 527).” Carl Jung is one of the first theorists to imply consciousness as a method to increase growth and evolution (Kasprow & Scotton, 1999).

Transpersonal theory and mindfulness meditation both articulate that levels of consciousness can increase self-awareness. The self-awareness can help establish better
regimens for self-care. In order to make a change for the better, one must first be aware of the problem. Awareness is the first step of making progress toward a change in mind, body, and spirit.

As we practice mindfulness meditation through our interventions described above, we move closer to our true self. Hence, transpersonal theory also requires heightened levels of awareness. Transpersonal theory is part of the maturity process. When we begin to mature our paradigms shift. This is also another way our awareness of self-increases.

Professional Lenses

Aneesha. My professional path has been very transformational. As a chemical engineering student, I began interning in different engineering departments. The company I was interning for eliminated my position. It was an opportunity to do something different, I learned I loved chemistry but the passion was missing. Chemistry was an interest I enjoyed; however, not my calling. I was fortunate to get on the job training working as a pharmacy technician. Since 1998, I have been working as a pharmacy technician. I discovered my heart was still not content. Interestingly, I wanted to remain as close to a science related field as possible so I began to research pharmacy schools, nursing schools, and law schools. I didn’t want to make any hasty decisions, upon my process I came across public health. Then I learned a friend’s son was murdered in 2009. In the process of supporting her and wanting youth violence to end, I began volunteering with young men who were affiliated with or in a gang and in a high school. I looked forward to the days I had to volunteer; they brought more joy to my life. I was having a discussion with another co-facilitator and he told me I should consider a Master’s in Social Work (MSW).
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Working in a retail pharmacy, home infusion, and a hospital gave me exposure to the trillion dollar pharmaceutical industry. I have seen too many meds prescribed, loss of jobs due to addiction of pain medication, and more importantly doctors are humans just like us. They are not Gods, they do not know, and we become human guinea pigs. Do not mistake what I am saying, medications are required under some circumstances; however, taking a holistic stance can make more of a difference on health and wellness.

This brings me to my reasoning for doing a dual Master’s in Holistic Health Studies (HHS) and Social Work. I wanted to learn more about complementary alternatives to medicine (CAM). Within this framework it embraces the concepts of “both/and” not “either/or”, which I think it is more conducive to health and wellness.

Since my trip to India I have really been drawn to the Buddhism culture. Although I am very intrigued by complementary alternative medicine, I still believe in the “both/and” concept.

Ifeoma. My entire working career has been in the social services. I once worked as a camp counselor for children living in the inner city. The job was repetitive from week to week, teaching children social skills, conflict resolution, and picking up garbage along the river way. I also work as a behavior therapist for children with Autism. I have been in this line of work for over five years and this too has become repetitive work. What I have found working as a camp counselor and a behavior therapist is that when the job becomes repetitive, I start to burn out. I lose interest in my work, my attendance drops, I start to feel anxious, stuck, and my self-esteem drops. When my mind and body reach a certain level of stress, my self-care goes out the window.

As a counselor, therapist, and social work student, I know what it is like to be stressed, burned out, and feel under appreciated. I have spent the majority of my life as a student and have been pushed to the edge of giving up on many occasions. Throughout my career and educational
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experience, I have learned and practiced some valuable self-care techniques. I have learned to reflect on my self-awareness, written numerous self-reflection papers, taken self-care assessments, encouraged to partake in any self-care activity I needed, and even experimented a little with yoga.

I have always been the type of person to put my needs last. Graduate school was the first place that signified the importance and really encouraged me to practice self-care. In a sense, I am new to the concept of self-care and to the practice of mindfulness meditation. However, I recognize myself as someone who needs to be more familiar with self-care and its many practices. As a future clinician it is important that I learn how to attune and take care of myself especially if I end up working as a clinical therapist.

Personal Lenses

Aneesha. Upon my return from Northern India, I reflectively think of my experience. I was very struck by their ability to be so happy, respectful, engaging, loving, kind, accepting, and helpful despite their circumstances. I compared Americans quality of life to those in India and thought how could this be? How are people living in a third world country capable of living a better quality of life than Americans? Don’t Americans live in the land of the free and opportunity? What is the difference? The difference is their culture is engrained in wellness. Their holistic approach to wellness involves meditation, yoga, Ayurveda medicine, and Tibetan medicine. The approach is “both/and” which also takes into account the person as a whole: diet, physical wellness, spiritual wellness, emotional wellness, and mental wellness. All of these are considered before prescribing a natural remedy and/or medications.

As I am working to become a clinical therapist, this is the approach I would like to have with my clients. In most cases, there are several underlying factors that could be stressors.
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Many times you may not be able to change your circumstances or control another person; however, you have the ability to change how you look at the circumstance or the person. Several years ago I was diagnosed with insomnia, depression, and anxiety. Since I have incorporated mindfulness meditation into my life, several dynamics have changed in my life. I have been able to manage my symptoms of depression and anxiety without medication and days of insomnia are not as frequent. My changes are not only internally but externally as well. Many of my students, colleagues, and a few of professors have noticed a change in some way or another. Not only am I a supporter of mindfulness meditation, I am a product of it. My intervention of mindfulness meditation increased my levels of awareness after practicing mindfulness meditation for the last 15 months. I plan to continue practicing mindfulness and applying it to areas in my life that I would like to improve. It will help me continue to recognize my implicit biases as well as build strong therapeutic relationships with my clients.

Ifeoma. I have always thought of self-care as any activity that one partakes in to balance the stress of everyday life with the inner need for comfort. For me this meant taking naps, getting together with friends, spending time alone, and just about anything that could make me happy. I never thought of meditation or mindfulness as forms of self-care. As a matter of fact before this research, I assumed mindfulness meditation was a variation of yoga. I quickly learned that I had a lot to learn about mindfulness and meditation. As a Nigerian American, I never viewed mindfulness or mediation as activities that were commonly practiced or ever practiced amongst my ethnicity. In other words, I do not recall seeing Nigerians or African Americans practicing yoga or meditating as I was growing up. I viewed it as a “white person thing” or something that monks did in a monastery.
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When Aneesha came to me with the idea of researching meditation, I was really hesitant. My hesitation stemmed from the idea of practicing methods I normally would not classify as relaxing. Although, I was excited about the idea of learning more about myself and learning how to love myself, I was also skeptical about the unfamiliar journey I was preparing to endure. I found Aneesha’s love for meditation inspiring and that combined with my desire to improve myself is what drove me to give this research a try.

**Reflexivity**

Reflexivity as a research principle comes out of feminist research and is concerned with problems associated with representing women’s voices in research, especially voices of women of color (Denzin & Lincoln, 2008). It is an important component of any kind of qualitative research because researchers are the instruments, and using a reflective process allows them to interrogate their biases while examining ways in which they themselves are a part of the research (Padgett, 2004). This is especially true in this project in which both of us are also subjects of our research. Therefore, we provide a few examples of our reflexive awarenesses below.

**Aneesha.** As both researcher and subject, maintaining awareness of each of these roles was challenging at times. During the intervention process, I had to be more mindful of my role as a researcher and not just get caught up in my mindfulness meditation experiences as a subject. Even though I was aware of my bias in this regard, I was able to maintain my consciousness as a co-researcher in this project.

In order to keep myself conscious as a researcher, I had to be very diligent in my role as a research subject. As the researcher, I used a timer to see if I was reaching my target goals. If I were only a research subject, I would have been less attentive to this kind of detail, and less meticulous in my record keeping. Because I enjoyed doing the practices as a subject, having the
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discipline of 2 daily logs and daily journaling helped me stay attentive to my role as the researcher. I placed reminder cards throughout my home to remind myself that as the researcher I had logs, several practices, and a journal entry to complete every day. In order to minimize the impact of my role as researcher on my role as a subject in this research, I did not calculate any of my pretest scores until after I completed the intervention.

Nevertheless, I believe I remained in harmony as a researcher and subject. I was aware of my challenges and biases, and implemented a system that would keep me mindful of my researcher role. The process was challenging as a co-researcher, but the impact on me as a subject was well worth the discipline.

**Ifeoma.** I attempted to complete the intervention process while staying aware of my roles as both researcher and subject. One of the areas in my life that I wanted to improve was driving mindfully. In the Mindfulness Awareness Attention Scale there was a question about driving mindfully. Although it was not one of our practices, it was something that usually came to my mind while driving and I remembered that question during the post test. I did score higher in that area on the post test possibly for that reason, but it was also the only assessment question I remembered. When taking the pretest, I did my best not to remember what any of the questions were. As a matter of fact, after completing the pretest, I put the assessment away and never calculated the scores until the posttest was completed.

During the intervention, I had many logs and implementations to complete. I found it difficult to complete all scheduled practices, but enjoyed completing the emotional and daily logs. There were some days I would forget to complete the logs and would have to fill in the data the next day. This could have provided inaccurate results in the log data. My weekly journals were typically written at the end of the week, when I was reflecting back on the week. This could
have presented data that reflected how I felt overall for any given week instead of data that reflected the implementation of practices.

Overall, I believe I stayed attuned to my roles as a researcher and subject. I noticed how unhappy I became as a subject with the amount of practices I had and made the decision as a researcher to eliminate some of them. I realized that decision could have an impact on the results but was necessary for the benefit of the subject.
Findings

The results of this research project will be presented by first providing a description of the two research participants. Next, we will present observations from the overall research process. Then, we present findings related to the implementation of our mindfulness interventions. We conclude this chapter by presenting data related to the impact of mindfulness on self-care.

Description of Participants

Aneesha. I am 41 year old African American female and mother. I am a dual degree student in the Masters of Social Work and Masters of Holistic Health Studies. In addition to being a student, I work 32 hours per week as a Hospital Advanced Practice Technician (HAPT) and 21 hours a week at a clinical intern providing individual, couple, and family counseling services. I started mindfulness meditation practices over a year ago upon my return from India. I was very intrigued by the culture. Despite the impoverished living conditions, the people were so inclusive, kind, helpful, generous, loving, giving, caring, empathetic, and compassionate. By contrast, impoverished or not, people who live in the US appear to be more exclusive, selfish, individualistic, rude, disrespectful, angry, sad, or living in despair. I wanted to know how this was possible. The answer seemed to be a holistic approach to living…..mindfulness meditation, among a few other alternative approaches to medicine, caught my attention.

Ifeoma. I am a 29 year old Nigerian American woman and part time MSW student. I work part time as a behavior therapist doing Applied Behavior Analysis therapy for children with autism. I also intern about 22 hours a week in a hospital as a crisis social worker in the emergency department and perform discharge planning on the inpatient psychiatric unit. I have had limited experiences practicing mindfulness meditation. Prior to this research, I practiced
mindfulness meditation in some of my classes as a student. For this reason, I am still a beginner to mindfulness.

**Observational Data**

Although the focus of our research was on how mindfulness practices might impact our self-care, we also observed other impacts of using these practices during the intervention period. Aneesha observed that she seemed to experience less countertransference at her work sites, and was able to listen more attentively and have more compassion during her sessions with clients. This was especially noticeable on days when she had back-to-back clients and other meetings/appointments. Aneesha also observed that she completed each scheduled practice and achieved her targeted times of practice on Tuesdays through Thursdays throughout the intervention. Aneesha observed that the time spent doing sitting/breathing meditation and movement meditation varied, whereas the time spent on mindful eating and doing the loving/kindness meditation was consistent.

Ifeoma observed that early in the intervention she felt overwhelmed by the number of practices, and as a result, discontinued the body scans, mindful eating and lovingkindness practices after week three. Although Ifeoma dropped body scans from her daily practice set, they were incorporated in her weekly introduction to mindfulness course. Ifeoma also noticed that she tended to procrastinate before starting her daily practices. While she did not record the amount of time spent procrastinating, she estimates it was roughly one hour per day, significant enough to report.

We also observed that while we each kept journals during the intervention period, there was a significant difference in how often and how much we wrote in our journals. Likewise, we noticed that we did not journal about everything we experienced in one day. Aneesha noticed
she wrote longer journal entries in the beginning and when they were handwritten, rather than when she wrote them using the computer. The time of day also varied, and once school began, Aneesha observed that she wrote less. Ifeoma noticed that she always hand wrote one page journal entries at the end of the day. Aneesha wrote daily, whereas Ifeoma wrote weekly, and this resulted in Aneesha having a lot more journal data.

**Findings Related to Implementation Data**

Since this project focused on the extent to which mindfulness practices might impact our self-care, we needed to document how well we were able to actually implement our mindfulness interventions. We each kept daily logs and written journals during the six week intervention period. We also collected pre and post intervention data using the Mindfulness Attention Awareness Scale (MAAS) as a way of documenting our progress with respect to mindfulness. In this section, we present themes that emerged from our journals, patterns we observed related to implementing our mindfulness programs (documented in our logs), and findings from MAAS data.

**Themes from Journal Entries**

We each had a number of themes emerge from our journal data, and in order to preserve the integrity of each, report them separately as follows.

**Aneesha.** Several themes emerged from my journal entries. These include emotional resilience, stress, and self-awareness.

*Emotional resilience* had to do with my ability to work through my emotions as they arose in the moment. It was not a matter of labeling emotions as good or bad; rather, it was an empowering experience of accepting my feelings for what they were, and realizing that what I did with them (how I responded to them) was most important.
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I journaled more negative emotions in the first five of days as reflected in the following journal entry:

_I am feeling irritable, resentful, and apprehensive but I don’t know why._

After the 6th day of experiencing negative emotions and buried feelings, I journaled a loving kindness meditation:

_**Today is a new day, yesterday is the past, and tomorrow is the future. Today is a gift which is why it is called the present. Stay in the moment. Be kind, loving, and gentle to yourself.**_

The journal entries noted over the next thirty five days included more positive emotions. I mention having more feelings of happiness several times throughout the journals. The following two entries reflect my ability to find love and kindness:

_I have noticed I show more compassion toward myself…. I have noticed I am more compassionate toward others._

My journals reflected more emotional resilience during the last 28 days of the intervention. The following two entries reflect the shift of learning how to be in the moment:

_I enjoy being still, in the present moment, with my emotion._

_I feel like a different person. I do not allow things to affect me one way or the other as I have in the past._

**Stress.** Stress was a common theme, both professionally and personally throughout the intervention period. Professional stress is related to both work and school. My journals show that stress can adversely affect my work. In the first fourteen days, the following two entries reflect the stress I was feeling:

_I find myself identifying with every client is some shape or fashion. Is this normal? Is this good or bad? What does this mean? Will this always occur?_
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I have been procrastinating on diagnosing my intake clients. I do not like labeling clients. Where do I begin? What if I diagnose them wrong? I feel so uncomfortable with this part of Social Work.

My journal entries noted feelings of professional stress as the spring semester was quickly approaching:

I have so many assignments to complete in addition to my research project.

Over the entire intervention, my journals show the use of the serenity prayer as a mantra that I used to help me reduce my stress:

God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.

My journals reflected personal stressors as well throughout the intervention. The following two entries reflected insight on my stressors and how to work them:

I work every day. It has been difficult keeping track of five calendars, I need to manage them better.

I am very concerned for my son’s safety. Too many African American males are losing their lives by the hands of police officers. Aren’t they supposed to protect and serve? The Jamar Clark case is too close to home. God please keep my son safe and out of harm’s way! This is also triggering my experience at the Wild Onion. God help me, this is too much to bare...

Self-Awareness. My journals growing awareness of habits and patterns had a number of entries reflecting a self-awareness that I tend to overextend myself, and that I have difficulty asking for help and receiving it.

I miss my beloved cousin; he was more like a brother and my best friend. He was a very special person in my life. Nobody understands me like him. He accepted me for who I am – the good, the bad, and the ugly.

My journal entries reflected an awareness that I was becoming less judgmental:

Lately, I have been thinking about my past more often. This is different. I know I can’t change it.
Entries made toward the end of the intervention period reflect more self-awareness, confidence in myself and ability to trust myself:

I am more engaged with my clients and coworkers... I am more confident with myself.

I have noticed my faith is stronger. I pay more attention to my intuition.

Ifeoma. A number of themes emerged from my journal data: feelings of calmness, challenges of practice, self-disappointment, and search for relief.

Feelings of calmness are reflected in my journal entries. Entries noted positive outcomes after completing the daily practice sets throughout the week. This theme arose four times from the six weeks of weekly journals. The journals noted my ability to find peace and extract calmness from mindfulness practices in week three:

Sitting meditation has become much easier. I find it peaceful and calming to not worry and focus on nothing.

The journal entries mention having feelings of inner peace several times throughout the intervention. Alongside the feelings of calmness, I also seemed able to appease myself more quickly when I became upset as noted in week four:

I have noticed how much faster it takes me to calm myself down when I become unsettled. I am less likely to ruminate and brush things off easier.

Journal entries show that feelings of calmness were most prevalent during the last three weeks of the intervention period. This is congruent with week five when my feelings of peace and joy were outweighed by negative feelings. However, my ability to let the negative feelings impact me were countered by how quickly I was able to calm myself. Week five brought out a care free attitude:

My worries feel so small. I don’t and haven’t felt bothered by much this week. Even when I did get angry, it didn’t take me long to calm and soothe myself. I felt happier this week,
calmer, with less sadness and anger. My mind has been easily redirectable because I am much more aware of when I start to wander.

Challenges of practice. The second theme that emerged from my journal data have to do with the challenges I experienced with implementing mindfulness practices. The challenges included difficulties focusing and prioritizing my practices.

The breathing meditation, sitting meditation and the online audio classes all required significant amounts of focus to stay present. There were times throughout the weeks that I found myself practicing mindfulness outside of my daily schedule. In one instance I journaled about the challenges encountered trying to generalize the different situations I practiced in:

I find myself trying to focus more on staying in the present moment. Conversations have been easier because I am challenging myself to stay present and focused whereas before I would normally just let my mind wonder.

Along with the challenge of focusing during mediation, I was also challenged by prioritizing and interrupting what I wanted to do in order to practice mindfulness. This challenge was documented in week two when I wrote:

I will admit that I did the bare minimal. I did the practices that I could naturally fit into my day like the sitting meditation, breathing meditation, walking and love and kindness. As for everything else, I found it really difficult to take time away from what I really wanted to do.

Self-disappointment. The theme of self-disappointment is one of the most prominent themes that emerged from my journals. This theme was presented three times in the first two weeks of practice and once again in week six, my reflective journal. Self-disappointment encompasses the negative feelings I had towards myself for not fulfilling my daily schedule of practices. The negative feelings I had consisted of guilt, stress, anxiety and shame.

Week one was the only week that I was consistent in implementing my daily practices. I followed the practice schedule closely, but also found the week to be stressful:
I really stressed myself out about making sure I did each practice every day and had a lot more negative feelings about myself when I could not do each practice every day.

In week two, as I gravitated to doing fewer daily practices, I saw an increase in self-disappointment. I hit a low point and made this entry:

This was not the best week of practice for me. I felt really guilty for not getting in every practice... I feel a lot of stress and anxiety for not sticking to my schedule. I feel bad for not being dedicated to the process and that I am letting the research down.

After week two I adjusted my daily practice schedule. The theme of self-disappointment did not arise again until week six when I wrote the final reflective journal:

Practicing every day for six weeks was a long time to commit to this process. Although I’m not proud of myself because I didn’t stick to my original schedule, I am pleased with what I accomplished.

Search for relief. The final theme that emerged from my journals is the search for relief. This theme emerged during weeks three and four of the intervention period. The search for relief sought to counteract the self-disappointment I reported in the journal.

The end of week three is when I made adjustments to my daily practice schedule and began to see improvements in my overall mood:

I think I have finally come to the conclusion that I am going to cut out body scans, mindful eating and love and kindness. I rarely do them and the stress of thinking about it and not actually doing it are bringing me down. I think that these are just too much for me.

The results of the adjusted daily practice schedule are better represented in week four because this was the first week I followed the new schedule. Week four was the point in the intervention where the theme of self-disappointment subdued. In week four I said:

This is probably the happiest I have been throughout the entire research and practice process. I have also notice this week that I have had a lot less negative feelings like the shame and guilt mainly because I am not stressing myself out about the other practices.
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In weeks three through five, the theme of self-disappointment was not present in my journals. During the same time that self-disappointment was not present, the theme of feelings of calmness was present. In week six’s reflective journal I stated:

*Once I cut out the practices I could not keep up with and focused on the ones I could, I became a happier person.*

**Implementation Patterns**

Each of us tracked the emotions we experienced every day on our emotional log. The emotional log was a chart with 23 emotions we could exhibit throughout the day. We could only check each emotion we experienced on any given day. We did not track how often we experienced the emotions, nor did we track how intensely we experienced them. Therefore, the minimum number of days an emotion could be experienced was 0, the maximum was 42. The emotions Aneesha experienced minimally during the 42 days were: self-pity (n=0), depression (n=0), guilt (n=0), shame (n=0), envy (n=0), pride (n=0) and hatred (n=0). The emotion Ifeoma experienced minimally during the 42 days was hatred (n=2). The emotion Aneesha experienced most often was concern (n=42) and the emotion Ifeoma experienced most often was irritation (n=40). Figure 1 displays the frequencies of emotions we both experienced during the intervention period (42 days).
We also both tracked the mindfulness meditation practices that we completed during the intervention period on a daily log. The intervention least implemented by both of us was the body scan, Aneesha (n=29) and Ifeoma (n=1). Aneesha’s most frequently implemented practices were: sitting/breathing meditation (n=42), mindful eating (n=42), loving/kindness (n=42) and meditation movement (n=42). Ifeoma’s most frequently implemented practices were sitting/breathing meditation (n=34) and the introduction to mindfulness course (5 of the 6 available audios were completed). These findings are summarized in Figure 2.
MAAS data. The implementation of our mindfulness practices is also documented via pre and post MAAS scores. Aneesha’s pre-test score was 61: On Your Way, and Ifeoma’s pre-test score was 39: Back in a Minute. These scores represent our baseline levels of mindfulness prior to the intervention. After the intervention, both of our scores increased significantly: Aneesha 83 (At One with the Universe) and Ifeoma 68 (Aware). This data suggests that each of our implementations were successful enough to produce some changes in our levels of mindfulness based on where we each started.
Impact of Mindfulness Practices on Self-Care

In order to document changes in self-care practices, we each used two assessments to measure self-care before and after implementing the interventions. The first assessment was the Self-Care Assessment (Appendix A). The other assessment was the ProQOL (Appendix B).

Self-Care Assessment Data

The Self-Care Assessment, was used to measure pre and post self-care practices. This measure contains six areas of self-care: physical, psychological, emotional, spiritual, relationship and workplace or professional.

**Physical self-care.** The range of possible scores for this dimension was 0 to 36. The scale for this dimension is: 0 – 12 minimally engaged, 13 – 25 partially engaged and 26 – 36 moderately engaged. Aneesha’s pretest score was 26 and her posttest score was 32. Ifeoma’s pretest score was 20 and her posttest score was 28. Aneesha’s specific areas of growth within this dimension were: exercising, taking time off when sick, dancing and taking time to be sexual. Ifeoma’s specific areas of growth within this dimension were: eating healthy, getting medical care when needed, taking time off when sick and wearing clothes that she liked.

**Psychological self-care.** The range of possible scores for this dimension was 0 to 36. The scale for this dimension is: 0 – 12 minimally engaged, 13 – 25 partially engaged and 26 – 36 moderately engaged. Aneesha’s pretest score was 23 and her posttest score was 32. Ifeoma’s pretest score was 14 and her posttest score was 20. Aneesha’s specific areas of growth within this dimension were: taking day trips or mini-vacations, noticing her inner experience, writing in a journal, do something at which she was not an expert or in charge, engaging her intelligence in a new area, being curious and saying no to extra responsibilities sometimes. Ifeoma’s specific
areas of growth within this dimension were: writing in a journal, doing something she was not an expert in, minimizing stress in her life and being curious.

**Emotional self-care.** The range of possible scores for this dimension was 0 to 27. The scale for this dimension is: 0 – 9 minimally engaged, 10 – 18 partially engaged and 19 – 27 moderately engaged. Aneesha’s pretest score was 14 and her posttest score was 24. Ifeoma’s pretest score was 17 and her posttest score was 22. Aneesha’s specific areas of growth within this dimension were: spending time with others whose company she enjoyed, staying in contact with important people her my life, giving herself affirmations, loving myself, identify comforting activities, allowing herself to cry and expressing her outrage in social action. Ifeoma’s specific areas of growth within this dimension were: giving herself affirmations, identifying comforting activities and finding things that made her laugh.

**Spiritual self-care.** The range of possible scores for this dimension was 0 to 45. The scale for this dimension is: 0 – 14 minimally engaged, 15 – 30 partially engaged and 31 – 45 moderately engaged. Aneesha’s pretest score was 26 and her posttest score was 34. Ifeoma’s pretest score was 17 and her posttest score was 25. Aneesha’s specific areas of growth within this dimension were: spending time in nature, finding a spiritual connection or community, cherishing her optimism and hope, trying at times not to be in charge of the expert, meditating, praying, singing, contributing to causes in which she believed, and reading inspirational literature or listening to inspirational talks, music. Ifeoma’s specific areas of growth within this dimension were: making time for reflection, cherishing her own optimism and meditating.

**Relationship self-care.** The range of possible scores for this dimension was 0 to 33. The scale for this dimension is: 0 – 10 minimally engaged, 11 – 21 partially engaged and 22 – 33 moderately engaged. Aneesha’s pretest score was 11 and her posttest score was 22. Ifeoma’s
pretest score was 10 and her posttest score was 16. Aneesha’s specific areas of growth within this dimension were: scheduling regular activities with her children, making time to see friends, call, check on, or see her relatives, staying in contact with faraway friends, making time to reply to personal emails and letters; sending holiday cards, allowing others to do things for her, asking for help when she needs it and sharing a fear, hope, or secret with someone she trusts. Ifeoma’s specific areas of growth within this dimension were: making time to see friends, checking on relatives and making time to reply to personal email and letters.

**Workplace/professional self-care.** The range of possible scores for this dimension was 0 to 33. The scale for this dimension is: 0 – 10 minimally engaged, 11 – 21 partially engaged and 22 – 33 moderately engaged. Aneesha’s pretest score was 12 and her posttest score was 25. Ifeoma’s pretest score was 14 and her posttest score was 16. Aneesha’s specific areas of growth within this dimension were: taking a break during the workday, making quiet time to complete tasks, identifying projects or tasks that were exciting and rewarding, setting limits with clients and colleagues, balancing her caseload so that no one day or part of a day is “too much”, arranging work space so it is comfortable and comforting, getting regular supervision or consultation, negotiating for her needs, having a peer support group and developing a non-trauma area of professional interest. Ifeoma’s specific areas of growth within this dimension were: identifying projects or tasks that were exciting, getting regular supervision and negotiating her needs.

This data shows that both of us experienced changes in levels of self-care across each of the 6 dimensions. These data are summarized in Table 1. *Pre and Post Test Scores for the 6 Dimensions of the Self-Care Assessment.*
Table 1. Pre and Post Tests Scores for 6 Dimensions of the Self-Care Assessment

<table>
<thead>
<tr>
<th></th>
<th>Physical</th>
<th>Psychological</th>
<th>Emotional</th>
<th>Spiritual</th>
<th>Relationship</th>
<th>Workplace &amp; Professional</th>
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<tr>
<td>Post-test</td>
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<td>28</td>
<td>32</td>
<td>20</td>
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A = Aneesha’s scores  I = Ifeoma’s scores

Professional Quality of Life Scale

The Professional Quality of Life Scale measures the dimensions of compassion satisfaction, burnout and secondary stress. The compassion satisfaction scale measures the pleasure that is gained from being able to work well as a helper. The burnout scale measures the likelihood of burning out. The secondary traumatic stress scale measures one’s exposure to trauma and the likelihood that one will experience secondary trauma.

Compassion Satisfaction. Aneesha’s pretest score for compassion satisfaction was 39, which is the average category. Her posttest score was 45, which is in the high category. Ifeoma’s pretest score for compassion satisfaction was 33, which was in the average category. Her posttest score was 38, which is also in the average category.

Burnout. Aneesha’s pretest score for burnout was 23, which is in the average category, and her posttest score was 15, which is in the low category. Ifeoma’s pretest score was 31, which is in the average category and her posttest score was 19, which is also in the low category.

Secondary Traumatic Stress. Aneesha’s pretest score for secondary traumatic stress was 26, which is in the average category and her posttest score was 18, which is in the low category. Ifeoma’s pretest score for secondary traumatic stress was 14, which is in the low category and her posttest score was 17, which is also in the low category.
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This data demonstrates that both of us experienced a change in our professional quality of life. These data are summarized in Table 2.

Table 2. Pre and Post Tests Scores for Professional Quality of Life

<table>
<thead>
<tr>
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<th>Aneesh</th>
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<th>Ifeoma</th>
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<td>Compassion</td>
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<td>Burnout</td>
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<tr>
<td>Secondary Traumatic Stress</td>
<td>26</td>
<td>18</td>
<td>14</td>
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Discussion

In this last chapter we interpret our findings. We discuss the findings supported by the literature, unexpected findings, implications for social work practice, and implications for future research.

Findings Supported by the Literature

A number of this study’s findings are consistent with what the literature would have predicted. We found Ifeoma’s theme, feelings of calmness, and Anee’sha’s theme about stress to be consistent with what the literature says about mindfulness meditation having a positive impact on daily life by decreasing stress, improving mood states, decreasing ruminating and distracting thoughts (Wisniewski, 2008; Garland, 2003). Although Ifeoma initially found she had many distracting thoughts when first implementing the interventions, her journals found that by weeks five and six there were less ruminating and distracting thoughts. Ifeoma’s journal also illustrated that she became happier and less stressed by the end of the intervention period. Even though Aneesha experienced a number of life stressors, the intensity of stress seemed to decrease after implementing mindfulness practices daily. The mindfulness practice did not eliminate stress, but it did help her manage it.

The second finding supported by the literature has to do with the challenges of practicing mindfulness meditation. Williams et al., (2010) mentioned that unrest in the mind while meditating can be a challenge for beginners. Ifeoma found this to be true throughout her journals. In the beginning of the intervention, she was surprised by the amount of intrusive thoughts she had while practicing sitting and breathing meditation. Towards the end of the intervention she had less intrusive thoughts and it became easier to redirect her mind back to the practice.
Aneesha’s journals indicated she developed self-compassion which was supported by the literature (Shapiro and Carlson; Lynn, 2010). The journal noted Aneesha was a harsh self-critic, it was difficult for her to show compassion to herself although she could extend compassion and empathy to others. After two weeks of mindfulness practices she became more compassionate toward herself, in turn it deepened her compassion and empathy toward others.

Another one of our findings is supported by Williams et al., (2010) and McCollum and Gehart (2010) who suggest that one of the biggest challenges for beginners is finding it hard to keep up with mindfulness practices in daily life. This particular difficulty for Ifeoma resulted in self-disappointment and the need for relief. As reported, she felt overwhelmed with the number and length of the practices, and did not see improvements until she modified her daily practice set.

**Unexpected Findings**

This study also has a number of unexpected findings. One unexpected finding is that Ifeoma did not show as much growth in the self-care assessment as anticipated. Ifeoma grew in three of the six dimensions of self-care. Baseline data revealed that she was partially engaged in physical and emotional self-care prior to the intervention, and moderately engaged afterwards. Her baseline for relationship self-care was minimally engaged, and changed to partially engaged after the intervention. One possible explanation for this is because she did not complete all the mindfulness meditation practices. Another possible explanation is that some dimensions of self-care may have been more important to her or weighed heavier on her emotions. For instance she may have been more engaged with emotional self-care because she was tracking it every day on the emotional checklist. She may have been more engaged in physical self-care because it was the start of a new year and she wanted to lose some weight. Since school was out of session
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during the intervention she had more time to attend to physical self-care. She may have been more engaged in relationship self-care because again, not having class allowed more time to spend on relationships.

Ifeoma also had a surprising post intervention score on the PROQOL assessment. Her score for secondary traumatic stress increased from baseline score of 14 to 17. One possible explanation for this is that Ifeoma began interning in the emergency room during the intervention period and may have encountered trauma patients. It is important to note that while the score increased slightly, her score is still at low risk for experiencing secondary traumatic stress.

Finally, as noted under observational data, Aneesha noted in her journal entries less countertransference with all of her clients after practicing mindfulness for two weeks. One possible explanation is she was able to accept previous misfortunes and relinquish baggage.

**Implications for Social Work Practice**

This research suggests a number of important implications for social work practice. These include setting realistic goals for implementing mindfulness practices, expecting the unexpected when starting a mindfulness practice, and utilizing supervision when implementing a mindfulness practice when possible. Our findings demonstrate that even though we both had daily practices tailored to our preintervention levels of mindfulness, we did not complete our practice sets as planned. We had rather ambitious goals, even in light of our differing experiences with mindfulness. We suggest that social workers interested in implementing a mindfulness practice start small with one or two practices a day for short amounts of time, and gradually increase duration and number of practices as they gain confidence. As social workers practice more frequently they begin to grow comfortable which can manifest into confidence (William et al., 2010).
We also want to remind social workers who are considering mindfulness practice to expect the unexpected. Mindfulness practices can deepen one’s self-awareness physically, mentally, emotionally, spiritually, professionally, and financially. All of this awareness can be very challenging, even though we think it’s a good thing to be more self-aware. Mindfulness will bring to the surface things that practitioners may have been avoiding, and once conscious, these issues require follow up. Without taking the time to follow up, these increased awareness can actually increase feelings of incompetence or disappointment in oneself. Obviously, this is not the point of starting a mindfulness practice! This is why practitioners need to be prepared to expect the unexpected, and to expect that they will more than likely become aware of feelings and issues that they have buried and not dealt with. Both of us found that becoming more self-aware awakened issues of internal emotional turmoil that we were not expecting.

We encourage social work practitioners and students beginning mindfulness practices to have a good support system in place while implementing a mindfulness practice so that they can discuss issues that arise as result of their increased self-awareness. This support system could include friends or family members who have been informed of your mindfulness practice and whose feedback/insights you trust. We also think it is important to meet with a supervisor regularly, in order to follow-up on how mindfulness practices may be impacting the therapeutic relationship. While Aneesha experienced less countertransference and stress as a result of the practices, it is just as likely that experiencing more countertransference and/or different kinds of stress is also possible as we become more conscious of our internal experiences.
Implications for Future Research

This research suggests the need for on-going research in this area using better instruments for measuring self-care, using more human subjects for more precise analysis of results, and working with clients.

We chose to use the Self-Care Assessment because it measured multiple dimensions of self-care, but we found that it did not provide a precise way of measuring the results. Our experience with PROQOL was better because it did provide a scoring guide, and a way to more clearly measure outcomes. Future replications of studies like ours involving more subjects would be strengthened by having clearer outcome measures. Collecting larger data samples would also make more detailed statistical analyses possible. While it appears that both of our posttest measures using PROQOL are significant, it would be helpful to know if they are statistically significant, and to also be able to compute correlations between variables, none of which were possible given the limitations in this study. We also suggest using a more finely tuned instrument to track emotions during mindfulness interventions. The emotional log that we used was limited in that it documented only whether particular emotions occurred on any given day. It did not document frequency or intensity, and this made it difficult to draw meaningful conclusions. In our case, it was helpful that we also collected qualitative data (via journaling) that supplemented the nominal level data on the emotional log. For this reason we recommend that future studies use instruments that are more precise, as well as triangulating the use of qualitative data along with quantitative data as a way of providing better checks and balances.

We recommend that further research increase the number of subjects so that researchers can collect more data on a broader range of subjects. This will allow researchers to do more comparisons between subjects on a variety of variables using t-tests and/or correlations to
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determine if pretest posttest differences are statistically significant; if there are significant correlations between variables such as compassion, burn out, secondary traumatic stress, emotions and self-care, and in general, providing a wider range of experiences. We also suggest that if future case studies or autoethnographies like this are attempted in which researchers are also the subjects of their research, that researchers consider methods for strengthening accountability during implementation. This might be accomplished by identifying persons who might hold them accountable to implementing the proposed interventions.

We also recommend more research that focuses on understanding the potential relationship between mindfulness practices and therapeutic issues like countertransference, effective listening, engagement, compassion, and attunement. It seems plausible that mindfulness interventions might improve practitioners’ mental, emotional, physical, and/or spiritual clarity, as well as strengthening relationships with clients, but we need more research to document this.

Conclusion

The literature review indicated that mindfulness meditation could have a positive impact on self-care, and our data suggests that the mindfulness interventions we employed did increase self-awareness and compassion satisfaction, as well as decrease the likelihood of burn out and secondary traumatic stress. This research suggests that social workers may benefit from incorporating some mindfulness meditation practices into their daily lives. Mindfulness meditation is a practice which deepens self-awareness, increases one’s sense of clarity, and in general contributes to good self-care. We found that self-care is taking the time to access and balance the physical, psychological, emotional, spiritual, relationship, workplace/professional, and even the financial dimensions of life. This research demonstrates that mindfulness
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meditation practices have the potential to offer social workers a new found sense of clarity, acceptance, patience, and self-compassion. More importantly, in our view, mindfulness meditation practices can help social workers be less reactive and judgmental with clients while increasing their capacities to be more proactive and compassionate.
References


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APPENDIX A

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)
___ Eat healthy
___ Exercise
___ Get regular medical care for prevention
___ Get medical care when needed
___ Take time off when needed
___ Get massages
___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
___ Take time to be sexual—with yourself, with a partner
___ Get enough sleep
___ Wear clothes you like
___ Take vacations
___ Take day trips or mini-vacations
___ Make time away from telephones
___ Other:

Psychological Self-Care

___ Make time for self-reflection
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___ Have your own personal psychotherapy
___ Write in a journal
___ Read literature that is unrelated to work
___ Do something at which you are not expert or in charge
___ Decrease stress in your life
___ Let others know different aspects of you
___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports, event, auction, theater performance
___ Practice receiving from others
___ Be curious
___ Say “no” to extra responsibilities sometimes
___ Other:

Emotional Self-Care

___ Spend time with others whose company you enjoy
___ Stay in contact with important people in your life
___ Give yourself affirmations, praise yourself
___ Love yourself
___ Re-read favorite books, re-view favorite movies
___ Identify comforting activities, objects, people, relationships, places and seek them out
___ Allow yourself to cry
___ Find things that make you laugh
___ Express your outrage in social action, letters and donations, marches, protests
___ Play with children
___ Other:
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Spiritual Self-Care

___ Make time for reflection
___ Spend time with nature
___ Find a spiritual connection or community
___ Be open to inspiration
___ Cherish your optimism and hope
___ Be aware of nonmaterial aspects of life
___ Try at times not to be in charge or the expert
___ Be open to not knowing
___ Identify what in meaningful to you and notice its place in your life
___ Meditate
___ Pray
___ Sing
___ Spend time with children
___ Have experiences of awe
___ Contribute to causes in which you believe
___ Read inspirational literature (talks, music, etc.)
___ Other:

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)
___ Take time to chat with co-workers
___ Make quiet time to complete tasks
___ Identify projects or tasks that are exciting and rewarding
___ Set limits with your clients and colleagues
___ Balance your caseload so that no one day or part of a day is “too much”
___ Arrange your work space so it is comfortable and comforting
___ Get regular supervision or consultation
APPENDIX A

___ Negotiate for your needs (benefits, pay raise)
___ Have a peer support group
___ Develop a non-trauma area of professional interest
___ Other:

**Balance**

___ Strive for balance within your work-life and workday
___ Strive for balance among work, family, relationships, play and rest

Appendix B

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never  2=Rarely  3=Sometimes  4=Often  5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I [help].
3. I get satisfaction from being able to [help] people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I [help].
7. I find it difficult to separate my personal life from my life as a [helper].
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
9. I think that I might have been affected by the traumatic stress of those I [help].
10. I feel trapped by my job as a [helper].
11. Because of my [helping], I have felt "on edge" about various things.
12. I like my work as a [helper].
13. I feel depressed because of the traumatic experiences of the people I [help].
14. I feel as though I am experiencing the trauma of someone I have [helped].
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a [helper].
20. I have happy thoughts and feelings about those I [help] and how I could help them.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
24. I am proud of what I can do to [help].
25. As a result of my [helping], I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [helper].
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

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APPENDIX C

Mindfulness Attention Awareness Scale (MAAS)

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what really reflects your experience rather than what you think your experience should be. Please treat each item separately from every other item.

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<td>Almost Always</td>
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I could be experiencing some emotion and not be conscious of it until some time later. 1 2 3 4 5 6

I break or spill things because of carelessness, not paying attention, or thinking of something else. 1 2 3 4 5 6

I find it difficult to stay focused on what’s happening in the present. 1 2 3 4 5 6

I tend to walk quickly to get where I’m going without paying attention to what I experience along the way. 1 2 3 4 5 6

I tend not to notice feelings of physical tension or discomfort until they really grab my attention. 1 2 3 4 5 6

I forget a person’s name almost as soon as I’ve been told it for the first time. 1 2 3 4 5 6

It seems I am “running on automatic,” without much awareness of what I’m doing. 1 2 3 4 5 6

I rush through activities without being really attentive to them. 1 2 3 4 5 6

I get so focused on the goal I want to achieve that I lose touch with what I’m doing right now to get there. 1 2 3 4 5 6

I do jobs or tasks automatically, without being aware of what I’m doing. 1 2 3 4 5 6

I find myself listening to someone with one ear, doing something else at the same time. 1 2 3 4 5 6
MINDFULNESS MEDITATION AND SELF-CARE

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I drive places on ‘automatic pilot’ and then wonder why I went there.

1 2 3 4 5 6

I find myself preoccupied with the future or the past.

1 2 3 4 5 6

I find myself doing things without paying attention.

1 2 3 4 5 6

I snack without being aware that I’m eating.

1 2 3 4 5 6

**MAAS Scoring**

To score the scale, simply compute a mean (average) of the 15 items. Higher scores reflect higher levels of dispositional mindfulness.

15-22 Clueless
23-27 Barely There
38-52 Back in a Minute
53-67 On Your Way
68-82 Aware
83-90 At One with the Universe

APPENDIX D

Emotional Log: *Mindfulness Meditation class.*

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### Table Notes:
- AM and PM times are provided for daily meditation and practice.
- Yes/No options are available for mindful eating, meditation movement, and emotional checklists.
A Meditation on Lovingkindness

Contents

1. Keep Your Practice On The Path

This meditation uses words, images, and feelings to evoke a lovingkindness and friendliness toward oneself and others.

With each recitation of the phrases, we are expressing an intention, planting the seeds of loving wishes over and over in our heart.

With a loving heart as the background, all that we attempt, all that we encounter will open and flow easily.

You can begin the practice of lovingkindness by meditating for fifteen or twenty minutes in a quiet place. Let yourself sit in a comfortable fashion. Let your body rest and be relaxed. Let your heart be soft. Let go of any plans and preoccupations.
Begin with yourself. Breathe gently, and recite inwardly the following traditional phrases directed to your own well-being. You begin with yourself because without loving yourself it is almost impossible to love others.

*May I be filled with lovingkindness.*

*May I be safe from inner and outer dangers.*

*May I be well in body and mind.*

*May I be at ease and happy.*

As you repeat these phrases, picture yourself as you are now, and hold that image in a heart of lovingkindness. Or perhaps you will find it easier to picture yourself as a young and beloved child. Adjust the words and images in any way you wish. Create the exact phrases that best open your heart of kindness. Repeat these phrases over and over again, letting the feelings permeate your body and mind. Practice this meditation for a number of weeks, until the sense of lovingkindness for yourself grows.

Be aware that this meditation may at times feel mechanical or awkward. It can also bring up feelings contrary to lovingkindness, feelings of irritation and anger. If this happens, it is especially important to be patient and kind toward yourself, allowing whatever arises to be received in a spirit of friendliness and kind affection.

When you feel you have established some stronger sense of lovingkindness for yourself, you can then expand your meditation to include others. After focusing on yourself for five or ten minutes, choose a benefactor, someone in your life who has loved or truly cared for you. Picture this person and carefully recite the same phrases:

*May you be filled with lovingkindness.*

*May you be safe from inner and outer dangers.*

*May you be well in body and mind.*

*May you be at ease and happy.*

Let the image and feelings you have for your benefactor support the meditation. Whether the image or feelings are clear or not does not matter. In meditation they will be subject to change. Simply continue to plant the seeds of loving wishes, repeating the phrases gently no matter what arises.

Expressing gratitude to our benefactors is a natural form of love. In fact, some people find lovingkindness for themselves so hard, they begin their practice with a benefactor. This too is fine. The rule in lovingkindness practice is to follow the way that most easily opens your heart.
APPENDIX G


Mindful Eating Script

**Holding**
First, take a _____ and hold it in the palm of your hand or between your finger and thumb. Focusing on it, imagine that you’ve just dropped in from Mars and have never seen an object like this before in your life.

**Seeing**
Take time to really see it; gaze at the _____ with care and full attention. Let your eyes explore every part of it, examining the highlights where the light shines, the darker hollows, the folds and ridges, and any asymmetries or unique features.

**Touching**
Turn the _____ over between your fingers, exploring its texture, maybe with your eyes closed if that enhances your sense of touch.

**Smelling**
Holding the _____ beneath your nose, with each inhalation drink in any smell, aroma, or fragrance that may arise, noticing as you do this anything interesting that may be happening in your mouth or stomach.

**Placing**
Now slowly bring the _____ up to your lips, noticing how your hand and arm know exactly how and where to position it. Gently place the object in the mouth, without chewing, noticing how it gets into the mouth in the first place. Spend a few moments exploring the sensations of having it in your mouth, exploring it with your tongue.

**Tasting**
When you are ready, prepare to chew the _____, noticing how and where it needs to be for chewing. Then, very consciously, take one or two bites into it and notice what happens in the aftermath, experiencing any waves of taste that emanate from it as you continue chewing. Without swallowing yet, notice the bare sensations of taste and texture in the mouth and how these may change over time, moment by moment, as well as any changes in the object itself.

**Swallowing**
When you feel ready to swallow the _____, see if you can first detect the intention to swallow as it comes up, so that even this is experienced consciously before you actually swallow the raisin.

**Following**
Finally, see if you can feel what is left of the _____ moving down into your stomach, and sense how the body as a whole is feeling after completing this exercise in mindful eating.
APPENDIX H

Aneesha’s mindfulness meditation practice schedule

Daily Meditation = sitting or breathing
Movement = walking or yoga
Mins = minutes

Week 1
Mon-Sun: 10 mins daily meditation, 15 mins mindful eating, 30 mins movement, 5 mins loving kindness

Week 2
Mon-Sun: 15 mins daily meditation, 15 mins mindful eating, 35 mins movement, 5 mins loving kindness

Week 3
Mon-Sun: 20 mins daily meditation, 15 mins mindful eating, 40 mins movement, 10 mins loving kindness

Week 4
Mon-Sun: 25 mins daily meditation, 15 mins mindful eating, 45 mins movement, 10 mins loving kindness

Week 5
Mon-Sun: 30 mins daily meditation, 15 mins mindful eating, 50 mins movement, 15 mins loving kindness

Week 6
Mon-Sun: 35 mins daily meditation, 15 mins mindful eating, 55 mins movement, 15 mins loving kindness
APPENDIX H

Ifeoma’s mindfulness meditation practice schedule

Movement = yoga or walking
Mins = minutes

Week 1
Sun: Audio
Mon- Sat: 3 mins breathing space, 3 mins loving/kindness, 20 min body scan, 3 min sitting med

Week 2
Sun: Audio
M-W-F: 10 mins movement, 5 mins breathing space, 5 min loving kindness
T-R-S: 5 mins sitting med., 25 mins body scan, 15 mins mindful eating

Week 3
Sun: Audio
M-W-F: 15 mins movement, 8 mins breathing space, 8 min loving kindness
T-R-S: 8 mins sitting med., 25 mins body scan, 15 mins mindful eating

Week 4
Sun: Audio
M-W-F: 20 mins movement, 8 mins breathing space, 8 min loving kindness
T-R-S: 10 mins sitting med., 25 mins body scan, 15 mins mindful eating

Week 5
Sun: Audio
M-W-F: 25 mins movement, 8 mins breathing space, 8 min loving kindness
T-R-S: 15 mins sitting med., 25 mins body scan, 15 mins mindful eating