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Mindfulness and Meditation: Transforming Therapeutic Presence in Clinical Social Work Practice

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Mindfulness and Meditation:
Transforming Therapeutic Presence in Clinical Social Work Practice

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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Master of 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.

MINDFULNESS AND MEDITATION

Abstract

This study explored how practicing meditation and mindfulness influences psychotherapy practice. Qualitative methods were used to recruit and interview mental health practitioners with a personal practice of meditation and mindfulness. Nine participants responded to interview questions in person, via email, or over the phone. Using Grounded Theory and open coding, eight themes were identified: (a) *definitions of meditation and mindfulness*; (b) *training obtained and/or pursued*; (c) *inspiration to begin practicing meditation and mindfulness*; (d) *frequency and method of practice*; (e) *integration into the clinical setting*; (f) *importance of neuroscience*; (g) *impact of meditation and mindfulness on self-care, burnout and compassion fatigue*; and (h) *future hopes for integration of meditation and mindfulness into mental health care*. A discussion of how these themes relate back to the literature is offered. Several implications for social work practice, policy, and research are suggested, including: (a) ethical considerations for practitioners offering mindfulness-based therapies; (b) the value of meditation and mindfulness to address practitioner burnout; (c) the relevance of neuroscience to meditation and mindfulness; and (d) policy recommendations pertaining to the expansion of alternative therapies for vulnerable populations.

Keywords: meditation, mindfulness, therapeutic presence, psychotherapy practice, mindfulness-based interventions

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Table of Contents

Introduction.....	1
Literature Review.....	3
Conceptual Framework.....	29
Methods.....	32
Findings.....	36
Discussion.....	64
Conclusion.....	76
References.....	78
Appendix A: Informational Cover Letter.....	85
Appendix B: Consent Form.....	86
Appendix C: Phone Script.....	88
Appendix D: Interview Questions.....	89
Appendix E: Demographic Questions.....	90

Mindfulness and Meditation:

Transforming Therapeutic Presence in Clinical Social Work Practice

Over the last several decades, research and practice in the field of mental health has expanded its focus to include more holistic approaches to health, wellness, and stress reduction (Finger & Arnold, 2002; Winnick, 2005). One holistic modality practiced by many individuals is meditation, particularly the mindfulness component of meditation. According to the National Center for Complementary and Alternative Medicine (NCCAM), a division of the National Institutes of Health (NIH), in 2007 it was estimated that nearly 20 million people had practiced meditation in the prior year (NCCAM, 2010). While there is limited generalizable data regarding the number of social workers who practice meditation, the literature suggests that many social workers and mental health practitioners are using meditation in both their personal and professional lives (Brenner, 2009; Dunn, Callahan & Swift, 2013a; Dunn, Callahan, Swift & Ivanovic, 2013b; Germer, Siegel, & Fulton, 2013; Gockel, Cain, Malove, & James, 2013; Grepmaier, Mitterlehner, Loew & Nickel; Leung, Chan, Ng, & Lee, 2009; McGarrigle & Walsh, 2011; Thieleman & Cacciatore, 2014; Turner, 2009; Vick-Johnson, 2010). The increasing wealth of literature studying the benefits of integrating mindfulness and meditation into mental health interventions deserves the attention of clinical social workers, specifically the effects of mindfulness and meditation on reducing stress and anxiety, reducing compassion fatigue and burnout, and enhancing therapeutic presence (Andersen, 2005; Brenner, 2009; Dunn et al., 2013; Gehart & McCollum, 2007; Germer et al., 2013; McGarrigle & Walsh, 2011; Turner, 2009).

Clinical social workers provide the majority of mental health services in the United States today (SAMHSA, 2008). As mental health service providers, practitioners are presented with challenging and demanding situations that test their ability to remain calm, present, and receptive to the needs of clients, as well as to their personal needs. Mental health practitioners experience compassion fatigue, stress, and burnout due to the demands of a job that can lead them to feel depleted rather than fulfilled and satisfied by their work (Lloyd, King & Chenoweth, 2002; McGarrigle & Walsh, 2011; Shapiro, Brown & Biegel, 2007; Shinn, Rosario, Morch, & Chestnut, 1984; Um & Harrison, 1998). Moreover, when practitioners become fatigued, client care is compromised through emotional unavailability, decreased self-awareness, and unmanaged countertransference (Gockel et al., 2013).

Practitioners and researchers of various disciplines have begun to recognize the benefits of Eastern-inspired contemplative practices, including mindfulness and meditation (Brenner, 2009; Dunn et al., 2013a; Dunn et al., 2013b; Germer et al., 2013; Grepmaier et al., 2013; Leung et al., 2009; McGarrigle & Walsh, 2011; Thieleman & Cacciatore, 2014; Turner, 2009; Vick-Johnson, 2010). There are a variety of well-established treatment modalities that incorporate principles of mindfulness such as Dialectical Behavior Therapy (DBT; Linehan, 1993), Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1994), Acceptance and Commitment Therapy (ACT), and Mindfulness-Based Cognitive Therapy (MBCT). The benefits of mindfulness are also supported by the findings of neuroscience (Chiesa & Serretti, 2009; Siegel, 2008).

While research supports the integration of contemplative practices into mental health treatment modalities, little has been studied about the therapeutic impact of

clinicians who practice mindfulness and meditation (Germer et al., 2013). In the past several years, literature has expanded to include studies about the value of a *mindful clinician*, and how mindfulness and meditation can enhance clinical skills (Brenner, 2009; Cacciatore & Flint, 2012; Germer et al., 2013; Gockel et al., 2013; Keefe, 1975; Kutz, Borysenko, & Benson, 1985; Turner, 2009). These studies offer a respectable start to acknowledging the benefits of mindful clinicians, and there is more to be learned.

The current study will review the established literature surrounding Buddhist philosophy and psychology, and how many practitioners are integrating these philosophies into mental health care. Additionally, this study will also review the literature pertaining to the stress of the social work profession, and how it can lead to compassion fatigue, secondary trauma, and burnout. Moreover, it will review the literature supporting contemplative practices of mindfulness and meditation as tools to help clinicians enhance compassion satisfaction and experience fulfillment in their work. The following research question will be examined in this study: How do mindfulness and meditation impact clinical social work practice?

Literature Review

The following represents a review of the literature surrounding the intersection of meditation, mindfulness, and clinical social work practice. A variety of themes surfaced, and the subsequent items will be presented: (a) Definitions and descriptions of mindfulness and meditation; (b) An overview of Buddhist philosophy and its congruence with social work values; (c) The variety of social work settings where meditation and mindfulness-based interventions are being implemented; (d) How practitioner

mindfulness impacts client outcomes; and (e) The influence mindfulness and meditation can have on enhancing multiple components of therapeutic presence.

Definitions and Terms

It is important to highlight a few definitions and terms that are significant to this study. First, this review of meditation and mindfulness from the roots of Buddhism is preliminary and simplified. Buddhism is an ancient religious and spiritual tradition that deserves detailed exploration. However, that is not the purpose of the current study. This discussion does not strive to be comprehensive, but rather provides an introduction to the philosophy of Buddhism.

Additionally, there are many terms used to describe the work of a clinical social worker in the therapeutic role. In the literature, researchers use different terms including therapists, therapists-in-training, clinicians, psychotherapists, counselors, and practitioners (Brenner, 2009; Dunn et al., 2013a; Dunn et al., 2013b; Germer et al., 2013; Grepmaier et al., 2013; Gockel et al., 2013; Leung et al., 2009; McGarrigle & Walsh, 2011; Thieleman & Cacciatore, 2014; Turner, 2009; Vick-Johnson, 2010). For the purposes of this study, the terms clinician, therapist, practitioner, and clinical social worker will be used interchangeably to describe someone who serves the role of a psychotherapist.

Finally, the main subject of this study is the practice of mindfulness and meditation. These terms are often used to describe the same practice, however among experienced practitioners meditation is often considered the practice by which mindfulness is attained (Germer et al., 2013). More detailed definitions of these practices will follow in the next section, but for the purposes of this study, the researcher will use

the terms meditation and mindfulness to imply the same practice, unless specified otherwise.

An Overview of Mindfulness and Meditation

Mindfulness meditation is one of many contemplative practices rooted in Buddhism, but is also present in other spiritual traditions (Barnett, Shale, Elkins, & Fisher, 2014; Keefe, 1975; Shapiro, Carlson, Astin, & Freedman, 2006). It has been in existence for thousands of years, but in the last several decades has gained more attention and acceptance in secular (i.e., non-religious) contexts (Barnett et al., 2014; Chiesa & Malinowski, 2011).

There are a variety of ways to define mindfulness and meditation. Some definitions are centered on Buddhist philosophy and principles with the intent to stay true to Buddhist roots (Barnett et al., 2014; Brenner, 2009; Grepmaier et al., 2007; Keefe, 1974; Lueng et al., 2009; Turner, 2009). Other definitions of mindfulness and meditation remain secular, meaning without religious association, increasing the likelihood that non-religious persons might be more receptive to these practices (Brown & Ryan, 2003; Chiesa & Malinowski, 2011; Dunn et al., 2013a; McGarrigle & Walsh, 2011). Germer et al. (2013) suggest a description of mindfulness that transcends religion, and includes core components that most definitions contain: “awareness of present experience with acceptance” (p. 7). Offered here is an introductory overview of the practices of meditation and mindfulness, and should not be considered a comprehensive discussion of the complexity of these contemplative practices.

Mindfulness meditation is one of the core practices of the Buddhist tradition. Many scholars of Buddhism and Buddhist psychology identify that cultivating the ability

to observe thoughts, feelings, and reactions without judgment or attachment to the outcome is a core practice on the path to freedom from suffering (Kornfield, 2008).

Brenner (2009) describes meditation as the essential component of Zen Buddhism, a sect emphasizing the importance of practicing *sitting* meditation to gain understanding of the Buddha's teachings, among many other complexities that will not be reviewed here. It is through the practice of sitting meditation that one develops the skill of mindfulness that can be implemented into daily activities.

Many definitions of mindfulness and meditation include similar essential components including observation of and non-attachment to thoughts. Early research on the integration of meditation and psychotherapy offers this description:

Meditation means... turning inward; it means quiet observation, reflection and awareness of ourselves; it means to be conscious of consciousness, to become a detached observer of the stream of changing thoughts, feelings, drives and visions, until we recognize their nature and their origin (Kutz et al., 1985, p. 4).

Similarly, Brown and Ryan (2003), describe mindfulness as “enhanced attention to and awareness of current experience or present reality” (p. 822). Through mindfulness and meditation, practitioners assert that space is being cleared in the mind and attention is directed to what is happening in the present moment without judgment or attachment, and with the ultimate goal of decreasing suffering (Gehart & McCollum, 2007; Germer, et al., 2013; Thieleman & Cacciatore, 2014). Another prominent voice of the integration of Buddhist thought and Western psychology is Jon Kabat-Zinn (1994) whose definition of mindfulness is the practice of “paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally” (p. 4).

Lisa Dale Miller (2014) writes about the importance of including the core philosophies of Buddhism in modern day clinical interpretations of mindfulness. She discusses an essential component of meditation and mindfulness as “awakened presence—an effortlessly embodied, fearlessly accurate reception of and interaction with the way things truly are” (p. xviii). This occurs through the practice of mindfulness and meditation, and when the “mind that is lost becomes found in the act of opening to and resting in the flow of experience” (p. 1). With these definitions of meditation and mindfulness, and an understanding of the desired outcome of meditation, we can now look deeper at a few types of meditation that people practice.

Types of meditation. The practice of meditation takes many different forms. According to the NCCAM (2010), mindfulness meditation, also known as *vipassana* or insight meditation, is more widely practiced in Western culture, and originated from the Buddhist tradition. It involves the practice of paying attention to what is happening in the mind while also paying attention to the breath, and noticing thoughts and distractions as they come with awareness and non-judgment. Mindfulness meditation can involve sitting, focusing on breath sensations, or walking slowly, but common to all methods is the meditator’s state of mind (Barnett et al., 2014; Kutz, et al., 1985). Mindfulness meditation can be practiced formally through sitting meditation or informally through integration into daily activities.

Conversely, transcendental meditation (TM) is more common in the Hindu tradition, and the focus is on a mantra or phrase with the goal of preventing thoughts and distractions from entering the mind (Barnett et al, 2014; NCCAM, 2010). The ultimate goal of TM is deep relaxation of the conscious mind, and a state of “pure awareness”

(Barnett et al., 2014). Transcendental meditation and mindfulness meditation are not mutually exclusive, however many seasoned practitioners tend to favor one particular school of practice over another.

Shapiro et al. (2006) write that mindfulness is “both a process and an outcome” (p. 4), and it takes the form of both mindful practice and mindful presence. They also refer to the “Big M” and the “Little m” of mindfulness; the “Big M” being mindful awareness that is integrated into every moment of life, and that is “fundamentally a way of being” (p. 5). “Little m” mindfulness is the formal practice of mindfulness, known to many as meditation. It is the formal practice, as described above, of conscious active attention to one’s experience, and nonjudgmental, non-attached responses to anything brought into one’s awareness.

Foundations of Meditation & Mindfulness

Buddhist philosophy of suffering. With a more thorough understanding of meditation and mindfulness, an exploration of the underlying purpose behind these practices is warranted. Common to most schools of Buddhist thought, and therefore to various meditation practitioners, is the philosophy pertaining to suffering (Anderson, 2005; Chiesa & Malinowski, 2011; Gehart & McCollum, 2007; Kornfield, 2008; Miller, 2014).

One central teaching of Buddhism is the Four Noble Truths. These teachings contain deep-seated realities about life and the existence of suffering. Essentially, the Four Noble Truths teach that suffering exists in the world and that there is a way to end suffering. Kornfield (2008) offers a critical distinction between suffering and pain in his summary of the Four Noble Truths: “Pain is inevitable. Suffering is not. Suffering arises

from grasping. Release grasping and be free of suffering” (p. 243). Application of the Noble Truths involves accepting, acknowledging, and enduring whatever it is we are suffering through and “holding it with dignity” (Kornfield, 2008, p. 244). It is essential, however, that suffering is held with an open hand so that once strong emotions are allowed, they can be let go, out of the realm of attachment. According to Buddhist philosophy, only then can a person truly be free from suffering.

Miller’s (2014) book on cultivating mindfulness rooted in Buddhist philosophy also outlines the heart of the Buddha’s teachings on the reality of suffering. The inevitability and universality of suffering in life is summed up in her interpretation of that Truth: “un-satisfactoriness (*dukkha*) pervades all experience” (p. 15). The nobility of this truth lies in the common experience of enduring difficult circumstances, and allowing these experiences to help deepen one’s sense of self-awareness and meaning.

Gehart and McCollum (2007) discuss the origins of suffering from the perspective of marriage and family therapy, and identify the concept of changing one’s relationship with suffering through “compassionately engaging it” (p. 216). In their conceptualization and description of suffering as a Noble Truth, suffering arises from attachment to constructs of the mind (Gehart & McCollum, 2007). We suffer when we become attached to ideas or stories around a particular circumstance, and then things do not turn out as expected. Gehart and McCollum (2007) suggest therefore that we can reduce our suffering by letting go of expectations and attachment to how we feel life ought to be.

Buddhists believe in the reality and inevitability of suffering, and for centuries have seen meditation as a clear path to end suffering (Andersen, 2005, Chiesa & Malinowski, 2011; Germer et al., 2013; Kornfield, 2008; Miller, 2014). Through the

practices of mindfulness and meditation, suffering is seen as one of the many obstacles in the mind that is overcome through paying attention without judgment, and by letting go of expectations and outcomes. The teachings and philosophy around suffering hold value for clinical social workers and mental health professionals working with clients who are often in the midst of pain and suffering (Gehart & McCollum, 2007; Germer et al., 2013; Miller, 2014).

Compassion and loving-kindness. In addition to the truth of suffering, Buddhism also teaches us about the importance of compassion for self and others (Andersen, 2005; Gehart & McCollum, 2007; Germer et al., 2013; Kornfield, 2008; Miller, 2014). Compassion comes through experiencing suffering, and through a paradigm shift that happens when one accepts life as it is rather than exerting control to change it (Gehart & McCollum, 2007). According to Kornfield (2008), compassion is an innate quality shared by all of humanity. The author shares that Buddhist texts describe compassion as the “quivering of the heart in the face of pain, as the capacity to see our struggles with kindly eyes” (Kornfield, 2008, p. 23). Miller (2014) augments this definition according to Buddhist teaching: “Compassion...is imbued with clear comprehension of suffering, inspiring a genuine determination to end suffering” (p. 114).

Western culture excels in the practice of self-loathing and self-hatred, and struggles with self-compassion and kindness toward oneself (Germer et al., 2013; Kornfield, 2008; Miller, 2014). Accompanying the philosophy of compassion is the practice of loving-kindness, or *metta*. Loving-kindness can be expressed inwardly or outwardly, formally or informally, and self-focused or other-focused (e.g., ‘May I (you) be free of pain and suffering; May I (you) be happy and at peace; May I (you) love and

accept myself (yourself) just at I (you) am/are). It involves the verbal expression of love toward oneself or others that nurtures positive emotions, and is particularly valuable in moments when it may feel opposite to one's visceral reaction (Miller, 2014). Loving-kindness is frequently a focus of meditative practice, and it is through this practice that a foundation of acceptance and joy is learned.

Through awareness and development of compassion and loving-kindness practices, one cultivates a deeper capacity for empathy (Miller, 2014). Germer et al. (2013) similarly identify that practicing loving-kindness for self and others is meant to cultivate compassion, which is “essentially empathy with an attitude of loving-kindness and a wish to alleviate suffering” (p. 68). This is an essential skill for successful interpersonal relationships and is especially important for clinical social workers in establishing a positive therapeutic relationship with their clients.

Modern Application of Mindfulness & Meditation

A variety of disciplines have begun to acknowledge the health benefits of meditation and mindfulness on the effects of stress and anxiety, as well as the positive impact they can have on various physical health issues (Barnett et al., 2014; Brown & Ryan, 2003; Chiesa & Malinowski, 2011). According to NCCAM (2010), people practice meditation to alleviate health problems such as anxiety, pain, depression, stress, insomnia, and the negative symptoms associated with various chronic illnesses like heart disease, cancer, and HIV/AIDS. Meditation affects the autonomic nervous system through “reducing activity in the sympathetic nervous system and increasing activity in the parasympathetic nervous system” (NCCAM, 2010, p. 3). Meditation also induces positive effects on vital functions such as organs, muscles, heartbeat, sweating, breathing

and digestion (Barnett et al., 2014; NCCAM, 2010). Research in neuroscience also supports the positive influence of meditation and mindfulness on the brain, finding that the brain's gray matter is permanently changed through these practices. This allows for enhanced learning, memory, and greater capability in interpersonal skills (Barnett et al., 2014).

Herbert Benson's *Relaxation Response* (1975; As cited in Barnett et al., 2014) presented some of the first notable research integrating meditation with physical and emotional recovery. He was a cardiologist who studied the impact of meditation on stress-related conditions, and found it to benefit anyone regardless of their reason for engaging in it (i.e., religious or non-sectarian). His research set the foundation for a myriad of other studies in a variety of fields. Significant for social work and the helping professions is Jon Kabat-Zinn's research resulting in Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2003). This program initially focused on health-care settings, but MBSR has been translated across a variety of settings including treatment for anxiety and depression, substance abuse, and eating disorders (Chiesa & Serretti, 2009). More recently, MBSR has been used in several studies involving the impact of the program on social work practitioners and students (Christopher et al., 2006; Gockel et al, 2013; McGarrigle & Walsh, 2011).

Mindfulness-Based Stress Reduction (MBSR) began in 1979 as a clinical and psychological intervention for patients with chronic pain (Chiesa & Serretti, 2009). It is an eight-week structured program, grounded in Buddhist mindfulness meditation, and applied mostly in secular contexts (Chiesa & Malinowski, 2011). Students of MBSR

learn three techniques (i.e., body scans, sitting meditation, and Hatha yoga) that are to be practiced for 45 minutes per day, six days of the week.

The success and efficacy of MBSR has contributed to a new wave of thinking in modern psychotherapy, and in other settings. Other evidence-based modalities rooted in mindfulness, meditation, and Buddhist philosophy include: Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, and Teasdale, 2002, as cited in Chiesa & Malinowski, 2011), which integrates MBSR and Cognitive Behavioral Therapy (CBT); and Dialectical Behavior Therapy, (DBT; Linehan, 1993), which was developed for persons who have characteristics of Borderline Personality Disorder, and focuses on the relationship between acceptance and change with a core component of mindfulness (Chiesa & Malinowski, 2011).

Integration into Social Work Practice

Meditation started as a contemplative practice foundational to the Buddhist tradition. While still an integral part of Buddhist and Hindu religions, anyone can practice meditation and mindfulness regardless of religious beliefs, as we have seen through its widespread application (Barnett et al., 2014; Keefe, 1975; Shapiro et al., 2006). People often use meditation as a way to relax, cope with anxiety, reduce stress, decrease pain, improve sleep, and enhance overall health and well-being. Keefe (1975) discusses meditation as being practiced for relaxation and calming, spiritual pursuit, enhanced interpersonal functioning and empathy, and increased self-awareness. Mental health practitioners, including clinical social workers, have begun to use meditation and mindfulness as a means to cope with the stress of their jobs, and to enhance their

emotional availability to clients and coworkers (McGarrigle & Walsh, 2011; Christopher, Christopher, Dunnagan & Schure, 2006; Gockel et al., 2013).

The application of mindfulness and meditation to the practice of social work can be seen on all levels and in almost any context of practice, and with many different client populations. We will turn now to a brief overview of where and how mindfulness and meditation can be applied to social work practice. A more in-depth discussion will then be presented on the application of meditation and mindfulness to practitioners and students providing individual therapy.

Micro-level integration. Micro-level social work practice primarily pertains to one-on-one interventions with individuals or families. One of the most common settings, particularly for clinical social workers today, is in the psychotherapeutic relationship. On an individual level, mindfulness and meditation can be valuable for both client and practitioner. Once a practitioner has developed a personal practice of mindfulness and meditation, they can begin to introduce concepts and practices into their individual work with clients (Brenner, 2009; Dunn et al., 2013a; McGarrigle & Walsh, 2011; Turner, 2009).

One example of an approach to individual therapy utilizing concepts of meditation and mindfulness is the Integrative Body-Mind-Spirit (I-BMS) approach proposed by Leung et al. (2009). In this proposed model for social work practice, the treatment goals include “promoting balance, fostering strengths, and facilitating meaning-making” (p. 305). Rooted in Eastern philosophies of Daoism, Buddhism, and Traditional Chinese Medicine, the I-BMS approach facilitates re-framing of the meaning of suffering when appropriate, and utilizes all components of clients’ personal strengths to activate

recovery. This is done through the application of practices like tai chi and qi gong, which are movement meditations, as well as through breathing meditation. This is just one example of how meditation and mindfulness, and their Eastern roots, have the potential to help clients at the micro level of practice.

Each protocol mentioned in the previous section (i.e. MBSR, MBCT, and DBT) has a group therapy and an individual therapy component. Some are more rigid in their requirement of participating in both the group and individual elements, but all are potential tools for practitioners to integrate depending on a client's specific needs (Leung et al., 2009; Turner, 2009). Dunn et al. (2013) present mindfulness as a clinical process, and as a tool to be used both formally and informally in a session. They suggest educating clients about mindfulness, leading them in meditation, practicing yoga or tai chi, and directing the client toward awareness of emotions and body sensations. Through incorporating mindfulness into therapeutic work with clients, Dunn and colleagues propose that awareness improves, ruminative thinking patterns decrease, and self-compassion grows.

Mezzo-level integration. Settings such as schools, social service agencies, hospitals, group homes, and higher educational settings are included under the umbrella of mezzo-level social work practice. Application of the principles of meditation and mindfulness in this level of practice is demonstrated through mindfulness as an essential component of self-care. The meditative model proposed by McGarrigle and Walsh (2011) offers a way to conceptualize how a practitioner's practice of meditation and mindfulness not only impacts themselves, but also their clients, coworkers, and agencies at large. Through the impact of decreased stress, and increased emotional availability to clients,

practitioners are more effective and efficient, which benefits morale and agency productivity.

Macro-level integration. The existing research investigating the impact of mindfulness and meditation interventions on macro systems is minimal (Brenner, 2009; Garland, 2013; Hawkins, Orme-Johnson, & Durchholz, 2005; Shonin, VanGordon, & Griffiths, 2014). Many effects of meditation and mindfulness are observed on an individual and intrapersonal level. However, when many people engage in behavior that changes their way of being and functioning in society, societal impact is possible.

One qualitative study by Brenner (2009) asked practitioners of Zen meditation about the influence of their contemplative practice on larger systems issues, taking into consideration that clinical practice “exists within a larger social service delivery system” (p. 464). Respondents in Brenner’s study spoke of awareness as a primary component of Zen meditation, and as clinical social workers this includes awareness of the client’s social environment. The results of his study include many implications for social work practice, including the far-reaching effects of individual meditation practice.

In one study, Hawkins et al. (2005) investigated the effects of teaching prison inmates the practice of transcendental meditation (TM). Some of the effects of implementing TM included reduced rates of recidivism (i.e., re-offending), decreased anxiety and hostility, greater optimism, and a boost in constructive activities (Hawkins et al., 2005). In more recent research, Shonin et al. (2014) completed a systematic review of correctional facilities implementing mindfulness-based interventions (MBIs). An important theme the researchers found is how the introduction of MBIs has the ability to teach inmates how to more effectively regulate their emotions, become less reactive and

hostile, and learn how to channel emotions rather than act out in a violent manner (Shonin et al., 2014). Several studies identified components of Buddhist philosophy that influence individuals to change their behavior, such as self-compassion, compassion for others, and greater awareness of the suffering of humanity (Shonin et al., 2014).

Although no direct correlation was found to reduce rates of recidivism, the researchers state that the development of mindfulness has the ability to regulate “key criminogenic agents” (Shonin et al., 2014, p. 50), and should be considered a viable method for reducing recidivism. It is through the implementation of meditation and mindfulness in settings such as prisons that will allow more widespread societal change to happen.

Mindfulness, Meditation, and Individual Psychotherapy

Clinical social work practitioners have been shown to use mindfulness and meditation personally in a variety of ways. Vick-Johnson (2010) reports the outcomes of a spirituality-based training program for social workers emphasizing the clinician’s spirituality as a therapeutic tool. The training program also emphasized the importance of developing awareness of one’s own spirituality and that of clients’ as insights into the therapeutic process. While the training program did not center on Eastern spirituality or any particular contemplative practice, many clinicians chose to practice meditation and reported greater spiritual attunement and self-awareness. This study demonstrates just one way that practitioners are encouraged to engage in meditative practice.

Dunn et al. (2013) completed a study hypothesizing that completing a mindfulness centering activity five minutes prior to a session with a client would elicit improved outcomes for clients due to increased presence. This example of mindfulness practice being implemented in clinical practice demonstrates a more simplified and

targeted use of mindfulness. Similarly, Turner (2009) and Cacciatore and Flint (2012) discuss the use of the *three-minute breathing space*, where practitioners take time in between client sessions to center, decompress after the previous session, and open themselves to whatever the next client brings with them. Turner (2009) notes that if any frustrations, fear, or anxiety arise in these moments, they can be met with curiosity and openness. The practice of brief mindfulness before each session demonstrates mindfulness practice as an essential component of being truly present with oneself and one's clients.

Practitioner Mindfulness Extends to Clients

Recent studies strongly support the evidence that the practice of meditation and mindfulness increases the practitioner's ability to be present, engaged, and available to their clients (Andersen, 2005; Brenner, 2009; Dunn et al., 2013a; Germer et al., 2013; Grepmaier et al., 2007; Turner, 2009; Gockel et al., 2013; Kornfield, 2008; Shapiro et al., 2006; Siegel, 2008). The manner in which studies have reached this evidence is varied, but focuses less on client report of outcomes, and more on practitioner report and inference.

A quantitative study carried out in Germany by Grepmaier and colleagues (2007) examined the influence of daily Zen meditation by psychotherapists in training on the treatment results of their clients. Client outcomes were measured through two questionnaires completed by clients immediately following the session, as well as upon their discharge from inpatient treatment. Additionally, the psychotherapists in training who were also being instructed in Zen meditation completed an assessment of the patient's perceived challenges upon admission and at discharge. The results of this study

indicated that patients who were working with practitioners engaged in meditation rated the quality of individual therapy at a higher level than when practitioners were not engaged in meditation (Grepmaier et al., 2007). Patients also perceived themselves as making greater gains in their ability to cope with challenges and develop new behaviors that they can integrate into their lives (Grepmaier et al., 2007).

In a similar study, Dunn et al. (2013) introduced graduate students to a five-week mindfulness training program prior to their engagement in the formal study. Student participants were instructed to engage in five minutes of mindfulness prior to a client session, unless randomly assigned to a “distraction” activity, such as talking with co-workers, checking personal voicemail, or reading emails. Immediately following the session, both client and therapist completed a *Therapist Presence Inventory*, and the client also completed a session rating scale evaluating therapeutic alliance and effectiveness. The results of this study indicated that therapists who preceded a session with a mindfulness meditation practice identified being more present in that session. Clients reported perceiving their therapist as highly present regardless of if they had completed the mindfulness exercise, but as more effective when they had engaged in it. This study further demonstrates the potential benefits of practitioner mindfulness.

Andersen (2005) indicates in his synthesis of the intersection of meditation and psychotherapy that meditation can assist people in restoring self-structures; increasing awareness of ongoing behaviors that cause conflict; regulate affect; and to gain skill in changing negative thinking patterns. Andersen (2005) furthermore suggests that mindfulness and meditation cultivate the capacity for empathy on the part of the practitioner, and in turn their empathy helps the client identify, acknowledge, and

embrace parts of themselves they have come to reject. Empathy promotes self-acceptance; exuding this to the client can help them on their path toward self-compassion and acceptance.

Similarly, Turner (2009) and Brenner (2009) discuss how a personal practice of meditation facilitates a deeper capacity for empathy. People feel validated when shown empathy, and when a practitioner models empathic behavior, clients can learn to experience compassion in their lives and for themselves. Turner (2009) asserts that clinical social work has always valued empathy as the foundation for a positive and protected helping relationship. When a practitioner is fully attuned to their compassionate nature, they are more effective in portraying genuine empathy to clients, therefore setting the stage for a more successful therapeutic relationship. Brenner (2009) similarly notes that social workers engaged in Zen meditation experience “non-duality... the ability to suspend distinctions, be fully present, aware of their experience, and responsive to the needs of the client” (p. 467).

Impact on Clinical Social Work Practice

There is great potential for meditation and mindfulness to positively impact both clients and practitioners. When practitioners are more attuned to their thoughts and feelings, they can be more present with clients. Furthermore, when a practitioner has a regular meditation practice, they are more apt and prepared to introduce meditation and mindfulness practices to clients. Empirical research shows us the neurological, physiological and emotional benefits of mindfulness and meditation (Barnett et al., 2014; Brown & Ryan, 2003; Grepmaier et al., 2007; Kuyken et al., 2010; Shapiro, Brown, & Biegel, 2007; Siegel, 2008; Thieleman & Cacciatore, 2014). A practitioner with the

knowledge and expertise of practicing mindfulness and meditation is a valuable resource for themselves and their clients.

Stress, burnout and self-care. Lloyd, King, and Chenoweth (2002) identify social work as a profession where stress and burnout is widespread. Social workers do not always have clearly defined roles. People who are drawn to the profession tend to be more emotionally vulnerable, and their expectations for what the work will look like and the reality of the work is often inconsistent. Additionally, the role of the clinical social worker is often one of *caring for* clients, which becomes depleting if the clinician neglects their own self-care. Self-care has been described as one's ability to "balance personal, professional, emotional, mental, physical and spiritual components in order to live in a balanced, energized manner that assists one in coping with day-to-day stressors" (Collins, 2005; as cited in McGarrigle & Walsh, 2011, p. 214).

The literature strongly supports the ability of meditation and mindfulness to help reduce burnout, reduce the effects of secondary trauma, and curb compassion fatigue (Christopher et al., 2006; Cacciatore & Flint, 2012; McGarrigle & Walsh, 2011; Shapiro et al., 2007; Shinn et al., 1984; Thieleman & Cacciatore, 2014; Um & Harrison, 1998). One example is that mindfulness helps clinicians develop *equanimity*, the ability to recognize the inevitability of pain and also to attend to the reality that they are not responsible for a client's suffering (Gehart & McCollum, 2007; Germer et al., 2013). With this certainty clinicians can allow themselves to hold a client's suffering with compassion and understanding, and ultimately know they are not responsible for the outcome of a client's situation. Clinicians then remove the commonly experienced burden of *fixing* a circumstance, situation, or client, which is frequently a source of burnout and

compassion fatigue (Gehart & McCollum, 2007; Germer et al., 2013; McGarrigle & Walsh, 2011).

The ATTEND model (Cacciatore & Flint, 2012) offers a valuable guide for the integration of mindfulness into bereavement care. The components of this model include: Attunement, Trust, Therapeutic touch, Egalitarianism, Nuance, and Death education. With an emphasis on attunement, this model stresses the importance of the therapist's role in cultivating mindful presence, which allows them to hold the space for a client to experience and integrate the loss into their life in a way that is meaningful and focused on what lies ahead. Additionally, Cacciatore and Flint (2012) reveal that mindfully approaching bereavement care can help the practitioner to combat the effects of having their own secondary traumatic responses.

Another study by Christopher et al. (2006) implemented a semester-long course for counseling students with the goals of personal and professional growth. The course included activities based on MBSR, such as hatha yoga (e.g., focused on the breath), meditation, body scans (e.g., awareness of body sensations), and qi gong (e.g., movement-focused meditation exercise). Students were allowed to choose which activity they wanted to engage in for 45 minutes, four days per week. This study addressed the issue of stress and burnout among mental health providers. The results of the study demonstrate that mindfulness helps clinicians step back from and use caution when confronted with stressful events through being present and nonjudgmental of thoughts and feelings that arise. This study's therapists-in-training reported having more tools to handle the stress of their daily lives, and specifically felt more equipped to work effectively with clients.

McGarrigle & Walsh (2011) implemented a similar study with graduate social work students. Using a mixed-method design, their study analyzed the effects of a weekly two-hour group session, spanning eight weeks, focusing on contemplative practices including meditation and mindfulness. The respondents in this study identified the interconnection between mindfulness, reflection, and self-care, and how this “occurred through recognizing stress, reflecting on its possible causes and then implementing coping strategies that decrease stress and increase well being” (p. 222).

Development of clinical skills. Many existing studies note the value of meditation and mindfulness for clinicians-in-training to learn, as they can enhance a myriad of therapeutic skills (Christopher et al., 2006; Gockel et al., 2013; Grepmaier et al., 2007; McGarrigle & Walsh, 2011; Shapiro et al., 2007). In Christopher et al.’s (2006) previously mentioned study with counseling graduate students, results showed how teaching mindfulness practices allowed students to understand the importance of self-care, and also to conceptualize the therapeutic process in a new and meaningful way. Students reported having greater self-awareness, feeling more capable of dealing with personal stressors, and increased confidence in working with clients. If meditation and mindfulness are part of the graduate student’s curriculum, they will be better prepared as skilled clinicians both in their capacity to help clients, and also to care for themselves.

Similarly, Gockel et al. (2013) interviewed clinical social work students regarding what concepts and skills they learned in their established curriculum that had helped them most in their clinical fieldwork. Results from their qualitative analysis indicated that education and training in mindfulness during their graduate education “facilitated a greater ability to be open and attentive to the learning process”, which naturally impacted

their work with clients in the field and “enhanced their ability to be more fully available” (p. 45). Students also reported how mindfulness training helped them feel less anxious prior to meeting with clients, subsequently heightening their ability to be present with their experience.

As previously referenced, the study by Grepmaier et al. (2007) involving training psychotherapy students in meditation and mindfulness and then measuring the outcomes of patients, also showed the significance of including these practices in clinical training. The results of this study indicate how mindfulness can positively influence therapists in training, as well as the people they treat (Grepmaier et al., 2007). Overall, these studies emphasize the potential of meditation and mindfulness to greatly enhance clinical skills and, as a result, be more effective in their treatment of clients.

Enhancement of empathy & therapeutic presence. In addition to being a tool for self-care and for development of students’ clinical skills, one of the more significant areas in the literature around practitioner use of meditation and mindfulness can be seen through how these practices enhance practitioners’ empathy and therapeutic presence (Andersen, 2005; Brenner, 2009; Gockel et al., 2013; Gehart & McCollum, 2007; Germer et al., 2013; Keefe, 1975; Miller, 2014; Turner, 2009). Through fully engaging in meditation and mindfulness, along with embracing Buddhist insights around suffering, the practitioner can greatly enhance their ability to have *mindful presence* (Gehart & McCollum, 2007; Germer et al., 2013). A benefit of mindful presence is that the therapist views their role as holding a compassionate and welcoming space for the client to bring anything that is weighing on their heart and mind.

According to Andersen (2005) empathy has been defined as the “nonjudgmental understanding of a client’s immediate frame of reference that helps the client to become more compassionate and empathic toward the self” (p. 492). He argues that Buddhist meditation increases the capacity for empathy and, coupled with Buddhist philosophy around ending suffering through meditation practice, therein lies a powerful therapeutic tool.

Christopher et al. (2006) note that contemplative practices are valuable for clinicians because they facilitate skill development in being present and connected with all who they encounter. Similarly, student practitioners indicated how mindfulness training helped them to focus, feel more engaged in the learning process, and feel less anxious (Gockel et al., 2013).

Turner (2009) asserts that a mindful therapeutic relationship arises from the clinician’s practice of mindfulness, as opposed to mindfulness of the client. Clinicians can encourage their clients to practice skills of mindfulness, but it is through their personal practice that clients will see the expressions of empathy and compassion that pour out of genuine mindful presence. After a client has been part of a mindful therapeutic dyad, there is increased likelihood that these qualities will radiate to the client and have a positive effect on the client’s ability to be with their suffering (Turner, 2009). Similar conclusions were reached with Dunn et al.’s (2013a) study analyzing the effect of a brief centering exercise before each client session. The therapists involved in the study acknowledged feeling more present in a session when they had practiced mindfulness.

Key principles of meditation and mindfulness practice, and of Buddhist philosophy, are compassion and empathy. Gehart and McCollum (2007) assert that

mindfulness is a natural cultivator of compassion, and it also builds mindful presence, which allows a practitioner to nonjudgmentally welcome anything a client brings to the session without expectation or evaluation, and with attentiveness and respect. When the clinician approaches a client with mindful presence, genuine empathy comes naturally through a deep understanding of the human struggle (Germer et al., 2013).

Self-awareness, attunement, and countertransference. The final areas that are identified in the literature as being positively impacted by practitioner meditation and mindfulness are: increased self-awareness, greater attunement to the client and self during session, and greater awareness to issues of countertransference (Brenner, 2009; Cacciatore and Flint, 2012; Germer et al., 2013; Gockel et al. 2013; Keefe, 1975; Miller, 2014; Turner, 2009). These three areas complement and build upon each other, helping the practitioner become more effective and resilient.

Self-awareness and Buddhist influence. Several studies name Buddhism and Buddhist philosophy as the key element in the cultivation of self-awareness among practitioners engaging in meditation (Brenner, 2009; Gehart & McCollum, 2007; Germer et al., 2013; Keefe, 1975; Turner, 2009). The aforementioned study by Brenner (2009) explored the influence of Zen meditation on clinical social work practice in his qualitative study. One main theme gathered from his research was how Zen meditation enhanced the awareness of the practitioner during the therapy session. Brenner (2009) identified six aspects of awareness in his qualitative research: “primacy of experience, systemic view, suspending hypothesis (not-knowing), grounded-ness (basic confidence), no distinction between self and other, and present focus” (p. 466). Moreover, Brenner (2009) identified that awareness allows the practitioner to suspend the fact that they are

different from their client, thus creating a space where the client feels fully accepted and heard.

One of the earlier studies exploring the intersection of meditation and psychotherapy (Keefe, 1975) offers that therapist effectiveness is enhanced due to the practice of meditation increasing the practitioner's ability to methodically bring the attention back to one object (i.e., the breath or the client sitting in their office). He discussed the use of meditation in its original Eastern context, and the behavioral outcomes relevant to therapeutic effectiveness such as heightened attunement to one's emotions, greater insight, and increased ability to remain present with what is happening in the moment.

According to Turner (2009), in the Buddhist tradition attention is developed through formal meditation practice, and through mindfulness meditation practiced through day-to-day activities. When formal meditation and daily mindfulness are practiced for a longer period of time, what are referred to as "receptive attentional skills" develop, thus increasing the practitioner's ability to be fully focused on the client, while also being alert, open, and accepting. What Turner (2009) is describing here as attention can be closely linked to attunement and self-awareness. With these skills, a practitioner's presence in the therapeutic relationship is greatly enriched.

Attunement. Cacciatore and Flint (2012) provide a prime example of how attunement is cultivated through mindfulness and meditation, and how it can positively impact the therapeutic relationship. In the ATTEND model mentioned earlier, attunement (i.e., the 'A' in ATTEND) is the central component to mindful bereavement care. The researchers suggest that daily mindfulness practice can assist the practitioner in looking

to the client as the expert on their needs, and then tuning into those needs regardless of any unexpected or unwanted feelings.

Cacciatore and Flint (2012) propose that attunement starts with mindfulness practice that includes paying attention to powerful emotions, sometimes negative, which often come up during sessions with traumatically bereaved clients. In so doing, the clinician is preparing to *be with* rather than *do for* a client in their time of intense emotion. Essentially, the theme of awareness showed that through the practice of meditation on the part of the practitioner, expectations, judgments, and agendas are withheld. The practitioner is then able to be fully present and engaged with whatever the client presents during the session.

Countertransference. The development of self-awareness and attunement naturally extend to a practitioner's ability to be mindful of any issues of countertransference that come up. Gockel et al. (2013) describe countertransference as "a key source of ineffective therapist behaviors such as judging, shaming, blaming, neglecting, or rejecting the client that interfere with the helping relationship and result in poorer outcomes" (p. 39). They identify mindfulness practice as a beneficial mediator of increasing awareness of internal affective reactions that can help clinicians to identify their personal needs, and for self-care and self-exploration.

Conclusion

The existing literature surrounding the use of meditation and mindfulness by clinical social work practitioners focuses primarily on beginner meditation. Many respondents and participants in the studies reviewed were practicing for the first time. The focus of the current study will be on practitioners who have practiced meditation

and/or mindfulness for one year or longer, which will provide a clearer picture of how these practitioners perceive their meditation practice to be influencing their clinical practice. In this study, the following research question will be examined: How do meditation and mindfulness impact clinical social work practice?

Conceptual Framework

There are a variety of theoretical perspectives upon which this study is grounded: (a) The strengths perspective with an emphasis on empowerment, (b) The bio-psycho-social-spiritual perspective that emerges from George Engel's general systems theory, and a corresponding holistic perspective offered by Canda and Furman (2010), and (c) a Gestalt approach presented by Senreich (2014) that integrates the preceding two theories as well as two others. Each of these frameworks allows for more thorough understanding of how the practices of mindfulness and meditation can influence clinical social work practitioners and clients.

Strengths Perspective & Empowerment

Unique to social work is the emphasis on the strengths and inherent resources a client has. The strengths perspective offers that each individual has the capability to make positive changes in their life and situation, regardless of what might be going on (Zastrow & Kirst-Ashman, 2007). Every person has the capacity for resilience, and it is through this belief that social workers empower clients. Empowerment is a byproduct of the strengths perspective and involves identifying and building upon a person's intrinsic strengths in order that they might be compelled to take positive action (Zastrow & Kirst-Ashman, 2007).

The empowerment and strengths perspectives provide not only a lens through which social workers can approach work with clients, but also through which they can engage in self-reflection. Social work practitioners who are skilled in recognizing strengths within themselves will have enhanced self-awareness and be more likely to identify their clients' strengths. Practicing meditation and mindfulness also has a similar effect upon a practitioner, and enhances self-awareness and positive regard for others (Andersen, 2005; Brenner, 2009; Gockel et al., 2013; Gehart & McCollum, 2007; Keefe, 1975; Miller, 2014; Turner, 2009). It is important for the purposes of this research to understand how the strengths perspective provides a method for conceptualizing how meditation and mindfulness impact both clients and practitioners.

Bio-psycho-social-spiritual Perspective & General Systems Theory

In a response to the medical model's fragmented view of the patient, George Engel developed the biopsychosocial (BPS) model, which aims to take into consideration all facets of a person's environment—physical, psychological and emotional, and sociological (1977; as cited in Sulmasy, 2002; NASW, 2005). General systems theory coincides with the BPS model, and according to DuBois and Miley (2005), the general systems approach involves change at one level inevitably impacting another level—all systems are interconnected. The BPS and general systems approaches are foundational in social work practice, and assist practitioners in viewing a client's situation from multiple perspectives.

In more recent years, researchers and clinicians have expanded this approach to include a spiritual dimension. The National Association of Social Work (NASW) suggests that the bio-psycho-social-spiritual (BPSS) perspective draws from the strengths

perspective, and many people find strength in spirituality (NASW, 2005). The spiritual dimension includes an individual's pursuit for meaning, and through acknowledging this dimension as a resource for an individual—in addition to all the other dimensions—people are allowed the opportunity to tap into their greatest potential. Canda & Furman (2010) assert that there is an “inextricable relationship between spirituality and the biological, psychological, social, and larger ecological dimensions of human experience” (p. 21).

The BPSS perspective is an essential framework to consider when looking at the intersection of social work and meditation. Many practitioners of meditation identify it as a spiritual activity, regardless of their religion (Brenner, 2009; Gehart & McCollum, 2007; Gockel et al., 2013; Turner, 2009). Moreover, clinicians who practice meditation will likely be more attuned to the spiritual dimension of their clients' lives, thus opening them to another area of potential strength.

Gestalt Therapy Theory

Senreich (2014) proposes an integrated framework based on the strengths perspective, ecological (systems) theory, and Gestalt therapy. The central tenets of this framework involve the preceding concepts and approaches, along with components of existentialism and phenomenology. One vital aspect of this integrated theory includes Martin Buber's concept of the “I-thou” relationship, which emphasizes the quality of the client-practitioner relationship, and the importance of honesty and genuine trust (Senreich, 2014, p. 56). Additionally, Gestalt therapy theory holds a phenomenological perspective, placing the client's experience at the forefront of the therapeutic relationship. Through the integration of all these pieces, there is great potential for an integrative

framework that truly considers a client's environment, experiences, and sacredness of being.

This framework is consonant with the practices of meditation and mindfulness, and the impact they have on the social work practitioner's ability to be present with, aware of self, and attuned to the client's strengths and needs.

Methods

Research Design

The purpose of this study was to gain a deeper understanding of how social work practitioners' use of meditation and/or mindfulness impacts social work practice. In order to fulfill this purpose, a qualitative, exploratory study was performed utilizing grounded theory. Qualitative methods were used to understand the subjective experience of individuals through personal interviews (Monette, Sullian, Dejong & Hilton, 2014). The context in which people live and work is a setting where qualitative research thrives. It is through qualitative methods that theories can emerge, as is the case with grounded theory (Monette et al., 2014; Padgett, 2008). Qualitative methods and grounded theory can be beneficial when researching topics about which little is known (Padgett, 2008), and where there is an absence of theory (Monette et al., 2014). The current study aimed to approach the intersection of mindfulness, meditation, and clinical social work practice, three areas that impact each other. It is important to examine these intersections because limited information is available in the body of social work knowledge (Garland, 2014).

Sample

The sample for this study was obtained through purposive criterion snowball sampling (Monette et al., 2014). Through knowledge and networking, this researcher

identified nine practitioners in the community: four clinical social work practitioners (LCSWs); one Licensed Psychologists (LP); three Licensed Marriage and Family Therapists (LMFTs); and one Licensed Professional Clinical Counselors (LPCC). Each of these practitioners was also identified as having a personal practice of meditation and mindfulness. Informational cover letters (see Appendix A), and consent forms (see Appendix B) were provided via email to interested individuals and acquaintances who knew of respondents meeting criteria for the study. After potential participants were identified and provided adequate information, the researcher reached out first by email, and on one occasion after no response had been received, by phone (see Appendix C). The researcher reminded potential participants of the purpose of the study, and inquired of their interest and willingness to participate.

Protection of Human Subjects

To ensure the confidentiality and privacy rights of all participants, measures were taken to protect all respondents involved in this study. All participants were provided with a consent form (see Appendix B) outlining the purpose of the study, explaining that their participation was voluntary and confidential. It also indicated the risks and benefits of the study, and provided the participant with pertinent contact information. Each participant was asked to review and sign a consent form prior to completion of the interview. Respondents were also offered a copy to keep for their records. All data recorded in-person or via phone was kept in a locked file, stripped of any identifying information and will be destroyed no later than May 26, 2015. Data gathered via email was kept in a file on the researcher's password-protected private computer, stripped of identifying information, and will be destroyed no later than May 26, 2015.

Data Collection

Upon identification of the nine respondents, nonschedule-standardized interviews were scheduled in-person, over the phone, or via email, according to the respondent's preference. Nonschedule-standardized interviews allow for some structure but center around a specific topic, and contain primarily open-ended questions that the interviewer can modify as needed (Monette et al., 2011). Based upon themes that emerged from the literature, the researcher composed nine interview questions that guided each interview (see Appendix D). Three interviews were conducted in-person in a location that ensured the participant's confidentiality, and were recorded with an audio recording device. Two participants responded via email to the same interview questions that were queried during in-person interviews, and responses were obtained through the electronic record of the email message. Four phone interviews were recorded using Google Voice software, which informed both parties that the phone call was being recorded. All participants were asked to complete a brief seven-item demographic questionnaire prior to the interview (see Appendix E), which gathered important information regarding the participant's biographical information and professional status. Demographic questionnaires and a list of the interview questions were sent to each participant prior to the scheduled interviews.

Data Analysis

Upon completion of interviews, the data was analyzed using grounded theory. According to Padgett (2008) grounded theory is used to develop themes from data. Through content analysis methods, the researcher transcribed and analyzed content from the interviews using open coding (Padgett, 2008). Upon developing codes to organize the

data, the researcher identified themes and sub-themes that were relevant to the content of the interviews, and that also addressed the research question.

Validity & Reliability

In order to ensure rigor of this study, measures were taken before, during and after the study was completed to help the researcher determine the results were valid and reliable. Upon starting the process of recruiting participants and engaging in the interviewing process, the researcher kept a journal of: (a) when and how participants were contacted; (b) dates and times of scheduled interviews; (c) difficulties encountered, including expectations, values, and biases; and (d) any significant observations about each interview. Through keeping a journal of field notes and observations, the researcher enhanced the validity of the results through being able to compare field observations with data obtained through the interviews, and to assess for any discrepancies (Monette et al., 2011).

To confirm the reliability of the data collection instrument, all interview questions were subjected to a professional review process. Through discussion and reflection with colleagues and clinical research committee members, the researcher refined the interview questions to make them clear, concise, and unambiguous. Content validity was present in the interview questions, given that they were developed from themes that emerged from the literature (Padgett, 2008). To enhance reliability of the results, a research colleague also reviewed the transcripts and completed an independent coding process to practice inter-coder reliability (Monette et al., 2011).

Strengths & Limitations of the Research Design

This study has various strengths and limitations. One strength of this study is that it contributes to the body of social work knowledge thus informing practitioners on valuable practices for both self-care and client care. This study also explores an area of the literature where little is known—the lived experience of clinicians practicing mindfulness and how they perceive the impact on their psychotherapy practice. It also allowed the practitioners who were interviewed to feel empowered and encouraged about what they are doing for themselves and their clients to ensure they are practicing with integrity and self-awareness.

In terms of limitations to this study, the researcher acknowledges bias in the research topic and identifies that this may have influenced how the study was carried out, as well as the interpretation of the results. Additionally, the technique of snowball sampling has some inherent limitations, including that it is limited to people who are part of a particular network of people, thus isolating those who are not part of the network (Monette et al., 2014). The sample was relatively small and homogenous, which limits the generalizability of the findings. Lastly, the mixed method of interviewing which led to three different mediums by which data was gathered (i.e. in-person, over the phone, and via email) may have impacted the consistency of the data. More data was gathered during in-person interviews than interviews conducted over the phone. This inconsistency also limits the generalizability of the findings.

Findings

A total of nine interviews were conducted and analyzed using open coding. Subsequently, eight themes emerged related to the role of meditation and mindfulness among practitioners engaged in clinical psychotherapy practice. These themes will be

explored in detail in the sections that follow. Themes that were identified include: (a) definitions of meditation and mindfulness; (b) types of training obtained and/or pursued; (c) inspiration to begin practicing meditation and mindfulness; (d) frequency and method of practice; (e) integration into the clinical setting; (f) importance of neuroscience to the advancement of meditation and mindfulness in clinical practice; (g) impact of meditation and mindfulness on self-care, burnout and compassion fatigue; and (h) future hopes for integration of meditation and mindfulness into mental health care.

A variety of quotes from participants will be included to illustrate the findings. The participants' real names will not be used in order to protect their identities. Instead, nine pseudonyms will be used: Angela, Sarah, Kate, Lydia, Jennifer, Grant, Nancy, Monica, and Amanda. In the next section, participants' demographic information will be outlined, followed by a presentation of themes.

Demographic Data

A demographic questionnaire was completed by each participant (see Appendix D) in order to gather data about age, gender, degree and licensure, setting of practice and types of populations served, and number of years practicing psychotherapy and meditation. Additionally, during each interview participants were asked what their theoretical approaches consisted of, which are included in this section of demographic data rather than in the following presentation of themes. Interviews were conducted with a fairly homogenous sample including eight females and one male. The participants ranged in age from 28-51 with an average age of 40.5 years. Four participants held licensure as an LICSW with a Master's in Social Work; three participants held licensure

of LMFT, including one who also holds a Ph.D. in Psychology; one participant held licensure as an LP and one as an LPCC.

There was a wide range of experience both in practice of psychotherapy as well as meditation and mindfulness. Participants reported having from 1.5 years to over 27 years' experience practicing psychotherapy, with an average of approximately 11 years. Additionally, participants reported having from 2 years to 25 years' experience practicing meditation and mindfulness, with an average of 13 years.

A majority of participants (five) reported primary employment at a non-profit agency. Four participants reported either having their own private for-profit practice or working at a for-profit agency in private psychotherapy practice. A wide range of populations are served by this participant sample, including children and families, adolescents, adults, couples, and groups. In addition, a number of individuals with a variety of mental health diagnoses are served including: anxiety, depression, posttraumatic stress disorder (PTSD), transition, adjustment disorder, and autism spectrum disorder (ASD). Moreover, four participants identified that they are in a management role and/or provide clinical supervision to others in their setting.

Finally, participants identified the theoretical perspectives from which they practice. There were a total of 21 theoretical models that were mentioned by the nine participants as being integral to their practice of psychotherapy. The theoretical models that were mentioned most prevalently were: trauma-informed or trauma-focused; Dialectical Behavior Therapy (DBT); Solution-focused therapy; Integrative or Eclectic; Psychodynamic; Cognitive Behavioral Therapy (CBT); Strengths-based; Family

Systems; and mindfulness-based approaches such as Mindfulness-Based Cognitive Therapy (MBCT).

Definitions of Meditation and Mindfulness

One of the first questions participants were asked was to share their personal definition of mindfulness and meditation. While there were a variety of responses, many core aspects remained consistent across participants including awareness, being present, intentionality and focus, reflection, pausing, and connection. Participant Grant defined meditation and mindfulness simply as “clear-seeing.” Another participant, Lydia, commented on the wide array of definitions around mindfulness and meditation but emphasized the common thread of intentionality: “Sometimes it’s about movement, sometimes it’s about breath, sometimes it’s about connection, sometimes it’s about something else, but it’s always the intentional piece...it’s more about intentional focus and awareness.”

Several participants spoke to the distinction between formal meditation practice and mindfulness practice. Participant Nancy reflected that there is:

...Traditional mindfulness practice, where you are taking time to be quiet and reflect inward and potentially have a focus... focus on your breath, visual imagery, a specific topic, a decision that you need to make...to me it’s a creative space where anything can happen.

This participant also reflected on the concept of “living mindfully... in terms of what you bring your attention to,” which suggests a less formal but equally intentional practice.

Another participant, Amanda, indicated that she believes “meditation to include mindfulness in a formal way but mindfulness does not need to include meditation.”

Most participants responded to this question with ideas related to bringing attention to the present moment. Angela identified that meditation and mindfulness for her is “being aware of the present, of the here and now, and...being in tune with your body and your current thoughts, and not focusing on what happened yesterday.” Jennifer defined meditation and mindfulness as “pausing to reflect on...what you’re experiencing in the moment.” Similarly, Monica said that it involves “integrating the mind-body-soul connection” as well as “pausing, creating awareness of yourself and others.” With many slight variations in definitions, all participants emphasized how their definition of meditation and mindfulness includes an integration of the mind, body and spirit to bring attention to what is happening in the present.

Variations in Training

A second theme that emerged pertained to the types of training participants had received and the absence of training that many shared as it relates to meditation and mindfulness, both on a personal level and a professional level. Five participants reported having some formal or informal training in meditation and mindfulness, and their training included a variety of more traditional and Buddhist-informed meditation training, as well as professional training in psychotherapy approaches that include mindfulness. Four participants reported little to no formal or informal training in meditation and mindfulness but identified goals to pursue training, primarily of a professional nature.

Formal and informal training. Participants identified a range of training experience that often included self-education and exposure through friends and associates. One participant, Lydia, reflected on the diversity of her training in mindfulness and meditation, stemming back to her childhood of being trained in figure

skating and the “silent, very focused body awareness” that she engaged in for many years. She remarks, “I had no idea that was meditation until about 10 years later!” This participant’s early exposure to meditation and mindfulness led her to pursue self-education: “...I bought a book about kundalini and a book about hatha yoga, and this was at age 17, so then I started looking into that and started practicing both meditation and yoga.” This participant went on to study meditation and mindfulness in other settings and ultimately led to her study in a “doctoral program that was grounded in meditative practice.”

This mosaic of training experience was also present in other participants’ responses. Nancy reflected that her training started “pre-the big meditation movement...around self-hypnosis.” She identified that “self-hypnosis was...relaxation training, it was meditative practices... there’s a whole group of mindfulness practitioners now that have their history and certification in self-hypnosis.” She has since been formally trained in Mindfulness-Based Stress Reduction (MBSR), and more recently has gone through a six-month training at Mayo Clinic’s Healthy Living program focused on “resiliency and well-being.” She also had the experience of a “group meditative practice” in the form of a “sweat lodge... that forwarded my learning and understanding.”

Others who reported having some training in meditation and mindfulness shared different experiences. Grant studied formally at a local meditation center for a few years, and has been part of another meditation community where he tries to go weekly. He stated, “I’ve also done the daily retreats, you know I’ve done nine-day silent retreats and I really want to do that yearly for my practice, because it’s quite amazing.” Another participant, Amanda, identified her training as “fairly informal, although I practiced on a

regular basis years ago with a meditation group once a week.” She also identified her training as being “Buddhist-informed.”

Goal-oriented toward more training. Among the four participants indicating little to no formal or informal training in meditation and mindfulness, it is significant to note that they all indicated a desire for more training. The training they expressed an interest in getting was more oriented toward integration of mindfulness practices into clinical practice rather than training for personal development of meditation and mindfulness practices. One participant, Angela, works with clients who are on the Autism spectrum and she identified the lack of research and training focused on using mindfulness with this population. She states: “I’d love to have some more training on how to use [mindfulness] with clients, but I haven’t really had a chance to dive into it that much.” Another participant, Jennifer, stated that she has “not had any formal training... but professionally speaking, I’m looking at becoming a Yoga Calm certified instructor...” She also expressed that her lack of training prevents her from bringing any mindfulness practices into the clinical setting: “I don’t feel competent enough to take that on right now... I don’t like to approach things until... being fully trained.”

Participants in this study shared a wide range of training experiences, from being formally trained in Buddhist-informed meditative practices to having minimal formal training and being primarily self-educated. While some have received more comprehensive training than others, a common thread is seen through the participants’ commitment to obtaining more training or consistently deepening their knowledge of meditation and mindfulness practices on a personal and professional level.

Inspiration to Begin Practicing Meditation and Mindfulness

The next theme that appeared upon analysis of the interviews pertained to how the participants became interested in starting to practice meditation and mindfulness. Many of the participants identified experiential exposure to meditation and mindfulness, either through yoga, religion, or guided imagery or relaxation exercises. One participant, Monica, shared her cross-cultural experience that led her into meditative practices:

I volunteered in Thailand when I was 23, that was kind of my first exposure at a temple with Buddhist monks... that exposure just fascinated me, kind of Eastern practices in general, it was really just kind of a train from there, like once I got exposed to some things it opened up the doors to learning so much more about meditation and mindfulness... but I think what kept me interested in it is seeing the benefits and feeling them for myself too.

Two participants expressed that their inspiration to begin practicing meditation and mindfulness started through experiencing yoga. Kate shared:

I'm a runner, and my personal trainer a hundred years ago said 'you need to start going to yoga, you need to have balance with running and you need to have stretching', and I hated the actual activity part of yoga, but I stuck with it for a year because I really started to enjoy the mindfulness aspect of it. And now I really like both; I just find a lot of peace in both.

Similarly, Jennifer stated that:

...Over the years of practicing yoga and meditation...was a really positive experience for me every time, and I always felt really good about myself and my mind and my soul afterwards. So, I just kept kind of going back to it.

Other participants shared a variety of experiences and relationships that inspired them to begin pursuing a practice of meditation and mindfulness. Amanda shared that her “interest in Buddhism inspired me towards meditation, and a wonderful professor in graduate school was another inspiration.” Angela was “looking for stress relief” when she discovered mindfulness practices, and she also identified that there are some “religious components” that guided her toward practicing meditation. Along similar lines, Grant expressed that it was his personal experience with anxiety and depression that prompted him to give meditation a try: “...in my late twenties I felt lost and depressed and highly anxious... I went to some place that was giving a talk, and they were doing meditation and I just connected to it.”

Frequency and Method of Practice

Another theme that arose from the interview data was how often people practice meditation and mindfulness, and what exactly they do to practice. Nearly all participants identified practicing mindfulness throughout their daily activities, especially during their workday. Out of nine participants, four shared having a formal meditation practice that they engage in anywhere from every day to once per week. The remaining five participants did not identify having a formal meditation practice, but instead practice active meditation (i.e. yoga, walking) and/or mindfulness throughout the day.

Formal meditation practice. While some participants identified having a formal meditation practice, the method in which they practice varied significantly. Nancy distinguished between her mindfulness practice and her formal meditation practice. She shared that her mindfulness practice “changes and evolves quite a bit...I use it very frequently throughout my workday...so it’s kind of integrated into my thinking,

integrated into my emotional regulation, integrated into my relationships...it's something that I live and breathe." On the other hand, she said:

For my formal meditation practice, most often in the last five years I would say it's been more of a sitting practice... I just need some quiet solitude place... my meditation practice right now is probably anywhere from five minutes to on the upper end it's about an hour... I want to evolve next into doing more yoga.

Nancy reflected on the diversity of her meditation and mindfulness practices. She discussed the importance of modifying, changing and growing with her practice as she continues to learn more about herself and adapt to changing circumstances.

Grant shared that he meditates "every morning for at least 15 minutes... I have a formal sitting practice." He also expressed: "Hopefully I'm being mindful all the time...that's the point, to bring it into all aspects of your life." Similarly, Lydia shared how she adapts her practice according to her personal needs:

I do formal sitting probably two to three times per week, and I do movement meditation daily, so more in terms of yoga, sometimes walking... I have some minute meditations throughout the day... a lot of it is more movement-based... it changes with the seasons. I kind of do what my body calls for...

Among participants reporting a formal meditation practice, they also identify integration of mindfulness practices throughout the day.

Daily mindfulness practice. Each of the five participants who did not indicate a formal component to their practice did share how they engage in daily mindfulness practice. There were many similarities among participants in terms of the nature of their mindfulness practice including taking moments during the day to breathe and reflect, and

also the practice of yoga throughout the week by some participants. Kate shared a unique way that she practices mindfulness:

...Throughout the day when I start to get really... overwhelmed or feeling anxious about things, I'll just stop and take pause, and just for a moment, say, listen to a song and try to pick out the different instruments and the different vocalists...or do something that gets me back to being focused on what's going on with me right now.

Likewise, Amanda said: "Mindfulness is part of my daily life and I practice that through breathing and grounding and checking in with myself."

In addition to taking moments to be mindful throughout the day, Angela shared what her mindfulness practice looks like:

...I'll use it kind of as-needed at work if it was a really crazy session or I just need a break—just to be with myself... going for a walk and just kind of focusing... I also practice yoga... twice a week.

Jennifer has a similar routine: "I practice more yoga on a regular basis, I'd say one to two times per week...I like to do just moments when I can to just stop and bring myself back to the present." Regardless of having a formal or informal meditation and mindfulness practice, participants shared in common the daily practice of mindfulness and taking time to be present with themselves and their experience.

Clinical Integration of Meditation and Mindfulness

One of the main themes that emerged from the interviews was the concept of how meditation and mindfulness are integrated into clinical practice. It became clear that there are two main ways that this integration happens. The first is through practitioners

bringing mindfulness-based interventions and skills into the therapy setting, either formally or informally. Six out of nine participants indicated that they use mindfulness-based interventions with their clients in some capacity. The second way this integration happens is through the practitioner's personal meditation and mindfulness practice and the influence that has on the therapeutic relationship. Nearly all participants identified the positive influence their practice has on their therapeutic presence.

Mindfulness-based interventions. Participants highlighted a variety of methods through which they integrate meditation and mindfulness practices into their work with clients. Several participants utilize simple breathing techniques as a skill that they teach clients for emotion regulation or to calm anxiety. One participant, Angela, who is a newer practitioner and has had less training in meditation and mindfulness indicated that, "I've used real basic aspects of [mindfulness], like some breathing techniques with clients, or just some kind of real basic centering approaches with some of my more anxious clients." Another participant, Nancy talked about how she uses the basic skill of breathing to introduce some of her client's to mindfulness-based approaches and the positive results she gets:

...When I'm introducing it I may not have them do it for more than a minute, or just to experience a cleansing breath, or just do a happy place visual imagery that's really safe that they create that's all theirs...sometimes it's unfamiliar and strange, you know it is a different place for a lot of people. But, breathing is really so basic that it works well.

Other participants talk about more intentional ways of practicing with clients in-session, such as guiding clients toward body awareness as they pay attention to their

breath. Lydia talks about the purposeful manner in which she uses mindfulness-based interventions:

I do a lot of focused breath work in session with people. It's a significant piece of it. It's a lot of connecting to the body and doing body awareness. So, when they start sharing a story or an experience I'll often re-direct back to 'what are you noticing right now as you're talking about that?' ... And having them re-connect and see what happens as we sit here and breathe... a lot of practicing bringing them back to their body so they can connect to their own inherent wisdom and dignity."

Kate identifies a similar way that she integrates mindfulness into her work:

I practice with many of my clients throughout the week. So during session we'll do some mindfulness activities... I will stop clients in session and I will say 'okay, what's going on for you right now? What are you noticing now?' ... I teach them how to do body scans and become aware of what's going on physiologically and paying attention to things like heart rate, pulse, body temperature... noticing how that all feels and how that is likely tied to what they were just talking about.

Two participants talked about the challenge of integrating mindfulness-based interventions into their work with clients on the Autism spectrum. Each of these practitioners made the observation that there is little guiding research on how to work with this population using mindfulness, yet they both see the potential benefits and are taking steps toward doing so. Grant stated:

I'm in a unique position because there's no research on Autism and meditation that I've seen, and it's different because they're very concrete thinkers... I teach

them as a practice that we can do it here, and we start off the therapy session with doing like five minutes of meditation... I try to teach mindfulness like DBT does... so I think it's appropriate for some, but not all the clients that I've worked with.

Similarly, Angela says that in order to start integrating mindfulness-based approaches, it "has to be the right client, especially in the population I'm working with. I mean, it's got to be someone who is able to regulate their body, and I don't always have clients who are anywhere near that." It is important to keep in mind that mindfulness-based approaches are not the most effective intervention for all clients, as these practitioners have identified.

On the other hand, Nancy talks about the potential for mindfulness and meditation to benefit almost any client:

When I work with people individually it depends on what they're presenting, but... when in therapy do you not talk about something that's related to relationships, or self-awareness, or trying to calm yourself down...so with a lot of people I do that type of training. If they start to escalate with anxiety we will stop and pause and do a breathing exercise or I'll teach that to them...When I'm working with children who have ADD, to help them focus their mind better I'll give them homework...there's opportunities with almost everybody to introduce it at some kind of level.

With each of these examples relating to how practitioners integrate mindfulness-based interventions into the therapy session, it is evident how they keep in mind what is best for the client and what is going to help them the most.

Influence on the therapeutic relationship. The second way meditation and mindfulness seem to be integrated into the clinical setting is through the practitioner's personal meditation and mindfulness practice and the influence this has on the therapeutic relationship. Most of the participants who were interviewed identified how their mindfulness practice influences their ability to be present with their clients in session. In turn, this increased quality of therapeutic presence has a positive impact on the therapeutic relationship through the clinician's ability to have greater empathy, understanding, and clarity of the client's presenting problem.

Many participants talked about how they take a few minutes in between client sessions to reflect and prepare for the next client. This is helpful in enhancing the quality of attention and focus they give to the client who is in front of them. Angela said:

I think it just helps me to be more grounded and more focused on what's currently going on... taking brief breaks for meditation or breathing helps me to be less stressed and I can just focus on the current situation and the current setting... it's hard to just kind of switch your mind all of the sudden, but I think just... taking a minute, regrouping, is helpful to focus on whatever client I'm working with.

Kate also shared:

I feel like I do a really good job of being able to transition from client to client, because I'm present in the moment with that client only... I'm not thinking about the next client or the paperwork I have to do—I am *present* with the people who are sitting in front of me.

Along the same lines, Lydia says:

I do moments, depending on how much time I have in between each session, to center and sort of do my own grounding so I'm present with the client. And at the close of each session—sort of a book ending like that... I'm very intentional, so... throughout the entire session I am... really aware of where I go, and coming back to the session, attuning to the person...

Some participants discuss the other benefits a personal practice of meditation and mindfulness can have on the therapeutic relationship. Monica identifies: "When I am... starting the day off that way, I just feel more in tune with the clients, more able to use that intuition... hopefully benefit the client in that relationship." Sarah identified that she is a "more centered therapist" due to her meditation and mindfulness practice. Grant observed that his meditation practice increases his self-awareness and ability to be more "mindful of myself, of how I might be feeling that day and how that can affect if I am being present with what's going on." He also said that his ability to tune into himself helps him to "... use myself as an example... as a tool."

Other participants reflected on the opposite end of the spectrum in regards to what happens if they neglect to engage in their personal meditation and mindfulness practice prior to a session. Nancy recalled some of her early work with challenging clients, prior to her commitment to mindfulness practices:

...It had more of an energy drain than I realized because I was not as aware... I'm sure many of those sessions on an energetic level; I was bringing part of one session into another... I was not being very mindful of that.

Lydia recalled a session where she was having discomfort in her own body related to a physical ailment and she "had a very difficult time centering... I was not there. I left the

session going ‘I had no connection at all’ and I felt terribly guilty about it. I wasn’t there in that moment.”

The same two participants also suggested the great benefits that come from a therapeutic relationship where the therapist is grounded and centered. Lydia notices that “the connections between clients... are definitely richer” when meditation and mindfulness are present within the session and outside of the session. Nancy shared:

I don’t feel like I’m serving my clients very well unless I’m holding that mindful, grounded space. To me, what happens in the therapeutic relationship with what energy I offer and bring to my client... so if I’m frenetic and un-grounded I don’t think I can serve them very well, because I can’t listen on that level. And I need to be able to listen and pay attention on all levels. It’s critical to me being present.

Integration of meditation and mindfulness into the clinical setting was identified in two primary ways through the content of these nine interviews: through practitioner use of mindfulness-based interventions with clients in session, and through the practitioner’s personal practice and subsequent influence on the therapeutic relationship. Regardless of how seasoned the practitioner, or the extent to which they personally practice meditation and mindfulness, it is evident through their responses that bringing these practices into the clinical setting is more often than not beneficial to both clients and practitioners.

Importance of Neuroscience

A smaller theme that appeared through participant responses was the important role that neuroscience plays in the effectiveness of meditation and mindfulness. Several participants are knowledgeable about the effects that meditation and mindfulness have on

the brain, and they offered this knowledge as rationale not only for their own practice, but also for presenting it as a viable treatment option. Monica expressed the hope that her meditation and mindfulness can energetically influence her clients by “helping them build new pathways and everything, because I’m a big believer in mindfulness and the neuroplasticity of the brain.”

Nancy referenced neuroscience in many of her responses, and identified the instrumental role it plays in how she engages in her work with clients:

In general I have a theoretical overview focused on shrinking everybody’s over-reactive limbic system and further developing their prefrontal cortex and executive functioning so that they can live by those higher principles of things like forgiveness, awareness, acceptance, compassion, purpose and meaning, so that people can connect, have better connections in relationships, as well as just overall better health. There’s a whole foundation of neuroscience behind it that I love to bring into my therapy.

Nancy also referenced how neuroscience impacts her own understanding of how meditation and mindfulness work in her own life: “I’ll even use [meditation] in the middle of a meeting if something is starting to trigger my own emotions and I need to... manage my frustration or whatever is starting to go off in my own limbic system.”

Finally, she illustrated the benefits of knowing how mindfulness impacts the brain when educating clients: “... the other part that works well is to talk about science; you know, ‘what I want to teach you about is how you can better use your parasympathetic part of your nervous system’.”

Another participant, Lydia, asserted that she would “like to see [meditation and mindfulness] recognized as valuable—because it is, I’ve seen it. There are a growing number of research studies that support it...” From these participants’ responses it can be seen that it is worthwhile for practitioners to learn about the neuroscience behind meditation and mindfulness. Not only will this increased knowledge support their continued practice of meditation and mindfulness, it can help in explaining and promoting to clients the potential value of including these practices in their therapeutic treatment.

Self-Care, Burnout and Compassion Fatigue

Another theme that arose from the interviews is how practicing meditation and mindfulness impacts an individual’s method of self-care, and also has the potential to reduce burnout and compassion fatigue. Many participants identified how meditation and mindfulness aid in stress reduction, increase self-awareness, improve awareness of what the body needs, and help with how they handle work-related anxiety.

Self-care. Several participants identified how their practice of meditation and mindfulness aids in their ability to practice self-care. One of the main ways participants talked about how mindfulness and self-care intersect is in the cultivation of awareness about a variety of personal needs. Lydia observed:

I’m very aware of cycle and patterns for my body... I think I’m aware of when I need more rest, when I need dietary changes, when I need more movement, and when I need to be with more stillness and kind of balance accordingly. When I need to reach out more to others, when I need more time in solitude...

Similarly, Grant talks about how his meditation practice influences his ability to step back and ask: “Am I really taking care of myself? Am I noticing that I’m feeling fatigued and noticing that in my body?”

Several participants noted how awareness of how they are treating their bodies increases with mindfulness practice. Angela recognized how mindfulness is “really helpful with that self-help piece of... making sure you’re eating healthy and focusing on what you’re eating and not eating distractedly.” Relatedly, Kate talks about how mindfulness helps her in moments when she feels the urge to eat due to stress:

Last week I was super agitated, so I went to the cupboard and pulled out a bag of chips... then I said ‘do you really need this right now? Is this going to help you feel better? Is this what you’re craving?’ And I was able to put it away and have celery instead. So, being more thoughtful in the moment about what it is I’m going to put into my body. Because I know that those chips aren’t going to make me feel good after the fact either.

Angela sums up her perception around self-care and mindfulness by stating: “... being less stressed... you’re more likely to take time for yourself, and go to yoga, and it leads to eating better—it just all kind of interconnects.”

Other participants commented that their self-care includes practices such as yoga, or other movement-based mindfulness. Jennifer said that she

...Will typically seek out the extra moments to either practice yoga... or any type of relaxation techniques after I’ve maybe been over-stressed or over-worked... I’ll even come into work a little early and start my day with a little bit of yoga in my office... I think that impacts how I pursue the rest of my day.

Grant talked about his daily ritual of biking to and from work every day, which is pivotal in his self-care routine:

...Taking care of myself at home, meditating and eating right, and biking helps a lot—it's a ritual that I do every day. You know, you kind of have to prepare every day, especially in the winter, and so it's kind of like I'm going on this quest to work back and forth. And then I have time to decompress my brain.

Two participants offered a nice summary of how they feel meditation and mindfulness help with self-care. Monica's statement sums up the essence of what many participants said: "Sometimes just doing mindfulness is enough for self-care in itself, but other times it raises awareness of needing to do more." On a similar note, Amanda says: "My meditation and mindfulness practice allow me to tune into myself and understand what it is I need." Regardless of how participants shared what they do to practice self-care, it was evident throughout their responses that practicing meditation and mindfulness increases awareness of personal needs, which makes self-care more effective.

Burnout and compassion fatigue. The other way participants related meditation and mindfulness to professional self-care is through the impact it has on combatting burnout and compassion fatigue. Many participants talked about how meditation and mindfulness practice increase their ability to compartmentalize clients' stories from their own. Nancy observes:

I'll notice it in my breath or energy or something, and if I start to react to what they're doing, or I'm getting triggered, I'll pay attention to my breath as I'm speaking with them so I can continue to hold that sacred space... so that I can

continue to give them security as they're talking about something that may be distressing to me.

Along the same lines, Amanda says:

Mindfulness has helped me to create containers and boundaries around my work and in doing so I can be more compassionate... I stay within my limits of what I know is good for me, like not seeing too many clients in a day or week.

Monica reflected on a time in her career when she did experience burnout and compassion fatigue:

When I first started off doing outpatient therapy... I was noticing that I was taking on a lot of the clients' stuff, and not really knowing what to do with it... It was an important time as a clinician to kind of figure that out... I was taking too much on of the clients' stuff and I didn't have a way to get rid of it!

Kate shared a similar story about a recent time when she was lacking mindfulness and good boundaries with work:

I was at a point where I was like, 'I don't think I can do this job anymore... So over the weekend I consciously decided I was going to be mindful and present in everything I was doing, and I wasn't going to check my phone, I wasn't going to do email, I wasn't going to do anything related to work... And I got out of bed this morning and I sprung right out of bed, excited to come to work and start my day!

Other participants talked about the demands of the workplace that lead to feelings of burnout. Angela talks about her new job that she enjoys:

They're very big about productivity and managing a big caseload, and I see lots of staff and people I supervise that just seem so stressed and high-strung all the time. So, I think [mindfulness] has helped me keep a better balance than some of the people I work with.

Lydia shared two distinct experiences of what she called “administrative burnout” and compassion fatigue. In terms of administrative burnout, she recalled a job working in the prison system: “administratively it was more difficult just partially the environment and the amount of work that was required documentation-wise and paperwork-wise, just in terms of the amount of clients we were working with...” She identified that “the meditation piece was significant there... in doing compassion meditation, loving-kindness practices, the *metta*—was really helpful for me during that time.”

Lydia also described her experience with compassion fatigue when she was a clinical supervisor having to enforce policies and procedures that she did not believe in:

It was a lot of systemic stuff there—a lot of government contracts and county contracts and extensive paperwork... and this really rigid adherence to a medical model, which is so counter to pretty much everything I believe in terms of healing practice.

She began to notice several physical symptoms that would come up as she got to work: “I knew that I was just having this very physical reaction to this environment and being there... but the minute I turned in the letter of resignation all the physical symptoms dissolved.” She identifies her meditation practice as a key component to being able to identify and resolve this experience:

The meditation practice, the mindfulness, I think that just helped me tune into that this is something that is about my environment and it's not in alignment, not resonating. I can't nurture that. So it helped me make better decisions professionally and take care of myself.

Participants shared a variety of experiences with burnout and compassion fatigue. Overall, they reflected upon the positive role that meditation and mindfulness play in helping maintain work/personal life boundaries, and again increasing awareness of personal needs.

Future Hopes for Meditation and Mindfulness in Mental Health Care

The final theme brought forth from the interview data was the variation of hopes the participants have in regards to the future of meditation and mindfulness in clinical social work practice and/or mental health services. All participants expressed hopes for increased integration into the delivery of mental health services, either on a client level or a practitioner level, or both. There was frequent recognition of the growing acceptance of meditation and mindfulness-based therapies, and the promising amount of research that supports the efficacy of these modalities. Some participants expressed their hopes for integration on a larger scale, including higher education, which was a common theme among participants.

Increased acceptance among professionals. One sub-theme that became apparent regarding future hopes for meditation and mindfulness was that practitioners would like to see their colleagues and agencies begin to—and continue to in some circumstances—acknowledge and accept the value of these practices for mental health. Jennifer simply stated that she “would like to see meditation and mindfulness more

present in mental health.” Grant identified that he would specifically like to see “more mind and body clinics. So, having a clinic that’s not just teaching to the clients, but that everybody that works there has a practice and it’s talked about and normalized.”

Correspondingly, Amanda shared her experience working at a clinic where the main focus is mental health and the mind-body-spirit connection. She stated:

...[I] Would like to see more support for mindfulness or meditation in various mental health clinics or practices. I work in an integrative clinic and it is very much supported and practiced by many of the clinicians. It would be great to see more settings like this as it really does create a healthy environment to work in and believe me—the clients feel that when they walk in the door.

Sarah shared similar hopes:

I would love to see these practices used more widely within the mental health system, especially when it comes to therapy with children. It would also be nice if these practices were recognized by other practitioners in the field, in order to provide more consistent care.

These practitioners voiced their common hopes of widening the influence of meditation and mindfulness through both increased practice and acceptance by clinicians, as well as more intentional focus by agencies and organizations to integrate meditation and mindfulness into their mission.

Greater access to meditation and mindfulness. Another sub-theme was how participants acknowledged that in spite of the growing recognition of meditation and mindfulness as integrative treatment options, access could be limited based largely on socioeconomic factors. Additionally, because medication has come to be known as an

effective treatment option, insurance companies will more easily buy into treating a person through psychopharmacological means first. Angela expressed her thoughts:

My goal would be... that it doesn't have that select group and that connotation of being 'earthy' or 'new age', or 'alternative therapy'... I think right now it kind of is for the 'privileged' because you have to go to someone and pay out of pocket if that's something you're interested in getting...

Lydia talked about her experience as a clinician in private practice: "It really brings a certain, a very specific population that come to me, that really end up doing the work, the ones that don't want medication, who want a very different type of approach than the traditional..." From what these participants can see, meditation and mindfulness as integrative treatment modalities are accessed primarily by people who have the necessary knowledge and the means.

Some participants also expressed their hope that some day medications might not be seen as a primary treatment option for mental illness. Instead, they would like to see mental health providers recommend integrative therapies including meditation and mindfulness. Nancy stated: "Our depression rates and chronic conditions are rising, and I think we need to transform psychiatric care and health care, and I think this is a critical component that is very cost-effective, and it feels good, so why not?" The issues of cost came up with another participant, Lydia, in her discussion of well-known mindfulness-based smoking cessation program: "Over 10 years of study, he's got a 90% abstinence success rate at the close of the program. He cannot get places to buy into it because they have funding from other programs—they've got quit-lines that are cheaper..." It would be beneficial if more insurance companies and medical entities would see the long-term

cost and health savings of mindfulness-based programs and treatments, which would thereby increase access for all people.

Lydia reflected further on the need for meditation and mindfulness to be considered a primary treatment option:

I would like to see it outside of the tagline of a “trend” and just more of... a really valuable resource, and have it be more first-tier treatment rather than last-tier treatment. Let’s try this before we try medication. Let’s take 12 weeks and focus on developing this ability before we even look at meds. And I’m not saying medications don’t have a place, but I think they’re too relied upon... Let’s look at how we can center and attune before we start labeling someone as severely ill when they might be someone who is severely out of balance, which is different.

There are shared hopes among these participants that if clinicians in the mental health and medical fields practice meditation and mindfulness more widely, that more insurance companies and payers of medical services will see these as viable treatment options. If this happens, there is hope that prescribers might also see the benefits of meditation and mindfulness, and consider it as an intervention before or in addition to medication.

The role of higher education. Four out of nine participants acknowledged the benefit that could come from implementing meditation and mindfulness as part of required course work for students studying to be mental health providers. Amanda said that she “would like to see it be an offering or perhaps a required class in the clinical programs. There is no harm that can come from a course in mindfulness.” Lydia echoed this sentiment:

I would love to see it integrated as a core feature that stems through all education and training for all practitioners. And integrated into all course work...I think it's the most valuable thing that anyone in any healing profession can do is to have the ability to be still, to be present, to have self-awareness in order to be present for patients. I would love to see it integrated into all educational learning and training as required.

Nancy also expressed her desire for meditation and mindfulness: "I would love to bring it into the schools, corporations, higher education—definitely make it more common language within mental health practices."

She also shared how she has started to bring meditation and mindfulness into her clinical supervision with new social workers. Nancy identified the importance of meditation to her own clinical practice and wishes that someone would have taught her the importance of self-awareness and self-care: "And that's part of what I teach now in my clinical supervision—I didn't have anybody who taught me about energy, you now?" Implementing meditation and mindfulness education among new clinicians could benefit them in their ability to be present with clients and take better care of themselves. It also has the potential to extend benefits to clients, organizations, and systems.

Conclusion

Nine participants shared their experiences with practicing meditation and mindfulness and how it impacts their skill and ability as clinicians to more effectively care for clients and care for themselves. A total of eight themes were found through interpreting the interview data. These themes portray many of the commonalities that participants shared in response to interview questions, as well as additional items that

emerged. We turn now to a discussion of how these findings answer the research question, and how the themes relate back to the existing literature around meditation and mindfulness in clinical social work practice.

Discussion

This research study sought to explore the question: How do meditation and mindfulness impact clinical social work practice? Nine participants responded to questions that were based upon themes found in the existing literature. Subsequently, several themes that emerged through the interview data relate back to the literature. While many similarities were found, there were also elements of the literature that the participants did not speak to. Additionally, some participants' responses shed light on new areas that deserve to be explored in future studies. The findings of this study offer insight on how meditation and mindfulness might impact the future of clinical social work practice.

Meditation and Mindfulness: Definitions and Practice

One of the primary variations among those who practice meditation and mindfulness is how they define their practice, as well as the manner in which they practice. Great diversity was found both in past research studies as well as the current study in terms of how individuals define meditation and mindfulness and the nature of their practice. Common elements of definitions found in the literature included: enhanced attention and awareness (Brown & Ryan, 2003); clearing the mind of things that are not happening in the present moment (Germer et al., 2013); paying attention with purpose and non-judgment (Kabat-Zinn, 1994); and observation of thoughts, feelings, and reactions (Kornfield, 2008).

In the current study, many similarities can be seen through how participants defined meditation and mindfulness as well as some differences. Participants defined meditation and mindfulness through descriptions such as intentional awareness, being attuned with body and thoughts, pausing to make space for thoughts and feelings, and integration of mind, body, and spirit. One key difference in what the studies in the literature found and the findings of the current study is the element of non-judgment (Gehart & McCollum, 2007; Germer, et al., 2013; Thieleman & Cacciatore, 2014). This is a concept that many studies mentioned particularly as it relates to Buddhist philosophy (Gehart & McCollum, 2007; Kornfield, 2008; Miller, 2014). However, none of the participants mentioned this as part of their definition of meditation and mindfulness.

Another component of defining meditation and mindfulness is the manner in which it is practiced. Past studies have distinguished between transcendental meditation, and *vipassana*, also called mindfulness meditation (Barnett et al., 2014; Kutz et al., 1985; Shapiro et al., 2006). While these share similarities, there are distinct variations depending on a person's level of understanding and/or inclusion of religious or spiritual elements, training, and personal values or customs. Barnett et al. (2014) and Kutz et al. (1985) address the practice of *vipassana*. *Vipassana* includes attention, awareness of distractions, and non-judgment and can be practiced through sitting, walking, or through other activities.

Many participants described the nature of their practice to be a daily moment-by-moment mindfulness rather than formal sitting meditation. None of the participants overtly identified alignment with transcendental meditation or *vipassana*, or any other formal type of meditation practice. However, based on how participants described their

practice there are several similarities to *vipassana*. Some participants identified having a formal sitting practice that also includes mindfulness throughout the day; this is what Shapiro et al. (2006) described as “little m mindfulness”. Others only described mindfulness practice that did not include a formal sitting meditation, what Shapiro et al. called “Big M mindfulness”. *Vipassana* is inclusive of both; the emphasis is on where one’s focus is while practicing (Barnett et al., 2014). While some schools of thought say that mindfulness and meditation are two separate but related practices, the participants in this study identified being practitioners of both. This integration of meditation and mindfulness is consistent both throughout past research studies as well as in the current study.

Integration into Clinical Practice

Meditation and mindfulness practices have been shown to have value in the alleviation of various mental health and stress-related conditions through the effect they have on brain activity and neurological functioning (Barnett et al., 2014; Brown & Ryan, 2003; Chiesa & Malinowski, 2011). Several evidence-based treatment modalities have been developed using meditation and mindfulness as their foundation, including DBT (Linehan, 1993), MBCT (Segal, Williams, & Teasdale, 2002), and MBSR (Kabat-Zinn, 2003). Based on the effectiveness of these interventions, many practitioners—including several of the participants in the current study—have begun implementing components of these treatment approaches as well as others.

The findings of the current study indicate that many practitioners have some training in the aforementioned treatment modalities, namely DBT and MBSR. These treatment protocols were identified by practitioners as practical ways to integrate

meditation and mindfulness into their work with clients. However, most of the findings in this study indicated a less formal integration of meditation and mindfulness into individual work with clients. Many participants identified their own methods of integration into work with clients, including focusing on breathing, awareness of body sensations, attunement to thoughts and feelings, and self-awareness. Therefore, while the implementation of formal treatment protocols such as MBSR, DBT, or MBCT can be effective, application of these skills on a smaller scale can also be helpful for clients.

Another similarity that is evident between past research studies and the findings of the current study pertains to how clinicians personally integrate meditation and mindfulness into their professional role. The findings of this study showed that many practitioners utilize meditation and mindfulness before, during and/or after a client session to center themselves and allow space to be cleared and opened for the next client. Similar concepts are discussed by Dunn et al. (2013), Turner (2009), and Cacciatore and Flint (2012) who talk about the benefits of using centering activities before client sessions to increase therapeutic presence. The consistency of support for this practice shows how clinicians can benefit from the effects of meditation and mindfulness, even if practiced briefly between sessions.

Impact on Clinical Skills

While many benefits of meditation and mindfulness come from direct integration into the clinical setting, as described in the previous section, a myriad of intangible benefits arise from a clinician's personal practice of meditation and mindfulness. The findings of the current study showed how practicing meditation and mindfulness helped participants feel more present, centered and grounded when they are with clients.

Additionally, some reported feeling more attuned with the client and better able to offer empathy. Studies by Turner (2009) and Brenner (2009) similarly found that personal practices of meditation and mindfulness facilitate a deeper capacity for empathy.

Some research has shown how meditation and mindfulness practice by the clinician can effect a client's treatment outcomes. In two different studies by Dunn et al. (2013) and Grepmaier et al. (2007), findings showed that clients of practitioners engaged in a mindfulness meditation activity prior to a session reported better engagement by the practitioner and an increased sense of validation. Additionally, clients of practitioners engaged in meditation rated themselves higher on a scale of ability to cope with life challenges post-therapy. While the findings of the current study do not speak specifically to client outcomes as a result of practitioner engagement in meditation and mindfulness, there are similarities in how practitioners describe their ability to be present with clients and their subsequent increase in ability to be empathetic and attuned to what the client is feeling. Therefore, these findings demonstrated that a clinician's practice of meditation and mindfulness could influence a client's treatment success in small or large ways.

Meditation and mindfulness have been shown to increase an individual's awareness of self including emotions, triggers, and stress-inducing situations (Cacciatore & Flint, 2012; McGarrigle & Walsh, 2011). For practitioners engaged in psychotherapy practice, self-awareness is an invaluable skill as it allows for a more stable therapeutic relationship wherein the practitioner notices any countertransference and does not get caught in it. The findings of Cacciatore and Flint's (2012) study showed how mindfulness practice including paying attention to strong emotions allowed practitioners to be more present in their work with traumatically bereaved clients. Similarly, the findings of the

current study showed that participants who have a mindfulness practice were able to be aware of their own emotions and feelings that come up during a session and set those aside in order to be more present with clients. Clinicians inevitably experience countertransference and can take on the client's emotional experience during sessions. Through implementing a practice of meditation and mindfulness, practitioners could be able to better manage these internal reactions to offer a higher quality of service to clients.

Because of the benefits that meditation and mindfulness have offered to psychotherapy practice for both clients and practitioners, many have begun to identify the value of introducing these practices to students early on in their education. Several studies have explored the impact of training psychotherapy students of various fields in the practice of meditation and mindfulness (Christopher et al., 2006; Gockel et al., 2013; Grepmaier et al., 2007; McGarrigle & Walsh, 2011; Shapiro et al., 2007). Findings from Gockel et al.'s (2013) study showed that students who began practicing meditation and mindfulness had a richer learning experience and also reported increased ability to be present with their clients. These results coincided with the findings of the current study where many participants identified the potential value of integrating meditation and mindfulness training into graduate programs. If these practices and skills are taught to clinicians early in their programs, they could have the opportunity to grow in self-awareness and learn the benefits of being truly present with clients.

Many studies supported the evidence that meditation and mindfulness can be instrumental in the abatement and prevention of stress, burnout, and compassion fatigue, and the enhancement of self-care (Christopher et al., 2006; Cacciatore & Flint, 2012;

Gehart & McCollum, 2007; Germer et al., 2013; McGarrigle & Walsh, 2011; Shapiro et al., 2007). The findings of Gehart and McCollum's (2007) study showed that elements of Buddhist philosophy in meditation and mindfulness allowed clinicians to reduce their stress and burnout through how they perceived the cause and effect of suffering on one's life. Other studies showed how meditation and mindfulness helped clinicians gain perspective and meaning, which subsequently enriched their self-care practices.

The findings of the current study correspond somewhat with these past studies, however there are a few key differences. While past studies cited the role of Buddhist philosophy in reducing burnout and stress, participants in the current study identified that their practice of meditation and mindfulness primarily enhanced their self-awareness. It is through this heightened self-awareness that these clinicians found their ability to be attuned to their personal needs in terms of self-care and curbing burnout and compassion fatigue. None of the findings in the current study cited the integration of Buddhist philosophy in self-care practices. However, respondents in McGarrigle and Walsh's (2011) study similarly noted the interconnection between mindfulness, reflection and self-care, thus, mindful clinicians were better able to implement appropriate coping strategies to deal with stress. While not all of the current study's findings were congruent with past studies, there is consistency in the value of meditation and mindfulness in practitioner self-care related to abating burnout, stress, and compassion fatigue.

The findings of the current study contribute to the existing body of literature surrounding meditation and mindfulness. There are many ways the current study's findings support what past studies have found, including the variations in how people define meditation and mindfulness, the ways it is incorporated into the clinical setting,

and the importance of including meditation and mindfulness as part of clinical education. There are also some differences between past studies and the current study, including discussion around Buddhist philosophy and how practitioners use meditation and mindfulness for self-care. The findings of this study highlight many implications for clinical social work practice as well as considerations for future research.

Strengths and Limitations

This study has various strengths and limitations. One strength of this study is that it contributes to the body of social work knowledge that informs practitioners on valuable practices for both self-care and client care. This study also explores an area of the literature where little is known—the lived experience of clinicians practicing mindfulness and how they perceive the impact on their psychotherapy practice. It also allowed the participating practitioners to feel empowered and encouraged about what they are doing for themselves and their clients to ensure they are practicing with integrity and self-awareness.

In terms of limitations to this study, the researcher acknowledges bias in the research topic and identifies that this may have influenced how the study was carried out, as well as the interpretation of the results. Additionally, the technique of snowball sampling has some inherent limitations such as the recruitment of a limited network of people. The sample was relatively small and homogenous, with only one male participant and eight females, thus limiting the generalizability of the findings. The mixed method of interviewing which led to three different mediums by which data was gathered (i.e. in-person, over the phone, and via email) may have impacted the consistency of the data. More data was gathered during in-person interviews than interviews conducted over the

phone and via email. Additionally, only four out of nine participants were clinical social workers; the remaining five held degrees in fields other than social work. This also limits the generalizability of the findings, particularly to the field of clinical social work.

Implications for Social Work

The findings of this study have far-reaching implications for clinical social work practice and for mental health care on a broader scale. Clinical social workers and other mental health providers are acknowledging many of the benefits of meditation and mindfulness. As more practitioners begin implementing meditation and mindfulness practices into their personal lives and into work with clients, the findings of this study shed light on important considerations for clinical social workers as they embark on integrative practice.

The first consideration gleaned from the findings of this study is the importance of training in meditation and mindfulness, and the concept of the practicing practitioner. Some participants identified their experience with formal and informal training in meditation and mindfulness practice. Those who had some training seemed to also report having a more in-depth meditation practice, and more understanding of the benefits of meditation and mindfulness. Those who did not have training expressed a desire for training, particularly in more formal mindfulness-based treatment approaches. Although meditation and mindfulness seem quite basic in practice, there are ancient philosophies and traditions surrounding them that are worthwhile for practitioners to learn about. With greater understanding of where meditation and mindfulness come from, practitioners can honor the history of these practices while then adapting them to their own needs and beliefs.

Additionally, practitioners who wish to incorporate mindfulness-based interventions into their psychotherapy practice would be remiss not to have a personal meditation and mindfulness practice. The findings of this study did not reveal strong support for this conclusion; however the importance of this can be inferred based on past research studies and the underlying messages of what participants reported. Ethically, practitioners should experience the types of interventions they use with clients to increase understanding, and to increase the quality of the therapeutic relationship. This is especially true for practitioners utilizing mindfulness-based interventions, as meditation and mindfulness are deeply rooted in self-exploration and self-awareness. When practitioners ask clients to engage in such personal practices, it seems particularly important—and ethically necessary—that the practitioner is also engaged in a similar practice. Conversely, merely because a practitioner practices meditation and mindfulness personally does not mean it is appropriate to integrate it into work with all client populations; it may not be the best treatment for some clients and the practitioner should be mindful of this.

Secondly, meditation and mindfulness should be introduced to social work students early in their education as a valuable tool for personal and professional development of self-care strategies, self-awareness, and clinical skills. The findings of the present study as well as past studies strongly support the inclusion of meditation and mindfulness training for individuals studying to provide mental health services. Institutions of higher education should consider the potential benefits to their students by offering them instruction on how to understand themselves better and to live more fully both in their personal and professional lives. When students do their own self-work

before engaging in therapeutic work with clients, they can know their triggers and what issues might come up in terms of countertransference. With greater awareness comes greater ability to address potentially harmful actions or reactions. Moreover, students and future clinicians who have greater self-understanding would be better able to practice effective self-care and will likely experience less burnout due to compassion fatigue and/or secondary trauma. This in turn helps the field of social work by retaining more practitioners.

Lastly, social work practitioners should consider how their practice of meditation and mindfulness could positively impact their clients, whether practiced jointly within the session or individually outside of the session. Social workers have an ethical responsibility to serve clients to the best of their ability. If meditation and mindfulness can increase a practitioner's ability to be more present, attuned, and empathetic toward their clients, it seems there is more to be gained than lost by trying it.

Implications for Policy

In addition to implications for social work practice, the findings of this study also indicate implications for social policy. Given that mindfulness-based interventions have only recently earned acknowledgement by the wider mental health community as effective treatment modalities, there is currently minimal reimbursement by insurance companies for these practices. Because of this, mainly private insurance companies have expanded coverage to include such treatments. Individuals receiving public insurance, often those with lower incomes, have limited access to alternative therapies. Practicing meditation and mindfulness does not cost anything to those who have the opportunity to learn about it; such opportunities should not be limited on the basis of income and

insurance coverage. Social workers should advocate for the expansion of insurance coverage to include mindfulness-based interventions, especially for those on public insurance.

Along similar lines, the medical model has been the dominant mode of treatment for most mental health disorders. This means that most individuals seeking treatment for mental illness will be offered medication as a primary means of treatment. Findings of past studies as well as the current study support the effectiveness of mindfulness-based interventions in treating some mental illnesses (Barnett et al., 2014; Brown & Ryan, 2003; Chiesa & Malinowski, 2011; Christopher et al., 2006; Gockel et al, 2013; McGarrigle & Walsh, 2011). Given the adverse effects of some medications over long-term use, social workers should advocate that alternative interventions, including mindfulness-based interventions, be offered as a primary treatment option before medications are offered. This is important for social policy as it addresses social injustice and could be a long-term cost-saving measure, as meditation and mindfulness do not cost anything to those who practice it.

Implications for Research

Finally, this study's findings lay groundwork for future research studies that would contribute to the ongoing advancement of meditation and mindfulness being integrated into mental health treatment and clinical social work practice. It would be beneficial for future studies to increasingly focus on the neuroscience behind the effect of meditation and mindfulness on the brain. Empirical studies of this nature would be instrumental in making a case for meditation and mindfulness in the medical community, which in turn might help address the aforementioned policy issues. Increased neuro-

scientific evidence would also help promote the benefits of practicing meditation and mindfulness to clinicians and clients.

Future research studies should also focus more intensively on how meditation and mindfulness influence the dynamics of the therapeutic relationship. It would be beneficial to know more specifically how clients perceive their therapists after they have been practicing meditation and mindfulness for variable periods of time. Additionally, it would be valuable for future studies to look more closely at a comparison of mindfulness-based interventions with clients whose practitioners are personally practicing meditation, and also with practitioners who are not personally practicing meditation. This would help further the importance of the practicing practitioner.

Finally, future studies should take a closer look at the influence of spirituality among clinicians who practice meditation and mindfulness. Many participants in the current study alluded to their own spirituality, but there were no explicit interview questions addressing spirituality. It would be valuable to explore how an individual's spirituality and/or religion influences their meditation practice, particularly as it is becoming more of a mainstream practice as opposed to being practiced within the context of Eastern religious traditions. A study such as this might help more skeptical practitioners consider trying meditation, regardless of their spiritual or religious views.

Conclusion

Meditation and mindfulness have been practiced for thousands of years in the context of Eastern spiritual traditions. In the past several years, these practices have become more widely accepted, researched, and applied in various medical and mental health contexts. Along with this growing acceptance, clinical social workers and mental

health practitioners have begun utilizing meditation and mindfulness practices in their personal lives for the purposes of stress reduction, self-care, and enhanced therapeutic attention, among many others. There have also been a number of empirically based treatment modalities that have a foundation of mindfulness. Through the responses of several mental health practitioners who have been practicing meditation and mindfulness in their personal lives, this study sought to understand the reasons people practice meditation, and the influence they perceive it having on their clinical skills, therapeutic presence, and self-care strategies. Meditation and mindfulness will likely continue to grow in recognition and practice in the mental health community, and it is important for clinical social workers to know about the potential benefits for both themselves and their clients.

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Appendix A

Informational Cover Letter

Hello,

My name is Leah Ghali and I am a student seeking my Master's degree in Social Work at St. Catherine University and the University of St. Thomas School of Social Work in St. Paul, MN.

The purpose of this letter is to request your participation in my research. You were selected as a potential participant for this study because you are a practicing psychotherapist who holds licensure of LICSW, LMFT, LP, or LPCC, and you also have a personal practice of meditation and mindfulness.

The purpose of this study is to explore how meditation and mindfulness on the part of the practitioner can have a positive influence on the therapeutic relationship, and how it might influence therapeutic outcomes. This research is important because studies have increasingly shown the neurological and psychological benefits of meditation, and more clinicians have begun to utilize it in both their personal and professional lives. This study aims to investigate the reasons why people practice meditation, and how they feel it impacts their practice of psychotherapy. This research may help to support and inform practitioners who wish to use meditation and mindfulness both personally and professionally.

If you decide to participate in this study, you will first be asked to complete a seven-item demographic questionnaire. Following that, you will be asked to complete an interview with me through one of the following methods: (a) A 45-60 minute audiotaped, face-to-face interview at the location of your choosing; (b) A 45-60 minute recorded phone call; or (c) responding to all interview questions via email. The method depends entirely upon your personal preference and what is most convenient for you. Prior to the interview, you will receive a copy of the interview questions for your reference.

The records of this study will be kept confidential. No identifying information will be available to the public at any point in the research process. Participation in this study is completely voluntary. If you decide to participate in this study, you may choose to withdraw from participation at any time.

Questions about this study can be directed to me any time at XXX. You may also contact Dr. Catherine Marrs Fuchsel, Clinical Research Chair, at XXX or Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (XXX).

I will contact you by telephone in the next two days to inquire about your interest in participating in this study and to answer any further questions you may have.

Sincerely, Leah B. Ghali

Appendix B

Consent Form

INFORMATION AND CONSENT FORM**Introduction:**

You are invited to participate in a research study investigating how practicing meditation and mindfulness can impact clinical social workers' ability to engage with and effectively treat clients in the therapeutic setting. Please read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Leah Ghali, a graduate student at St. Catherine University and the University of St. Thomas under the supervision of Dr. Catherine Marrs Fuchsel, a faculty member in the School of Social Work. You were selected as a possible participant in this research because you are a practicing psychotherapist who holds licensure of LICSW, LMFT, LP, or LPCC, and you also have a personal practice of meditation and mindfulness. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to explore how meditation and mindfulness on the part of the practitioner can have a positive influence on the therapeutic relationship, and how it might influence therapeutic outcomes. Research has increasingly shown the neurological and psychological benefits of meditation, and more clinicians have begun to utilize it in both their personal and professional lives. This study aims to investigate the reasons why people practice meditation, and how they feel it impacts their practice of psychotherapy. Approximately 8-10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to engage in an interview with the researcher through one of the following methods, depending on your preference: in-person, over the phone, or via email. You are being provided this consent form to review prior to the interview, and upon your consent, the interview will be scheduled. Also upon your consent, you will be given a brief seven-item demographic questionnaire that is to be completed prior to the scheduled interview. The interview will consist of nine questions that will be presented in one session. If the interview is conducted verbally (i.e. phone, or in-person), it is expected to take approximately 45-60 minutes. If you choose to respond via email, you can expect to be occupied for approximately 30-45 minutes. Each verbal interview will be recorded via an audio-recording device; phone interviews will be recorded using Google Voice software that informs both parties the call is being recorded; email responses will, by their nature, be recorded on the researcher's computer. There are no expected time commitments following the completion of the interview. Applicable quotations from the interview will be used without any identifying information in the researcher's final paper and presentation.

Risks and Benefits of being in the study:

The study has minimal risks. The content of this research encompasses a component of personal spirituality that can be uncomfortable for some people to discuss. There is a chance that you could experience discomfort in discussing or addressing some of the

questions asked during the interview. You are encouraged to inform the researcher if this is the case, and it is within your rights to terminate the interview at any time.

There are no direct benefits to you for participating in this research. However, your participation in this research will further the knowledge base in clinical social work practice, and allow for the expansion of research on meditation and mindfulness practices.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. The results of this study will be reported in a public presentation on May 18, 2015.

I will keep the research results on a password-protected computer, accessible only to the researcher for the duration of time working on this project. I will finish analyzing the data by May 15, 2014, after which all original reports and identifying information that can be linked back to you will be destroyed.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Leah Ghali at XXX . You may ask questions now, or if you have any additional questions later, the faculty advisor, (Dr. Catherine Marrs Fuchsel at XXX), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at XXX.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study, and for the researcher to audiotape the interview.

Signature of Participant	Date
Signature of Researcher	Date

Appendix C

Phone Script

*This script will be used as a general guide when placing outgoing or taking incoming calls from prospective participants:

Hello! Thank you for taking the time to talk to me about my research. I look forward to answering any questions you might have, but first let me tell you briefly about my research and myself. I am in my final year at St. Thomas/St. Kates' MSW program, and this is my final clinical research project. Throughout my research process and my own personal experiences, it has become increasingly clear the value of practicing mindfulness and meditation, especially when providing psychotherapy. My hope through this research is to learn from practitioners like you and to contribute to the body of knowledge regarding the integration of meditation and mindfulness into clinical practice.

If you decide you would like to participate in my research, what will be asked of you is to schedule a convenient time for an interview where I will ask you questions relating to your personal practice(s) of mindfulness/meditation and psychotherapy. This interview can be in-person, over the phone, or via email according to your preference. It will take about one hour depending upon which method you choose. Your responses will be audio-recorded but kept confidential for the duration of my data analysis.

Appendix D

Interview Questions

1. What are your theoretical approaches?
2. How do you define meditation and/or mindfulness?
3. What inspired you to begin practicing meditation or mindfulness? How frequently do you practice?
4. What has been your training in meditation and/or mindfulness practice? (Formal, informal, Buddhist-informed, secular, etc?)
5. Do you integrate meditation/mindfulness practice into the clinical setting? If yes, in what capacity, how? If no, have you thought about doing so?
6. How do you perceive the influence of your meditation practice on your interactions with clients? Can you provide an example of how your personal practice of meditation/mindfulness has impacted your work with clients? (before/during a session, after?)
7. Does your meditation practice influence your method(s) of professional self-care? If yes, can you provide an example? If not, what are your ways to promote professional self-care?
8. What has been your experience with burnout and/or compassion fatigue? What role, if any, do you feel meditation/mindfulness might play in combatting burnout and/or compassion fatigue?
9. What would you like to see happen in the future related to the role of meditation and mindfulness in clinical social work practice (or mental health service delivery)?

Appendix E

Demographic Questions:

Please take a few minutes to briefly answer the following questions:

1. Name:

2. Age:

3. Sex:

4. What is your professional degree and licensure:

5. How long have you been practicing psychotherapy?

6. How long have you been practicing meditation?

7. In what type of setting do you currently work: (e.g. private/public, non-profit/for-profit, etc.)

8. What population do you most commonly work with: (e.g., diagnosis, age, individual, family, group, children, adolescents, adults, elderly, etc.)

Thank you for your participation.