Mindful Grounding and Trauma

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by

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Mindful Grounding and Trauma

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I hereby declare that this dissertation has not been submitted as an exercise for a degree at any other institution, and that it is entirely my own work.

Signed:

Acknowledgments

I pay homage to the Triple Gem: the Buddha, the Dhamma, and the Sangha.

This research project could not have been possible without the loving and caring presence of my parents Haroutioun and Hripssimé Bartanian, who have spent sleepless nights as I struggled with asthma attacks and midnight fevers for many a night. These struggles reached their highest pitch when in August of 1978 our home was barraged with the red-hot shards of shrapnel pieces, the result of a mortar attack the explosion of which injured both my parents and me. This life-altering experience that had shaken up our family down to its roots, became an instigator for me to see the frailty and unreliability of placing my faith in what was familiar to me, at the tender age of eight. I had lost the ability to walk, having lost a portion of my foot, along with a traumatic head injury that left shrapnel behind arteries that no surgeon took the risk of extracting.

Thus, after having spent nearly a month in the ICU, I was given back to the care of my parents, who for years were my support, my feet, my hands and my eyes to the world. It was here, embodied in the characters of my parents that I saw the meaning of dedication, generosity, loving kindness, and selflessness that set the standard for me, as I emulated them throughout my life ever since. Here, I remember the rebellious yet generous nature of my father, who always instilled in me the spirit of questioning and not handing over myself to blind belief in all its forms. The inquisitive and investigative mind that was instilled in me by my father, whose rationality, dedication, generosity to others, and especially the elderly, make him a bona fide Buddhist, in my book. Here was a man who had lost his father at the age of twelve and who would see his Genocide-surviving widowed mother sweep floors to make a few pennies a day, so that she could put food on the table. Turning to her, this twelve-year old young boy had told his

mother that she no longer had to work at rich people's homes, and that now he was to take care of her. This, he did as he went to work as a barber's apprentice, at the age of twelve, and his mother (my grandmother) never had to work for anyone again to support her family. This quality and many other characteristics became embedded in me; they sustained me when I would face much difficulty and hardship over the years. Similarly, the resilience of my mother through hard times of war as she cared for me and my three siblings, her dedication and love towards her family, are what course freely through my veins, while the forgiving heart of my older brother, Hagop, is an everyday inspiration teaching me much about life and the work I do.

This research project has in it all the markings and kindly fingerprints of these and many other individuals, some of whom I will attempt to express my appreciation for. In a sense, this work has taken me over a decade to complete, perhaps being even a lifetime in the making, with many challenges and obstacles. Aside from being beneficial to my field of knowledge about the mechanism of trauma in those who survived it, it is the culmination of my personal journey throughout.

Being the grandson of the Armenian Genocide survivors who had lost everything and were barely able to make it out of Turkey at the turn of the twentieth century, I knew very well what it meant to be a minority struggling to survive in a foreign country. I saw and lived it every day, especially after my own injuries. Here, I understood that when trauma is not transformed by being processed and induced into self-growth it passes on to the next generation, for as the oppression from the outside (or the one expressed against oneself) builds up vertically, it manifests in the form of horizontal anger and violence, either expressed outward to the world, or imploded within the individual. But I knew that there could be healing if trauma were to be put in a context by noting the many factors of self-transformation it promotes and the resiliency it

can help bring about, through the application of truth: truth of intention, truth of action, i.e. the truth of behavior.

Now, living a life of a PTSD survivor, I know how the past can eat away at the roots of what many consider security or a genuine sense of safety; but, as the anticipation of future victimization was always ready to pounce, I saw myself constantly looking back through the help of childhood fantasy (trailed by a few more decades) asking myself an infinity of "what if's," or "why me's?" However, the sense of uncertainty was able to bring about in me the urgency that I could not live in a fantasy of Disneyesque life, while ignoring the very certainty of death. This, I was able to come back to again and again, and which eventually brought me to the Dhamma.

Over the years, I was able to find myself at the feet of many a teacher, including my very first guide towards pursuing proper learning in the Dhamma, Ven. Dr. Havanpola Ratanasara, Ph.D., who took me in into the College of Buddhist Studies like a father, to start my journey into the academic learning in Buddhist Studies. Soon, I was given my Buddhist name of *Candana* (pronounced "Chandana"), and then a few years later, Bhante Ratanasara, at the auspices of the Sangha Council of Southern California, ordained me as a lay Buddhist Minister.

From my earliest days at what used to be Hsi Lai University back in 2002, I remember how the campus had only a few classrooms lit up, and I was in attendance in nearly every one of the courses that were offered throughout each semester with Drs. Warnasurya, Ph.D., Guruge, Ph.D., Thich Ahn-Hue, Ph.D., LMFT, Kenneth Locke, Ph.D, Lewis Lancaster, Ph.D., Bruce Long, Ph.D., Santucchi, Ph.D., all of whom I was thankful for their support and kindly guidance, as well as for tolerating my incessantly raised hand asking questions in order to encourage the ever-curious mind that has been with me from as far back as I could remember. I recall at this time, how I was part of a handful of students working on the WASC accreditation committee

when we did not have it yet, and later in the design of the then newly confirmed, “University of the West.”

Over the years, I have seen many professors come and help this university become greater than before, among whom I have had the pleasure of knowing and working with Vanessa Karam and Jane Iwamura, Ph.D., not to mention Dr. Hiro Sasaki, Ph.D., as well as Victor Gabriel, Ph.D., Jitsujo Gauthier, Ph.D., and Miroj Shakya, Ph.D. I recall the many hours I sat in Jane’s office, sharing with her the tumultuous journey of mine wanting to complete the Ph.D. courses and move on to A.B.D. status, reaching it and then having to do it again, given the many variables that would unexpectedly present themselves. Here, I recall Dr. Sasaki, whom I had found online when I saw that my Alma Mater (UWest) now had an MFT program, as I was researching where to attend for my graduate studies in order to get my degree as a Marriage and Family Therapist. Dr. Sasaki, in hearing about my already completed coursework, minus the dissertation in obtaining a Ph.D. in Buddhist Studies, urged me to return back to UWest and finish my doctoral studies, and to also pursue my MFT studies at my Alma Mater. It is to him that I owe a great deal, for I had completely given up on resuming my doctoral work.

Thus, I was soon to find myself sitting at the office of Dr. Iwamura, discussing the several years of work ahead of my journey back into the academic arena in pursuing a Ph.D. in Buddhist Studies. Many were the hours where Jane sat with me, listening to my frustrations, even at times sharing in my tears during those hard times, as she comforted me with her warm words, guiding me through the dark alleyways of academic red-tape and the frustration of having to return back to the Doctoral program, which also entailed taking newly required core courses, as new catalogues kept coming out. Similarly, given the compassionate and loving presence of Vanessa Karam on the UWest campus through the years, I cannot adequately express my

appreciation of her kindness, as she listened to my concerns, while extending her support both morally, academically, and professionally. I must again mention here the humanity and conscientious demeanor of Drs. Victor Gabriel, Ph.D. and Jitsujo Gauthier, PhD., as both continuously reached out with understanding of my situation, as well as the history of difficulties I encountered in my past doctoral work. I appreciate and thank you for your continued support.

I am especially grateful to all the students I have been privileged to teach, whether in the capacity of a K-12 teacher, or in college and university, as I saw myself in a roomful of fellow human beings, who allowed me to share what life had shown and taught me, along with the guidance and blessings that had been generously showered upon me by my teachers. Teaching allowed me not only the opportunity to be a direct witness to the wondrous workings of an individual's growth, but it has also given me a rare glimpse at how one may be able to traverse time and space and bring about changes in the future while having one's feet firmly rooted in the present.

Seeing my patients in pain and suffering, it was not difficult to see how I could perhaps apply the lessons I had learned over the years and offer them some respite. It was at such a time that I approached my supervisor, Nicole Nardon, LMFT, and asked if it would be possible to administer an intervention that I had been working on and developing for some time. This was in response to the frustrations experienced with some of my patients who were struggling with anger outbursts, lack of attention in class and were now getting in trouble for it, as well as a few others who were experiencing ongoing psychological pain due to past trauma and were even engaged in self-harm. Therefore, given the approval to address these symptoms that had for months proven to be unaffected with other forms of interventions, such as guided imagery, challenging old beliefs, motivational interviewing, breathing and other mindfulness techniques I

was taught in my MFT graduate program, I was now to see for myself if the Dhamma could work to alleviate pain in these patients when presented in a simple and practical manner. Here, the encouragement I received from my clinical supervisor at PUC, Nicole Nardon, LMFT, was indispensable as in seeing the results and positive outcomes whereby patients were responding remarkably to the Mindful Grounding (MG) intervention, she recommended that I present it to other clinicians at the agency's headquarters. Furthermore, the director of the clinical program at PUC, Christine Sartiaguda, LMFT, in view of the evidence of MG's symptom reduction with patients, supported the clinicians' work by adding the instructional guide of the MG onto PUC's inventory of interventions as she included it in the online resources. This was a great honor and show of support, for which I am again grateful.

The work I have done within the session room that eventually led me to develop an intervention addressing the trauma of my patients, could not have been possible without the trust, fortitude, and willingness of these fellow human beings who would come in every week, entrusting me with their authenticity of being. The genuineness of the emotional and psychological scars and open wounds these patients had carried, along with their narratives, were now being asked to be discussed, opened up and revealed, sometimes for the very first time, as they presented to their individual psychotherapeutic sessions. This was a humbling experience for me, every single time it occurred. For this I am grateful to them. The consequent rapport and bridge building would have been an impossible task without their willingness to trustingly allow me, this stranger, into their world. For this I am truly grateful, as I continue to do my work as a clinician, as well as a Dhamma teacher, guiding my students on their journey in the Buddhist Path.

The entirety of this project, and my life of the past decade or so, however, could have been unfolded quite differently had it not been so greatly impacted by my re-introduction to the Buddha's Dhamma through the teachings of my teacher, Ven. Vimalaramsi Mahathero, of the Dhamma Sukha Meditation Center. His book on the *Ānāpānasati sutta* was so poignantly necessary for me, especially after roaming from one teaching to another, as I tried to decipher and practice what was being offered as the "genuine" teachings, as intended by the Buddha, while having already dedicated over twenty years of my life to the practice. Hearing Bhante V. (the way most of his students refer to him) for the first time as he read from the early *suttas,* and especially the way he explained the technique of meditation without reliance on the commentaries, was a breath of fresh air, as I suddenly saw the confluence of both *jhāna* and *vipassanā* practices; no longer was I required to perpetuate the inner schism I had been made to believe to be a representation of "never the twain shall meet," as I began to taste the fruits of the Path, in this body. In Buddhism, we are discouraged to use terms such as "eternal" or "eternity," but if I were to use either of these terms, I would comfortably refer to them while describing my gratitude to my teacher, Bhante V, as do my own students over the years. One such student in particular has been Narine Jallatyan, a noble disciple indeed.

This research project could not have come together into the shape that it currently is without Narine's ever diligent drive to help me in this project with her willingness to edit, proofread, re-edit, re-proofread, etc. as she spent countless hours working closely with me to bring everything together, while offering me her suggestions, critiques, and recommendations. Calling myself a proud teacher given your speedy progress on the Path, fills me with utter gladness, as well as appreciation for your kind and persistent patience in putting into a coherent

state what often seemed no more than a digital plethora of a giant yet scattered mass of writings, not to mention transcribing and dictating hours upon hours of Dhamma and impromptu talks.

I am also deeply grateful to two more teachers on the Path, whom I have been privileged to study with. Firstly, Ven. Dr. Punnaji, Ph.D. of the Buddhist Mahāvihāra at Brickfields in Malaysia, who allowed me to go deeper into my practice given his explanations in studying the *suttas* beyond the commentaries and going back to the source of Lord Buddha's Teachings, as preserved in the Pāli *Nikāyas*. His willingness to work with me on my earlier effort in completing my PhD dissertation proposal was a great honor, as he agreed to function in the capacity of one of my key advisors on the committee, prior to him passing away. Bhante Punnaji's introduction of the term "harmonious" rather than "right," adjusted the significance and relevancy of each of the steps of the Eightfold Path for me, as it expanded my understanding of the Dhamma *vis à vis* its application into my daily practice and those of my students, as well as patients within my therapeutic work.

Also, I am indebted to my other teacher, Sayadaw U Tejaniya of the Shwe Oo Min Dhamma Sukha Monastery in Myanmar, for his unique way of guiding and helping me bring the intricate functionality of *vipassanā* practice into a language of ease and relaxed attitude, while keeping true to the value of having, developing, and maintaining a practice founded upon having Right View ("*Harmonious Understanding"*). This has been crucial for both deepening my understanding of the Dhamma, and that of the people I have been sharing my understanding of the Four Noble Truths with, in the capacity of both a teacher and a clinician.

Dedication

Oh Dhamma

True Refuge beyond all that is passing

Comfort in the windy world that knows not stability

Kindness embodied in the words of the Sage,

Hero beyond comprehension

Teacher of Gods and Men.

How lovely is that my eyes filled with gratitude

Never cease to express their joy as the heart restfully flutters in your lap

Dhamma, sweeter than my Mother's milk

You truly became my mother…you are my Mother

May the heart learn and develop to understand

The arising and passing of greed, anger, and delusion.

Abstract

MINDFUL GROUNDING AND TRAUMA

By

Garbis J. Bartanian

The qualitative research on this intervention involves therapists and their work with patients within the field of mental health, working with inner city and under-served teens from 12 to 18 years' old in Middle and High School settings. While providing care to patients, one of the key elements used in therapeutic interventions is that of mindfulness. Thus, while using mindfulness-based techniques, such as Mindfulness-based Stress Reduction (MBSR) or Dialectical Behavioral Therapy (DBT) or Cognitive Behavior Therapy (CBT), therapists worked to treat patients' symptoms. Often however, many of the therapists using these interventions faced situations where patients began exhibiting maladaptive behaviors with their original symptoms being left intact or severely intensified. Furthermore, in using mindfulness techniques many of the patients working through severe anxiety found themselves dissociating from their bodies in an attempt to avoid re-experiencing powerful traumatic emotions. Thus, two main issues resulted, a) symptoms got worse, and b) dissociation from the body took place.

As a response, I devised an intervention that incorporated principles of Buddhist meditative practice such as virtue, mental cultivation through awareness, and subsequently wisdom, i.e. the three trainings (*sīla*, *samādhi*, *paññā*). The goal of this intervention is to alter patients' automatic reactions of being drawn into overwhelming feelings and the dysregulation of bodily sensations, and instead to simply ground the patient by intentionally directing their

thoughts and attention to the here and now, while using the body and its parts as anchors of awareness. Thus, the intervention was coined the “Mindful Grounding” (MG).

In using the MG, patients were able to meet their treatment goals much sooner than originally anticipated in their initial assessment during intake. In some cases, therapists observed reduction of anxiety, depression, anger, and post-traumatic stress disorder (PTSD) symptoms within one or two sessions from first introducing patients to the MG intervention.

The process of experiencing the body thus in a new way as prescribed by the MG, involves helping patients become calmly reacquainted with their own bodies. It is through this connection of body and mind that they develop a deeper and more existential connection with their world, as they heal with the insight gained through acceptance and understanding of their trauma and thereby rebuild their lives.

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Chapter 1: Introduction

Introduction

The goal of Buddhism, at least as far as Theravāda is concerned, is to understand and transcend suffering while using the tools given by the Buddha, namely the Four Noble Truths, and through them, the Eightfold Path, in whose eight limbs we find Right Mindfulness (Bodhi, 2000). Thus, the Buddha did not just teach mindfulness, be it in his formulation of the Eightfold Path, the Five Faculties, Five Powers, or the Seven Factors of Awakening. Mindfulness is a tool, one ingredient among many other ingredients, especially that of wisdom which (mindfulness and wisdom), when joined together allow the practitioner to use the six-sense bases as they make contact with the body to liberate the mind through knowing, i.e. seeing beyond delusion (*yathābhūtaṁ pajānāti*), (Bodhi, 2012). It follows that by not seeing, i.e. not understanding the conditional nature of the way one thinks, processes, and holds on to things and experiences erroneously, suffering persists. Therefore, wisdom born of understanding is the key, something that mindfulness alone cannot provide and something that is reflected in the way mindfulness has been promulgated within secular circles, especially in the world of therapy (Kabat-Zinn, 2013; Marich & Dansiger, 2017). When mindfulness is practiced appropriately, however, as Luang Por Chah describes, it does bring forth wisdom, which depends on witnessing whatever passes through the mind with right view. If we practice right mindfulness, therefore, it will give birth to wisdom (Chah, 2001).

Given the nature of the prevalent interest in the field of mindfulness in the last decade or so, where the qualities of right mindfulness are lacking, this research study aims to demonstrate the value of the religious texture and flavor of mindfulness practice, indicating its effectiveness in therapy without the need to resort to purely secularizing the practice. Having been trained in a

variety of Buddhist meditative practices within the last twenty-five years, and specifically in *Mettā* and *Vipassanā* as found within the Theravāda tradition, I have witnessed the life-changing benefits of mindfulness both in my life, as well as in those whom I have taught in the capacity of a Dhamma and meditation teacher. This practice and my trust in its effectiveness were the compelling agents for me to want to reintroduce mindfulness in therapy sessions.

During my one-year employment as a mental health provider at an agency called Partnership to Uplift Communities' (PUC), I was given the opportunity, along with other therapists, to work with patients who presented with a variety of emotional, psychological, and behavioral problems. As trained Marriage and Family Therapy (MFT) clinicians under supervision, we served both Middle and High School students while using different interventions stemming from our individual therapeutic modalities. It was here, in our work with individual patients and their families, that our respective trainings were put to the test in the course of their treatment periods.

The fact that mindfulness has become a ubiquitous term found in all arenas of contemporary life, but more so (it seems) in therapy than perhaps any other area of human endeavor, means that scientific scrutiny was soon to closely accompany its proliferation. Not surprisingly, compared to a mere handful articles in the 1970's, today there are nearly 18,753 citations of articles discussing mindfulness and meditation, of which 47 have come to sufficiently prove the value of mindfulness practice. In addition to critically separating the scientifically verifiable fact from those that lack it, such efforts often present us with beneficial data, as has been the case with the recent 2016 meta-analysis of how childhood trauma can be treated while using Mindfulness-based Cognitive Therapy (MBCT), according to Daniel Goleman and his colleague, Richard Davidson, in their recently published book *Altered States*.

Additionally, it was demonstrated how there was a reduction in relapse of severe depression, exceeding 50 percent, far surpassing thus the prognosis of medication use as the sole means of treatment (Goleman & Davidson, 2017).

The benefits of mindfulness have long been acknowledged in Asia, and specifically within the early Theravāda tradition, in its contemporary usage within the helping professions, as well as in chaplaincy. An example of this may be provided through the work of Pamela Ayo Yetunde, who as a Buddhist Chaplain has been helping patients while using Buddhist principles of working with trauma and pain and emphasizing the role of intention in the communication of care, a crucial element in bringing about healing within patients (Yetunde, 2011). I myself was compelled to find ways to help my patients, instead of passing them on to other therapists, when I noticed the poor rate of success in using mindfulness interventions the way they are taught and practiced within the therapeutic profession. Here, looking back at my own life as a survivor of trauma, and considering the benefits of practicing the Dhamma through the years, it became encouragingly clear to me as to where the solution lay.

Here, as we discuss the use and potential usefulness of mindfulness in therapy, it is worth adding that therapists are not necessarily guaranteed a high success rate while applying mindfulness as an intervention without first building an essentially strong therapeutic alliance with the patient. Furthermore, the quality of the very intention of helping in the process of treating another being, through the experience of loving kindness and compassion, demands a special emphasis (Yetunde, 2011). In other words, the clinician's own experience of the benefits of the intervention and thereby their trust in it as key requisites for therapeutic success cannot be overemphasized. The success of MG, then, presupposes the capacity of a clinician to model

authentically a sense of ease or grounded-ness within their own body, given that the clinician has tasted empirically what he or she is attempting to guide the patient toward by the MG.

The intention behind developing an intervention such as the MG was to make this practice, which would allow a taste of liberation from suffering, available to patients, while sharing with them a technique that could be applied using easy-to-follow steps that would not necessarily require any experience in meditation, nor an in-depth understanding of the Dhamma. My goal in devising the MG was to help patients grasp the principles of the Four Noble Truths of (1) seeing the nature of suffering, (2) the origin or cause of suffering, (3) the cessation of suffering, and (4) the way leading to the cessation of suffering, *while* using the medium of the physical body (while being the closest thing to patients, unfortunately, for many the body was also the one thing they despised the most). The MG was offered to help patients live an engaged life through body, speech, and mind, while experiencing the fullness of life via the six sense doors as they learned to choose thoughts and actions instead of following patterned lifestyles.

To see the value and use of an intervention like the MG, where right mindfulness has a central role, we need to first understand the way trauma affects the human brain and the lasting impact it has on the quality of one's psychological, physiological, and social functioning. Here, the decades-long research done by psychiatrists Dr. Bessel Van der Kolk and Peter Levine, while working closely with combat veterans struggling with PTSD, provide us with many clues as a result of discoveries made in the field of trauma. Similarly, the connections drawn by Dr. Steven Porges that helped us understand the impact of trauma on the central nervous system as a result of his Polyvagal theory, which paved the way for many trauma researchers to follow. Today, the work of such pioneering researchers allows us to uncover the many layers of what takes place in the human brain, body, emotions, relationships, and central nervous system (CNS) as a result of

having experienced traumatic events. The experts have often concluded that symptoms of PTSD or trauma, which frequently include those of anxiety and depression, are not bound by time (Levine, 2010); in other words, they have the power to make those who suffered them into lifelong victims, which often takes place through a significant disruption of the person's basic physiological, psychological, social, emotional, behavioral processes (Porges, 2017; Van der Kolk, 2015).

When trauma takes place, whether in the form of a once-occurring event or chronically built over time, layer by layer, the person experiencing PTSD will lose the sense of safety as insecurity and hyper-vigilance become part of the norm. Herein the journey begins, where the kind and comforting hands of loved ones are sought constantly (Frederickson, 2013). Honesty, truthfulness, and warmth experienced within the relationships these patients engage in, along with the search for a sense of security to somehow rebuild what has been taken away and torn apart, becomes a lifelong work. In order to accomplish this, some will seek out the sense of comfort outside of themselves while others will first try to look for it within, realizing that ultimately each of these qualities mentioned above are impermanent and thus will be taken away.

This constant struggle, once trauma occurs, to find a sense of safety amidst uncontrollable factors that is the world outside of us, is what Fritz Perls calls humanity's suspension between impatience and dread, each one requiring the gratification of a need that the person reaches outside of oneself to appease. Being geared towards self-preservation, fear and anxiety are experienced by all organisms, big and small, as a natural reaction/response to stimuli received from the environment. Fear arises as a direct response to the presence of a definite threat (that is to unfold), where the fearful person lacking much control to tackle or face the danger adequately, undergoes emotional, psychological, and physiological upheavals in

anticipation of the horrors that are to unfold (Van der Kolk, 2015). When confronted with danger, unwanted emotions are experienced, which bring about "bad thoughts" that one spends most of one's life battling against to try and remove (Perls, 1973). Anxiety, on the other hand, has to do with the anticipation of future danger as one ruminates over possibilities but without necessarily in the presence of a clear danger or threat; hence the organism undergoes a series of negative mental interpretations or concepts of "what if's" that at times may even become as debilitating as the experience of fear itself (Hanson & Mendius, 2019). These in turn become the ever-playing tapes or narratives looping in the mind of our patients, i.e. favorite stories they like to tell others (Vimalaramsi, 2012).

In their significant joint work titled *Buddha's Brain,* neurophysiologists Hanson and Mendius, both of whom are meditators as well, have made it accessible to both the expert and the novice reader alike principles that the fields of evolutionary biology, neuroscience, neurophysiology, neurobiology, psycho-immunology (to name a few) are demonstrating today as it relates to the ways in which the brain is influenced and sculpted. In their work, they clearly indicate how these same principles, now being established by science, were echoed and defined in the Buddha's elaborations on the workings of the mind and ways to strengthen it, as these two researchers attempt to augment the teachings by providing the scientific backing of what takes place within the psycho-emotional-physical body and its behaviors, given the environmental factors involved (Hanson & Mendius, 2011). Much like the other emotions that humans experience, they explain, both fear and anxiety do have their positive functional aspects, especially in relation to the evolutionary and developmental advantages they have each provided us and our ancestors throughout history. After all, those early humans who were cautiously walking into the tall grass with some level of fear of a possible saber-tooth lurking about hiding,

waiting to pounce on them, were better able to pass on their genes than those who never even considered the possibility of such natural threats, thus never propagated their DNA (Hanson, 2013). Similarly, with a healthy amount of anxiety, we find ourselves completing tasks, making resources available or bringing about discoveries as we stand facing challenging or dire circumstances in the world around us, whereby we become proactive in our decisions, which we follow up with definitive actions (Lewis, & Haviland-Jones, 2008).

Thus, realizing the validity of what trauma research tells us, and given the responsiveness witnessed within my own body while practicing mindfulness the way it is taught within the Pāli *suttas* as I addressed my own trauma symptoms for years up to point of working at PUC, I knew there was a connection there that needed further exploration which would be helpful perhaps to others as well. This was the impetus in wanting to provide an intervention that brought about both mindfulness, in a capacity that went beyond what was offered within the field of therapy, and a sense of physically grounding the patient's awareness within the living experience. My goal was to help the trauma patient reconnect with their body but without being overtaken by negative memories, which were often locked inside their bodies (Van der Kolk, 2015).

1.1 Why the Mindful Grounding intervention? Before discussing this grounding intervention, the question of what it means to be "grounded" may require some elaboration. Grounding, as it relates to the purposes of this therapeutic research involves the sense of committing oneself to living in the confines of the present moment, without seeking a form of escape from it. Some patients have often been witnessed to become "disconnected" from experiencing the world around them, while being faced with the recall of certain details about their traumas. Some resort to escaping the present either through mentally traveling to another domain of experience by visualizing other (usually opposite) possibilities rather than the one

occurring at the moment or trying to push themselves out of the body by “cutting oneself off” from it. MG, as a way of safety mapping, tried to address this serious issue, as it worked to use the body reflectively in the present moment by helping the patient to gently ease into experiencing it during and in spite of difficult emotions; the physical body then became a supportive respite for the patient, who felt comfortable in it. The MG has allowed the individual to take a lead role in their life through reflection, along with an understanding of how they are responsible for their thoughts, that essentially, whatever they put in the forefront of their mind, they will come back to again and again.

While grounding, the toxic narrative patients carry within themselves is being allowed to find “new words” to be brought to the patient’s purview, inculcating new positive emotions. Therefore, in administering the MG, we are not just trying to ground or force the person to “withstand” the intensity of the present moment with all the experiences it may offer, but to allow the patient to safely and gradually experience the insight of a new paradigm, one that is growth inducing. This paradigm would allow patients to no longer see themselves as captives to their own cycle of suffering.

The value of MG becomes even more relevant when considering that many of us today are suffering from information neurosis, something that occurs whenever there is too much stimuli that paralyze our ability to think, now experienced by humanity given the current state of information saturation in the digital age. While hindered by excess information due to hyper-arousal for example, one cannot gain understanding, therefore is unable to see beyond the tangible, to have insights (Yetunde, 2011). This is a key factor in looking at the benefits promised in introducing mindfulness to the world, as the neuroscientist Rick Hanson reminds us how ‘awareness does not need a self to operate,’ (Hanson, 2013).

Furthermore, grounding the body with awareness and Right View is of key importance in addressing the disconnect that many patients undergo between experience and their body. By becoming more present and mindful, especially during the first few moments of experiencing something new, our awareness becomes highly pronounced (Hanson, 2013). If we are to understand subjectivity as just a way to structure experience, then in such moments of sharp awareness, given the presence of wrong views, whether as a result of past traumatic memories or fears of their repetition, for example, unwholesome states come to dominate one's subjective world, influencing even the validity of the information coming through the six sense doors, i.e. the body's experience of the world (Tejaniya, 2016). This is often what we may see in many who are struggling with depression, anxiety, and other negative symptoms falling short from realizing due to the disconnect that has taken place between the subjective experience, which relies on explicit and implicit memories, and the body that is experiencing it (Burns, 1999).

Today, our youth are at risk of developing comorbidity factors by becoming depressed and/or severely anxious with an exponential rise in cases of self-harm and suicidality, leading to further increase in the use of psychiatric and pain medications (Van der Kolk, 2015). This compels us to explore ways of sustaining a level of attention and learning both at home and school where children with various mental health disorders are in desperate need for interventions that could modulate their affect and motor behaviors (Conway, 2014). In using generic mindfulness techniques that we were advised, as per workbooks used in training (McKay, Wood, & Brantley, 2007), however, many therapists at PUC were frustrated with the results obtained from using mindfulness interventions to address symptoms of depression, anxiety, and trauma. This also meant that patients were missing the opportunity for growth by dissociating

from their sense of self, instead of learning ways to self-regulate their emotions (Siegel & Bryson, 2011).

In my work in the field of therapy, I have often observed how mental health practitioners prescribe mindfulness as an intervention for those suffering from extreme levels of stress, depression, anxiety, and anger. Models such as Mindfulness-based Stress Reduction (MBSR) (Biegel, Brown, Shapiro, & Schubert, 2009), Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2017), or Dialectical Behavioral Therapy (DBT) claim much success in helping patients with various disorders (Lovelle, 2005), yet without introducing them to the foundations of meditation practice. It is no wonder why at best, these serve as a mere temporary relief where sadly, symptoms resurface, and in many cases with more severity. This, without properly "grounding the person" by having them live through whatever experience they are provided for while being thoroughly present within their body can be quite dangerous, especially for those who suffer from schizophrenia or major depressive disorders (Vendel, 2017). Furthermore, in trying to help patients many may be tempted to use a "cookie-cutter" mindfulness approach, which may be causing more harm than good, especially while working with individuals with severe anxiety, depression, or early childhood sexual trauma, given the intense emotional reactions generated in reliving the trauma or depersonalizing themselves from their bodies (Levine, 2010). Grounding is essential then because it helps a person reconnect with the present, instead of being taken into dwelling in memories of the past with the fear-inducing anxieties of re-experiencing painful experiences, or the fear of impending doom and gloom of a bleak future.

1.2 Mindfulness as a way of connecting to the body. Traumatic experiences that happened to us in the past continue to induce states of psychological arousal without granting the person

any hope of freedom from them, i.e. danger without any possibility of relief from them, not even those of fight, flight or freeze that render us true captives (Levine, 2010). Although Dr. Peter Levine, a leader in the field of trauma research (and a survivor of traumatic experience himself) warns how when left unaddressed, this state of being temporarily frozen in time turns into a lifelong trait, he nevertheless stresses the wedded and intrinsic relationship between spirituality and trauma (Levine, 2010). Given the appropriate instructions, sensate and affective states experienced within and through the body have the potential to transform experiences of fear and helplessness caught within it. This can come about in the presence of awareness of the six sense objects via the physical body (Tejaniya, 2011).

When emotions are left unprocessed or unaddressed in therapy, especially those that may be classified as maladaptive, and given a series of demanding or unpleasant life situations, no matter the person's age or background, the individual facing them may simply react to these influences in maladaptive ways (Van der Kolk, 2015). One such way is "removing" oneself from the emotionally charged situation through dissociation, resulting in cognitive dissonance, which often means there is a lack of accurate understanding. This inevitably leads to one's perception becoming distorted, resulting in abnormal emotional responses, a common denominator in the symptomatology of many patients struggling with mental health (Burns, 1999).

In order to address this and other problems in the cognitive processing of individuals, one of the tools therapists can use is to help patients learn to *feel* again; feel with their bodies. This would not amount to much, however, unless there is also an accurate understanding on the part of the patient of the world around them through experiencing the genuineness of living, despite the tormenting emotions that might be waging inside them (Schuman, 1980). If our mission is to help patients overcome a painful past, according to my observations it is quite impossible to

accomplish this without first connecting the patient to their bodies (with awareness), where their emotions from the past are caught in an endless cycle of repeating (Baniel, 2009; Van der Kolk, 2015). The disruption of such vicious cycles, therefore, becomes a worthwhile therapeutic task, in the form of introducing healthy coping skills that bring about self-regulation with a clearer sense of a relational self. This in turn can lead one to a higher sense of emotional wellbeing, thereby enhancing the quality of one's life.

1.3 Other mindfulness-based practices that inspired the development of the MG. In an effort to develop an intervention that could help patients with their needs, I explored the work of others in the field that incorporated mindfulness in one form or another while using the body. These included, among many others, the Self Realization Fellowship's (SRF) *Energization Exercises* that were first introduced in the late 1920's by Paramahansa Yogananda leading to the initiation of Kriyā Yoga, a branch of Rāja Yoga (Yogananda, 2006). Aside from similarly dividing the body into segments, this practice soon was proven to be inappropriate in serving the purposes mentioned earlier, given that its intention primarily being to energize the body through a sequence of tensing and relaxing each section of the body, thus physically waking it up, the patient's level of anxiety would increase exponentially during emotionally intense moments. This was altogether different in objective and outcome than the intended treatment goals established in therapy.

Another similar tool that I explored was that of using awareness to scan the body and its sensations as per the techniques introduced by S. N. Goenka and his teacher U Ba Khin (Goenka, 1987), while using the *Satipaṭṭhāna Sutta* (Ñāṇamoli & Bodhi, 2001) in the form of "dry" or straight *Vipassanā* as influenced by the commentarial work of the *Visuddhimagga* by Ven. Buddhaghoṣa, (Ñāṇamoli, 2010). This latter work has been influential in the way insight or

vipassanā practice has come to be represented, taught, and practiced through the years, where it has the meditator focus on the fullness of the experience at the exclusion of all else, be it coming through the body, feelings, the mind, or mental concepts. This invariably has the capacity to lead the person (experiencing trauma) to become overwhelmed in its intensity, thereby causing more harm to the patient (Treleaven, 2018). What causes this is the absence of the relaxed step that is essential to allow the patient to constantly check in with themselves (Vimalaramsi, 2012), whether through the use of the breath, tranquility of the mind, softness of the facial and bodily muscles, or the awareness of a kind presence, i.e. that of the empathic therapist in the room. The emphasis of placing one's awareness in the center of the sensation, which the Goenka method teaches, proved unsuitable as this was contraindicated for patients, who had consistently recurring memories of severe trauma with intense fear and anxiety that would only be exacerbated via this practice.

1.4 A culture of mental disorders and psychopharmacology. Given the lack of time, patience, and empathy in those people in the lives of the patients, be they parents, teachers, or physicians, we often turn our gaze towards "quick fixes," i.e. drugs. Of course, it goes without saying that in cases where there are genetic or biological factors at play, prescription medications become unavoidable and truly lifesavers, especially when integrated with healthier lifestyle choices and habits. However, this need not be our *modus operandi* while working with patients with ADHD; at the very least we need to look for alternative modes of treatment, including body work, kinesthetic, tactile-based activities and mindfulness-based interventions.

Children and adolescents dealing with various disorders ranging from attention deficit/hyperactivity disorder (ADHD), anxiety, conduct disorder, etc. face considerable peer, social pressures, and academic challenges, where depression becomes yet another symptom to

bear (Conway, 2014). There may often be a temptation for parents or even patients themselves to medicate away feelings of depression and sadness as they normalize taking medications as indispensable to living a healthy life (Preston & Johnson, 2016). Research in the area of cognitive functioning behind various states of mind has been growing in the recent past, especially as it relates to mental disorders and their symptomatology. Often, depression or anxiety are blamed for the negative cycles that many individuals struggle with as they reach for various over-the-counter and prescription medications as their last resort, while still being caught in the seemingly inescapable grasp of their mental disorders (Siegel & Bryson, 2011; Kallapiran, Koo, Kirubakaran & Hancock, 2015; Hanson & Mendius, 2009; Heller & LaPierre, 2012).

Considering that the environment we live in is not a vacuum, given that it acts on our very biology, risk factors such as a major lack in the areas of attentive parental figures, safety and security, loss, grief, relocation, lifestyle choices, etc. and a slew of other considerations may need to be taken into account prior to prescribing medications to patients (Watters, 2010). Instead, we may explore ways of sustaining a level of attention and learning in school, where children with ADHD are exposed to interventions that could modulate their affect and motor behaviors (Conway, 2014). What we are seeking, hence, is a state of integration, where wellbeing is experienced in a balanced and meaningful way given the two hemispheres of the brain working together in harmony, between what Dr. Siegel calls the extremes of "emotional flood" and "emotional desert" (Siegel & Bryson, 2011); here the "flood" represents emotional richness and saturation, while the "desert" symbolizes rigidity towards taking in new affective information.

In treating children with ADHD, researchers have demonstrated the importance of empathy, starting with the therapeutic alliance as well as in the design of interventions that help

patients move away from idealized fantasy to acceptance of reality, whereby external situations are distinguished from internal ones. This underlying importance for the inclusion of empathy within the matrix of a workable intervention became the impetus for the development of the MG, as it allowed patients to develop the ability to self-regulate their emotions while understanding the connection between their psychology, emotional wellbeing, and interpersonal behavior (Conway, 2014). The MG works differently because it has room to address the needs of patients and their unique dispositions, including differing cognitive levels of processing. Here, MG has the potential to achieve symptom reduction of various disorders with or without the need for medications, depending on the case in the presence of regular therapy.

1.5 Staying put and experiencing the world through the body. The process of experiencing the body in a new way, as prescribed through the MG, involves helping patients become reacquainted with their own bodies, after having their relationship with it severed due to trauma. It is through this newfound connection that they develop a deeper and more existential relationship with their world as experienced through their physical body and heal with the insight gained through acceptance and understanding of their trauma (May, 1994). This, in contrast to disconnecting from their body which is how many patients seem to deal with their disorders, by moving their attention outward through various distractions (Van der Kolk, 2015). Such a state of affairs inevitably requires for patients to reconnect and somehow come to relax into their own body, and with consistent practice, develop an awareness of the connection that used to exist between body-mind prior to the traumatic event(s) (Levine, 1997). Thereby begins the process of recognizing the symptomatic (*akusala*) states of mind, the moment they appear, and through gained insight and discernment that follows, to be able stop themselves from being pulled into habitual negative states, and hence bring about a wholesome state of wellbeing (Rahula, 1974).

Seeing through, with right mindfulness, the established patterns of negative processing allows patients to see a separation between themselves and the cycle of suffering by reestablishing a sense of control within themselves, which often lacks in those who have been victims of trauma (Levine, 2010; Van der Kolk, 2015). This understanding gives the patient a clearer picture of the presence of craving (through past ignorance of the negative cycle of pain), whereby one becomes asymptomatic (*kusala*) by gladdening the mind through understanding (Analayo, 2003). The MG does just this by helping the patient connect the body and the brain leading to a state of balanced harmony, where one uses the body as an anchor, while seeing oneself separate from their unwholesome states of mind. This is supported by the recent movement in the field of therapy where researchers have proposed and applied interventions that allow the patient to establish a firm connection with the physical sensations received through the body, monitored by a continuous flow of reflective awareness of the body (Martinez, 2016).

Through awareness of one's thoughts, feelings and behaviors as they occur in the present moment, a balanced steadiness of mind is achieved, given the fact that attention shapes new neural circuits (Hanson, 2013). Instead of having an adverse outlook towards memories, with proper application of mindfulness-meditation that considers the specific needs of patients, the MG intervention opens doors to new learning. This takes place by revisiting past trauma while drawing upon data from experiences taking place and felt through the body in the present moment, thereby allowing patients to respond to them in a new and healthier manner (Kallapiran et al., 2015). Furthermore, with the rise of wisdom one begins the enjoyable process of making choices that do not solely rely on past habits, as lesser pleasures are relinquished in favor of greater ones, with longer lasting enjoyments (Hanson & Mendius, 2009). This requires settling in and finding solace in oneself through the development of a sense of agency, a state that is

opposite to feeling helpless due to the negative bias of the human mind: a trait we inherited evolutionarily from our ancient ancestors that kept them from being eaten by predators, hence allowing them to survive external ordeals (Hanson, 2013).

Whether working with sexual trauma, PTSD, severe or general anxiety, depression, etc., the MG serves as a resource for the therapist to adjust to the needs of the specific patient. Often this entails helping the patient reconnect (in many cases, for the first time) with their body by softly addressing the energy that is stuck within the system, manifesting as depression or fear (Van der Kolk, 2015). Facilitated by an empathic therapist, who is mirroring them through the steps of the MG, the patients learn to intentionally move their body with trust and thereby overtime surrender to the whole process of the intervention (Blum, 2015). This brings a state of special "non-reactive awareness" that engages with the body irrespective of the activities it is involved in (Analayo, 2003, p. 170), thereby mobilizing the healing power generated by a body that is moving more creatively, with a natural and inner celebratory way (Gordon, 2009).

1.6 Therapeutic role of the Dhamma. Freud wanted to develop a society into a psychotopia by the means of therapy, where human beings would have the capacity to abstain from psychopathology, i.e. a healthy society (Freud, 2017). Interestingly, however, 2600 years earlier that same vision had not only been conceived but also discovered, along with an actual step-by-step process delineated by the Buddha to actualize it (Punnaji, 2011a; Vimalaramsi, 2012). While looking at what the Buddha clearly outlined in his discourse to the monk Malunkyaputta in the *Malunkyaputta sutta vis à vis* craving, for example, as he discussed the implicit removal of the poisoned arrow of ignorance (Ñāṇamoli & Bodhi, 1995), today it is common for us to come across researchers from the fields of psychology, family therapy, social work, and neuroscience, among others, who agree with the teachings of the Buddha (Hanson & Mendius, 2009).

Under the guidance of an experienced teacher or therapist, mindfulness when practiced in a dedicated manner has the quality of loving kindness within it, in addition to compassion, altruistic joy, and equanimity towards oneself and others. This can be seen as synonymous with a fully lived experience of the moment that the Buddha explains in the Shorter Discourses or *Kuddaka Nikāya's Udāna*, namely, how one simply lives experiencing the objects of the six sense doors, but without adding one's own interpretation or identification with them (Ireland, 1997). When seen thus, before radiating these qualities outward, naturally they need to be permeated within oneself first as indicated within the practice of the MG, much like a meditation teacher guides the student through the "divine-abidings" or *brahmavihāras* (Vimalaramsi, 2012). This, therefore, makes it necessary to know how to utilize the tool of mindful living, a key factor generally missing in how mindfulness is taught today with individuals not having tasted the fruits of the practice, perhaps in their eagerness to share or teach it. When practiced in the right way, however, mindfulness leads the patient to calmly notice what is taking place in the mind not just in the presence of the three defilements or poisons (*kilesa*), but especially noticing the sublime states of mind.

Among the six qualities of the Dhamma as mentioned in the *suttas*, we find qualifiers indicating to its "timeless" nature in being "visible here and now" (Walshe, 1995, p. 241). According to this principle, whatever practice one engages in needs to "result in a marked increase in one's level of awareness" (Analayo, 2003, p. 22). Similarly, in using the MG, patients were observed to respond to the treatment experientially, whereby in following a specific meditation practice (MG) while using the body, they experienced a state of serenity and eventually understanding or insight, owing also to the mirror neurons being activated through the affective and cognitive mirroring of the intervention by the therapist in the room (Blum, 2015).

It is safe to say that the validity of an intervention such as the MG is reflected in the form of progress in the patient's own life *vis à vis* the reduction of their suffering, which is reflected in the teaching of the Four Noble Truths (*catu āriya saccā*) first introduced by the Buddha in the *Dhammacakkapavattana sutta* or "Turning the Wheel of the Dhamma," seen in the *Saṃyutta Nikāya* or Connected Discourses (Bodhi, 2000). As such, once patients have seen the benefits of an intervention, suffering becomes a choice as soon as they see how craving and wanting things to be different than what they are result in suffering (Vimalaramsi, 2012). By understanding the mechanics of how suffering takes place and how attaching ourselves to ever-changing emotions perpetuates it, patients become able to experience the Third Noble Truth through the relinquishing of suffering (Tejaniya, 2010).

1.7 The futility of mindfulness without Right Understanding. It may easily be argued that most living organisms have the ability for mindfulness, much like a dog becomes mindful of a piece of bone in front of it, a cheetah of the presence of its prey, or a military sniper of their victim. When introducing the practice, these can hardly be considered as the way mindfulness was intended to be experienced, at least so far as the teachings of the Buddha are concerned. What begs the question is whether there is something else that is needed in order to bring about the transformation that the Buddha described, i.e. the relinquishment of suffering. The answer to this was also provided for us, and that is wisdom. As Ashin Tejaniya, the contemporary meditation teacher from Burma who is now introducing *vipassanā* in a more relaxed way, teaches in his book with the same title, *awareness alone is not enough* (Tejaniya, 2011). It is doubtful that otherwise narrowing one's awareness at the exclusion of every bit of sensory perception may ever lead one to experiencing insight, because for insight to take place, one needs "information" coming in (Punnaji, 2011a).

As mentioned above, the complexity of sensory and cognitive experience for which awareness itself would not suffice is often seen when one closely examines the way emotions function, which leads us to understand that emotions do not stand alone as in a vacuum per se. Instead, the very *experience* of an emotion involves the embodiment of thoughts, judgments, and other cognitive factors, all of which come to connect us to both ourselves and others. This point of connection is embodied in what the prominent existential therapist Rollo May called "the sphere of our existence, which is on hand here and now, spatially expanded, present here, i.e. in evidence to eyes and ears." (May, 1994, page 341). Given our desire to oversimplify things or experiences, however, we often find ourselves attributing emotions uniquely to this or that cause. Because of the neurological or biological factors involved, the phenomenology of understanding emotions is one way of looking at our living experience in a healthier manner (Hanson & Mendius, 2009). Therefore, when we discuss awareness itself, we see that it contains an element of active participation by the individual experiencer, which is where a complex series of connections and higher or executive order functions take place within the brain's circuitry (Siegel & Bryson, 2011). This is then inputted contextually based on specific needs, goals, and history, i.e. habitual processing where perceived stimuli become fused when fired together (Lamme, 2004). Thus, the presence of sensory and contextual information adds onto the reality or reliability of the memory being recalled.

Awareness accompanied by Right View and Right Understanding can be a doorway to recovery for patients with histories of trauma as they heal both emotionally and cognitively. Given our limited information and explorations of the vastness that is life, as children, we may find ourselves in positions where we become frightened by an object or a person that is unfamiliar to our sphere of experience. This is especially the case for those living through

traumatic experiences. By taking this outward projection of the unknown and fixing it in our mind, while also maintaining its negative colorations, fearful flavors are attached to it. This then becomes added to our experiential library of thoughts, feelings, and their constituent behaviors, which we then use to navigate through life (May, 1994). In turn, it becomes the paradigm by which many live and operate, using maladaptive and distorted interpretations of life. Invariably, this kind of situation necessitates the introduction of right information, i.e. Right View and Understanding in order to challenge these cognitive distortions and allow the individual to experience life, perhaps for the first time (Hanson & Mendius, 2009).

The shape of the brain is dependent on what we habitually give attention to (Hanson, 2013). Although important, initial changes taking place in the brain are short-lived; one needs to acknowledge here the brain's need for social factors, such as bonding, cooperation, positive interaction and engagement with those we trust, as opposed to being on edge as in states where the autonomic nervous system is on alert or survival mode, which for many individuals with traumatic pasts is the normal, familiar state of being. Therefore, learning must take place at the brain's limbic level which, interestingly enough, is closely tied to our memories of the past that in turn dictate our anticipation, in this case of dream or worries of a not-so-safe future (Ogden, Minton, & Pain, 2006). Dr. Dan Siegel, a professor of psychiatry who has worked extensively to incorporate mindfulness into child therapy circles, mentions how this type of brain integration is needed for all healthy brains in a formula called FACES, i.e. Flexibility, Adaptability, Coherence, Energy, and Stability of thoughts, feelings, perceptions, and behaviors (Siegel & Bryson, 2011). When the brain is introduced to new data coming in through the sense doors, and when it is allowed to give them space by practicing new habits, especially those that go counter to old and unhealthy modes of behavior, wonderful things begin to happen (Van der Kolk, 2015). There is

newfound freedom for the person. This freedom, brain researchers conclude is the result of consciously developing new habits (through practice), while utilizing intentional awareness or reflective, i.e. wise attention, whereby parallel synaptic paths and even entirely new brain cells are created, propelling our train of thought into completely new and uncharted neural territory (Rae-Dupree, 2008).

Furthermore, the simple fact that we may react to something does not necessarily indicate that we are aware of it, and this is an area of study that researchers are exploring for more evidence to explain this process of perception without awareness (Meirikle, 1992). This is often called "blindsight" by neuroscientists, first observed in brain-damaged patients, who were unable to execute certain tasks unless they were able to see or look at them individually (Ramachandran, 2003). As most of us can attest to it, however, we are often moving our bodies, let alone saying words, humming tunes, and of course having the mind wander ceaselessly without a trace of awareness being involved in the process. Although to simply be aware is something that many organisms can accomplish, does it bring about a spec of insight to the experiencer, one can ask? For example, if a human being, a dog, or a bird is resting by the street corner and a car speeds by, they might all become aware of it. But does this necessarily mean much to these different species of beings, as stated above? Mindfulness, or in this case awareness by itself is not enough; there needs to be the element of added wisdom, along with reflectively establishing oneself in the body as a foundation (given its numerous moment-to-moment experiences) or processing of the information that the stimuli generated in the mind; a level of pondering that goes far beyond mere 'knowing that we know' (Tejaniya, 2010).

In the *Sabbāsava sutta* of the Middle Length Discourses (*Majjhima Nikāya*), we meet the Buddha discussing the seven ways to eradicate the three taints (desire for sensual pleasure, desire

for further becoming, and the taint of ignorance), through abandoning them by "seeing" (Ñāṇamoli & Bodhi, 2001). This seeing is done through wise attention, which in Pāli language is called *yoniso manasikāra*. And what one is attending to wisely are the Four Noble Truths, which here correspond with *Sammādiṭṭhi* (Right View) of the Eightfold Path. By "seeing," one gains the understanding of the First Noble Truth, i.e. the Truth of Suffering (Bodhi, 2009).

1.8 Patient-therapist relationship grounded in empathy. MG is not designed to work on its own, much like *sati* when used in isolation (without wisdom) as extricated from the family of other required steps to bring its full impact in removing ignorance. Similarly, the MG works in conjunction with other tools found in the toolbox of a versatile and empathic therapist using models such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT), CBT, DBT, etc., and only after a healthy therapeutic rapport has been established. But we cannot discuss the various "tools" that are to be used in the rich inventory of a compassionate therapist without considering the supremely relevant one among them, i.e. that of the therapist. Here we are reminded of the Buddha's words from the *Sallekha sutta* in the Middle-Length Discourses or *Majjhima Nikāya,* number eight: '*It cannot be, Cunda, that one who is sunk in mud can pull out another, who is sunk in mud*' (Ñāṇamoli & Bodhi, 2001). Using the MG, patients were slowly invited to turn towards their experiences that occur in the present moment, rather than running away from them or pushing them away into the future or blaming a past (Van der Kolk, 2015; Brewer, 2017). This is accomplished through the trust in the therapist, the process, therapist's intention and ability to be compassionate, i.e. being genuinely involved in helping patients develop a sense of curiosity towards a possible positive outcome (Blum, 2015). Furthermore, in using the MG, both during sessions and at home, patients were able to develop noticeable capacities of discernment,

especially in making choices, whether by thought, speech, or action in their daily lives. Thus, the presence and groundedness of the therapist is a key factor in the success of the MG.

The healing power of loving-kindness and empathy within therapy sessions cannot be overstressed here especially when it comes to patients with depression who often experience apathy, as they lack the self-regulatory tools to deal with painful memories of the past and present and become therefore unable to self-sooth (Hanson, 2009). To this end, incorporating the *brahmavihāra* or the divine abiding practices of loving-kindness and empathy sought to further enhance the effects of the MG in helping patients going through depression (Punnaji, 2011a). This was done through mirroring as patients developed trust towards their therapist, who served the role of liaison or proxy, while patients began developing the capacity to extend these benevolent qualities towards themselves, and their own traumatized bodies (Vimalaramsi, 2014).

Based on research (and common understanding), in order to be successful in one's attempt to help patients, a therapist cannot remain aloof or passive, but fully and actively engaged in the process; in other words, for therapy to be effective and optimal, a therapist must be willing to personally develop along with the patient, by also allowing themselves to become vulnerable (Yalom, 2002; Frederickson, 2013). Whether being directive or more organic in one's therapeutic approach in working with patients, the engaged therapist is always on the lookout for cues, be they verbal or non-verbal, on the part of the patient (as well as within). This, because such internal indicators only come to add to the narrative that patients have shared, or further, tell an entirely different story altogether (Yalom, 2002). This observational skill is crucial, especially while working with children, who were taught to be seen but not heard (i.e. not allowed to speak), necessitating the development of sophisticated facial or non-verbal cues (Eckman, 2007).

With more than 400 models of therapeutic methodology that often come with their own techniques and principles, it is no wonder how we discover that often the uniqueness of the person and the self of therapist are neglected or at least not given their proper significance. The work on oneself is therefore not encouraged in the world where these patients can grow and develop. As Fritz Perls stressed, whatever we may be calling therapeutic must be applicable and comprehensible to those it professes to help; otherwise it is mere hiding behind psychological jargon (Perls, 1973). Therapy is an ongoing assessment. Knowing this full-well, the therapist, recognizing that we are samples of the society at large, focuses more on the relationship being built *with* the patient, rather than making it just *about* the patient (Yalom, 2002). This means the patient is introduced to a wider purview that may at times be challenging for them, and vice versa. However, ultimately, when patients present to sessions, they are trusting themselves to learn more about life and themselves, as they develop into higher and better versions of themselves.

Whatever tools are to be used in therapy sessions, it is essential for the therapist to remember that the ultimate and most important tool or intervention to use is oneself, so long as the "self of therapist" continues to evolve and develop, along with that of the patient. To ensure such a function, whether using the MG or other intervention, the therapist is highly encouraged to not just be an administrator of the intervention, but also allow oneself to be available to its effects (Yalom, 2002). This, therefore, requires the therapist to be fully immersed in the process, especially in the case of the MG, while ensuring that one remains open not only to the six sense doors and the data they provide, but also to new possibilities. This will be crucial when noticed by the observing eyes of the patient (Whitaker, 1989).

We cannot have successful therapy without the presence of empathy. To this end, as therapists we must take up the role of empathy and support for the patient through the family system as well whence they come. This is a crucial part of any feasible treatment plan, as we aim at reaching an integrated plan of care, with the achievement of the state of happiness as the goal. The introduction of various interventions throughout the treatment process is simply an effort to bring this about (Winek, 2009). Involving the family has been observed to be equally effective even when there are no actual physical family members for a patient present, whereby through the connections made, "adoptive" family members may be allowed into one's field of experience through the reestablishing of trust, of authenticity of coming out of one's shell of denial, embarrassments, and silence (Crnkovic, 1998). This may come to counteract the background risk factors, such as the symptoms involved in the case of a family struggling with chemical dependency, i.e. not trusting, not understanding, or lacking open communication (Wallin, 2007). The empathic orientation of the therapist, especially in this case, is extremely important in reigniting within the patient the capacity for trust and honest communication both with themselves and others.

This active role of the therapist is a key factor that many of today's secular mindfulness approaches used in therapy forget to consider (Johnson, 2017). Perhaps this is partially due to the current modalities being more concerned with the narratives shared by patients in sessions, instead of the therapist having a directive role, where insight takes place in the mind of the patient. Today, the word "insight" has become a taboo term in the field of therapy, giving way to approaches that advocate the autonomy of the patient, although many of these individuals continue suffering (Winek, 2009) as they experience recidivism. It is worth stressing here that many of the founders of therapeutic models, whether systemic or otherwise, insisted on insight as

the great indicator of not only successful therapy, but of bringing forth wisdom and genuine empathy within the persons involved in the therapeutic process (Keeney, 1983; Whitaker, 1988).

Interestingly enough, our job as therapists is not to make our patients more comfortable; our job is to make them be comfortable *with* and *around* the distress they are experiencing (Whitaker, 1989), therefore not something to be avoided or moved away from. To this end, during therapy intakes, especially in the case of working with couples, one of the key elements of a therapist's Scope of Practice (a legal requirement pertaining to the working capacity of therapists in the State of California) is to inform patients that by undergoing therapy they do agree to the possibility that their current relationship might be severed. The reason for this is the potential for the sheer un-layering of habitual patterns and modes of thinking and projecting one's hopes and fears onto the world; thus, life is seen through new eyes due to insights experienced in therapy (Wallin, 2007).

Furthermore, the key role of empathy for successful therapy can be considered within the context of character development. In a culture that is always looking for something sustainable to hold on to, today's youth (along with adults) is in a constant quest for character (Yetunde, 2011), whether in themselves or elsewhere, as in social media, politics, or sports. However, as the author James Hillman eloquently states, in our substitutions for character we will always come up empty. His reasoning is that character disappeared from our midst in the Twentieth Century, along with its self-serving foundation that has been dubbed 'objectivity', a euphemism for knowledge without value (Hillman, 1999). This may be missing to consider the point, however, that character, much like gold in its purest form, needs to be tempered in dire circumstances, where in the presence of a strong will, the rarest among us are brought out from the seeming

defeat of suffering. One of the purest forms of human qualities is also produced as an outcome of such a transformation, that of empathy (Goleman, 2005).

The effort needed to build oneself a character is now identified as one of the keystones for developing empathy within oneself (Goleman, 2005). It is no wonder therefore to see how the role of empathy within therapy has been recognized due to its effectiveness in preparing the groundwork for building rapport between clinician and patient. Aside from deepening the relationship between the key figures in a two-person therapy, i.e. clinician and patient, empathy renders a compelling emotional investment to the treatment process, enough so that it has been key in the development of character education, violence prevention, school discipline, anti-bullying, and drug prevention (Goleman, 2005). This is done through the experiencing of the representation of one person's mental state as closely linked to the experienced representation of another (Bateman & Fonagy, 2016). This does not necessarily mean that these representations need be identical, but that the feelings and thoughts of each individual are strongly contingent on each other (Bateman & Fonagy, 2016).

While working with patients with borderline and antisocial personality disorders, researchers Bateman and Fonagy explored interventions that would allow a therapist to understand the patient in a deeply experiential level. Here, they looked at ways to understand those mental states that work behind apparent behavior. Their results led them to the principle of "mentalizing," a term that describes the ability to empathically relate to another being and their circumstances. This, the researchers discovered to be the contextual outcome of attachment relationships (Bateman & Fonagy, 2016). Similarly, the world-renowned psychoanalyst and expert on personality disorders Dr. Otto Kernberg, also looks at the value of mindfulness while working with patients, by calling it the self-reflective awareness of intrapsychic processes, this

given his findings based on empirical studies which demonstrated how increased awareness of self and of significant others can even lead to increased insight within the patient (Kernberg, 2012).

It is this capacity for insight that also helps with mentalizing which, according to Bateman and Fonagy, is key to the development of self-regulated, adaptive, intimate, and constructive relationships among patients, who have lost their sensitivity of it, i.e. mentalizing: the ability that is no longer available for many patients (Bateman & Fonagy, 2016). This loss is often the result of experiencing devastating times of anxiety and stressful attachment bonds in early childhood (Wallin, 2007). However, given the findings of trauma research, we now know that with mindfulness of the body and the gradual exposure of past events, the patient relearns to come back to their window of trauma tolerance (Van der Kolk, 2015). Thus, by seeing mindfulness practice not merely as a way to de-stress, but more as a means of renewed perspective and a transformed paradigm, one becomes the holder of wisdom, one to live by revolving around health and wellbeing, which is not so far off from what the Buddha intended for it when first introducing mindfulness to the world (Tejaniya, 2011).

1.9 Summary. Living moment to moment is quite different from living with awareness from moment to moment, and this is something that is very difficult for patients struggling with anxiety, depression, and trauma of all kinds. The reason for this is that these individuals, although highly sensitive to the fluctuations within their mind, whereby they become thoroughly victimized by them, nevertheless keep themselves remote from their emotions and feelings (Wallin, 2007). This has often been the primary reason why mindfulness has not been the ideal choice of intervention used in therapy, given the separation that occurs for many between awareness of the body and the present moment of experiencing, especially those who have been

victims of abuse or are struggling with severe anxiety or trauma. One needs to be reminded here of how we identify with our *loudest* feelings (Levine, 2010). What this means is that by dismissing one's awareness of living the life found within each moment, the person truly is no longer engaged in his/her own life, living a life that is removed. It is here that continuously returning to either the breath or the mind with gentle but persistent awareness helps these patients to dis-identify from overwhelmingly troubling emotions. One thus carves out a larger space within their mental space and living experience where further discernment is gained into the relationship between the body, emotions, and one's mental wellbeing, the integration of which brings the person to a fuller moment-to-moment living experience (Wallin, 2007).

If we are to view the Dhamma as an intelligent way of looking at suffering (First Noble Truth), then we can see this to be the result of the emphasis the Buddha placed on investigating the cause(s), i.e. origin of suffering (Second Noble Truth), (Vimalaramsi, 2012). This point cannot be overstressed, given the relation between investigation and wisdom, and how at times we accept certain emotions simply because of habituation, which is another reason why often many treatable illnesses may masquerade as depression or anxiety. In other words, it is fair to say that we feel the way we think, (Burns, 1999). It is worth mentioning that by extirpating the role of *sīla* and *paññā* from the three-part equation (*sīla* - *samādhi*- *paññā*, i.e. virtue/moral discipline, collectedness of mind, discernment/wisdom) which the Buddha formulated in structuring the Dhamma, one's efforts are bound to be ineffective at best, and dangerous at worst, for the three trainings work to complete each other, as they bring out the potency and full spectrum of the function of mindfulness. *Sīla* thus takes the meaning of giving up negative, maladaptive states of mind, where the greed of holding on to what has been customary for the mind, i.e. negative states, is relinquished. Viewed as such, one sees how *sīla* can make one's practice 'beautiful in the

beginning, while *samādhi* makes it beautiful in the middle, and *paññā* makes the practice beautiful in the end' (Chah, 2001). Thus, although three separate parts of the practice, they merge and become one.

One cannot practice *sīla* without *paññā* (wisdom), the factor that determines how successful our practice will turn out to be, given the function of the investigative quality of wisdom (Tejaniya, 2011). Thus, one gives up what is bad or wrong, and takes up what is good or wholesome. This is a crucial part of making mindfulness work (Vimalaramsi, 2014). Excluding the two (virtue and wisdom) and barely using a portion of the third, i.e. mental cultivation in the form of mindfulness, can hardly be described as a faithful representation of the practice of mental cultivation (*samādhi*). Mindfulness, viewed thus in its fuller capacity, is not about reduction of stress, especially when we see how often life with its difficulties allows the individual to gain most out of it, through the very stress experienced. Science in its domains of biology and astronomy, for example, proves how life comes out of intensely stressful situations, as do stars and entire solar systems out of gaseous nebulae. Hence, through mindfulness, wisdom is developed *while* one faces the difficulties of the friction created due to the presence of the three defilements: greed, ill will, and delusion. The same is true while looking at another group of stress-inducing states of mind, i.e. the five hindrances (*nīvarana*), which include (1) attachment or lusting after the pleasant, (2) aversion or anger, (3) sloth and torpor, (4) restlessness and worry, and (5) doubt. Through the suttas, we see the emphasis put on these principles as being critical to the development and even the very Awakening of the Buddha, as he pushed through his encounter with Mara's five daughters, i.e. the five hindrances.

The Buddha's message throughout his teaching career as delineated in the *Nikāyas* centers on the value of one's living experience, therefore giving importance to various

phenomena that arise in the mind (wholesome vs. unwholesome). Many of the patients, who present at therapy sessions are in miserable spaces while experiencing their lives, with a multitude of factors that keep them imprisoned in negative states of mind. This became especially evident through my close work with patients who were caught in the pangs of suffering, be it fear, anxiety, trauma, anger outbursts, or wanting to hurt themselves or others. The urgency of the Dhamma, therefore, became directly relatable to me in the work I was doing with my fellow human beings, as I tried to help them not only as a therapist, but also as a Dhamma teacher (Yetunde, 2011).

Having seen the undeniable effects of the Dhamma in my life, both as its student and practitioner, while helping me deal with and overcome the fears and anxieties I have experienced from being a victim of PTSD due to my injuries in war-torn Lebanon, I knew it could be applicable and even useful in treating the patients that were under my care as I worked at PUC. Here, I was reminded of the late eminent Pāli scholar and meditation guide, Venerable Bhikkhu Katukurunde Ñāṇananda's words that the depth of the Dhamma has to be seen in its lucidity, much like one sees the bottom of a tank when the water it contains is clear and lucid (Nanananda, 2010). This lucidity is found in the very qualities the Buddha used to describe his Dhamma, i.e. *sandiṭṭhiko,* which denotes for it to be experienced here and now, this especially when we are discussing the Third Noble Truth, whereby there is an ending of suffering (Bodhi, 2000). Therefore, by providing a method of learning that quiets the mind but not at the cost of abandoning awareness of one's own body and alertness of mind, this research project simply became an extension of my Dhamma work. Through my work with other clinicians in this research study, my goal was to help them support patients to learn how to cultivate their mind to the point where mental stillness is experienced *while* also having access to see and 'observe how

the mind moves from one state or consciousness to the next,' without identifying with the scars of the past or the fears of the future (Vimalaramsi, 2012).

Chapter 2: Review of Current Literature

Review of current literature

In researching this topic, it was encouragingly obvious to see how Western psychotherapy has been making headway for new ways of learning about the connection that exists between the way thoughts, experiences, and emotions function through and manifest upon the very physiology of the body (Van der Kolk, 2015). Today, robust research is showing us how experiences of trauma are not only registered within the body, but are often triggered, given similar situations (or emotional reminders) that have some comparability with a traumatic event from one's past (Levine, 2010; Ogden, 2006). The evolutionary role in how these factors within the mind-body connection have come about provides a clearer scientific perspective to the Buddhist interventions, such as mindfulness-based methods I hitherto had practiced and therefore had a clear understanding of their effectiveness. These included straight or "dry" *vipassanā* mentioned earlier of the Mahasi method from Burma, as well as the Goenka method of observing bodily sensations, both of which are based on the *Visuddhimagga* of Ven. Buddhaghoṣa.

Through the MG, I have been discovering how the manner in the very perception was changing within patients regarding their bodies, especially those who, given their past traumas, had negative or even harmful attitudes towards themselves in the form of cutting or hurting their bodies (Levine, 1997). On the other hand, trying to live a wholesome life in a way that incorporates mindfulness, yet somehow excludes virtue and a foundational consideration of consequences of our intentions behind actions we commit through ethical living, can hardly be described as such (Bodhi, 2016). It is no surprise therefore, that today's social psychologists are starting to look not far from oneself, i.e. to our ignorance, hatred, and greed, which are the harmful common denominators in all beings (Hanson & Mendius, 2009).

Here, by not going outside or seeking after sensual objects one attains a higher state of tranquility, hence keeping precepts in itself becomes a Dhamma practice, which leads to a reduction in the negative qualities found within the mind (Jayasaro, 2014). Using mindfulness while it is being supported by precepts allows us to develop patient endurance with unpleasant experiences in our lives, which is essential in working through past trauma, especially in gradual exposure treatment protocols (Cohen, Mannarino, & Deblinger, 2008). This creates self-esteem, confidence, while keeping the mind light and bright. In referring to the role of patience in one's life and practice, Ajahn Sumedho from the Thai forest tradition explains it as a patient and peaceful co-existence with the unpleasant (Sumedho, 2004).

Patience and precepts help strengthen the roots of our mindfulness, establishing one in the practice that entails holding up an active, steady stream of mindfulness (Punnaji, 2011b). In the simile of salt, even the Buddha resembled it to 'salt that is necessary in every curry dish,' whereby mindfulness has to be there all the time in one's practice. Similarly, the steadiness of mindfulness as an object (awareness of awareness) has to be constantly adjusted; seen thus, maintaining precepts becomes an act of mindfulness, because the precepts help to bring about the tranquility of mind, i.e. establishing oneself in a state of peace, instead of looking outside of oneself for pleasures to keep one appeased and reduce the tension in the mind (Punnaji, 2011b).

Studying the Dhamma closely, one can see that it is about understanding with wisdom (or Right View), a very important quality to develop while being fully engaged in one's day-to-day activities. Through right view and right understanding one acquires the ability to see and recognize the states of mind that arise, as a result of calm observation. By allowing them to come to the surface thus, one is able to gain insight through working with the hindrances and not by pushing them away. This allowing stems from the sense of curiosity, which is none other than

turning toward our experience rather than away from it (Brewer, 2017).

Today, researchers in the fields of psychology, neuroscience, and neurophysiology slowly but surely are taking steps to put understanding and wisdom together as well, as in addressing the needs of patients suffering from back pain, for example. These latter are witnessed recovering completely from their lifelong suffering due to the understanding they gain through simply reflecting on their levels of stress and anxiety (Sarno, 2015). Dr. Sarno, a world-renowned rehabilitation medicine at New York School of Medicine, has been a key figure in the field of exploring the role of psychosomatic symptoms and how they relate back to the overwhelming pressures of daily living with its stressors not only on a person's emotional state, but also on one's body, in the form of various spinal issues, such as chronic back pain, in this case. Thus, by closely looking at psychosomatic diseases, and armed with the knowledge provided by research and their physicians, these patients relinquish their old cognitive paradigms; once suppressed emotions are acknowledged, new ones are introduced into the sphere of their awareness as an outcome (Sarno, 2015).

2.1 Neuroscience and reflective awareness. Today, research in the field of neuroscience and therapeutic methodology has found a direct correlation between the body and various mental-emotional disorders, as the world-renowned trauma specialist Dr. Levine states: "the body initiates, and the mind follows" (Levine, 2010, p. 135). The works of such experts in the field of psychotherapy and psychiatry as Drs. Bessel Van der Kolk, Peter Levine, Pat Ogden, and Janina Fischer have become indispensable in bridging the gap between traditional therapeutic "top down" modalities that emphasize the supremacy of cognitive abilities in working with trauma, and those of "bottom up" that look at how the body reacts in response to memories of trauma. Given their work, both trauma therapists and their patients are presented with modalities

that incorporate novel interventions in the treatment of post-traumatic stress disorder (PTSD) for example, along with similarly incapacitating disorders affecting both body and mind (Hanson & Mendius, 2009). Their understanding has to do with the intelligence that is gained through reflectively becoming aware of physical sensations and their critical relationship in producing feedback within the person, i.e. behaviors resulting from the various experiences undergone in the past, not to mention their interpretations (Levine, 2010; Van der Kolk, 2015). Here is where today's science turns our attention to reflective self-awareness (Levine, 2010), as it helps the individual make room for supportive self-acceptance, regulating intense sensations, and even developing insight by gaining a better understanding from these extreme sensations and remnants of psychological trauma. Here we need to mention how the sense of self is a self-regulatory endeavor, and in the case of those who have experienced distressful situations in their neurodevelopmental stages, this happens to be a quality that is severely lacking (Van der Kolk, 2015).

In her extensive work with helping people reconnect with their bodies, author and body-movement teacher Anat Baniel, teaches her students to allow themselves to open to new levels of learning instead of embracing the sameness they have been used to accepting. This way, newness is revealed while feeling the world through their bodies (Baniel, 2009). Here, the brain learns to do things that are qualitatively different from what it has been accustomed to, where given the exposure to the new information, the brain "switches on" and novel experiences are added to its repertoire of experiences (Hanson, 2013; Siegel & Bryson, 2011). However, it is not just about adding new information or acquiring new knowledge; although our brains are acquiring new data and learning new skills, it is the organic learning that is taking place where the brain switches "on" (Siegel & Bryson, 2011). Here, the vitality created from the joining of both mind and body

comes about from creating (in a safe environment) in us the trusted vulnerability to new possibilities, as we begin to open ourselves to being changed by new experiences (Baniel, 2009). For example, researchers have stressed the effects that the human touch has on the limbic system, which is a key factor in developing the ability to learn how to self-regulate as it balances the central nervous system with the interchange of sensory information picked up by the body from the environment (Van der Kolk, 2015). Conversely, when bad things are happening around us and the body picks up these sensations, they inevitably affect how we feel about ourselves. Whether applying movement or remaining stationary, bringing awareness through reflection into the physical presence of oneself, i.e. the body, has been proven to develop a higher functioning within the brain, as it helps individuals to self-regulate (Levine, 1997; Van der Kolk, 2015; Fischer, 2011).

Grounding the body, therefore, while experiencing it in a safe setting was at the core of remedying patients, who were accustomed to disconnecting by dissociating or breaking awareness from their bodies, the present moment, as a means of avoiding the cyclical re-experiencing of traumatic events (Van der Kolk, 2015). Fortunately, to verify the merits of these statements, we have the support of research that has been ongoing in the field of Somatic or body experiencing techniques that were introduced largely by world-renowned researchers Drs. Levine, Fischer, Ogden, and Van der Kolk, among many others. Aside from the rigorous studies and their findings, we also have today exercises introduced by these same researchers that incorporate some level of mindfulness or awareness of the body, yoga, Tai Chi, etc. (Ogden, 2005; Levine, 2010; Fischer, 2011). What is interesting is that all these findings place great emphasis on the tranquility of the mind but not at the cost of removing one's awareness from the body, which they often see as the gateway for finding peace from past hurt, suffering, trauma and

fear (Hanson & Mendius, 2009; Van der Kolk, 2015; Ogden, 2005).

This matches the findings the Buddha himself revealed through his practice as a *bodhisatta* and taught later as the Awakened One, wherein he exclaims in the Middle Length Discourses' *Dvedhāvitakka sutta* (Two Kinds of Thoughts): '*[I noticed how] when my body is tired the mind becomes tired, when the mind is tired it is far from tranquility. So, I steadied my mind internally, quieted it, and brought it to a state of tranquility and stillness'*, (Ñāṇamoli & Bodhi, 2001). Thus, one's attention is brought and kept inward in a state of collectedness, and as the late Ven. Punnaji, one of my meditation teachers explained, the mind becomes able to remain undisturbed without searching for happiness in the world outside or external circumstances. This he called 'tranquil introspection' (Punnaji, 2011c).

Neuroscience and psychology seem to be doing their part to catch up with the discoveries made by the Buddha, as the results obtained by Western researchers in the field of therapy seek to bridge the gap between body and mind, and how our bodies "keep the score" of trauma experienced in the past (Van der Kolk, 2014). As a treatment method, Prof. Van der Kolk explains how introducing physical exercises such as yoga or breathing techniques allow one to ground one's experience within the body while emotions come to the surface, helping the patient to come back to the present and experience being in it. Similarly, Drs. Levine, Fischer, and Ogden emphasize the role of sensorimotor experiencing in treating patients, whereby fragmented parts of oneself coalesce instead of seeking a state of self-alienation as a result of overwhelming life events, causing further psychological and social distancing (Ogden, 2006).

The research of the aforementioned experts in the field of trauma studies has been greatly influenced by the extensive and pioneering work done by Dr. Stephen Porges, specifically through his Polyvagal system model looking at how brain chemistry and the human nervous

system work to influence one another (Porges, 2017). In his discovery of the Polyvagal system, Dr. Porges, professor of psychiatry, elaborates on how the body, in shifting its focus to use its social engagement system, allows a natural mode of response as a coping skill to the various crises one may experience in life (Porges, 2017). In dealing with trauma along with severe anxiety, today's clinicians, therefore, have the good fortune of being exposed to newly made discoveries in the field of trauma studies. This is due largely to the rigorous scientific research (and their findings) in the field with the pioneering work done by Drs. Porges, Levine, Van der Kolk, Fischer, Hanson, etc., whereby we are being offered a new paradigm in the way trauma is caused, how it is processed within the body, how its symptoms manifest in the life of patients, as well as what we can do to effectively address and treat them (Siegel & Bryson, 2011; Hanson, R., & Mendius, R. 2009; Hanson, 2013; Levine, 2010; Van der Kolk, 2015).

2.2 How trauma is processed in the body. Recently, groundbreaking research on the way the body processes suffering that was coined "Neuro-Affective Relational Model" (NARM) by its developers Laurence Heller and Aline LePierre, looks at the emotional challenges (from the therapeutic perspective) posed by a disturbance in the organization of five biologically-based principles. These were identified as the need for connection, attunement, trust, autonomy, and love-sexuality (Heller & LaPierre, 2012). Here, one is introduced to the mechanism whereby traumatic experiences take away one's capacity for connection with self and others. This, the founders of NARM, both of whom are seasoned clinicians, describe as the impairing of the sense of aliveness within the person, bringing about all kinds of psycho-physiological disturbances in the individual (Heller & LaPierre, 2012).

Unlike the past "top down" model where the cognitive or mental processing was given precedence over looking at the body and its sensations to find out about the true effects of trauma

and its proper treatment, trauma researchers today have conclusively demonstrated the superiority of the "bottom up" model (Van der Kolk, 2015; Levine, 2010). Using various body work such as yoga, and sensorimotor experiencing, the effectiveness of the "bottom up" model has been demonstrated as patients learned to reflectively become aware of the sensations manifesting within the body, developing in the meantime the agency to self-regulate their emotions (Ogden, P. & Minton, K., Pain, C., 2006). On the other hand, in their attempt to understand the mechanisms of how the mind-body connection processes pain, anxiety, fear, and similar negative states, Heller and LaPierre have integrated both the top-down and bottom-up approaches of cognitive sciences, somatic experiencing, and bio- and neuro-feedback. This effort culminates in the way the nervous system is regulated by these two modalities but without ignoring an individual's past traumatic experiences (Heller & LaPierre, 2012).

Without holding on to any of these models too tightly, today well-versed trauma therapists can have the tools to help teach patients a way of life that does not disconnect them from it, i.e. living life reactively. Instead, patients benefit from being encouraged to pause and gradually become titrated in accepting their present negative feelings and tolerating difficult emotions while remaining in their bodies (Levine, 2010). Furthermore, by living their lives "reflectively," they are able to take a moment even in the midst of intense emotions, to slowly check in with the very sensations experienced in their bodies (Fisher, 2011). This can be done while also gauging to see the quality of these emotions where patients develop the capacity to explore closely what it is that makes them happy (or feel wholesome), and what puts them into a negative cycle of emotions, i.e. unwholesome states (Hanson, 2009).

2.3 Therapy: symptoms, diagnosis, and interventions. We are living in exciting times as new discoveries are being made in the fields of neuroscience and psychoneuroimmunology

(Martinez, 2016), especially when we consider how these discoveries influence the work done in family therapy and mental health. With researchers exploring the efficacy of various interventions, both as patients and clinicians, however, we still find ourselves challenged by long-held beliefs of symptomatology and even the temptation to over-diagnose or seek out psychopharmaceutical means of treating patients (Waters, 2010) in our desire for quick results. It is, therefore, understandable as to how alternative ways of addressing mental health concerns of patients, such as mindfulness have become attractive (Preston, O'Neil, & Talaga, 2015).

In discussing symptoms, one is unavoidably faced with depression which has become the disorder of choice of our modern time, and as Dr. James S. Gordon of the National Institute of Health states, depression is positioning itself as the end point of a pathological process (Gordon, 2008, p. ix). Many therapists, including this author, struggle on a daily basis to negotiate through the pages of the *Diagnostical and Statistical Manual of Psychiatric Disorders* (5^{th} edition), i.e. the DSM-V, as we try to find reasons for patients to *not* be labeled given the symptoms they exhibit, which in this example would be major depressive disorder for which there are a myriad of classifications and subcategories. However, due to the need for the involvement of third-party entities in the course of patients' treatment, such as insurance companies paying for their services, often a clinician has no other options but to give a diagnosis that classifies them as the owner of that disorder (Preston, O'Neil, & Talaga, 2015).

The prevalence of depression and the number of patients diagnosed with it in our society indicates that sadly it has become an unavoidable downward spiral for many, including of course the patient, but also the therapist in the form of regression of treatment. Usually depression has biological causes and symptoms with children, especially those experiencing psychomotor agitation, such as in cases where they exhibit symptoms of acting out due to depression (Siegel

& Bryson, 2011). However, given the stressful lifestyle of parents, there may be the temptation for parents or even patients themselves to try to remove the feelings of sadness and depression via medications where such use of medications is seen as normal and necessary, yet another problem in taking responsibility and spreading the current "American way of life" (Watters, 2010).

Candace Pert, a neuroscientist and pharmacologist who did her pioneering NIMH (National Institute of Mental Health) work on endorphins and hormone-receptors, argued that much of the research that has gone into the formulation of the chemical imbalances and the promotion of drugs like Zoloft and Prozac, is tenuous at best (Pert, 1999). Similarly, in his book *Unstuck* (Gordon, 2009), the psychiatrist James Gordon makes the same point by challenging the medical or "disease" model of depression and the widespread and epidemic dependence on chemical anti-depressants. It is this narrow "disease" model that gives the person the sense of helplessness and hopelessness to resort to thinking that the states they are experiencing are similar to those suffering from insulin dependency due to diabetes (Watters, 2010).

Whether working with substance abuse like drug addictions or patients with trauma, depression, and anxiety, it is no surprise therefore to see that what takes place in these patients is a major disconnect in their relating with their own bodies, as if they were two (or more) distinctly different things, with medications being called in to bridge the gap, as it were (Gordon, 2009). This goes counter to the integrity of a human being, especially one presumably living with the freedom to make choices and have some semblance of control over one's life and one's actions, i.e. the body (Baniel, 2009). In contrast, using the "non-disease" approach takes the "victim" mentality out of the addiction (and the addict). In his work with addicts, researcher Stanton Peele directly questions modules of therapy that have been used for decades, namely the

12-step programs, which leave those with addictions with 60% recidivism. Instead, Peele offers a method of tackling the issue of targeting addiction through personal effort, by not looking outside of oneself but directing one's attention to the source of these addictions within (Peele & Thompson, 2015). Here is where I Peele's ideas hold much value, especially as he brings in the time-tested practice of mindfulness that has been in use as part of Buddhist practice for over twenty-six centuries.

Today's researchers are turning to challenge the mechanism behind looking outside of oneself for relief, as they are questioning the very logic behind the accepted notion of powerlessness one experiences while caught in the vicious cycles of addiction, rampant with feelings of guilt and shame (Martinez, 2016; Keeney, 1983). This, especially because when we look at the neurobiology of how trauma effects patients' body and mind, we see how for some the trauma itself serves as a way to self-discovery and insight, whereas with others it does not. Further, the fear of facing the impending reality of these internal non-integrated memory/sensations of trauma freezes these patients in place, while the shame of being different and humiliated due to their trauma demoralizes these individuals (Treleaven, 2018). While applying mindfulness in working with those in this latter group of patients, fear and shame become identified as the factors keeping them stuck in their trauma (Treleaven, 2018). To be susceptible, therefore, to feeling petrifying emotions that put the central nervous system (CNS) into a fight/flight/freeze state causes more fear to spread in both mind and body, forcing the patient to try and suffocate these sensations of terror and helplessness by burying them inside.

Although countless patients benefit from the wonderful help provided by psychopharmaceutical medications as they regain some sense of normalcy to have a decent life, as a culture we have generally stopped at suffering; it comes as to no surprise, therefore, to see

patients often become convicts of their own convictions (Burns, 1999). Today, there is an explosion in anti-depressants and antipsychotics, especially those that are being prescribed to children and teens (Preston et al., 2015). It is no wonder then to find depression becoming an epidemic in our modern age, while few among us pause and consider how through encouraging the use of drugs without looking at other ways of remedying the dysregulation within the person is both unethical and clinically nonviable (Peele & Thompson, 2015).

Many of the patients today who come to therapy and many more of those who have not yet found their way to a therapy session, are unable to hold and process their emotions, which is often termed as affect dysregulation (Schaefer & Drewes, 2014). Given the nature of how children learn through seeing, we can fathom how the impact of witnessing emotional dysregulation in the adults in their lives, leads many if not most of these children to having affect dysregulation themselves when presented with myriad life challenges at various developmental stages, wherein they also fail to meet their milestones, and especially so once they become adults (Siegel & Bryson, 2011). This does not need to be the case, and herein the Buddhist wisdom has a great deal to contribute to the field of therapy by directly allaying the suffering of patients, while showing them how to develop the curiosity in how the mind works (Tejaniya, 2016).

Given the world we live in that is saturated with information and social media, it is no wonder how individuals have lost their ability to modulate and find their bearings, and become able to self-regulate their emotions, as a result of which they choose bitterness, self- or other-neglect, negative self-talk, or self-alienation in dealing with their emotional and mental disorders (Levine, 2010). The inner commentary or self-talk in individuals experiencing suffering is often observed to constantly engage in comparing themselves to others and their own experiences, while holding a rigid position that leads them to being critical of themselves (Hanson &

Mendius, 2009). By looking at pain experientially, with right mindfulness and understanding, however, patients receive the psychoeducation of looking at all experience, both good and bad, as an impersonal process taking place in the presence of the appropriate conditions (Vimalaramsi, 2014). Of course, here the individual's role or responsibility is also delineated as a key factor in the unfolding of their experience of feeling good or bad (Tejaniya, 2011).

We must be quick to indicate how many of the circumstances that lead our patients to seek therapy include a history of domestic violence (DV), sexual trauma, physical abuse, partner violence, and substance abuse, among a slew of other risk factors (Winek, 2009). Here we need to clarify that although the circumstances of the past often remain out of one's control, the manner with which one relates to these events or consequences, however, is often within one's control. Guiding the patient to arrive at this understanding requires the therapist to be gently responsive, while applying loving kindness, compassion, clarity of delivery, and softness of heart, instead of looking at diagnostic and protocol manuals coldly using a set of interventions that are to be used given the symptoms of the patient presented in session (Yalom, 2002).

What is required then is allowing the person to learn to explore different possibilities for themselves beyond what they have been accustomed to, i.e. living a maladaptive reactionary life, going from bad to worst form of existence. All forms of therapy, in one way or another promise or claim to have been formulated to serve this purpose of reducing suffering, at least temporarily (Van der Kolk, 2015; Yalom, 2002; Whitaker, 1989). Fortunately, this state of maladaptive reactionary life is not the case for everyone as patients acquire resilience based on how they respond to stress. In discussing stress, a term that encapsulates the struggle with the fight-flight-freeze experience one undergoes when in an emotionally demanding if not traumatic situation, one cannot ignore its significance as it relates to one's growth as a person with an expanded

repertoire of skills and adaptabilities. Today, researchers have concluded that the manner with which we handle our stress results in either empowering or numbing us. This, because even though we may find ourselves calming down via some stress management techniques, we may also be reducing our coping skills, rendering us both inadequate and unwilling to face challenges in life which in turn limits growth (Baniel, 2009). Because of the presence of resiliency, thus, many discover the truth about how at times we learn by what we do not have at our disposal (Hanson, 2013; Siegel & Bryson, 2011). These are the success stories.

Our future is nowhere else embodied than in our children, who much like adults when given the opportunity of being heard, in the presence of empathic and responsible adults may learn to express their emotions without the addition of guilt, or any distortions of the truth (Aronson, 2012). This is skyrocketed by children's natural ability to ruminate and imagine possibilities in the presence of safety and congruency manifested through the behavior and expressions of adults. With loving discipline, care, and proper education, children thus grow into healthier and more self-regulated adults, aware of their emotions and genuine mouthpieces of truth, which they can use to gain insight about themselves and the world (Lewis, & Haviland-Jones, 2008).

In the field of children's literature, we have seen efforts made to indicate how children often engage in "inner bullying," calling themselves harsh and cruel names, thus failing to extend kindness and compassion to themselves, including extending this attitude towards their bodies. In her work, *My New Best Friend*, children's author Sarah Marlow helps children develop the groundwork for self-efficacy and emotional resiliency, where instead of finding themselves being lost in maladaptive thoughts, or being unkind and lacking compassion towards their bodies, children are shown how much showing kindness and understanding while addressing others'

needs, they are inculcated to become gentler and softer towards themselves as well (Marlow, 2016). This contrasts with the narrative that makes many a parent be oblivious of the fact that their child is bullying themselves, instead of being bullied by another, something that once realized and addressed early through specific therapeutic interventions can reestablish a child's self-regulation and sense of wellbeing, as well as encourage kindness towards oneself (Marlow, 2016). When it comes therapy, demonstrating empathy to alleviate symptoms of depression would be through modeling it to our patients. This helps patients facing disturbances in their neurodevelopment create new patterns instead of repeating old ones (Dixon, 2007).

Here, incorporating the *brahmavihāras* in therapy becomes especially relevant. In their seminal work *Altered Traits*, researchers Goleman and Davidson collaboratively produced a definitive book on the science of meditation and its influence on the biochemistry of patients, an area of study they rigorously explored, as well as applied individually in their own lives as a form of practice (Goleman & Davidson, 2017). They show in this work how mindfulness and the application of the *brahmavihāras*, specifically compassion, can help a person tremendously in understanding and overcoming their maladaptive symptoms. This, in relation to the biochemical footprints they leave on the brain, as well as the body, thus leading researchers in the right direction in their quest to understand the effects of trauma.

In considering the benefits of mindfulness as an intervention, we must also include then the similarities it shares with having and developing a secure attachment relationship with those individuals that are safe in a person's life, which in the context of treatment must include the therapist, given a strong therapeutic relationship. However, this does not present us with the entirety of the formula for success in the administration of any intervention as such, for this requires several other ingredients as no therapeutic tool functions in a vacuum. Mindfulness,

similar to a secure attachment, has the ability to enhance and further strengthen the activity levels between our sympathetic nervous system (SNS) and the amygdala (the emotional center in the brain) (Hanson, 2013). After all, not having a secure connection between these important parts of the brain is sadly what is observed in those with insecure attachments, who have a preoccupied stance towards their emotions, hence leaving them unresolved (Wallin, 2007). Again, one comes across the need for a stable presence of a safe and secure individual, especially in the treatment process, i.e. a relationally and empathically conscious clinician, to make the intervention work. Thus, along with other variables, such as empathic listening and attuning to (and with) the patient, the application of mindfulness practices in conjunction with an understanding of the Four Noble Truths, as well as relationally connecting with one's own patient and doing so with compassion, come to formulate the recipe for an effective intervention such as the MG.

2.4 Mindfulness and ethics. Traditional secular mindfulness techniques are often geared toward having the practitioner pay close and sustained attention to whatever comes up in the mind or is experienced in the body. For many trauma survivors, however, this may lead to exacerbation of symptoms where the person may even become re-traumatized due to the mindfulness practice (Treleaven, 2018). With an emphasis on 'being present,' mindfulness in its secular pedagogy often is removed from its broader nexus of principles originally designed to help individuals overcome suffering, where instead it finds itself rarely discussing the role of ethics (Kabat-Zinn, 2013). Researchers in the field of psychotherapy like Wallin introduce mindfulness practice as a way to get to know one's own mind (Wallin, 2007). Jack Engler, another researcher on the subject of the correlations found within psychoanalysis and Buddhism, even describes the moment to moment attention given to psychophysical phenomena, where there is hardly any reactivity taking place within the person's mind, as a process where all

manner of psychological stimuli get to be "reinvested" with conscious awareness, resulting in the background mental functions to be brought to the forefront of awareness instead of being automatically regulated (Engler, 2003).

What is being explored here therefore is the question, "What do we mean by being present?" After all, for decades Eastern Thought and many modern New Age proponents have been talking about this, telling their followers to be "here and now!" but with elaboration. Unfortunately, this mystical reference to the "present/now" time and place has often been seen and understood as an end in itself, for when the suffering comes to one's sphere of experience, the person stands there nakedly, alone, to bear all that the present may have in store for them. It is no surprise therefore to see patients wanting to dissociate and evacuate their bodies of awareness. Here we can add that, although researchers like Jon Kabat-Zinn have been promoting secularized modes of delivery for mindfulness as a form of intervention for reducing stress, as in MBSR, they nevertheless have come to also "denature it in fundamental ways," (Williams & Kabat-Zinn, 2011). This is a recipe for more suffering. After all, can mindfulness without ethics truly be called wholesome? (Payne, 2015).

Much like removing a crucial part of an equation out, when factors such as moral discipline or virtue and wisdom are left out from the pedagogical culture that finds itself subsumed under the fashionable lens of mindfulness, we run into problems. Thus, it is no surprise that mindfulness today often leaves much to be said in providing a sustainable and lasting intervention to help people in dealing with their personal, emotional, and psychological suffering (Jayasaro, 2014). While scholars such as Jay Garfield of Smith College point out the importance of cultivating ethical discipline, some other secular mindfulness proponents such as

David DeSteno of Northeastern University, are promoting a mindset of disengaging mindfulness altogether from its ethical backbone (Garfield, 2011).

2.5 Empathy: the foundation for the relational model. Whether amid therapeutic circles, pop psychology, media, and even politics at times, the usage of the word "empathy" today has become commonplace (Gladstein, 1983). This is no surprise, for empathy happens to get closest to representing the experience of "feeling with" another person (Wallin, 2007; Gladstein, 1983). Applied in this way, especially when we, therapists are urged to come back to ourselves while working on our "self of therapist," empathy has the potential to make us better human beings, well-suited to help our patients in the room. After all, the journey begins within oneself, for the moment we stop empathizing with and understanding ourselves, we do the same with our patient on a deeper level. This helps us avoid merely developing a series of lifeless interventions, followed by equally lifeless treatment plans, depleting our sessions from their life-enhancing potential for both therapist and patient (Yalom, 2002).

The empathic clinician or therapist must have a charitable view of the patient (Christensen, 1998). It is for this reason that the playful, authentic, and fully present yet humorous attitude of certain therapy models such as that of the symbolic-experiential therapist, can bring about a sense of ease and "reality" to the whole experience of family therapy (Whitaker, 1989), facilitating symptom relief and thereby promoting what some researchers have called "post-traumatic growth" (Kalaydjian, 2015). To this end, the role of transparency with our patients is key in deepening the therapeutic alliance that must be worked on from the initial meeting in order to have a fruitful treatment. Healthy relationships function on transparency as their foundation; expressing vulnerabilities therefore is a crucial part of treatment (Christensen, 1998).

Therapy is in part an education in relationships. This is especially the case in regard to one's relationship with oneself, which also includes the physical body. We are creating an atmosphere of love, of generously letting go of our pain, our suffering, by restfully staying in the body in a safe therapeutic atmosphere. The act of giving up of our hang-ups and attachment to our trauma becomes a liberating practice (Jayasaro, 2014). However, until this transformation takes place, some patients having negative beliefs about themselves as in the case where there is a lack of safety or security, fall into depression while becoming further negatively biased (Hanson & Mendius, 2009). Unfortunately, this negativity bias, which the brain has developed as a form of self-preservation in the face of challenging and life-threatening circumstances within the environment, is often left un-investigated. Lacking the function of discretion, those introduced to mindfulness, especially individuals with hardly any knowledge of the place of mindfulness in the grander contextual relevance within the tradition of Buddhism, may easily be pulled into a state where they cannot distinguish between what is wholesome or good, and what is unwholesome or bad.

This is especially reflected in the way children begin their brain information processing by constantly going back to old outcomes, i.e. rewards or punishments of actions or expressions of their emotions from the past. Evolutionary psychologists and other scientists propose that this may be an evolutionary trait for the brain, in trying to keep us out of harm's way. Here, we need to provide a healthy balance between both parents and teachers in helping to "mold" the child's brain, whether through speech or role modeling (Hanson & Mendius, 2009). By skewing reality thus, life for these people becomes based on one's own feelings *about* how they see the world in and around them. Willingness to this acceptance plus committing oneself to a treatment plan that

addresses the reappraisal of these negative biases, leads one to behavior change (Siegel & Bryson, 2011).

In treating children with various traumatic disorders, relaxing the body is one of the key steps that needs to occur first before moving on to other functions such as helping patients develop empathy towards themselves and others (Hanson, 2013). Because relaxing takes place as the central nervous system "feels safe", as mentioned earlier, in order for us to feel safe with others, we need to first feel safe "under our own skin," (Porges, 2017; Hanson & Mendius, 2009). Thus, researchers have demonstrated the importance of empathy correlating it with the experience of safety, starting with the therapeutic alliance and in the design of interventions that help patients move from idealized fantasy to acceptance of reality, whereby external situations are distinguished from internal ones (Siegel & Bryson, 2011). This allows patients to develop the ability to self-regulate their emotions, as they understand the connection between their psychology and behavior (Conway, 2014).

Being social animals that respond to empathy, as clinicians one of the best ways to demonstrate empathy to patients is to help alleviate their symptoms of depression through modeling the capacity to care and have compassion towards them (Yetunde, 2011). Here, the effectiveness of a therapist's ability in bringing about a higher state of awareness within patients by mirroring their experiences has been clearly demonstrated (Blum, 2015); this can take place by intentionally relating back to the patient either through "conscious somatic body-based empathic reflection," or "psycho-physical empathy" (p. 115-116). This is especially true when we are dealing with patients facing disturbances in their neurodevelopment as they are often stuck in patterns of repeating old unhealthy experiences (Siegel & Bryson, 2011; Keeney, 1983).

To address the previously stated negative impact of trauma, the presence of empathic involvement that considers the effects of fear and shame is indispensable for an effective treatment plan that would be followed in ameliorating patients' symptoms. Empathy itself, although a crucial element in making most interventions palatable for patients, however, cannot go far without a truthfully present participation, i.e. mindful and grounded presence on behalf of the clinician also. This truthful participation on behalf of the therapist has the power to cut through the patients' jaded point of view *vis à vis* the world, which spreads beyond the single patient into the microsystem of the family or population group itself. Hence, helping the individual family member or patient to disarm oneself from the negative emotions of anger, rage, resentment and their merciless hold on their very being, allows the family to heal and indeed, the whole society (Kalaydjian, 2015).

The very ability to develop affective empathy to respond to another's pain is now a difficult task, even within therapeutic circles (Gladstein, 1983). Further, the psychologist and founder of the Emotion-Focused Therapy (EFT), Dr. Leslie Greenberg explains how given the recent research in the area of interventions geared towards empathic relationships and evidenced-based treatments, therapists now have a better understanding of emotions, which comes to greatly help us in designing appropriate interventions for the range of affects identified (Greenberg, 2015). These span from awareness of adaptive emotions to the regulation of dys-regulated emotions, and the transformation of maladaptive ones.

Needless to say, empathy on the part of the therapist includes knowing *how* to introduce interventions as well as *when* to do so. Having pointed out the importance of stress, as responsible therapists, we must know our patients and *how much* they would be able to tolerate or even want to gain awareness of their body, feelings, mental states, or explore the theme of the

negative cycle of trauma they have been victims of (Van der Kolk, 2015). This is especially the case with those having experienced complex trauma that requires far greater attention and a variegated treatment approach than mere introduction of an intervention. If we are to "impose" interventions on patients when they are not ready, or even worse, when those administering are not well versed in them or short of considering the multi-layered unique circumstances of the patient and their symptoms, one may at best produce short-lived or in some cases, even detrimental results. For example, *trying* to relax causes more tension in the brain and body (Martinez, 2016), whereas by gently allowing ourselves to just fall back into the body first, while giving it awareness as we notice where there is tightness, one can slowly but surely help the mind slide into a state of relaxation (Vimalaramsi, 2012; Punnaji, 2011a, b, c). Throughout this study, clinicians were instructed to use their own discretion and clinical judgment when it came to choosing the appropriate time within sessions to use the MG. They were encouraged, however, to use it in the beginning and end of sessions to establish the patient in space/time. This was especially recommended for certain populations, such as patients struggling with ADHD symptoms, given their challenges with maintaining attention, as well as being hyperactive.

2.6 Awareness, intentional remembering, and PTSD (post-traumatic stress disorder). Robust research has now produced enough data that turns once held hierarchical top-down theories that explained how our thoughts control everything we experience, on their heads (Hanson, 2013; Van der Kolk, 2015; Fischer, 2011). This is simply captured in the phrase, "the body initiates, and the mind follows" (Levine, 2010, page 135). Scientists now see how the collection of our thoughts, memories, and awareness of what we do and think, is a complex web of not only what we do, but also of what and how we *feel*. In other words, the intrinsic motor activity of our biological functioning forms our understanding of both past and present;

interactions with our environment form the very fabric of our living experience and memory (Levine, 2010).

Early childhood trauma hardwires the brain due to the ancillary environmental factors taking place around the event, as perceived by the child (Hanson & Mendius, 2009). In the hands of a competent therapist undertaking a careful assessment of the patient and their history of symptoms, as well as the timeline of symptoms, it is not surprising to find that many of our patients may be suffering in fact from complex trauma, the result of many other traumas (Siegel & Bryson, 2011). Additionally, neuroscientists have identified that repressed emotions cause reduction in blood flow, as the autonomic nervous system's response to the situation, which drops our immune system's white blood cells that are needed to keep our immune system strong enough to fight disease (Hanson, 2013).

On the opposite side of the spectrum we find Prolonged Exposure (P.E.) therapy, originally devised to address the symptoms of veterans experiencing PTSD, but which now is being used to help adolescents (Foa, Chrestman, & Gilboa-Schechtman, 2008). According to Prolonged Exposure (P.E.) Therapy, memories cannot hurt the patient; in fact, the memories that are intentionally awakened are seen as beneficial tools for patients' treatment. However, this is a model that many therapists are cautious in using with patients, especially given the drop-out rate of patients from therapy due to its intensity if not done carefully and through gradual progression in the presence of a solid therapeutic alliance between patient and therapist. This, because for many victims of trauma dealing with the devastating impact it has on their lives, the last thing they would want to engage in is to repeatedly relive the details of their trauma (Foa et al., 2008).

Many patients in fact, given their trauma and their willingness to address them, may instead choose to deflect. What is meant here by deflection is when instead of answering to our

questions, patients answer what they want to address to avoid the most important aspect of their situation. The verbal, in other words, becomes the least reliable or least relevant source of valid information for the therapist, as one becomes more adept at reading patients' nonverbal cues. Therefore, having a therapist who is comfortable with one's own body is essential for successful treatment to take place, because this would be felt by the body of the patient (Van der Kolk, 2014; Levine, 2010). Whether working with an individual, a couple, or a family, staying with the body results in bringing these individual family members closer to each other where one starts to co-regulate with the other. This happens with individuals as well as partners, because the person we regulate with is also the one we trust (Greenberg, 2015).

What we need to remind ourselves is that trauma therapy does not mean that one has to hurt in order to heal. In other words, we do not address the events in the patient's life when we can work instead on treating the patient, as they begin to heal the moment there is acceptance. It is this atmosphere that is facilitated with the unconditional acceptance on the part of the clinician (Greenberg, 2015). We cannot feel safe with someone unless we feel safe in our own bodies first. Thus, in mindfulness interventions, we as clinicians need to be cautious that patients are not pushed too quickly into sensing the fullness of their trauma, especially in experiencing the intensely negative emotions within the body, thereby incapacitating oneself from being able to reflect on them. After all, the very fact that the CNS is designed to protect the body/mind, it will seek to dissociate as a form of self-preservation, this in the face of re-traumatization by having the patient "sit with the sensation," as it is often taught by modern secular mindfulness advocates (Treleaven, 2018). Thus, we need to be aware of these factors before being too eager to force mindfulness, i.e. "top down model" of cognitively forcing the body to undergo experiences (that it is ill-equipped in fully facing) on patients (Siegel & Bryson, 2011).

2.7 "Right" vs. "wrong" mindfulness. The world today is being inundated with the benefits of mindfulness, whereby one does not need to be working in the field of spirituality or psychotherapy to see this. The ability of the brain to enhance its capacity for growth and to decide on developing new patterns, as patients are encouraged to interrupt the function of negative maladaptive patterns, requires them to see and govern their cognitive/emotional behaviors. This ability to look at oneself goes beyond merely becoming aware of something, therefore requiring a deeper understanding that leads to wisdom, whereby differentiation takes place between choices that lead to a change in one's worldview. This is at the premise of what is meant by acknowledging the differences between right and wrong types of mindfulness.

In exploring what Buddhist teachings have to offer to this field, and aside from looking at primary sources within the Buddhist literature, i.e. the Pāli *Nikāyas*, the work of two modern teachers of Buddhist meditation (who happen to be two of my meditation teachers) have been crucial in this research project. These include Sayadaw U Tejaniya and Ven. Vimalaramsi, both of whom are senior Theravāda Buddhist monks and Buddhist Meditation teachers, who have focused on using the *Satipaṭṭhāna* but through incorporating a relaxed attitude into their individual practice (Tejaniya, 2010; Vimalaramsi, 2012). Here, it has been key to assiduously adhere to living a virtuous life, i.e. via the precepts, along with an emphasis on relieving pain and suffering in the here and now, as emphasized within the *Nikāyas* (Vimalaramsi, 2014; Kraft, 2013). This seems to be contested by modern proponents of mindfulness within the therapeutic arena, such as Dr. Jon Kabat-Zinn, via MBSR (Kabat-Zinn, 2013), which he popularized, as well as mindfulness-based therapeutic modalities like DBT and CBT (Dattilio, 2010). Contrasting these secular renditions of mindfulness with those of Buddhist teachings will be addressed in this

study, especially as they relate to the three trainings (virtue, mental cultivation, wisdom), and how these play a crucial role in the overall wellbeing of the individual in therapy.

- ***Mindfulness, as presented in the current culture.*** Mindfulness, as it is taught in today's culture, at least within the therapeutic arena, often finds itself lacking the factors that lead to wisdom and insight, which enable a person to break away from being a prisoner of unhealthy habits. Much like a highly cherished heirloom recipe that includes several ingredients, when most of its key and time-tested constituents are removed except for one, understandably, we may surmise that the outcome will in no way be what the recipe originally entailed. This is the issue around my topic on mindfulness, as it is generally taught today. Given the nature of the prevalent interest in the field of mindfulness during the last decade or so, it is no surprise to find how today many disparate areas of human endeavor are using the buzz word "mindfulness" in attempting to peak readers' interest, in contexts ranging from food to better sex (Mintz, 2013). This is no surprise, given that we do find such skewed interpretations of mindfulness as a way to gain more pleasure even in the suttas, where a monk is described within the *Alagaddūpama Sutta* ("simile of the snake"), for example, proclaiming how the Dhamma and the pursuit of pleasure are not in opposition to one another (Ñāṇamoli & Bodhi, 2001). Needless to say, he was severely chastised by the Buddha for his deluded views.

Today, mindfulness is seen as a pursuit to a "feel good" state, which is also generating a backlash due to its relapse rate with patients dealing with addictions, anxiety, depression, and other mental illnesses. This may not come as a surprise given the preponderance of many a weekend mindfulness teacher certification courses that are being offered across the country with such well-known secular teachers as Jon Kabat-Zinn (Kabat-Zinn, 2013). While well intentioned, many so-called experts are in fact under-qualified according to proponents of mindfulness

meditation such as Dr. Florian Ruths, a consulting psychiatrist at London's Maudsley hospital, due to the rising cases of patients who are developing depersonalization symptoms (Booth, 2014). With its spread, mindfulness today has an urgent need for adequately trained teachers, who approach the technique from a systemic perspective (Winek, 2009), especially while addressing patients' mental health needs experientially by joining into the experience of the intervention (Blum, 2015; Test, 1981). Hence, to be able to appropriately apply mindfulness means making sure not to leave out crucial elements of the meditative practice, which arguably require a deeper exploration of mental cultivation through embodied and somatic mirroring (Blum, 2015), as well as encouraging the patient to slowly and compassionately make space for the experiencing of trauma instead of dissociating from it (Schore, 2011), as they learn to self-regulate (Ogden & Minton, 2000).

Not understanding the role of greed, aversion, and delusion on what is passing through our six sense doors may very well serve to further confuse an eager-to-learn public. After all, what is often worse than a lie is misrepresenting (or partially revealing) the truth to individuals, or "manicuring" it to fit the palate of a public that is becoming ever so mesmerized by the fashionable theme of mindfulness. In my work with yoga as a certified yoga instructor, creative endeavors, sports, even business, I have observed how mindfulness has been introduced to somehow enhance the lucrativeness of a business venture (Scott, 2017) and, in the field of therapy, even claim to replace medication by becoming a universal panacea. However, what needs to be asked is whether removing mindfulness from its original context of the three-fold trainings of ethics, meditation, and discernment, makes it *less than* what it is intended to be or do (Gauthier, 2013).

Here, a point can be made about meditation not being the same as therapy. Meditation simply is a tool that enhances the level of a person's capacity to understand one's experience and grow from it. Therefore, one's emotional and mental background assessment is essential; after all, that is what meditation teachers do *prior* to giving *individualized* instructions to their students, as steadiness of mind is established (Kallapiran et al., 2015). On the other hand, in the more traditional Buddhist mindfulness practice what we are finding are cases where the very intensity of being alone (or in a group) for long periods, such as in a meditation retreat, is sometimes placing the person face-to-face with the raw experience of being completely submerged in the "here-and-now," usually in the presence of intense negative emotions. This can and usually becomes problematic when other factors are not being considered while screening individuals for such trainings, especially for those beginners who desire quick results or have preexisting psychological histories yet want to engage in a serious program such as attending 10-day-long intensive meditation retreats (Treleaven, 2018).

Unfortunately, in their fervor to spread mindfulness trainings, many are foregoing this important step of assessing the individual's mental and emotional health, in addition to proper guidance and understanding of how to address such problems when they do occur, possibly due to lacking years of experience proper. One particularly disturbing example is the case of Megan Vogt, who attended a S. N. Goenka Vipassanā retreat recently in California. After completing the 10-day silent intensive *vipassanā* retreat, Ms. Vogt committed suicide trying in vain to contact the center for help. Aside from casting a rather dark shadow on the practice of meditation, the case of this Maryland woman who ended up having incoherent, suicidal, and psychotic thoughts, brings especial attention to the responsibility that we, as meditation teachers have in being extremely careful with what we present to listeners who are eager to learn (Vendel, 2017).

- ***Is mindfulness enough by itself?*** In my direct work with patients, I have seen the limitation in just becoming "aware" of the body or breath as a solution to their problems. By neglecting to consider that "mindfulness" as such is merely one tool and therefore not an all-in-one intervention, often a therapist will be doing the patient a major disservice. So, while many have been using mindfulness as a way to relieve stress, to deal with depression, or to overcome fear, unfortunately, they have brought about more emotional upheavals in their patients (Treleaven, 2018), whether in the form of dissociations, more anxiety, and in some cases even nervous breakdowns and suicide. Mindfulness, therefore, requires understanding, i.e. skillfully applied insight while connecting to the body in the reality of the present moment given the many experiences one is going through (Tejaniya, 2011; Vimalaramsi, 2012).

Thus, it is crucial to separate ourselves from simplistic ways of understanding, explaining, and especially applying mindfulness while helping patients work through emotional dys-regulation. This, however, is an unfortunate ongoing reality, yet a predictable problem amongst well-meaning circles within the mainstream movement of using mindfulness, such as graduates of Dr. John Kabat-Zinn's mindfulness workshops, and the derivative groups of individuals who continue to promulgate it. Furthermore, the primary function of mindfulness are the precepts, whereby we hold them in our mind and consciousness, guaranteeing us safety, given the control and responsibility that one can exercise thereby in contrast to events or memories of traumatic incidents from our past (Jayasaro, 2014). Using the precepts, i.e. living a wholesome life (by abstaining from using harmful statements about oneself, self-bullying, and in many cases, self-harm and "cutting") offers the patient protection against the unwholesome states of high-levels of anxiety, negative thought or negative self-talk, etc. To this end, patients become cognizant of the fact that stress in itself may not necessarily be a bad thing, for it can

easily become an impetus for a state of wellbeing, as in the case of placing the heart or cardiac muscles under stress via physical workouts in order to improve one's health, blood pressure, and overall quality of life (Hanson & Mendius, 2009). Failure of keeping and breaking of precepts, therefore, becomes a failure of intelligence or working with understanding (Jayasaro, 2014), especially when we consider that applying the precepts in one's life leads to freedom from suffering and its causes (Vimalaramsi, 2014).

- ***Moving the patient from avoidance to the present moment.*** A key ingredient for successful therapy is a firm understanding that therapeutic work takes place nowhere other than in the present moment, without pretenses (Frederickson, 2013). Using the MG, patients are slowly invited to turn towards their experiences that occur in the present moment, rather than running away from them or pushing them away into the future or blaming a past (Van der Kolk, 2015; Brewer, 2017). This is accomplished through gradual exposure, trust in the therapist, the process, and the therapist's intentions, i.e. being genuinely involved in helping patients develop a sense of curiosity towards positive outcomes (Blum, 2015).

While using MG, patients are shown how to gradually develop the capacity and tolerance to accept the Dhamma of the present moment, as it happens (Vimalaramsi, 2012). This has the potential to develop into a larger worldview where the constraining environmental or situational factors that may have brought about their disorder(s) can be seen for what they, i.e. processes that are conditional, therefore temporary and subject to change (Tejaniya, 2011). Although gradually, MG nevertheless helps the patient to notice and address the fear or anxiety experienced in the body usually perceived in the form of tightness in the body or tension in the brain (Vimalaramsi, 2012). By noticing them when they are still in their earlier stage thus, the

hindrances are better handled instead of having the person become victims to them (Tejaniya, 2011).

Researchers today have uncovered how self-alienation and structural dissociation are similar, each of which has the person separate oneself from experiencing life as it happens, while they live in the angst and suffering, fearing that the worst will happen if they remain in the present (Van der Kolk, 2015; Fischer, 2011). Thus, the patient becomes a victim of their thinking and their fear of impending doom, as they put on the impenetrable shield of refusing the experience of their bodies, while formulating different narratives conjured up to counteract the potential menace of the past, or fear of a dreadful future (Perls, 1973). Here, the therapist looks beyond the content into the pattern of behavior and communication, which are revealed as symptoms. It is here where, as Dr. Janina Fischer states, an expert in the field of trauma research, the symptoms become better able to tell the story than the narrative (Fischer, 2011). The question then becomes, "how do we help people befriend their vulnerability?"

Admittedly, one may quickly come to the conclusion that something more is needed other than promising practitioners to relieve their levels of stress, albeit temporarily. As Ven. Analayo mentions in his *Satipaṭṭhāna: The direct path to realization*, there is after all such a thing as "wrong" mindfulness (Analayo, 2003). As the Buddha mentions throughout the suttas, we need to be able to question our motives and objectives in a very critical manner (Bodhi, 2012). Investigating the wholesome versus unwholesome roots of states of mind, therefore allows us to make a clear distinction between worldly and otherworldly. The development of this quality or ability nurtures an intuitive ethical sensitivity that is an essential asset to establishing oneself on the path for a harmoniously lived life. It is here that the process of choosing our life through affectively aware spiritual living, allows us a greater understanding while finding a deeper sense

of connection owing to the principle of relating with others, but not without first developing the capacity to have a strong sense of relatedness with ourselves and our bodies, its sensations, environments, etc. (Frederickson, 2013).

Here, the same principle of inquiry applies to the purpose behind our desire to practice mindfulness, be it for enhancing our lives or reducing patients' mental disorders. It is here where the greatest benefit might be gained by patients who have undergone (or are continuing to undergo) traumatic experiences, while being caught in a vicious cycle of further suffering from one day to the next, without a relief in sight. The work of Drs. Barbara Frederickson, Bessel Van der Kolk, Dan Siegel, Pat Ogden, Peter Levine, and Rick Hanson, among others, is quite encouraging as they strive to develop evidence-based practices which are proving helpful in working with trauma patients while connecting them back to their bodies via mindfully reconnecting to the body (Frederickson, 2013; Van der Kolk, 2015; Siegel & Bryson, 2011; Ogden & Minton, 2000; Levine, 1997; Hanson, 2013).

By disowning the traumatized child within us, we are in effect just surviving the trauma. Incorporating modes of relaxation that suppress heavy and unresolved emotions from past fears, anxieties, and trauma for the sake of a sense of peace do more harm in the long run. In doing so, often patients are shown ways to disown the child within by dissociating from themselves and by acting out against their circumstances, all of which takes so much energy to do. This is the opposite of what wisdom or reflecting on the emotions, or the body's own reaction to different thoughts, sounds, sights, tastes, smells, and touch could initiate, bringing about a higher form of understanding within the individual. In essence then, this becomes a practice that nourishes well-being, contentment and inner peace (Hanson, 2009).

Here, the therapist engages with the patient while using the fragmented pieces of a self, in an effort to integrate them into a sense of wholeness. This coherent self, therefore, helps the patient feel safe and energized within, while adapting to and being flexible with situations, especially in relating with others and responding to circumstances outside of themselves (Wallin, 2007). However, when not applied appropriately or wisely, efforts of recovery including interventions that originally meant to bring about a state of harmony can even reignite a state of dissociation within the person, and/or their relationships.

2.8 Linking trauma with emotions. Attachment is not just meant to give us love, care, or a sense of belonging, but it is also meant to protect us from danger. Thus, the source of safety can also be seen as the source of danger. According to Dr. Janina Fisher, another key expert in the field of trauma research, our autonomic nervous system (ANS) develops according to the nature of this attachment. Thus, neuroscientists and psychotherapists both look at everyday experiences through the lens of memory and vice versa, whereby they have seen how our memories are shaped, as well as distorted at times by the new experiences and data coming in, thus effecting things like testimonials made by eyewitnesses. In this way, trauma can even cloud one's perception of the world, how they understand or perceive reality.

This impact of trauma on how one perceives the world can be significant to consider, especially when biologically speaking, negative experiences have made our amygdala susceptible to negative experiences, even the hypothetical ones, whereby cortisol is released by the hypothalamus (triggered by the amygdala) as it flows into the bloodstream, stimulating and "hijacking the amygdala" (Siegel & Bryson, 2011). The stress-hormone cortisol thus flooding the system eventually starts killing off cells in the hippocampus, which begins to shrink, thereby eliminating our ability to process information carefully and with consideration, which requires

calming down of the amygdala. As a result, we end up being stressed, worried, irritated, in other words, vulnerable to the vicissitudes of life, further perpetuating our negative vicious cycle (Hanson, 2013).

In looking at the inner state of trauma patients, scientists have looked at the limbic system of the brain, especially at the amygdala and its role in detecting threat from external stimuli, as it remains critical for the acquisition and expression of fear conditioning, while modulating social and cognitive functions (Hanson & Mendius, 2009). Further, the amygdala has come to be seen as a bridge between social perception and cognitive (attention and memory) functions, thereby ensuring that stimuli that are detected as potential threats are not only noticed, but especially remembered given the joint function of an active brain and emotion system. Depending on the situation, researchers observed how these result in an interpretation of either a threat (emotionally charged) or neutral, mundane events (Lewis & Haviland-Jones, 2008). In therapy, there is a saying, 'crisis trumps everything.' This is a reality that those in the helping professions work to learn the tools for and have the experience in effectively addressing, which Dr. Daniel Goleman calls "emotional hijacking," where the machinery of survival-based, emotional reactivity is minimized (Goleman, 2005).

According to the Polyvagal theory, after a traumatic experience a person's body attaches itself to the fear and holds on to it, in some cases for the entirety of one's life (Porges, 2017). This invariably makes the person feel uneasy while being around others, always anticipating some dreadful set of circumstances to unfold, as their central nervous system is always kept on high alert, maintaining a state of constant hyper-vigilance (Hanson & Mendius, 2009). Although the person may desire intimacy, and the experiencing of love and affection, however, their body will not allow this to take place, given the constant state of dis-ease and tension. Therefore, to

counteract this lifelong imbalance in trauma patients, researchers such as Drs. Porges and Van der Kolk, among others, offer for the person to practice techniques that bring awareness to the body (Porges, 2017; Van der Kolk, 2015), as one undergoes different experiences, not only when the person is safe but especially when there is some form of response to perceived threat. According to research, neurophysiologists can state that the information we base our world of experience upon is highly dependent on a person's own interests, goals, and objectives, especially when we consider how it is the response one has towards events that is significant regarding trauma, and not the qualities of events (Porges, 2017). To this end, a distinction is made between everyday memory (purposeful with the added influence of demands placed by the individual), and traditional memory, which is mostly concerned with the data recalled (Lewis & Haviland-Jones, 2008).

Here, of special interest is the autobiographical memory that is comprised of knowledge sorted according to certain periods of one's lifetime, as reflected upon what or how one views their life is to unfold. The method with which autobiographical memories are distinguished is through generative retrieval (active and intentional) and direct retrieval (outside one's own influence and open to immediate stimuli). These in turn are processed through the amygdala given their emotional signature or significance to and for the individual (Hanson & Mendius, 2009; Lewis & Haviland-Jones, 2008).

In his formulation of the term "window of tolerance" or the optimal arousal zone, according to Dr. Dan Siegel, a professor of psychiatry, one can tolerate and express emotions that one can think *and* feel. Therefore, people can think and feel at the same time (Siegel & Bryson, 2011). When considering the difficulties that many children face while growing up, we can see how difficult circumstances and traumatic events have tremendous impact on the kind of

life that they will be inheriting from their childhood by infiltrating the very thinking and feelings of a person during their earlier developmental stages. For many, avoidance becomes the only answer, because avoidance is a chemical response by our autonomic nervous system (ANS) to deal with trauma, and in the case of many children growing up, it is the feeling of being made insignificant. One needs to consider the fact that feeling memory is implicit, which means that we do not create a narrative as much as with emotional memory. Trauma then does not become a mirror event. We "remember" the event without words given that they are experienced as a memory (Fisher, 2011).

Emotional memory converts the past into an expectation in the future, something that trauma victims, and especially those struggling with PTSD, have to deal with and work through throughout their lives on a daily basis. Much like the handle of a pen holds the tip in place to be dipped into the ink, where the handle represents cognition and the tip, the emotion, they work in unison. Hence, in order for someone to feel jealousy, anger, fear, surprise, exhilaration, or sadness, etc. first there needs to be a series of thoughts that have already been reasoned, given various bits of data that are cognitively processed, i.e. causes to consequences or responses (Hanson & Mendius, 2009; Lewis & Haviland-Jones, 2008). Thus, how we relate to the thoughts cognized places the necessary emotional "weight" onto them, i.e. appraisals we attach to the significance of the thought, memory, or experience we have had in the present or past that invariably manifest in the body (Darwin, 2009; Ekman, 2007). Without adding one's flavors to things experienced, patients are slowly encouraged to see, hear, touch, taste, smell, and think free from outside factors such that are tinged by fear of past trauma or the dread of their future repetitions (Tejaniya, 2011).

This evaluation of one's experience and its processing, therefore, needs a level of cognitive functioning in the background to which our emotional responses are added, in other words, the meaning we give to stimulus received from our environment (Frederickson, 2013). The remnants of experiences for example, may manifest as they often do long after an event has taken place, whether in walking away from an argument or driving in LA traffic where road rage is rampant, hours later we may find ourselves still feeling emotions of anger, resentment, rage, etc. We find that this has reached alarming, if not devastating, levels in trauma patients (Ogden, 2005; Levine, 2010; Fischer; 2011; Van der Kolk, 2014).

Whether pronounced or latent, emotions manifest as a response to whatever is taking place in the mind as outside factors or conditions come to trigger, i.e. manifest the internal states within the body, where they may even be overwhelming, as in when we are suddenly moved to tears of joy and nostalgia in our heart or shake with fear of an impending disaster (Van der Kolk, 2014; Lewis & Haviland-Jones, 2008). Here we can further mention how schemas, which are "well-integrated packets" of information, offer us the data or knowledge about the world and events taking place around us, whereby they come to colorize the world given the external stimuli received (Lewis & Haviland-Jones, 2008). Based on the seminal work of Darwin, scientists today have learned how affective expressions are directly influenced by behavioral responses. In discussing the evolutionist approach to facial expression, we see how these "residual actions" occur in combination with other factors such as vocalizations, postures, gestures, skeletal muscle movements, and other physiological responses. According to this evolutionist theory, some facial expressions are universal and reliable markers of discrete emotions where discrete facial expressions correspond to underlying subjective experiences (Lewis & Haviland-Jones, 2008).

When social scientists and psychologists reveal to us how even our bodies are designed for connection and love, it is surprising to find how people are afraid of touching each other or even themselves, not necessarily sexually even (Fredrickson, 2013). So much stands in the way of receiving or giving love for a human being these days, to the extent that ways of truly connecting with each other, where basic human, non-pretentious, and relaxed conversations take place are becoming scarce. As social animals, we function primarily as emotional organisms, more so than other animals. After all, this probably is the reason why our brains take the longest time among other mammals to reach their full development. It is surprising therefore, to see how philosophy, mostly an intellectual endeavor, has treated emotion as a mere aspect of cognition, meanwhile minimizing its influence on the physiology, along with the social and behavioral dimensions of one's experience (Lewis & Haviland-Jones, 2008). The importance of emotions cannot be overstated here, given their ability to signal the "significance of a situation to a person's wellbeing." One's understanding and cultivation of emotions holds the key to having the person develop an intuitive knowing, one's inner wisdom (Bennett-Goleman, 2001), hence, the absolute need for us to process our emotions, instead of pushing them down or subverting them into lifeless embodiments of words. Thus, through empathy we may evolve and learn how to self-regulate by transitioning through an awareness of adaptive emotions, the regulation of dys-regulated emotions, and via the transformation of maladaptive ones (Lewis, & Haviland-Jones, 2008). This becomes quite relevant when we consider that the human brain has a natural and biological proclivity towards thinking about the worse or negative situations first, before considering the positives (Hanson & Mendius, 2009).

- ***Reflective mindfulness of the body and trauma.*** To begin discussing trauma the therapist needs to first conduct a thorough assessment of the patient's age, family history,

developmental milestones, psycho-social factors and environmental stressors among others, all of which come to delineate a clearer outline as to who the patient is and the extent of the underlying traumatic influences affecting them. In this sense, a fuller assessment becomes key in understanding the patient being presented at the session in front of us. What is also important to remember is that assessments can never truly be considered as complete, for they are ongoing within each session, especially under the watchful eyes of the prudent therapist. Data collected become constantly layered thus with stronger and more appropriate lenses that present an integrated purview of the patient and their symptoms, which thereby become better addressed while pursuing the treatment goals that were jointly agreed upon at the onset of therapy.

- ***Biological need for safety.*** As human beings, the need for safety is biologically inherent in us; the very sense of it is encoded into the fabric of our lives where it comes to full fruition in the relationships we cultivate, including and starting with the one we have with ourselves. Modern research in the field of higher brain function and its connection to the feeling of safety is reflected within what the founder of the Polyvagal Theory, Steven Porges calls the internal visceral sensitivities, which shed light on the importance our environments have on our developmental milestones and even creativity *vis a vis* the presence of threatening factors. The experience of trauma is known to impact our sense of reciprocity, belonging, mutuality, and attunement once there is an absence of these fundamentally crucial factors during the initial biological development of an individual (Porges, 2017).

Once experienced, trauma stays with us whether through physical scars or those that are invisible to the eye, i.e. memories that leave a person captive for an entire life, due to the merciless grip with which they continuously traumatize a person, long after the onset of the actual event(s). Because of the brain's inherent negative bias, the traumatized person finds

oneself re-traumatized with every decade as the brain reshapes itself along with the body to their own detriment, where symptoms of substance abuse, alcoholism, violence and aggression in turn lead the victim to traumatize others, thus a vicious cycle is perpetuated and suffering spread. Fortunately, the research done by trauma experts such as Dr. Bessel Van der Kolk, who has been helping countless trauma victims reclaim their lives and reconnect severed relational bonds, serves as evidence that the brain can develop the capacity for pleasure, self-control, trust and connection, yet again (Van der Kolk, 2015). One of the ways this is explained is through what Dr. Peter Levine describes as the "unspoken voice" of the inherent language of our body's expressions given the "dance of life" (Levine, 2010, page 11).

- ***MG's interdisciplinary scope and the cognitive/affective capacity of subjects.***

Whether we are trying to learn a new language, master a new skill, or even develop an appreciation for something, be it music or a work of art, to slow the pace of our thoughts, at least initially, gives us the opportunity to develop strong intuition in it (Kahnman, 2003). Slowing down intentionally as we observe the body or the breath, allows us the capacity to perceive subtle workings that are going on, which are at the foundation of cognitive-affective connections (Hanson & Mendius, 2009). This is what seems to be taking place when patients carefully follow the instructions for the MG. Thus, depending on the time the patient has to do the intervention and how deep they want to experience its effects, one may choose to divide the body into further and more isolated sections, mindfully allowing oneself to sink into each of the parts, while taking their time.

Depending on the capacity of patients to process and explore, another form of this intervention can be applied by incorporating breathing into each of the areas "scanned" as we zigzag our way up, gently gaze at them, "breathing" into each area at a time. Yet another

advanced form of this would include reversing the motion by moving backwards once we complete the upward motion, as we go over each area and finally end up back at the beginning body part. Here, we need to constantly remind patients to take their time as they scan their body, by slowing down the awareness that is moving around the body. Slowing down intentionally as we observe the body or the breath, allows us the capacity to perceive subtle differences. Here, we are reminded of how researchers have been developing programs to help children with learning impairment by slowing down the very sounds the patients heard, in order to assist their hearing limitations (Tallal & Merzenich, 1998).

If therapeutic models used today, unfortunately continue to have a singular theoretical approach, they will not be able to best help patients, hence not work. Therefore, what many are discovering is the value of having a poly-theoretical models' approach that includes many disciplines including biology, evolutionary psychology, neuropsychology, biofeedback, somatic experiencing and body sensate-focused therapies, etc. (Fischer, 2011). This interdisciplinary model is indispensable in effectively addressing our patients' needs, as well as monitoring their development through the stages of the therapeutic process (Gehart, 2002). Given the flood of data pouring in from discoveries made in neuroscience (Brewer, 2017; Frederickson, 2013; Hanson & Mendius, 2009; Siegel & Bryson, 2011), we have seen the value of developing a cross-collaboration between psychology and neuroscience where therapists benefit from research findings. Here, MG as an intervention attempts to address neurobiology, psychology, somatic experiencing, and biofeedback, among others. With the newly gained knowledge, therapy is moving from explicit, analytical, verbal, and conscious (rational left hemisphere) to implicit, integrative, nonverbal, and unconscious (emotional right hemisphere) (Schore, 2009).

- ***Dealing with trauma through Right Effort.*** In Buddhism, we are taught that all phenomena must be correctly understood, which leads us to use insight throughout all sorts of experiences that occur within this mind-body process (*nāma-rūpa*). After all, reality as it is seen, is none other than experience, beyond which there can be no absolute certainty (Bodhi, 2012). Through the practice of relaxing the body, one relaxes the mind and vice versa, one discovers 'a great purity of mind due to the absence of mental defilements (*kileśas*).' This purity is a result of understanding and therefore abandoning and not that of suppression of the hindrances (Ñāṇamoli, & Bodhi, 2001). Therefore, much like a doorkeeper, relaxed awareness of the breath allows us to guard the doors of our senses against unwholesome (*akusala*) states, while admitting only the wholesome ones (*kusala*), (Ñāṇamoli, & Bodhi, 2001).

Along this line of thought, we have the relaxed step being reintroduced by two of my meditation teachers, the American Theravāda Buddhist monk, Ven. Vimalaramsi, who calls his method Tranquility Wisdom Insight Meditation (TWIM) (Vimalaramsi, 2012), and Ven. Punnaji, who has striven throughout his life to reintroduce the role of relaxing and calming the body as a crucial step in fully understanding the connection between the body and the awakened mind (Punnaji, 2011c). They both teach how by relinquishing the tension in the brain (via the mind), one can go deeper and deeper into levels of stillness previously unknown. Ven. Vimalaramsi, for example, has developed the following technique to help the practitioner, which he coined as the "6 R's," namely:

1. Recognizing *the arisen tension in the mind (one identifies as craving, while investigating the mind)*

2. Releasing *the tension through letting go of the grip one has on craving for things to be other than what they are (aversion or dosa)*

3. Relaxing *the mind and body*

4. Re-smiling *which he identifies as introducing a wholesome factor into the practice*

5. Returning *to the object of meditation, and finally,*

6. Repeating *the whole cycle as many times as needed*

The emphasis here is on developing wisdom, but not at the cost of separating oneself from living and experiencing the truth of the present, or as Ven. Vimalaramsi calls it, the 'Dhamma of the present moment' (Vimalaramsi, 2012). Here, the person is encouraged to 'make meditation fun' and not to fight or try to change whatever is happening, but instead observe while noticing the distraction, which in this scheme is equated with craving (of wanting to have things be different than what they are), and then go through the entire 6Rs, but do so in a flowing motion rather than compartmentalizing each step. The method seems to incorporate both *samatha* (calm abiding) and *vipassanā* (insight practice); in fact, the yogis who happen to attend his retreats are known to experience and advance through the *jhānas* (deep states of absorptive understanding), as well as experiencing levels of insight (Vimalaramsi, 2014). According to Ven. Vimalaramsi, by using the "6Rs" one is essentially practicing a key step from the *Satipaṭṭhāna* (Four Foundations of Mindfulness), i.e. "tranquilizing the bodily formation" (*saṅkhāra*) (Ñāṇamoli, & Bodhi, 2001, page 146). Similarly, by using the 6Rs one is also practicing Right Effort (*sammā vāyama*), another key step of the Eightfold Path. This is explained through recognizing and letting go of the unwholesome (craving), and instead smiling and returning to the wholesome (object of meditation), whereby the steps of Right Effort are followed, i.e. prevention and elimination of unwholesome states, cultivation, and the maintenance of wholesome ones. Thus, according to the *Satipaṭṭhāna sutta* and its longer version found in the Longer Discourses (*Digha Nikāya*) (both of which may very well be responsible for the

introduction of "mindfulness" as such), one becomes fully aware of bodily and mental activities by tranquilizing and relaxing the bodily sensations and activities (Punnaji, 2011b). Therefore, one develops and puts into use the sensitivity towards various feelings without manipulation of feeling and sensations as one goes on tranquilizing (or relaxing) mental activities and working *with* and not *against* the hindrances (*nīvarana*) (Kraft, 2013).

By the same token, one may clearly see the importance of the breath in maintaining a *relaxed* state of mind, serving as a method not to necessarily enter into deeper layers of consciousness, but in the case of therapy, to allow the patient regain a state of balance, with a mind that is clear and able to make decisions after careful reflection (Brewer, 2017). This itself is one definition of freedom, where a person is no longer compelled to follow habitual patterns of behavior, sinking further into the downward spiral of maladaptive ways of thinking, the outcome of which is more suffering. It is, after all, the release from pain that patients are seeking, whether knowingly or unknowingly, every time they show up to sessions. Regaining awareness through reflective and aware living, following the steps of MG patients were shown ways to no longer float around uncontrollably in the tumultuous waves of past trauma, at the mercy of the emotional mind (Hanson, 2013).

This state of invited awareness, according to neuroscientists, is believed to assist in the integration of both the higher and lower parts of the brain, whereby the newly integrated brain begins to modulate the way one's body reacts to outside circumstances (Siegel & Bryson, 2011). It is here, with the practice of mindfulness or guided meditation, that the trauma patient is able to regulate their central nervous system's defensive responses through the rewiring of the neural circuitry in the brain (Porges, 2017). Considering the wider social implications of this, reigniting our society by availing of present resources in order to apply stringent educational standards for

new generations of humanity to learn critical thinking, may finally help turn knowledge into wisdom, which are two completely different things. This would also allow children to get back to nature and moving their bodies more, instead of relying on social media or the news to tell them what and *how* to think, hence helping them and our patients to genuinely connect with others to feel their pain *and* joy, i.e. empathically (Hanson & Mendius, 2009).

It is no surprise that scientists have even discovered activities like dancing to be quite therapeutic in their work with patients with mental disorders (Edwards, 2017). This makes one wonder whether our eagerness to medicate our young may in fact be taking away from them the opportunity to develop their neural networks that innately are designed to support and thrive on empathy (Hanson & Mendius, 2009). Here, we can define empathy as the capacity to feel the inner world of a person, which inherently functions in developing the very support such a person may be lacking. This is significant when we treat ADHD's co-morbidity factors, such as depression or low self-esteem as patients start feeling more and more isolated (Preston et al., 2015).

One could say that relating to oneself and others empathically is part of Right Effort. Hence, in one's clinical work with patients much like having the Right View is crucial to setting up a treatment pathway in the right direction, so it is with the effort being placed throughout one's therapeutic work. This comes alive during treatment and is distinguished throughout in the presence of the clinician's display of Right Effort. Realizing that we are social animals that respond to empathy, therefore, one of the best ways to demonstrate empathy and help to alleviate symptoms of depression would be for the clinician to model empathy to patients, the younger they are, the better. This is especially true when we are dealing with patients facing disturbances in their neurodevelopment as they are stuck in patterns of repeating old experiences. If we are to

accept the findings of neuroscientists that neurons are constantly forming new connections through experiences, wherein "neurons that fire together wire together," then it only makes sense to refocus our attention on the experiences ADHD patients have, especially in the introduction of new and healthy experiences (Siegel & Bryson, 2011). For example, in mindfulness meditation, one is led to new learning by drawing upon past data from experiences, but given the awareness of thoughts, feelings and behaviors in the present; a balanced steadiness of mind is achieved owing to the fact that attention shapes new neural circuits (Kallapiran et al., 2015). Herein, one begins the enjoyable process of making choices that do not solely rely on past habits, due to the rise of wisdom as lesser pleasures are relinquished in favor of greater ones, with longer lasting enjoyments (Hanson & Mendius, 2009).

- ***Trauma: Buddhism and science in dialogue.*** In discussing the attitude with which one relates to oneself, especially the physical body and its experiences, it is helpful to look at the Buddhist Teachings to gain a different perspective on the types of unwholesome thoughts that are at play in the presence of negative mental states. Thus, we learn about the three kinds of unwholesome thoughts, i.e. sensual thought, ill will, and aggressive thought, which produce blindness, lack of vision, and absence of knowledge, all obstructing wisdom. As a remedy, the Buddha offered the three counteracting wholesome thoughts that do not produce vexations in the person, i.e. thoughts of renunciation, of friendliness, and of harmlessness (Ireland, 1997).

If we are to study the teachings of the Buddha within the Pāli canon in a thorough manner, we may come to see that insight takes place along with recognizing *how* the mind works and unfolds, as one relaxes into the state of stability. This reflective practice, which Ven. Punnaji called the return to the original equilibrium, is achieved by establishing oneself firmly in mindfulness, whereby continuous awareness is maintained as one observes how the different

mental states arise and pass away, especially the maladaptive ones (Punnaji, 2011c). Seeing them, one develops understanding by not attaching to them any sense of identity (Tejaniya, 2011). This state of relaxed body/mind with full awareness, therefore, allows one the experience of a gladdened mind, i.e. giving the yogi a glimpse of what the Buddha mentions in the Dhammapada: 'We are the Happy Ones,' (Vimalaramsi, 2012). Approaching mind work thus, we may see how this itself becomes one method of applying Right Effort (or Harmonious Exercise) of the Eightfold Path. The point is further clarified as we look at the way the *Satipaṭṭhāna* stresses right effort as 'the relaxed and tranquil observation of one's own living experience' (Punnaji, 2011b).

Having a distorted view of the world means there is a lack of right view, rendering many fellow human beings unable to trust the world, life, and their surroundings (Haas, 2015). As sufferers of various disorders, our patients have reached a point in their lives where they simply are not able to process information correctly, where many are disconnected from their bodies, lacking the ability to feel, which drives so many to want to injure and cut themselves, and for some even to commit suicide. To this end, the six sense doors, according to Buddhism, are no longer providing information to help these individuals understand how things work, as far as information received truthfully from the environment. On the other hand, through trust and forgiveness one can learn to reconcile with and use the physical body as the bridge to reconnect back with the reality life (Van der Kolk, 2015). To make this happen, patients are to be reintroduced to their bodies; for those who having survived sexual trauma or abuse, this would mean forgiving their own bodies, while beginning to look at them with friendly eyes. This practice of forgiveness and manner of relating to the body, therefore, seeks to help the patient start by observing the body and its sensations as they are, without adding anything to them;

slowly but eventually, this could lead them to insight (Punnaji, 2011a). Therefore, with right view, while using the body to mindfully ground themselves as they maintain awareness of the six sense doors, patients begin to live again, and this time with freedom (Hanson, 2013).

Another useful way of relating to the patient experiencing suffering is to continue exploring the way they have committed themselves to the delusions of cognitive distortions, as their paradigm of looking at the world remains highly influenced by the fabrications or formations (*saṅkhāras*). These fabrications, as we know from the Buddhist Teachings, colorize our behavior as they are dictated by the nature of our thoughts that manifest in one's speech, both internally and externally, as well as in bodily actions. Here, the silent monologue (of the *saṅkhāras*) continuously and actively torments the patient who engages in throwing "verbal daggers" at oneself (through sub-vocal speech), and soon begins tossing them at others, thereby keeping one stuck to the cycle of ongoing state of blind and painful existence (Ñāṇananda. 1971). By *saṅkhāras* here one may understand the activating processes or the fuel that give momentum to one's living experience, based on past habitual patterns of behavior, be they thought, speech, or action-based. This may be also bridging the gap between our understanding of the Dhamma as a practice reserved to meditation, versus that of being engaged to the point where it can influence individuals in a therapy session. The latter is the case, because wisdom does not have a language (Sumedho, 2004).

If we look at the six qualities of the Dhamma carefully, especially the quality of its "timeless nature" (*akāliko*) and of being *"*immediately effective" *(sandiṭṭhiko),* one may begin to see that the Buddha gives the teachings with the clear intention that what he was sharing with us was something that could be practiced all the time. Given the nature of the work being done in therapy, this timeless quality of the Dhamma acquires a different emphasis on a moment by

moment basis for one is being liberated from the demons of the past, truly enabling them to taste the fruits of it during this present life (Vimalaramsi, 2014). Thus, if we understand the Buddha's teaching as applicable throughout one's life, and if we agree that most of one's life occurs outside of the meditation hall and away from the meditation cushion, then one's living experience (in the presence of our full sphere of bodily perceptions) must be seen as the very fuel that gives one energy to progress out of ignorance, by looking at and applying the information coming in through the six gates, and extremely valuable for that matter. This is another reason why working with trauma patients, who are in psychological and physical pain, offers itself as a prime area to demonstrate this quality of immediacy of the Dhamma (Tejaniya, 2011).

If we agree that the Dhamma is "immediately effective" (*sandiṭṭhiko*), in other words, that it is able to address one's vicissitudes of life, and therefore not intended to work some of the times only or be effective partially, then the value of our practice begins to bear fruit once awareness is brought into everyday life (Rahula, 1974). In contrast, if we were to look at *samādhi* as one-pointed concentration, we would see how there is a rejection of the completeness of human life, where experience is amputated by focusing on a single object and one being engrossed in it, which is what concentrating strives to do through the *suppression* of one's hindrances (Vimalaramsi, 2012). Mindfulness, understood thus, becomes not about the reduction of stress (Bodhi, 2009), especially when viewed in the backdrop of the person gaining wisdom and understanding, only after having gone through the vicissitudes and stressors of what a fully engaged life may offer (Tejaniya, 2016). If the evidence from our own lives is insufficient to demonstrate the verity of this fact, then we can look to science through its many disciplines, such as biology and astronomy, where we see a fledgling green leaf pushing its way as it penetrates through concrete or a star with its adjoining planets forming out of the nebulae that had resulted

from cataclysmic explosions of a once-destroyed massive star. In the same way, wisdom is developed through mindfulness *while* the individual faces the difficulties of the friction created given the presence of the three defilements, greed, ill will, and delusion (Tejaniya, 2010).

The Path called the Dhamma is designed to lead one to wisdom, but only after dealing with the obstacles presented by life, its traumas, relationships, and other unavoidable difficulties of living. Mindfulness is not a subtle method of escaping stress, nor achieving its reduction. It is important to note here that stress is not the same as *dukkha* or unsatisfactoriness or suffering, for if there is no stress in one's life, and all aspects of it are removed from one's life, that would essentially also negate the presence of character developing in a person. Whether looking through the pages of some mythological tradition from any human culture, even those seen in modern-day superhero movie remakes, the hero-to-be must encounter *and* overcome stressful ordeals, and by learning from them become the hero, yet another reference to the Gautama the *bodhisatta*, transforming into the Buddha.

Whatever practice one engages in needs to reflect some form of effect, which in this case happens to manifest the changes taking place in one's state of mind, i.e. personality changes that follow a specific meditation practice, thus bringing about the experience of serenity and insight, together in skillful cooperation. Through the Buddhist scriptures, we see how a calm mind is described to bring about a development of tranquility, which when supported by right view and wisdom, allows the development of deeper levels of insight (Dhammananda, 1992). Although not necessarily described as a supramundane level of understanding, when we are talking about insights gained within a person's treatment, the term *yathābhūtaṁ pajānāti* (seeing things as they come to be) as described in the *Nikāyas* may often take place at this point, and herein comes the role of appropriate attention (*yoniso manasikāra*), which equals being established in the

Eightfold Path, as the person applies mindfulness of their thoughts and experiences while witnessing and observing various states of mind come up (Bodhi, 2000). It is with this appropriate attention given to the present physical body, and with clear comprehension (*sati sampajañña)* that the individual suffering in both body and mind may learn to see the inevitable character of change taking place within suffering itself, be it a hurtful memory, fear, anxiety, or trauma. After all, within the Dhammapada's verse 277, we read, "All conditioned phenomena are impermanent"; when one sees this with Insight-wisdom, one becomes weary of *dukkha* (i.e., the *khandhas* or aggregates). This is the Path to Purity (*"Sabbe saṅkhārā aniccā'ti, yadā paññāya passati; Atha nibbindati dukkhe, esa maggo visuddhiyā..."*) (Dhammananda, 1992).

The confidence a patient gains after having experienced insight, therefore, is not from the outside, nor from the therapist, but ultimately from one's own level of self-revealing wisdom (Yalom, 2002). This wisdom is a result of the sense of safety that takes place within the patient, replacing their point of focus that had thus far dominated their lives, abandoning their attention to the negative coping mechanisms in the form of unwholesome thoughts, poisonous sub-vocal speech or self-talk, and maladaptive behaviors (Yetunde, 2011). Therefore, by changing the object of attention while adopting a new meditation object, mindfully grounding oneself in the body, change takes place within the person, as evidenced by the mind and body relaxing with a deep sense of inner freedom (Tejaniya, 2011).

This is the objective of *satipaṭṭhāna* – appropriate mindful attention to one's experience (body, feelings, emotional states, and mental objects) in a constant and involved way (Vimalaramsi, 2012). One finds the experience of *samādhi* achievable through the application of the teachings of the Buddha as found in the *Satipaṭṭhāna sutta*, wherein one becomes fully aware of bodily and mental activities by tranquilizing and relaxing the bodily sensations and activities

(Gunaratna, 1981). Here, the breath becomes inherently connected to the rest of our being, serving as a bridge while maintaining its unique and intimate relationship with our emotions, mind, and body (Analayo, 2003).

What the individual using mindful grounding is directed to do is not fight the invading negative thoughts, nor the various feelings experienced in the body, which has often been the case with many of the ill-advised methods of applying mindfulness, but to the contrary, it is allowing these sensations to be there without becoming engaged in and with them. In other words, these negative thinking energies are used in the MG as coordinates to establish and know one's true position in the present experience of living. The foundational part of one's experience that is anchored in the reality of the present moment for all these individuals, therefore, is the body, i.e. the North Star for their journey back to wholeness.

In studying the Dhamma as Buddhist practitioners, we see how through the practice of relaxing the body one relaxes the mind, a mechanism that in turn naturally relaxes the body further, which results in a cycle whereby one discovers a greater purity of mind being experienced due to the absence of mental defilements (*kileśas*), (Ñāṇamoli & Bodhi, 2001). This purity of gladdening the mind is a result of understanding that develops within the person, and therefore, not merely of being mindful of the different sensations taking place, which for many of the trauma patients would be quite detrimental (Analayo, 2010). With MG, patients are slowly introduced to a method that allows them to neither run away into different imaginary places or times by abandoning the realness of what they are experiencing, nor suppressing them. They are especially not being told to sit through and re-experience their anxieties or even worse, their horrible traumas. Instead, patients are gently encouraged to allow the experiences to manifest via memories, but while reminding the patient of these being mostly manifestations of the mind (due

to the memories), through verbal prompts that are designed to be used as benchmarks to help them become rooted in the presence of the body, while noticing the tension and tightness produced through the mental and emotional experiencing. Thus, one develops and puts into use the sensitivity towards various feelings without manipulation of feelings and sensations as one goes on tranquilizing and relaxing mental activities and working with the hindrances (*nīvarana*). Observation is key here; there is no manipulation or trying to force any specific mental (*dhammas*) or emotional states (*citta*) to come about, instead to be in a relaxed and mindful state that brings about peace, both within and without.

At this juncture, I am reminded of the words of the Buddha from the *Saṃyutta Nikāya*, repeated to me by one of my meditation teachers, Bhante Punnaji:

Piti manassa kāyam passambati.

Passaddha kāyo sukhaṃ vediyati.

Sukhino cittaṃ samādhiyati.

Samāhite citte dhammam patubhāvo.

Samāhite citte yathābhūtaṁ pajānāti.

When the mind is purified, the mind experiences happiness

When the mind is happy, the body relaxes.

When the body relaxes, one feels comfortable.

When the body begins to feel comfortable, the mood of the mind enters a state of deep serenity (samādhi).

When this takes place, Dhamma appears in the mind,

Thus how things come to be are revealed to a happy mind (SN 47:10; SN 55:40; AN 6:10; AN 11:3; MN 118; SN 52:13).

Therefore, one needs to go beyond merely working the body and focus on the work that is necessary in transforming the attitude one has towards what we understand as "happiness." Here, we need to understand that according to Buddhism, happiness is not the same as experiencing sensual pleasures, whereby one tries to avoid pain and maximize pleasure (while working to minimize pain). Knowing full well that we cannot have what our futile efforts promise, i.e. permanent pleasure, what one then experiences is a state of constant struggle to alleviate a state of discontent and dissatisfaction, the source of unhappiness (Punnaji, 2011a). In Buddhism we see how it is explained that the moment we desire something, the body becomes tensed. This tension makes us uncomfortable through the action of wanting to obtain the object of desire, i.e. releasing the tensions (Freud, 2017). This tension release is what we have come to accept as happiness. Disturbance takes place because of our reactions to the stimulations received through the senses. According to this understanding, therefore, happiness is not to be gained by stimulating the senses; it is a state of mind that is not disturbed. Thus, the mind that does not experience disturbance is one that has become tranquil, and therefore happy (Punnaji, 2011b). When the mind is calm, we experience happiness all the time, even if at times the body is exposed to painful situations. On the other hand, when we are hurting, we tend to hurt others, due to our emotional disturbances (Punnaji, 2011a).

We are involved with life either passively or as active participants. We can try and let go of the steering wheel as each turn and curve on the road takes the helm of our lives, at which point we discover life to be a confusing state of affairs, and we begin to ask questions that lead us on fruitless searches, much like the attempt of a dog to catch its own tail. Through the MG, we are teaching individuals to develop the mental calm, the emotional audacity and patience to become reflectively involved with life, and perhaps for some, for the very first time. As the Thai

Forest meditation teacher and student of the late Laung Por Chah, Ajahn Jayasaro beautifully states, our patience or endurance becomes the supreme incinerator of the defilements (Jayasaro, 2014).

2.9 Summary. The MG is not just another mindfulness practice that merely uses the body. It includes key principles that link its practice to the Eightfold Path, to the Four Noble Truths, even to the experience of insight, i.e. wisdom and the cessation of suffering, albeit on a mundane level (as opposed to the supramundane experience of *Nibbāna*). Thus, the intentionality carried into the therapy session via the therapist's willingness to alleviate suffering is authentically connected to the rich experience that is embodied in, for example utilizing loving kindness or compassion, rendering it inseparable from successful therapy.

Today, as a population humanity finds itself living through an exciting time period where seemingly disparate branches of research from neuroscience, neurobiology, neurophysiology, evolutionary psychology, bio-psycho-immunology, and psycho- and trauma-therapy are contributing an enormous wealth of information to explain what makes human beings be the way they are, as they point to the causes of suffering. The research outcomes are clear in their explanations that in order to heal the mind, not only the body with its causal and environmental factors must be considered but also the very involvement and responsibility of the individual in the choosing of one's thoughts, words, and actions, what is of indispensable importance. More than ever before in human history, there is a collective of scholars, researchers, and therapists working together as they come face to face with the 2600 years old teachings of Lord Buddha, and his clearly elucidated principles of *sīla, samādhi, paññā* that provide humanity with the roadmap for the alleviation of suffering. Given the provided knowledge, these various domains of scientific research are eagerly placing their data-backed conclusion at the fact that the mind is

the ‘forerunner of all states,’ as the Buddha declared in his very first verse of the *Dhammapāda* (Dhammananda, 1992).

Chapter 3: Methodology

Methodology

Growing up in a brutal world, I have seen the worst that one man can do to another, and I have been on the receiving end of some of it. As a child I grew up in Beirut, Lebanon, during its fiercest war, where I fell victim to it by losing limbs and a big part of my childhood. In a sudden deafening explosion, I lost a portion of my foot along with a massive head injury when a mortar attack, along with its shards of metallic shrapnel, took its toll on my eight-year old body. The trauma experienced from the explosion on that Sunday night in August was further peppered by a continuous stream of terrorizing events for another 17 years, which meant I would be haunted for a large part of my life with the symptoms of PTSD, depression, and anxiety. For nearly two decades not having access to anything related to the Dhamma, I had to grasp whatever spiritual or religious principle, doctrine, or practice I was able to reach. Therefore, after spending years looking for meditation practices ranging from yogic breathing practices of *Prāṇāyāma* and SRF's energization exercises, to sitting and watching the various sensations of the body in Goenka's or Mahasi Sayadaw's straight *vipassanā* retreats for another twenty years, I knew there was something missing in my practice. It became clear to me that although the knowledge gained was helpful in exploring trauma experienced, the full understanding had not developed that would incorporate the Buddhist teachings into them. In other words, the reconciliation of both body and mind, due to the latent presence of deep residual traumatic memories had not been allowed to surface, for they were suppressed given the nature of my one-pointed concentration practices.

What a person endures may at times truly push them to the utmost that is humanly possible, especially considering that one may never find out how much one can truly endure,

unless or until placed face-to-face with unimaginable circumstances that could test one's utmost levels of tolerating suffering, in all of its types. But sometimes, when faced with such trying circumstances, those may very well be exactly what a human being needs in order to bring forth a much grander and superior version of oneself, given the resiliency these ordeals may inculcate within the person, which in my case reached its highest pitch with the help of the Teachings of the Buddha, as I was reintroduced to them, but this time by directly accessing the *Pāli Nikāyas* and not the commentaries. Seeing the everyday situations with the matter-of-fact approach that the Buddha displayed as he addressed listeners' concerns and ailments, was enough to help me address my own traumatic wounds, while trusting the Triple Gem through this body. The enriching and lasting impact of these personal experiences was the enabling force behind the development of the MG.

What led me to this research project was the need I was seeing in a population of patients that was hardly able to find a sense of freedom from its dependence on long-term care. Patients were being passed on from one therapist to another, and in some cases from one agency to another, so long as they were in school where they could still get mental health services. Hence, when the opportunity presented for me to work as a mental health provider for a year at the agency called Partnership to Uplift Communities (PUC), as part of my graduate program in Marriage and Family Therapy (MFT) at Alliant University/California School of Professional Psychology, my decision was quick to agree to work there, given the population that was to be served and its enormous need for mental health services. In my effort to complete 500 hours of clinical and relational hours for my practicum at PUC, I started working with four schools on two different Los Angeles campuses, with two of them being Middle Schools, while the remaining two were High Schools, for the 2016-2017 school year. Working in this position was

on a purely volunteer-basis. While the patients (students) I was assigned to as their therapist originally numbered only eight, they increased to over 28 by the end of the school year.

While working with patients at PUC, we often saw cases with symptoms of severe trauma, sexual and physical abuse, depression, generalized anxiety, PTSD, oppositional defiance, anger outbursts, bullying, and a slew of other emotional, behavioral, and cognitive disorders. Soon, many of us clinicians discovered that for a number of those individuals in treatment, quite often the interventions introduced in order to help treat them were either limited in their effectiveness or were altogether ineffective. What was especially disturbing for me was the realization that in some cases, other interventions even proved to be counterproductive. This latter group included patients who were being introduced to mindfulness practices as utilized within therapeutic contexts.

These were frustrating situations that many of us, therapists, were faced with, when the willingness and desire to allay the suffering of some of the patients were proving inefficient especially in circumstances where mindfulness of bodily sensations or the breath, as well as guided imagery were being used as interventions. Often such frustrations involved these patients being negatively impacted by the seemingly “safe” interventions, such as mindfulness, especially when patients were finding themselves becoming more aggravated or angry, experiencing uncontrollable anxiety or conversely, they were witnessed breaking themselves off from reality completely, as they dissociated from their living experience altogether.

As therapists, we have a vast array of interventions that we can apply in our treatment plans given our specific theoretical orientations, i.e. Cognitive Behavior Therapy (CBT), Symbolic-Experiential Therapy, Narrative, Prolonged Exposure, Emotionally-Focused, etc. Many interventions, however, may at best suppress symptoms only to manifest a day or two after

the sessions. Here, while applying basic mindfulness techniques with patients, ages 12-18 years' old, I found myself having to address a series of mental health issues with interventions at my disposal that did not seem to work. The more contextual understanding I gathered, and the observations I made given their level of responsiveness to the interventions introduced, the better I knew how to proceed. It was here, once I was able to build trust with the patient, that I attempted to introduce an intervention that incorporated several aspects of mindfulness practice and brought it into the patient's body.

This turned out to be the Mindful Grounding (MG) intervention that brought forth positive patient outcomes with rapid progress towards their therapeutic goals in the form of a dramatic decrease of symptoms, thus leading to termination of treatment. Using the MG, patients were able to experience a sense of presence while consciously bringing attention to various parts of the body in a sequential manner. With a foundation in trusting the therapeutic process (and the therapist), this MG gave patients access to a sustained state of awareness of the whole body without drifting into the past or the future, given the involvement of multiple sensory modes of processing, i.e. visual, auditory, tactile, and kinesthetic perceptions, as they would find peace and relax into the present moment.

3.1 The MG: what is it? The Mindful Grounding (MG) was designed to address the need for an intervention that applies principles of body-mind connection while maintaining the patients' awareness of their thoughts, feelings, and behaviors within the present moment, and while maintaining a calm and balanced state of mind. The MG involved sweeping the body one part at a time as it allowed the person to look at different body parts sequentially, while establishing kinesthetic awareness of it. By bringing the focus into the current sensations experienced within the body, especially during symptomatic episodes, the MG facilitated an embodied self-

awareness, grounding the person in the here and now as opposed to dissociating or causing them to avoid their emotions (Price, Wells, Donovan, & Rue, 2012).

- ***Grounding in the details of trauma.*** To unpack the meaning of "grounding," it can be helpful to note here that structure in the form of establishing or grounding oneself in the body is necessary; after all, this is found in the details revealed in our assessments and interactions to be observed in the patient. Later, these details will become the very things that will be needed to challenge patients' distorted cognition. These details are necessary to be explored, for we cannot heal secrets. Trauma's prize is about moving on from it (Fischer, 2011). The way we have changed for the better is all that we carry away from having experienced bad things. The success of a treatment method lies in its ability to help the patient move away from the trauma, versus making the trauma one's own identity. Here, with MG, patients were taught how to contemplate their feelings, and how one feels and comes to *know* the world and oneself in relation to it, as they go through the steps of Mindful Grounding (MG), while sensing, through the body, the inner world of emotions and the outer, i.e. environment.

When emotions are left unprocessed or unaddressed in therapy, especially those that may be classified as maladaptive, and instead given a series of demanding or unpleasant situations, no matter the person's age or background, the individual facing them may simply react to these influences in maladaptive ways (Van der Kolk, 2015) such as by "removing" oneself from the emotionally charged situation, resulting in cognitive dissonance. One way of helping patients overcome many of the hurdles that stand in the way of therapy is through coping, but not at the cost of undermining or suppressing emotions. Therefore, no matter the trauma that many of these patients have endured, once these emotions are given a voice, patients become better able at reducing experiential avoidance as they learn to capably adapt to situations (Burrows, 2013).

This takes place without experiencing adverse long-term effects or perpetuating the trauma symptomatology, and instead increases patients' quality of life.

In using the MG with the help of an empathic therapist who maximizes the resource of the trust developed between oneself and the patient, the patient is gradually exposed to the trauma, by consistently revisiting it. Eventually, this takes place *in the presence* of difficult emotions that otherwise might have forced them to "flee the scene." However, given the sense of safety they feel in the therapy room with the therapist (initially), they develop a sense of tolerance to allow themselves to breathe into the emotions, while being grounded in their bodies.

By learning the MG technique/intervention, patients were shown to stand in the present moment, pause and occupy their body, and own up to what is happening in the immediacy of the moment, as they reflect back into whatever reality they experienced through the body. This means not looking anywhere else, nor being victims of old reactions, and instead standing with a new vantage point with a freeing vista that helps transform their interior landscape (Bennett-Goleman, 2001). Through repeated sessions, and by constantly going back to mindfully grounding themselves, patients can begin asking questions like: *What is happening? Why is this happening?* This opens the door for more understanding, i.e. Second Noble Truth, and Third Noble Truth, whereas the MG itself helps them practice the Fourth Noble Truth as a way to experience relief.

- ***Uniting feelings and thoughts through body awareness.*** Without having a clear understanding and awareness of one's own emotions and their connection to the body, how can we connect or even relate to each other? Essentially, this is often at the crux of many relational problems that children perpetuate as they grow into adults and while they build their own families. However, as with adults, children's ability to master these and even gain insights

through their feelings and thoughts differs considerably from one individual child to another (Siegel & Bryson, 2011).

A propensity of humans that is shared with other animals is that of adapting and adopting the characteristics of the systems they join. This is directly related with the hermeneutic understanding or worldview the patient has: the blueprint with which they relate to and connect with whatever experiences that present themselves to the six-sense doors. Using the six-sense doors to go deeper into levels of insight could also point out the non-substantiality of whatever fears that are being held onto, such as fears in phenomena or experiences in relation to which the patient has certain phobias. This was accomplished while being grounded in the body and in the presence of sensations the individual was aware of. Therefore, the first line of defense against maladaptive behaviors became none other than connecting to and with the body.

- ***The full participation of the therapist, as a requirement of MG.*** A key area that requires addressing is that of the therapist in administering this or any other intervention within the scope of one's practice (Winek, 2009). This is especially the case when therapists are often encouraged or want to use a novel intervention, whether it is mindfulness, watching of the breath, or even facilitating art therapy techniques in sessions. This, however, is especially the case when applying loving kindness thoughts or forgiveness to oneself or others in order to bring about a greater sense of happiness (Vimalaramsi, 2012; Punnaji, 2011).

Gaining solid understanding of patients' symptoms, whether they be the result of a particular adult attachment pattern (Wallin, 2007), trauma, or a deep interpersonal wound (Martinez, 2016), requires a framework that looks at the human mind, its relational context and its transformation, all of which need to be grounded upon the importance of childhood development, given the relationships with other human beings within the life of the individual

(Heller & LaPierre, 2012). The interventions used within psychotherapy today become much more effective when they take into consideration all the above-mentioned criteria, as well as when augmented by the latest research in trauma studies, attachment theory, neuroscience, relational psychotherapy, and the vastly important practice of mindfulness (Wallin, 2007).

What is sadly ignored or often underappreciated is the level of participation of the therapist along with solid preparation, where often we presuppose that the individual presenting an intervention to patients is well versed in it, or in the case of MG, is well grounded oneself. What is being proposed here is that whatever the intervention happens to be, whether *mettā*, mindfulness of breathing or that of grounding, what we need to realize is that hardly any of these interventions could be considered to be a passive affair; they require effort and work and are based on a genuine wish for the welfare of ourselves or others. This is often missed in one's efforts to teach or share techniques in order to help others, and instead there develops a relationship where the therapists are teaching "at" or handing something "to" others, without much of a dedicated involvement on their part. Here, one cannot underestimate the role of close family members and genuine friendships that play a significant part in the healing process (Heller & LaPierre, 2012).

Here, it is important to consider Dr. Barbara Frederickson's words again in relation to synchrony that needs to be present for the experiencing of happiness. Dr. Frederickson mentions how behavioral synchrony needs to be present between the child and their caregiver in order to bring about the child's (patient's) development of self-regulation. This inevitably allows the child (or patient) the capacity to channel their emotions by controlling their own behavior, due to the selective attention given to them (Frederickson, 2013). A word of added support may be offered also regarding the role of family members, where with the permission of the patient,

family members (or close friends) may take part in helping the patient become more grounded by gently touching the hand or other part of the patient's body (Levine, 2010; Fischer, 2011). Participating in the MG oneself, as the therapist, alongside the patient has been reported to have an even stronger impact due to its normalizing and social-bonding values.

- ***Possible obstacles for clinicians to fully commit.*** Having taught various subjects that ranged from biology, physical science, computer science, health, nutrition, and philosophy for nearly 17 years, and now as a clinician, I have seen how much like a teacher (or students), clinicians often find themselves emotionally overwhelmed due to many factors. These include meeting the set quota of patients they need to see per week, following a rigorous procedure to protect themselves (and their agency) from any and all legal action, all the while having to prepare endless series of reports per patient, do enough billable invoices for services rendered, and do them the proper way, while explaining everything they do in therapy to supervisors. Given all this, it is understandable how many can think of keeping themselves not fully vested in their patients, i.e. treating therapy as just another "job." This trait in the healing profession became obvious to me rather quickly, having seen it years earlier as a High School teacher among some fellow teachers.

Whatever the area of study or practice, before instructing others one must know and be well versed in the subject, since without having experienced it for oneself, it would be difficult, if not impossible, for one to instruct others properly, at least in a lasting and convincing way. This especially is the case with teaching and guiding mindfulness. Given the ability of children and youth to not only be blatantly honest, but to "see right through adults", and given the history of many of the children coming to therapy, what is usually observed is the disconnect between

this population of youth and the adults in their lives. This therefore can often become a risk factor, if therapists ignore the significance of this scrutiny on behalf of children.

It becomes an undeniable fact that if we are to make any progress in administering the MG or any intervention, the authenticity of our presence and intent to help while being fully present, needs to be intact. After all, here were human beings who were opening up parts of themselves that had not been revealed to anyone else, due to their lack of trust, history of trauma and possibility of being hurt again. It was here that communicating while using a language that patients could relate to, understand, and appreciate was crucial. This also meant that I had to be invested in the work that I was doing with them, having seen its effectiveness myself while dealing with my own Post-traumatic Stress Disorder.

Furthermore, the "Self-of therapist" (the capacity to always work on developing oneself emotionally within the practice, while engaging in an honest and truthful exploration of any issues that may arise due to or during one's work with patients, seeking personal therapy, and spiritual practice, among others) and the systemic theory in whatever methodology of therapy or approach used, need to match the ecology of the patient. This requires constant monitoring, which in therapy takes the form of continuous assessment of the patient and oneself (Whitaker, 1989). Also, in applying mindfulness in our interventions, we need to do so with a clear contextual consideration as we pull back and look at the world around the individual, their environment, their traumas, their relationship to their bodies, etc., including the social context (Treleaven, 2018). This will involve the relationship that the patient has with the world, but through the medium of the body and how the sensations collected are interpreted by the mind in the presence of memories, and other latent tendencies inherited from the past. Given that people manifest their symptoms in different ways, ultimately it is self-reflection that is being

promulgated in the introduction of the MG to the patient, allowing them to resort to trusting in the genuine experience of whatever occurs within and connecting to the body. Here is an opportunity for the person to learn from one's past traumas, thus making the MG an indispensable intervention in the toolbox of a skilled therapist, who is not there merely to conduct an objective assessment of the patient and their symptoms, but to also make room for inner growth.

3.2 Mindful Grounding (MG) as an Intervention. The MG was developed to address the unique symptoms of those patients who had not responded to other interventions such as belly-breathing, noticing body sensations, sand tray, drawing and play therapy, to name a few. After several attempts at applying principles of mindfulness, as per the guidelines handed to therapists within both the therapeutic manuals and trainings offered by the PUC agency where I volunteered, it became clear rather quickly that for many of my patients these were to prove utterly useless. Frustrated by the desire to help but stranded with no feasible therapeutic intervention to which these patients would respond positively, with the consent of my direct clinical supervisor, I resorted to applying what I knew worked in my life, namely, Buddhist principles of meditative practice.

It was here that instead of seeing the normal clinical outcome of patients dosing off from following mindfulness techniques, or intensifying their negative symptoms of hyper-vigilance, extreme levels of anxiety, and in some cases that of dissociation from their experiencing of the body, these patients were observed, for the first time, to slowly become able to rest acceptably into their own bodies. Thus, I presented the MG first while verbally communicating it during my individual supervision meetings with my clinical supervisor on site, after which my supervisor asked me to present and share it with other clinicians at PUC. To this end, she suggested that I

write up a step-by-step instruction for it, which she would also share with her own supervisor, who happened to be the director of clinical programs at PUC.

- ***Therapists as subjects.*** While the words clinician, subject, and therapist are used interchangeably within the body of this research project, the word "subject" will always be referring to the individual therapists who took part in this research. The MG intervention was introduced to clinicians by first contacting supervisors, who comprised licensed marriage and family therapists and clinical psychologists working at Partnership to Uplift Communities (PUC) (the agency where I worked for one year, as I completed my Marriage and Family Therapy (MFT) internship), and professors of the MFT program at Alliant University/California School of Professional Psychology. The interviews conducted for this project came from a pool of self-selected therapists, who decided to take part in it. From the 52 individual therapists attending the presentation on the MG, 24 expressed interest in participating, out of which 16 could not follow through due to various personal reasons and time constraints. This left the final number at 8 interviewees who verbally consented to participating in this study. All of these therapists were finishing their last year of the MFT program and preparing for their comprehensive examination, while also completing their clinical, i.e. practicum hours at their respective agencies.

While working with patients during the span of a year, participating therapists applied different interventions in addressing various disorders presented, as per the information gathered from the assessments of patients. The group of 8 participating therapists within the study claimed having learned mindfulness techniques within their individual MFT programs at their respective universities. All participants expressed having mindfulness as one of their common interventions they use (or have used previously) at least during one or more of their therapy sessions. By

choosing to administer the MG to their patients, therapists integrated it with their individual treatment goals and timeframe allotted.

- ***Accessibility of both author and the intervention.*** Further presentations followed for clinicians where I was able to provide clarifications and share my own experience in using the intervention for clinicians to have a better sense of its usefulness while administering it. Prior to each presentation, whether in group or individual settings, a printout page of the step-by-step guide to the MG was made available to subjects on an 8"x11" paper with instructions on how to conduct the intervention. In addition to the school facility where the study's subjects, i.e. therapists were able to connect with me, I had made my name, contact information, such as phone numbers and email addresses available on the MG guide, as a way for subjects to reach me in case they required clarification or had questions pertaining to the MG. Availing myself of resources within classroom settings, group supervisions, and therapy facilities or sites visited where therapists worked, I was able to answer questions received from these clinicians regarding the MG's applicability to address various disorders patients might be experiencing. Here, I was able to explain Buddhist principles in relation to holding onto negative states as in grasping to, which lead to more fear and pain in patients, thereby perpetuating *dukkha* or suffering (Analayo, 2010). These were expressed to therapists in therapeutic terms, therefore, without identifying or labeling them as Buddhist. This way of explaining, which in therapy falls under the category of "psychoeducation," I often used with patients as well as their family members to clarify and point out the benefits of letting go as we make room for new experiences (Gehart, 2014).

In addition, after presenting the intervention, I have contacted subjects directly and indirectly (through supervisors), while having one-on-one discussions with them**.** Having received the consent from these supervisors, I was able to present the intervention to groups of

subjects (therapists) on four separate occasions, in addition to numerous times on an individual basis. I have explained how to administer the intervention, as I described the procedure to therapists and the alternative ways of applying it with patients with different capacities (Gehart, 2002). Following the method of SMART: specific, measurable, attainable, realistic, timely (Doran, 1981) in preparing patients' treatment plans and weekly progress notes, it was crucial for me to go over the MG steps with individual therapists (following the procedures of the SMART methodology) to better incorporate it into their treatment goals. Furthermore, once presented to focus groups of therapists, this intervention with its "how to" guide was posted on the agency's website by my supervisor, whereby current therapists from various schools continue to have access to it once they refer to the agency's interventions' inventory. The link is provided below. https://intranet.pucschools.org/ClinicalCounseling/Shared%20Documents/Handouts%20from%20Trainings%20and%20Interventions/Mindfulness/BodyGroundingExercise.pdf

- ***Easy-to-follow directions.*** MG guide provided clear instructions which increased compliance from patients. The simple, clear, and specific steps delineated in the MG helped the patients remember how to use it, without confusing them by being vague, especially in the case of children who were dealing with anxiety, aggression, or difficulty in following directives from others. In my work with patients, I noticed the value of simplifying a set of instructions in order to make any intervention work for them. To bring this about, the steps of the MG were broken down into brief explanations, helping patients to identify thoughts and feelings and in the context of time, i.e. past and future, where they experienced no control over what arose in their mind and bodies. This meant being practical in offering "bite-sized" instructions throughout my work, as well as in my efforts to psychoeducate patients and their families on the workings of the mind and the impact of emotions on behavior. MG happened to be the culmination of this endeavor to

help patients develop the agency to reclaim their lives in a body that they become able to love again. Mindful Grounding intervention was thus broken down into the following steps:

1. Standing up with arms slightly to the sides
2. Looking down to one foot, lifting the toes up momentarily, tap them down twice
3. Sweeping in an alternating or zigzag motion, one limb/section of the body at a time, from one side of the body to the opposite (ex. left foot, right foot, left knee, right knee, etc.)
4. With each part, making sure you *look* at the location you are mindful of, as you say:

• **This is my left foot** (tapping it to the ground)
• **This is my right foot** (tapping it to the ground)
• **This is my left knee** [or the leg] (gently touching with the hand/finger closest to it)
• **This is my right knee** [or the leg] (gently touching with the hand/finger closest to it)
• **This is my left hand** (touching it gently with the opposite hand/finger)
• **This is my right hand** (touching it gently with the opposite hand/finger)
• **This is my left arm** (touching it gently with the opposite hand/finger)
• **This is my right arm** (touching it gently with the opposite hand/finger)
• **This is my torso** (touching it gently with the opposite hand/finger)
• **This is my face** (touching it gently with the opposite hand/finger)
• **This is my Beautiful body** (using both hands to point to the body)

5. Looking to the left hand as you point in that direction, say:

• **This is my Past** (pausing momentarily)

6. Looking to the right hand as you point in that direction, say:

• **This is my Future** (pausing momentarily)

7. Looking at the body by pointing with both hands to the torso, say:

• **This is my Present** (pausing momentarily)
• **Where am I?** (Here the subject responds to their own question)
• **I am safe** (subject states each of these while looking at their own body)
• **I am here** (subject states each of these while looking at their own body)
• **I am now** (subject states each of these while looking at their own body)

As the patient progressed, according to their disposition and willingness to participate within the session, the intervention became further detailed (noting the various parts of the body,

more micro, i.e. arms → hand → forearm → index finger → phalanges, etc. instead of noting the larger areas in one sweep).

Here it is worth mentioning how with those experiencing anxiety, trying to apply basic mindfulness or relaxation techniques may in fact cause more disturbance and tension in the brain and body, thereby hindering the entire therapeutic process. Thus, allowing patients to just restfully fall back into the body first, while giving it awareness as they noticed where there was tightness, slowly helped them slide into a state of relaxation. To this end, in the presence of attentive and present therapists, using the MG has allowed patients not to have any negative reactions.

- ***Applicability to the three stages of treatment.*** The MG was used throughout the three primary stages of therapy and was pertinent to their goals, i.e. initial, intermediate, and last stages of therapy. The initial or early-phase involved developing the therapeutic relationship, problem assessment, goal setting, and early referrals (Gehart, 2002). The middle-phase considered a more specific approach in addressing problems, which are patient-specific. Finally, the late- or last-phase addressed long-term issues, solidifying gains, strategies for handling future issues, and giving out referrals.

3.3 Data collection. The subjects for whom this intervention was intended happened to be therapists who administered the MG to see its effectiveness, whether applying it on themselves or for their patients who were undergoing therapy for a wide variety of emotional, behavioral, and psychological disorders. As a process and outcome of research, this ethnographic work sought to study the group of therapists, i.e. culture-sharing group, as it explored their patterns of values, behavior, and language (Creswell, 2007) pertaining to the administration of the MG to their patients. Here, I sought to apply a systemically subjective approach in studying the

experiences of clinicians working in the field, in order to gain insight into the complexity of their interactions while using the MG with their patients.

In addition to verbally communicating their findings to me in the form of one-on-one interviews, clinicians willing to participate as subjects were encouraged to write up their experiences in using the MG into journals, without using any identifying labels in order to protect their patients' confidentiality and instead using patient initials. As it relates to having their responses collected in order to be published, they requested to have these documented as anonymous. In total, two journals were submitted.

Overall, the data for this study was collected via interviews, journal entries, and transcripts (if available), wherein Q & A sessions with subjects were conducted to gain understanding as to the rate of success in using the MG in sessions. Prior to giving subjects the pre-study questionnaire, I gave them an hour-long presentation on the MG that included significant amount of time for questions and answers to better equip them with the real-life examples of how the MG had been used successfully in my sessions thus far. The purpose of providing the subjects of the study with the pre-study questionnaire was to establish a baseline that would serve several functions. These included the familiarity and comfort of these clinicians in using different interventions, their openness to trying new tools, as well as hopefully their unbiased willingness to try the MG as an alternative to other interventions they were used to.

Whether speaking of language, descriptions, explanation, and epistemology of the therapist (Keeney, 1983), the questions were layered in terms of strata or frames of reference that related therapists' experience in using the MG *vis à vis* its effectiveness. The questionnaire included 15 items that were asked of subjects both at the beginning and completion of this study,

which was at the end of the school year. The list of the fifteen questions asked by this author of the subjects during the Q & A sessions included:

1. *Before using the intervention, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say described you best?*
2. *Could you describe how you administered the intervention?*
3. *What has (have) your experience(s) been like while using this tool?*
4. *How often would you say you remembered to use the MG when other interventions did not seem to work?*
5. *How often would you say the MG actually worked in reducing symptoms?*
6. *Have you used the MG on yourself? What was (were) the outcome(s)?*
7. *What disorders or symptoms did you try to address while using this tool?*
8. *How often have you used this as an intervention in your treatment plans?*
9. *Have you noticed any differences overtime in your patients' behavior or mental state since using the MG? How would you describe these differences?*
10. *Would you prefer using this MG with any other interventions? Why? Why not?*
11. *How would you describe patients' treatment outcome after using this intervention?*
12. *Do you see yourself using this intervention in your treatment plans in the future? With which populations?*
13. *Do you recommend this intervention to others? Why?*
14. *What is your critique about this intervention? Do you have any recommendations on how to improve the intervention?*

15. *Now that you have been using the MG, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say describes you best?*

- ***Some demographic information.*** Clinicians participating in this study were not selected, but elected themselves, given the goal of this research project to try out the MG with their patients with whom other interventions had not been very successful. All therapists used in this study identified themselves as female and chose not to express their sexual orientations. Further, the subjects used in the study also identified themselves as 72% Hispanic, 20% Caucasian, and 8% mixed, with ages that ranged between the ages of 23 and 34 years' old.

As for the patients, the method by which they were chosen for therapy was through referrals to the agency, whether they came from school staff, parents, supervisors, or in some cases via self-referrals, and included both male and female patients. It is worth noting here that unlike the accepted therapeutic nomenclature of "client," throughout this work instead of "clients," these individuals are referred as "patients." However, within the consent forms and responses collected from study subjects, the term "client" has been kept to maintain the authenticity of their authors' intents. The population of patients seen by the subjects of this study were primarily self-identified as ethnically Hispanic (comprising 88% of the patient population) and African American, at 12%. The patients stated that their families identified themselves as Catholic, Seventh Day Adventist, and Christian.

The population of patients had endured many social, immigration, legal, and financial hardships, and many of them continued to live in dire circumstances, as these individuals came from families that were financially of low socio-economic status (SES). Per reports by therapists, i.e. the subjects of this study, these patients in sessions were all able to communicate in English.

The patients seen by the subjects of this study were explained as to the nature of this study and agreed to participate in it by signing the PUC agency's generic authorization forms. These signed documents indicated patients' consent for services, with their agreement to multiple intervention protocols according to the clinical judgment of therapists, as they addressed patients' symptoms while supporting progress towards their treatment goals.

- ***Therapist/author's own observations in using the MG, gathering data, and conducting assessments.*** Once informed consents were signed and documented, I began looking at patients' history, accumulating their psychosocial data not just through notes taken by previous therapists but by first displaying an empathic demeanor to facilitate the foundation for trusting rapport between patient and therapist (Gehart, 2002). This often entailed using healthy and selective self-disclosure, whereby I began telling about myself and why I was there, in order to help patients to feel comfortable to open up to the process. Being open in disclosing information about ourselves can be helpful; for example, many patients thought that therapists were being paid at PUC and they were shocked to find out that none of us were, for it was completely voluntary. Here, therapeutic self-awareness is a crucial asset for any therapist who is conscious of his/her emotions, values, behavior, as well as worldview. Having a good grasp of these dynamics and psychological processes as a therapist, therefore, is key in helping patients be able to work through their own difficulties (Kanel, 2012).

After having introduced the MG, I have met with patients almost on a weekly basis, wherein I would go over their understanding of the intervention to clarify it for them, as well as learn ways to modify it by asking them pertinent questions on their use of the MG. I presented patients with hypothetical scenarios derived from their past experiences and asked them whether there may be differences in their handling of such similar situations. Also, patients would

describe events from their previous week of any emotionally charged incidents or moments of interaction, where they in fact utilized the MG. By building a strong and loving rapport with patients, my mission also included giving them homework assignments whereby they were encouraged to use the intervention at least during 1 out of 3 times per week, instead of having to resort to their usual unhealthy reactions. Later, I used these to help patients see for themselves the changes taking place within them, as reflected through other relational aspects of their lives like their families. Here, their affect and mood were constantly monitored and recorded. Alongside the progress notes I prepared for each of my patients to share with my supervisor, I have documented the changes observed in patients since the beginning of using the MG. I have been in contact with school counselors and administrative staff and teachers, as well as present at Individualized Educational Planning (IEP) meetings, where vital information has been exchanged and discussed, allowing patients to be promoted to come out of the IEP status as a result of their academic and behavioral improvements.

It is always a challenge for health providers to adequately collect sufficient data on patients to interpret and draw conclusions from. This is especially the case in mental health, where therapists need to closely work with several entities in the lives of patients from schools to families, as well as other agencies that may be involved (Gehart, 2014). Therefore, one cannot overstate the importance of having a clear understanding of appropriate assessment and intervention practices given diversity and possible risk factors (McConnell, Wackerle-Hollman, Roloff & Rodriguez, 2014). Thus, in my work I applied various assessment methodologies in making sure the aforementioned criteria were included, and that my patients were safe and not in danger due to lack of information or appreciation of these factors. One of the ways to assess a patient's improved mental state is to review their progress, to check-in on the importance of

continued practice, and how they are using the skills introduced to them over time. Assessment also includes predicting the challenges they would encounter in the future, while helping them become more flexible and tolerant with set-backs, and treating these as foundations to go further, as well as learning from them to develop a better sense of self-efficacy.

- ***An added challenge faced by therapists at my clinical site.*** Each year, clinicians who joined the agency at PUC would start the New Year at a new site, i.e. a charter or LAUSD-contracted school. Once assigned, clinicians would be given caseloads that included a number of patients whom they were to work with, along with their families or caretakers while addressing their relational needs. What therapists quite often face at this and similar settings is the problem of how to go about and reestablish a trust or therapeutic alliance that hopefully existed between the patients and their previous therapists (Davis, Foley, Crigger, & Brannigan, 2008).

Creating the optimal relationship between the therapist and patient is and has always been a major issue for healthcare providers, which they try to tackle before attempting to apply interventions to address existing symptoms (Winek, 2009). This was no different with my practicum site, where often therapists were challenged to reestablish therapeutic alliance with patients as they reintroduced them to therapy at the beginning of each new school year. Meeting a new patient, therefore, meant for the new clinician to find new ways of "reaching" the patient to better help them, what often translated into a dire state of affairs at best where symptoms either became worse, or remained the same at best (Siegel & Bryson, 2011).

Patients, who were fortunate enough to receive therapeutic services, sadly included many who were on some form of psychiatric medication, with a high risk of becoming addicted to them or even worse, to some kind of street drug. This, in addition to having to assess them for suicidal ideation and self-harm, clearly meant that there was a sense of urgency for therapists to

quickly connect with patients on a deeper level early on in treatment (Winek, 2009). My caseload of patients was no different, where many of them had been seen by a number of other therapists in previous years, and after working with them for a year and completing their one-year contracts, these therapists had moved. This usually meant that many patients were disillusioned and somewhat hesitant to start a relationship with a new therapist, who after listening to their pain and giving safety to their private lives would be leaving, once their practicum year and contract was over.

3.4 Consideration of diversity factors. As a social reality, cultural elements such as immigration status, socio-economic status (SES), gender, sexual orientation, race, religion, class, age, language barriers, etc. often present as critical identifiable elements that separate us as a population. This requires therapists, now more than ever, to become not only more aware but to be able to exercise empathic connectedness in a demonstrable fashion, given the nature of the relational work that is therapy. This competence can go beyond one's ability to "tolerate the other" while assisting families to deal with their difficulties in the 21st century, in a world that keeps changing, diversifying, where socio-cultural divides are often misunderstood, and things get to be easily misinterpreted. Therapists in the helping professions, being the product of this same society, which remains unavoidably diverse and foreign to them at times, often find themselves struggling to develop these capacities. It is only in the presence of individual willingness to go beyond what is familiar and given one's innate level of EQ and empathic relatedness as a therapist that change can happen.

These difficulties may be the cause(s) for some therapists to remain at arm's length, if not further, in truly being able to help family members reach a level of understanding whereby they may be able to resolve their issues. To this end, therapists who are versatile in reaching over by

transcending their own cultural biases may in fact be able to bridge gaps of diversity as mentioned above and understand their patients. This is reflected in the very manner we use to deliver the MG or any other intervention, which becomes more important than the intervention itself (Yalom, 2002).

Therefore, before we work with our patients and their families, especially those from ethnic and cultural backgrounds other than our own, we need to have already spent the time and energy in studying them. Here, especially as it relates to mental disorders and the suffering they cause, it is extremely important for us to gain the knowledge of ways people differ from each other given the following criteria (McGoldrick & Giordano, 2005). To this end, whether in assessing my patients or beginning to administer the MG to them, it was important for me to ask questions such as: "How do you feel about your body? What are the parts of your body you like/dislike?" In this regard, a useful list of criteria was developed that addressed these considerations:

1. How they perceive pain
2. What they see as symptoms
3. How this is communicated, be it pain or symptoms
4. Their beliefs about symptoms
5. Their attitudes toward therapists and doctors
6. The treatment they desire to receive

3.5 The need for a new therapeutic framework. Mindful Grounding (MG) was designed to address the need for an intervention that applies principles of body-mind connection while maintaining the patients' awareness within the present moment. The MG involved sweeping the body one part at a time as it allowed the person to look at different body parts, while using a

gentle touch of finger or hand (or tapping the foot onto the floor) to establish a kinesthetic awareness of the body, as it was touching the area noted. By bringing the focus into the current sensations experienced within the body, the MG was designed to facilitate an embodied self-awareness, grounding the person in the here and now as opposed to causing them to dissociate or avoid their emotions (Price, Wells, Donovan, & Rue, 2012). This was done in a much more engaged manner, in a relatively shorter timespan as compared to traditional breathing or other mindfulness practices that are commonly taught by therapists today.

Some of the benefits of MG and the needs it came to address included emotional self-awareness and self-management, social awareness through empathy towards one's own relationship with the body, and relationship management. These aspects of self-discovery inevitably gain a stronger momentum through the presence of crisis and trauma that many of the patients at the agency were quite familiar with, and often from a very young age. For these individuals to benefit from therapy proper, there was a need for a paradigm shift, one that looked at crisis or the experience of trauma not as a danger, but as an opportunity. To this end, patients were directed to look at guilt as a wasted emotion, so long as it did not serve to help the person grow. In other words, guilt (and similarly negative feelings about the past and its repeatability) does not coexist with healing and growth if its main function is to present reality through distortions, and herein lies the need for us to return to the body.

Noticing the fullness of experience through the body has the anchoring effect of placing the person in the surety of life. However, what can we do when the living experience is a doorway for more pain, i.e. threatening the mental, emotional, and physical wellbeing of the individual? In order to answer this question, we must first create space for the individual to find comfort in the knowledge that they do have control, even over the outcomes of the past via the

way they experience it in the present. Thus, as therapists we help patients first to gradually become able to accept the past and its traumas without trying to negate their presence (Van der Kolk, 2015). Next, we inculcate patients to accept the fact that they do not feel good, for even such a declaration indicates a level of control, their freedom to speak out against the discomfort. After all, it is owing to this very control in announcing how they feel that they have presented to therapy. Through the means of psychoeducating patients with information on trauma, the relationship of thoughts to feelings, and their impact on the way we behave and act, the patient slowly becomes able to have a clearer diagram of what is taking place within their mind which is influencing how they come to view and experience their lives. Thus, with the development of acceptance and the ever-expanding network of possibilities taking place in the brain, versatility becomes one's native tongue, allowing one to go beyond any limitations one may have once had, especially in the context of dealing with mental disorders.

MG was able to allow the person to utilize an appreciative inquiry of what is taking place within the body, given a certain sensation or the recollection of some traumatic events, or the experience of spiraling down into episodes of depressive states (Van der Kolk, 2015). This intervention helps the patient to differentiate oneself from the pain of seeing oneself as one-and-the-same with their symptoms, their depression, trauma, or sorrowful past. It helps the patient break free from identifying themselves with their distress, thereby making room for growth-promoting changes to take place (Fischer, 2011).

As the late prominent psychologist and expert on emotions, Dr. Barbara Frederickson states, 'Our bodies act like verbs' (Frederickson, 2013), as they broadcast everything we feel. Our brains constantly register and respond to our environments, which orchestrate a slew of bio-chemicals in the neural network thus shaping our body from inside out (Hanson & Mendius,

2009). Changing the quality of our mental and emotional health thus leads one to consider the role of love in the possibility of bringing about such a change, especially in looking at the manner by which we address ourselves.

3.6 Summary. The goal of MG included activating the awareness of the body in order to increase the possibility for improved mood within patients. After all, inactivity, a common phenomenon with most patients seen in therapy, is often both a cause and effect of a depressed mood. This creates a baseline for the patient to notice when there is an imbalance in their mood, as they start looking for a "feel good" state of mind or an activity. And here, looking at the relevance of activities as part of treatment would help us see that activities bring meaning and purpose to our lives, allowing us to counteract the hopelessness or helplessness that may be leading patients to depression or keep them stuck in depressed moods. All these contribute to higher sense of self, given patients' mood that has now been brought under the patient's control with the grounded awareness of themselves. Thus, MG improved the quality of patients' lives by enabling them to establish connection to the body, hence to the present experiencing of life. Additionally, through increasing activities whereby they could engage in it, they were to enhance and ameliorate their state of being.

As clinicians work on de-shaming the wounds and injuries that have been carried by patients from the past, the individuality that was robbed of oneself slowly gets to be restored. Thus, the hate one has held closely to one's heart is seen for what it is, and the patient finds oneself almost forced to heal from the pain. Here, one needs to consider that people who have been hurt experience a loss of their sense of self. This is the reason why therapists strive to normalize the hurt with concrete acts of atonement. In looking for this atonement, we often

forget the role of the crisis, or the injuries caused by it, for they open up a person to greater potentials of discovery and healing.

Whether we are therapists or patients, giving space for ourselves to settle in the present requires trust, loving-kindness, and empathy (Hanson & Mendius, 2009), all of which come to foster individuals' capacity to emotionally and socially relate to other human beings through stress regulation and affect processing (Schore, 2009; Van der Kolk, 2015). Here, we may define empathy as the capacity to feel the inner world of a person, which inherently functions in developing the very support such a person may be relationally lacking (Conway, 2014). This therapeutic qualifier is at the core of making psychotherapeutic interventions work (Yalom, 2002), and which happens to be the reason why the MG came about.

Chapter 4: Results

Results

The outcome of this research does not pretend to be formulaic as it is measured subjectively, given the multitude of qualitative variables involved. To this end, the results being presented reflect the general leanings and attitudes along with the successes (and in some cases failures) of the work done by the clinicians, i.e. the subjects of this study. In considering the indicators of positive outcome within therapy, as clinicians, we look for evidence that point to the reduction of symptoms that patients have presented with initially at their earliest session. Additionally, to indicate a change or decrease in these symptoms, one needs to gauge their frequency and intensity, especially as it relates to the impairment these symptoms have on the patients' major life functions, which usually include their personal, family, social, and academic functioning.

In this regard, the information gathered from clinicians rendered in the form of journals, private interviews, and especially a fifteen-item questionnaire that was conducted at the beginning, as well as conclusion of the study, came to indicate the overall success of the intervention. This came in the form of positive therapeutic and treatment outcomes, whereby the frequency of patients' symptoms had decreased considerably, and in many cases the treatment goals that were established at the beginning of therapy were reached. Furthermore, clinicians often reported that treatment had to be terminated for several patients, given that there was no medical necessity with treatment goals being met.

4.1 Initial results obtained by this author (a supportive factor). The work I had done on this study where I designed and used the intervention successfully with patients struggling with different symptoms and diagnoses, served as a foundation for the effectiveness of the MG

intervention, enabling this study's subjects to test its reproducibility. Thus, whenever necessary, with the help of this author checking in with the subjects on the usability and applicability of the intervention as a treatment tool, the clinicians had the opportunity to not only get clarification on the MG but also learn ways of overcoming challenges that often arise with the introduction of a new intervention that falls outside the scope of their training. Here, the opportunity to present to groups of clinicians both at the university practicum classes for therapists, as well as those facilitated at the headquarters of PUC agency have been tremendously valuable, given that these presentations served as forums for the introduction of the MG. These demonstrations were invaluable in elucidating the various steps of the MG for those clinicians who eventually chose to take part in this study.

Unlike in breathing or traditional mindfulness techniques, while using the MG, clinicians witnessed patients eventually being fully present to their experiences of anger, fear, anxiety, etc. instead of running away from them or finding ways to divert or escape the intensity of such moments, as many had experienced by dozing off (this, according to clinicians interviewed whose reports will presented below). Here, within the therapeutic process, the therapist becomes the facilitator who helps the patient stay present no matter what is being experienced emotionally. It is not uncommon, then, to find patients becoming tearful as they find themselves facing their fears with the help of the intervention.

4.2 Relational work and its impact on the data collected. The subjects' wholehearted involvement and administration of this intervention had oftentimes been dependent on their own delivery method, their dispositions at that time, as well as the receptivity of the patient within the session. Explaining the workability and feasibility in applying the MG was crucial in having these clinicians invest their time and energy to make it a part of their therapeutic toolbox. It was

essential for clinicians in their participation, as subjects, to not only understand how to administer the intervention, but also add to it their unique and human touch. It is important here to note that one of the key requisites of a good therapist is the capacity to relate to their patients empathically (Whitaker, 1989; Yalom, 2002; Fischer, 2011), in addition to their clinical expertise in establishing a therapeutic alliance and rapport while working closely with patients towards reaching their treatment goals.

4.3 Data collection. The data collected has been appropriated through (1) individual fifteen-item questionnaire that was administered at the beginning and the conclusion of the study, (2) information gathered through the sharing of journals by participant clinicians that were two in number, and (3) one-on-one informal interviews. The latter inventory provided further information pertaining to:

(a) the types of diagnoses the intervention attempted to address,

(b) the demographic data on the individual patients of the subjects/clinicians (age, gender, sexual orientation, etc.),

(c) the roster of patients that clinicians had on their case load, and the number of patients who were administered this intervention,

(d) any challenges faced during the administration of the intervention,

(e) any changes or alterations made to the intervention itself while using it,

(f) the amount of time dedicated to including the intervention and the frequency of its application during sessions, and

(g) the outcomes generated from applying the intervention with their specific patients.

4.4 Pre-study and post-study questionnaires. In responding to the fifteen-item questionnaire outlined below, the subjects initially presented with statements that indicated their

familiarity to some form of mindfulness techniques. However, as was expected by the end of this study, many reported having developed a wider perspective, especially due to the presentations given by this author at agency meetings. Here, the subjects were observed providing responses that reflected an understanding that developed alongside the application of the MG while treating their patients, as they further refined their skill in administering the intervention.

- ***Questionnaire data analyzed.*** Below each of the fifteen-item questionnaires provided here, I have included a brief explanation as to the intention of the question and the purpose beyond its inclusion. This in turn is followed by a summation of the responses collected from each of the participating therapists from both the pre-study and post-study stages.

1. *Before using the intervention, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say described you best?*

With the first question, subjects were asked a scaling question that was geared towards gaging their level of comfort or apprehension in approaching this intervention. It became clear through the responses obtained that 75% of the respondents felt some level of anxiety and uncertainty at least in trying the MG for the first time. This number was significantly reduced when this question was re-visited during the post-study period, where the level of confidence and trust in the application of the MG had gone up to 90%. This indicates a major shift in both the openness of the clinicians while feeling comfortable enough to resort to using this intervention, as well as their eagerness to try it due to generally positive outcome obtained when applied with patients.

2. *Could you describe how you administered the intervention?*

The second question was seeking to delineate the approach that each clinician took in administering the MG with the intention of trying to find better ways of delivering it in sessions. This question was designed as a crucial step geared towards further improving the MG in the future, by the means of identifying potential problem areas and addressing them to enhance its efficacy. In answering this question, nearly 60% of subjects stated that although the instructions on the MG guide that was provided during the presentation were clear enough, they would still require more practice in delivering it before feeling comfortable in using the MG. Here, the consensus among the subjects was that they would need to communicate with me further to clarify the means of appropriately administering the intervention as they go on using it during the life of the study.

The rest of the participating clinicians each expressed that before applying the intervention they had to first establish a healthy rapport with the patient while also obtaining the necessary bio-psycho-social data about them and especially details about the symptoms and their history. In obtaining the results at the conclusion of the study pertaining to this question, 96% of clinicians reported administering the MG without referring to the guide as they normally had done initially, indicating a level of comfort and ease in their administration of it. Furthermore, nearly 80% of subjects described how in the beginning stages of therapy they would model the MG for their patients; however, as they continued working with them, many of these clinicians were simply verbally communicating the directions of the intervention to their patients or letting the patients themselves vocalize the instructions as they did the intervention in front of their therapists by themselves.

3. *What has (have) your experience(s) been like while using this tool?*

Here, although each clinician responded with specific details about their own experiences, what was noticeable, however, was the fact that all clinicians described feeling excited when first using the MG. The qualitative interpretation of these responses showed how during their initial attempts at administering the MG with patients, they liked the malleable and less restrictive nature of the intervention, which inevitably made the whole process become playful for both them and their patients. This was later revealed during individual discussions and further presentations, making the MG even more appealing for them as a clinical tool. What was clearly noticed in the post-study responses to this question was the level of certainty in view of the benefits of the MG, as subjects highlighted the many successes they witnessed. Here they discussed how patients' symptoms were drastically reduced and how in some cases these clinicians had to terminate mental health services with these patients due to treatment goals being met before the end of the school year.

4. *How often would you say you remembered to use the MG when other interventions did not seem to work?*

In obtaining responses to question number four, clinicians were asked to express their preference in using the MG versus other possible interventions in working with specific patients dealing with certain symptoms. Here, it was clear that the theoretical orientation of each clinician was going to play a big part in their choice of interventions, as these would be often reflections of their preferred therapeutic modalities. Knowing that they were participating in a research study often meant that clinicians needed to be applying the MG as part of their interventions' toolbox. This was expressed by nearly 75% of the clinicians; however, their willingness to have the added support of interventions they were much more familiar with, having used them in the past, was also noted in their responses at the beginning of this study.

What was noticed though as the study progressed was the change in the clinicians' choices of applying their usual interventions, especially in reference to cases where their normal intervention of choice was now replaced by the MG. In their discussions with me, six out of eight clinicians expressed how in their minds they had initially decided to have only one or two of the patients in their caseloads designated for this study with whom to use the MG. What was interesting was that these same clinicians expressed how by the fifth or seventh administration of the MG with these patients, it was clear for them that it could also work and work well with their other patients, even though the nature of their symptoms and therefore diagnoses were often different.

5. *How often would you say the MG actually worked in reducing symptoms?*

In designing the fifteen-item questionnaire, it was important for me to provide study subjects with questions that would further clarify their responses given their experiences with this intervention. To this end, question number five was designed to augment the responses obtained from question number four by the means of further clarification. Given their desire to help their patients by providing them with the tools and coping skills to address symptoms of depression, anxiety, thoughts of self-harm, as well as anger, either towards oneself or others, clinicians were eager to offer them tools that they knew worked. This was contrasted by repeatedly trying to apply interventions that neither reduced nor in some cases properly addressed the symptoms, something that was the case with 50% of the clinicians at the beginning stages of the study as expressed in their responses. To this end, during the follow-ups and conversations brought up within supervisions, these clinicians were encouraged by their supervisors to instead try the MG with these difficult cases. This eventually led subjects to use this intervention more often, while adjusting the MG to the unique needs of their patients, and

thereby developing an appreciation for the intervention's "convenient" and "portable" nature, as several of these clinicians described it.

6. *Have you used the MG on yourself? What was (were) the outcome(s)?*

To encourage the clinicians to take part in the intervention, this question was geared towards inspiring the self-application of the MG by the subjects themselves. By inviting subjects to experience the possible benefits of the intervention while helping patients, it was intended for subjects to be more invested in demonstrating its efficacy to their patients. Subjects responded that they had all used or at least attempted the MG on themselves prior to administering it to their patients. This has been the case given the fact that I had asked them all to join in as I was going through and administering the intervention during the presentations, which I had conducted prior to their willingness to take part in the study.

While using the MG on themselves, over 80% of respondents expressed the inherent success to be found in first having tested and "tasted" its benefits. At the beginning stages, although all participants had been exposed to using the MG, nevertheless, they expressed to me in different settings how they still needed more practice in administering it onto patients. Thus, they considered the probability of positive outcomes to be mutually related with therapists feeling comfortable in applying it onto themselves first.

As anticipated, given their earlier responses, clinicians stated how they were glad that prior to administering it within sessions, they could rely on the positive outcomes that they had gained in dealing with their own personal anxieties, frustrations, and other mental and emotional upheavals as a foundation of trust in the efficacy of the MG. This was crucial in providing therapy to their patients who came to them seeking quick results as they struggled with various mental and emotional disorders. Therefore, in answering this question, subjects confirmed the

theory that through the self-application of the MG, they found themselves better equipped at administering it successfully to their patients, while experiencing positive outcomes such as drastic reduction in the frequency of symptoms mentioned above.

7. *What disorders or symptoms did you try to address while using this tool?*

Clinicians participating in this study were involved addressing a wide range of disorders that often manifested in patients through depression, various types of anxiety, fear, trauma, and overwhelming, hyper-aroused states of being that ended up impacting the personal, family, social, and academic functioning in nearly all patients. As reported by clinicians, some of the diagnoses that were being addressed included PTSD (Post- Traumatic Stress Disorder), major depressive disorder, general anxiety disorder, dysthymia, oppositional defiant disorder, disruptive mood dysregulation disorder, early sexual trauma, ADHD (Attention Deficit Hyperactivity Disorder), among others. As mentioned in the description of question number four above, this question too served in helping delineate the approaches used by clinicians in using the MG, along with its frequency in being included as part of the primary clinical tools for treatment plans.

8. *How often have you used this as an intervention in your treatment plans?*

It was clear that given the responses received from subjects, this question was largely related to the post-study questionnaire phase, where its relevancy would become more apparent. Nearly all participants expressed in their answers that at least given their first attempts at using the intervention, both on themselves and once or twice with their patients, they thought the MG had a "clear-cut" and an easy-to-follow set of instructions. This approach, however, became adjusted by these same clinicians at the post-study stage whereby they expressed that there were many elements about the intervention that they had not considered when first perceiving it as "simple." This was further explained by subjects as they pointed out how the beneficial aspects

of the intervention were significantly intensified when relational factors were brought into focus in their work with patients. This exponentially increased the times when they applied the intervention given the credence it had gained in helping patients achieve their treatment goals.

9. *Have you noticed any differences overtime in your patients' behavior or mental state since using the MG? How would you describe these differences?*

Here clinicians were being asked to share the changes that had taken place in the symptomatology of their patients since the onset of this study, as they paused to elaborate on the differences in patients' behaviors, emotional and mental status, and their choice in actions. While providing answers to this question, a little over 40% of participants stated that initially they did not consider the MG to be more effective than other mindfulness techniques they had tried previously. Given the answers received as the study progressed, however, it became evident to nearly 80% of clinicians that their patients were becoming more present and grounded even though triggers for depressive tendencies, anxiety, and emotional and mental dysregulation were being experienced, yet with far less occurrence of disassociation or exacerbation of symptoms.

10. *Would you prefer using this MG with any other interventions? Why? Why not?*

When first being asked this question during the pre-study stage, clinicians were clearly not expected to place the MG as a top choice of intervention to be used in their efforts to work on patients' treatment plans. Nevertheless, this question was valuable as a way to help them give the intervention an opportunity to be explored further by being tested in their sessions. Through the presentations where I introduced the MG, used as the preamble for clinicians to become familiar with its applicability, over 70% of subjects when first replying to the pre-study version of this question, reported that they would use it with other mindfulness interventions such as breathing and relaxation techniques. However, it was further added that they would use the MG as a

supplementary tool to help strengthen their clinical protocols while working with patients. The remaining 30% indicated that given what they had witnessed in both the presentations I had made, and in their own application of it on themselves, they would be open to include MG as one of the key interventions to be used in every session. As they explained, this was due to the quick applicability of the MG as well as the ease of administering it.

11. *How would you describe patients' treatment outcome after using this intervention?*

One of the most basic criteria that is looked for within all therapeutic settings is the effectiveness of the treatment modalities used while working with patients, which is clearly demonstrated in the form of outcome measures. It is here that a clinician's work can be shown and appraised given the changes taking place in the individual patient and the achievement of the treatment goals that had been established at the onset of therapy. Through the answers provided to this question, the progress made towards the attainment of treatment goals for each of their patients while clinicians used the MG came to demonstrate its effectiveness to a great extent. This was reflected in the responses that were obtained wherein 90% of subjects reported varying levels of success that indicated to them the feasibility and ability of patients to ground themselves no matter their age, gender, background, or even their individual disorders. Given the range of positive outcomes in their patients reaching established treatment goals, most of the clinicians were observed describing how the MG was useful in that it was able to help bring about the experience of insight for many of these patients. This was evidenced by patients expressing to their therapists how they were now able to question their old views and reactions to situations, which itself is a clear proof of success in treatment, because it allows the patient to question their worldview and especially the credibility of their cognitive distortions.

12. *Do you see yourself using this intervention in your treatment plans in the future? With which populations?*

The goal for this question was to learn about clinicians' thoughts on the potential inclusion of this intervention into their therapeutic protocols, which would again allow for further accommodations to be made to the MG and its administration in the future. Because interventions are not expected to be universally effective with all populations, this question sought to scrutinize further the MG *vis à vis* its applicability and therefore effectiveness when applied to certain demographics of populations, including a range of disorders. Here, during the pre-study questionnaire, 80% of participants believed that the intervention would not work with each and every patient that they had on their caseloads. This was understandable, given the very nature of this question, at least in the beginning stages of clinicians' exposure to the MG's effectiveness. As the months went on, and therapy continued for many of the patients who were introduced to the MG and were becoming more and more familiar with it, clinicians had to revisit their earlier conviction in using this intervention with only a certain number of patients as now they had included it as one of the key interventions to be used in their treatment plans. As for the specific population that this MG might be best suited for, in the post-study phase of their responses, clinicians had to struggle in their response to identify a specific population where it would work best. This, because after having applied the intervention on a wide spectrum of symptoms as mentioned earlier, the MG had proven to be equally effective with patients struggling with severe anxiety, sexual abuse, ADHD, conduct disorder, as well as those experiencing depression.

13. *Do you recommend this intervention to others? Why?*

By having clinicians respond to this question, my purpose was to help encourage subjects of this study to widen the scope of this intervention by making it available to other clinicians. This, of course, would be possible only after subjects had validated its usefulness and feasibility in their clinical practice. When presented with this question at the beginning of the study, clinicians only had their brief experiences and exposure to the MG via the presentations I had done where they were first introduced to it. So, it was not expected for at least many of them to recommend this intervention, simply because they did not have enough experiences in administering it, and therefore in seeing the results. To this end, I was looking forward more so to their responses to this question at the conclusion of the study, because this would also indicate the reliability of the MG, if any, in delivering positive outcomes. Thus, during the post-study stage clinicians expressed that they would recommend this intervention to other clinicians.

14. *What is your critique about this intervention? Do you have any recommendations on how to improve the intervention?*

This question was intended to probe and bring forth thoughts, comments or observations that subjects might have pondered at one point or another during the study as they administered the MG. The aim of this question therefore was to elicit further information that would come to refine the structure, function, and especially the application of this intervention by individual clinicians. Clinicians were observed being appreciative of this question as they provided their thoughts and comments given the experiences they had while administering the MG. A few of the comments often reoccurred given this question indicating a common concern that at least five out of the eight clinicians shared. These had to do with the challenges experienced while working with patients who were diagnosed with ADHD. According to the responses, clinicians appeared

to have had a difficulty in trying to get and maintain the patients' attention for an extended period of time, even if that meant in some cases for only a minute or two.

Furthermore, it was reported how at times, some of the patients that clinicians worked with expressed discomfort and "annoyance" in looking at their bodies for extended periods of time, as they became more present. This seems to have been the case with a great majority of patients, at least during the beginning stages of administering the MG. Another comment involved one of the clinicians expressing her initial critique about a certain aspect of the MG as it related to one of her patients who had experienced major sexual trauma at the age of five. Here, although progressing slowly but steadily, this patient was unable to point at her own body and was especially finding herself unable to call it "beautiful" as indicated in one of the steps of the MG. After exploring the causes and conditions behind this obstacle, I proposed to use this hindrance as a possible opportunity for overcoming a deeper wound that had been left unattended during the decade-long series of therapy sessions that this child had undergone. Thus, it was jointly decided by this clinician and me, to allow the patient space and time as she gently reintroduced the MG into the session, but only after more work had been done with the patient, and the therapeutic alliance further strengthened between patient and therapist. The outcome of this effort was that nearly five sessions later when the clinician attempted reintroducing the intervention to her patient, on the fifth session after the mentioned episode, the patient herself asked if she could vocalize each of the steps of the MG instead of the clinician. This was followed by the utter and joyful dismay of this clinician when she observed this same patient not only point at herself but gently touch her chest with her fingers, and smilingly utter the words: "this is my beautiful body."

As for the ADHD concern, with the suggestion of my clinical supervisor, I encouraged these clinicians to conduct their sessions outside, i.e. in the basketball court, the school's farm, as well as the zoo area where patients were not only exposed to various stimuli but were shown how to bring in the steps of the MG as they experienced, for example, holding and throwing the basketball, feeling its texture, feeling their feet touching the ground, their intention to throw the ball, etc. (and similarly with walking in the farm and looking at the different sights, the animals as well as feeling the smells). It was later relayed to me by these clinicians after having tried at least once the modification of the MG thus, how they saw their patients "settle in" and become "more alert and present," while also sustaining their eye contact with the clinicians for longer periods. As this example indicates, it is important to make our interventions both open-ended and malleable for adjustment as we modify them to fit specific circumstances, as well as disorders like the one we saw above in the ADHD example.

15. *Now that you have been using the MG, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say describes you best?*

Asking this item again at the end of the questionnaire gave an opportunity for clinicians to recap their experiences while working with their patients, and instead of merely looking at the outcomes as if in a vacuum; here they were being asked to also include themselves and their states of mind as crucial variables that would come to influence the treatment, whether in using the MG or any other intervention. As anticipated, at the conclusion of the study, clinicians unanimously expressed their level of proficiency in using the intervention while also maintaining a relaxed demeanor as they smoothly "flowed" through the steps. This, several clinicians emphasized to be a crucial element in also helping their patients become better able at self-

regulating their emotions. Furthermore, in several of the answers provided by clinicians to this question, it was evident that being anxious oneself while administering the MG would only come to minimize or hinder its intended purpose. Therefore, based on their responses, clinicians clearly conveyed and explained the MG to their patients, as itself being a tool for patience to reflectively reconnect to their living experience via the body, thereby bringing about a state of calm and tranquil observation of the mind/body process in relation to their symptoms.

4.5 Data collected from journals. In order to obtain further details from this study's subjects, clinicians were asked to present data they could share in discussing the outcome measures *vis à vis* their use of the MG while working to address their patients' symptoms. Although highly encouraged to keep a journal during their time while participating in this study, it was left up to the discretion of each of the eight participating clinicians to keep or to share one. To this end, only two such journals were obtained from the subjects willing to share their work, thoughts, emotions, and feelings about using the MG. It was noted in both of these collected journals, that the administration of the MG in the very first session with a specific patient, hence prior to having first established a strong enough rapport and therapeutic alliance, could have been ineffective as both study subjects expressed their regret in "having tried it too early" or that they "should have waited until there was a stronger connection established" between therapist and patient.

- ***Analysis of the journals.*** Looking at the journals collected, the feasibility of the MG and its usefulness happened to be predicated by the difficulty or ease of level in using it, and the question of whether it was "going to work." One of the themes that rang common for both journals was the following question: "is it worth my time?" The presentation on the administration of the MG and its feasibility at group meetings with clinicians (where two of

these subjects - the owners of these two journals were present), had provided them with the clarification that this intervention might be what they were looking for, especially in certain cases where their patients were unresponsive to other interventions.

While going through the journals, it became evident that the symptoms being addressed for the patients with whom the MG was applied as an intervention involved primarily severe anxieties, lack of concentration, dysthymia, and trauma. As it relates to the usual interventions used with such patients, the typical ones included TF-CBT (Trauma-Focused Cognitive Behavior Therapy), breathing exercises, imagery/visualizations, sand-tray activities, and other generic mindfulness practices (Cohen, Mannarino, and Deblinger, 2008). Seeing that both subjects had been from the same cohort and having done training with TF-CBT, both referred to their first choice of interventions as that of the TF-CBT while addressing patients with trauma and anxiety symptoms.

Subject A in discussing her experiences in the journal, states how at first having gone through the psychoeducation and the coping skills introduction stages of the intervention with the patient, she noticed that her two patients were not responding as she had hoped they would. For example, one of the patients was experiencing a sense of separation from herself and everyone around her, causing her to become afraid and this eventually led her to inform the clinician that she was going to stop coming to therapy if she had to go through the same "techniques." While continuing to use the TF-CBT with her second patient, she had noticed her other patient become more agitated and anxious, refusing to continue with this "talk-therapy thing," as the patient had described it, mentioning how "it's simply not working." With this latter patient, the symptoms of anxiety were becoming more and more exacerbated given the

significance of the severe acculturation factors such as immigration and deportation of family members that the patient was undergoing.

Similarly, in the descriptions within the pages of her journal, Subject B states how at first it was frustrating for her to come up short in giving "effective tools that worked and worked fast to reduce the severe symptoms" of some of her patients that she was seeing on a weekly basis. Here, Subject B writes how she wished that the agency would allow clinicians to meet their patients more than once or twice per week, especially with a few of her patients that she found would truly benefit from such an arrangement. Subject B states how she was ready to try any intervention to simply try and help "a few of her clients."

In my discussions with these two and other clinicians that took place at the L.A. Sotomayor High School complex where these clinicians and I would see patients daily, it became clear how often providing a clarification on one or more of the steps of the MG was helpful to these clinicians in enhancing their understanding of the intervention. This usually would present itself in the form clinicians describing during supervisions and in their private discussions with me, as to how making a small adjustment in the intervention or becoming more cognizant of giving more time with a certain body area that is being observed during the MG, "made all the difference in the world for the client." This was observed in the statements made by the two clinicians in their journals, whereby after having used it two or three times with their patients, they could see positive outcomes such as the trauma patients becoming more able to relax in their bodies, their tone of voice becoming calmer, and similarly with the breath, which would become more stable instead of erratic. By noticing physical changes such as these, along with a relaxed and steady eye contact with the clinicians themselves, these subjects reported their

patients smiling at them right after having tried the MG for more than five or seven minutes within the session.

In addition, Subject A mentions near the end of her journal how her patient with severe anxiety had approached her one day and asked if she could teach the MG to two of her friends. This, the clinician apparently found both unexpected and gratifying at the same time, because this particular patient of hers had come with many risk factors in her life that exacerbated her symptoms. After working with her for nearly two and a half months where the clinician had applied the MG only during the last five sessions, here was a patient who had reduced her symptoms by over sixty-five percent and was now telling some of her classmates about the benefits of therapy and how they should also try it.

- ***Additional excerpts from journals.*** It was helpful to read the actual words of the study subjects, as they candidly discuss their experiences with the MG while reporting on their progress in its administration. For example, within clinician A's journal, we see her reflections on her first time using the MG intervention, as she writes:

"I thought to myself how I like this intervention, because unlike the other times where I applied mindfulness techniques to help address clients' symptoms, it was so easy to remember the steps, and especially for my clients. When I asked them about how often they use it when they get into their episodes, for the most part, I was getting responses like, "it's fun, and I can remember it.""

Here we see examples testifying to the feasibility and ease of application of the MG as it is applied in treatment.

Subject B:

"The presentation he [referring to this author] *made was compelling enough for me to give it a shot, because with some clients I was really frustrated and everything I tried was not helping, at least sustainably. So, I thought to myself, I had nothing to lose. But as he pointed out on several occasions, I had to try it first on myself, which at least in the beginning was something I didn't want to do. After two or three attempts, I felt I was calm enough to give it a try and so I did. I didn't realize how tedious it would be in the beginning to go over every single part of my body. At one point it became tiresome but then I remembered his statements about checking the breath and the quality of my thoughts, and their speed, as I am going over these body parts, and I noticed a difference."*

Furthermore, this clinician later shared in her journal that she was better able to see how the body, feelings, and thoughts connect and how by holding on to things we allow pain to persist, as she resembled this whole process to a "mindless machine" (*anattā*). This was a crucial factor for me to have designed this intervention as I was trying to weave into it elements of the Dhamma, *vis à vis* aspects of the *Satipaṭṭhāna* and its importance in seeing the processes behind experiencing the body (*kāya*), feelings (*vedanā*), mind/mood (*citta*), as well as their relationship to the Four Noble Truths, and specifically to the first of these, i.e. suffering/pain (*dukkha*), (Anālayo, 2017).

"As I tried the MG, I started thinking about what he said yesterday in his presentation about being aware of the body, especially when he mentioned the differences between feelings and emotions. I didn't know they were different! Very interesting I guess when you think of feelings being just made up of painful, pleasant, and neither. It really makes things a lot simpler, in a way." She later adds in an entry a few weeks later, *"As I was doing the MG with "EA"* [patient's initials], *and while we both tried to be aware of each body part as we swept up, I asked*

her to pause a few seconds longer with each segment. When she did, and in a few minutes later, I noticed her suddenly having a sigh of relief. Her facial expression too seemed different, less tight or cringed. When I asked her what it was that she was experiencing, she said: "a big weight got lifted off, as if." Her smile said it all! After exploring this further with her for several sessions, we discovered how she had been holding on to her fear of losing her parents. I see what he meant during the presentation, how holding onto something including loved ones could be painful."

Subject A:

"At first, I was not saying the words 'this is my left leg, this is my right leg, this is my left shin, this is my right shin….' I thought it was unnecessary, but when he mentioned how this was crucial to help the client become more grounded and trusting of themselves, I began to see his point, and thanks to his psychoeducation of how one's own voice can have a powerful impact on the mind and especially in relaxing a person, I tried to experiment with it. It was really cool to see how fast I was noticing the differences even in my body, and the funny thing is that I could also hear my breath, but I was not even concentrating. In fact, I could also hear people down the hallway speaking even though my door was shut, and I could still feel my left elbow, right heel, and all I had to do was think of these parts. It's strange, but I feel a sense of freedom and my brain feels light for some reason, and people are making comments…about my smile. I have to ask him if the MG has got something to do with it."

Subject B:

"Perhaps it's the fact that I am kind of OCD, but I was concentrating on every single step and making sure every step was done 'perfectly.' But after talking with him several times, he told me of that manner of doing the steps that it can be counterproductive as well as cause me to have

headaches and lose my patience if not become irritated not only about the intervention but even with others. Instead, he recommended for me to make it more like a flow and to just think about each body part such as left heel, right heel, left ankle, right ankle, etc. I felt after trying this like he said, that I was kind of cheating or messing up the technique but soon I tried to let the process take over and observe even by just looking at these areas without even saying them or calling them out to myself. This seemed to do the job for me. With one of my clients who struggles with selective mutism, I found this to really be working well, because I would get hardly a sentence or two out of him throughout the whole session, and that's on a good day. But when I introduced the MG to him to address his on and off depressive episodes, I had him just look down to the different body parts one at a time by mentally naming each of them. It was quite surprising to find out in one of the sessions how my client presented me with a drawing of himself he had done with each of the segments of the body used in the MG. He had designated each of these segments by using a different color. He later stated that he was going to place this in his room to remind him, which by the way he said to me while using words."

4.6 One-on-one informal interviews. Aside from the data collected via the fifteen-item questionnaire and the journals, I also made myself available to answer any questions or clarify for clinicians any issues that might come up with the MG and its application. This meant that subjects of this study had access to me via phone, text, email, and in person, where I explored at times the concerns that they had about the challenges they sometimes met with, while working with certain patients and their symptoms. In addition to these informal interviews and meetings that were geared towards the technical aspects of the MG, I also shared in the celebration of the successes these fellow clinicians experienced when patients made substantial progress by

achieving their established treatment goals faster than expected, as was the case with several of their patients.

- ***Samples of interviews.*** These meetings with clinicians, many of whom I had known through my cohort at the graduate program of my MFT studies, allowed me to partake in their vulnerabilities as they became open at times while disclosing some of their own experiences, especially when they self-administered the intervention. The consensus with most of these cases touched upon their discovery of how easy using the MG was. Other comments expressed how they "became comfortable with it [MG]" and began using it more often, whether "in elevators," meeting and working with "difficult families" in sessions (Subject E) or going to "important interviews." This latter individual shared how she had applied for a job as a registered MFT intern, but was dealing with severe performance anxiety as her contract with the agency was about to expire, expressing: "it [MG] was so simple," as she could "do it even while sitting across from" her future boss, "without her knowing" it (Subject D).

I found these interview sessions with individual clinicians to be particularly important because they gave me an opportunity to delve a bit deeper into the Dhamma and the principles behind alleviating suffering, especially as it relates to mentioning the teachings I was trying to incorporate into the MG, at least in a somewhat generalized and loose way. Here, I was able to mention the difference in how mindfulness is generally taught today, and the kind of mindfulness that can develop into wisdom while taking charge of how the mind moves from one thing to another, i.e. choosing one's thoughts between wholesome and unwholesome as mentioned in the *Dvedhāvitakka sutta*, (Ñāṇamoli & Bodhi, 2001). This, however, I was unable to fully immerse myself and my audience into, as it relates to going into in depth explanations of the Dhamma within the therapeutic arena and in my intention for using the MG, given the purely clinical

protocols to be adhered to, and the cultural prejudices that some clinicians may have been prone to having. Fortunately, by looking at the outcome measures of patients, this abstention on my part from sharing specific Buddhist terms transparently (with this study's subjects) became self-evident, without the need therefore, to explicate it further in detail; this of course, given the presence of an invested and engaged clinician guiding the patient.

Subject A:

"The practice of the MG helps patients take responsibility for their thoughts, words, and actions, which are the three sides of the CBT Pyramid that I use in almost all of my sessions…although, I did not know emotions are different than feelings. This is giving me a wider perspective, and a better sense of how to work with my emotions (jealousy, anger, sorrow, sadness, joy, being forgiving, loving, etc.). This is making more sense of CBT and my understanding of human behavior, in general."

Subject B:

"I must say, how while using the MG clients have become better behaved, involved and more caring towards their peers, more loving and considerate towards their siblings and parents. It's almost like they're becoming disciplined by first loving themselves! Checking first with their bodies before reacting like they used to do, is not only making them become calmer, but more "mature" I think, but in a good way. I even had one client wanting to show it to his grandmother and asked me if it would be OK."

Subject C:

"I have to admit, I never liked using guides or charts. I like to do things with my body, and it's the best way for me to learn, and I'm sorry to say this, but I didn't refer much to the guide you gave us. Because when you showed us the intervention the first time, when you did it at

our office in Burbank, I wanted to give it a shot, and that's why I volunteered. But I never thought it would be that effective, and I'm not talking about only clients, here! I used it on myself, and still do whenever I feel overwhelmed and emotionally messed up. It helps me to get things in order, if that makes sense. I might be feeling lousy one moment, but when I just do a quick scan starting with my feet, sometimes I don't even get to my arms. I'm already perfectly relaxed, and my mind is so serene and comfortable. I can't describe it. But even more interesting is, when I'm struggling with some major issue, after doing it and immersing myself fully in it [MG]*, whatever it was that I was worried about, is not there anymore."*

Subject D:

"Back when I first began using the intervention, I was somewhat hesitant in using it. But, because I had willingly decided to take part in the study, I felt I had to at least try it a few times. So, I did, but only with those clients I thought that responded well with other interventions I had used already. I guess I did not want to try something with a client that was already challenging for me to work with. I know this was not the best approach to take, in hindsight. I guess, I was afraid I would not be doing it right or administering it, because I hadn't tried it enough myself, even though I saw at least two presentations of it, and you [referring to the author] *gave me your number in case I had questions about it. But, after trying it a few times myself, including once with my cousin who's 15, I was shocked to see how fast it worked in letting me just sink into myself, and at least momentarily, or for the rest of that day, to completely forget my worries, and just be. It was really relaxing, and I felt refreshed. Needless to say, the following Monday when I was back to work, I tried it with two of clients back to back; one had issues of anxiety while the other, disruptive behavior. I was amazed at their response. By the time I did the intervention with each, I could see how different they were as they left my office, compared to how they came in."*

Subject E:

"I remember one time, when I had to work with a client who was dealing with a breakup with his girlfriend of a year and was very depressed and in tears as he presented to the session. He was a senior student, going through a breakup. What I noticed with him was something else, right after I showed him the intervention. We did it together, because I thought getting back into his body, like you had mentioned, usually can toss the person out of their "headiness" and into the present, I think that is what you had mentioned in one of your presentations. Anyhow, instead of being in tears, the guy was soon smiling, and during the latter half of the session, he was sharing with me his plans once he's done with school and how he was going to spend his summer. This was the same client who the front desk had called me to see ASAP, as he was in crisis that day… crying his heart out when I first saw him. The intervention really did its magic. It's now my secret therapeutic "Harry Potter" wand!"

Subject F:

"I found it challenging to get my clients to agree to doing the MG intervention, for some reason. I myself wanted to do it a few times, but never together with my clients. After conversations with colleagues in the study, who already were using it, I saw myself gravitating towards using it. Even though I had agreed to use it and do my part in the study, for some time I still was not bringing it into my sessions. Until, one day I thought of giving a try, and not because my other interventions and coping skills I was giving to my clients already were not working. They were helping my clients. I finally, one day, decided to use it [MG] *in a session with a client, who had responded positively to many other interventions already. I wanted to do my due diligence and at least try it on a single client and see what happens. In doing so during a few sessions, I made sure I was observing the client carefully and scrutinizing his responses as I*

led him step by step through it. Initially, there was not much of a difference I have to say, at least noticeably. Later, as I was getting my client's feedback on the intervention, I learned how it "felt strange" to him. Probing further, I observed him describe how he had somehow felt being "very much in the room" while also feeling the presence of his anger in his chest getting less and less. This was something he had never described previously, at least in terms of localizing it somewhere in his body. This was interesting for me, enough so that I had to try it with at least two or more clients, just to establish a control. We worked together from session to session, using the intervention, until my client was able to sense it before "things got out of control" and he got in trouble due to his history of anger outbursts. He was able to see the triggers showing up, before it was too late. Pretty cool stuff. And by the way, I have used it more than once on myself ever since, with good results."

Subject G:

"I looked at what you had introduced us to with an admittedly suspicious attitude, because since being enrolled in our graduate [MFT] *program, I had pretty much attended every training and workshop on different therapy interventions I could get my hands on. So, there was some apprehension when I heard of the effectiveness of this intervention. But then I listened to the cases you've had where clients did not respond to anything you tried. I knew you teach meditation and when I heard that the mindfulness techniques that we covered at our trainings did not work, I realized that I was not the only one experiencing the same issue, which made me think maybe this is something I could try, plus I had nothing to lose. There were at least 5 clients that I tried the intervention with while at PUC. What was quickly noticeable was the way I could mold it* [the MG] *to my style of doing therapy, which took more of an organic feel as my clients became more relaxed and playful, even though I was having them go through the different parts*

of the body and spending some time on each. The outcomes were even more surprising I have to say, because soon my supervisor advised me to terminate some of them much sooner than I had originally thought I would, as their goals were met."

Subject H:

"I'm glad I was introduced to your intervention. It caught my attention pretty fast when I saw how it had elements of body awareness, breath, challenging maladaptive and distorted views of oneself, but without the guided meditation bit, which honestly, I've always hated and never liked using. In a way, I was somewhat not so surprised when I saw clients responding so positively as I began using it with them, given what I heard you describe in class for us, and how it pulls them back into living in the present instead of dissociating, which was a problem for some of my clients. I think taking this intervention while incorporating it with others, therapists can really make their treatment plans much stronger and efficacious such as incorporating it with the "Miracle Question," Socratic questioning or motivational interviewing questions, expands clients' paradigms by challenging their false beliefs."

4.7 Mindfulness: a doorway to the Third Noble Truth. As therapists, we see patients who come to us having tasted some of the worst that life could offer, be it sexual trauma either by strangers or by family members when they were barely able to walk, parents with substance abuse, broken families, foster homes, abuse of all kinds, neglect, and addictions, to name a few. It became evident from this study, that in their administration of the MG clinicians helped their patients not only reoccupy their bodies with intentionality, but to also begin to question their old beliefs and cognitive distortions. This transformation can be summarized by addressing their symptoms while asking two main questions: (a) *How many of our thoughts are truly ours?* And by the same token, (b) *How many of our actions are truly intentional, or done with awareness?*

In working with patients, subjects of this study were able to address these questions through bringing one's attention back to the body through reflective awareness.

To be able to live life harmoniously while having the capacity to face everyday challenges, as well as the scars of the past, and still be able to grow into a richer version of themselves, means that the individual is no longer living life by default. By taking control over their lives thus, one can taste the cessation (at least on the mundane level versus the supramundane, i.e. *nibbāna*) from suffering, i.e. the First Noble Truth. This, however, is not an easy task, even though the MG helped to demonstrate in more than one instance how it can be a simple tool, requiring us to reconnect with our bodies with kindness and forgiveness, which is something that many of our patients have lost touch with long time ago, or never had the opportunity for it, in the first place.

Not having a solid sense of safety in their lives and lacking control of what might happen to them, what these patients encountered in life was that their harsh environments came in to fill up the vacuum, as they were left behind by the uncertainty of a torn childhood. However, given their work with patients in the course of a year, clinicians participating in this study witnessed the lack in the ability for these individuals to self-regulate their emotions, while being in the pangs of negative behaviors affecting their major life functions, due to severe symptoms. This, in addition to the tendency to resist following directives from adults or authority figures, quickly made it clear how in order for these patients to begin to heal, while also learning healthy coping mechanisms to work through their symptoms, trust had to first be reestablished within them, as well as hope in human kindness.

Soon it became evident that for many of these patients, it felt as if they were simply prisoners in a perpetually maladaptive downward spiral, unable to exercise self-control or to

even think and imagine better possibilities for themselves. The disconnect that existed between what they perceived to be a harsh world and a physical body they were ashamed of, hated, or wanted to damage and destroy, was soon discovered as one that could be bridged. Working to rebuild this harmonious relationship is crucial in treatment, as this became even more pronounced given the experiences of clinicians using the MG with patients. It became evident that once this crucial step was added into the fabric of constructing a healthy therapeutic rapport from the very beginning of therapy, patients followed along the model set by their clinicians, and established treatment goals began to be met.

4.8 Limitations. The success of MG depends heavily on how the clinician administers it. The intervention is a tool and the mode of delivery is extremely important. When faced with situations where heavy emotions are brought forth by the patient while applying the MG, especially during the session, the question arises for the clinician as to what to do or how to respond. It is important to note here that the session itself is merely a launching pad, the main experiment ground and the tutoring arena for allowing the patient to become accustomed and more familiarized in how to apply the intervention well, so that they could do it on their own, outside of the session, which is the main objective.

Another limitation would involve the checking-in period, which happens at the beginning portion of each session. The check-in process itself can indicate whether the clinician has done a good job as it relates to the patient properly following or even having understood the intervention in the first place. Another way of measuring this outcome would come in the form of having the patient report on the occurrence of the symptoms during the week and especially in their reduction of frequency, if applicable. However, all of these rely on the “relatability” of the clinician as well as the thoroughness of their instruction while demonstrating the intervention.

Furthermore, in addressing any negative reactions that may arise while using the MG, as when at times a patient might re-experience certain traumatic memories, it is imperative for clinicians to constantly report on and candidly discuss their cases with their supervisors, in an effort to approach such situations. To this end, clinicians worked closely with this author, brainstorming and discussing through case-conferencing and reporting on their progress in the study while using the MG, which proved itself to be crucial to the success of utilizing the intervention. Not having these resources or the willingness to participate in such meetings and case-conferences can most certainly be called a limitation, if not unethical, given the level of competence and scope of practice that all clinicians must adhere to according to the AAMFT code of ethics (American Association for Marriage and Family Therapy, 2018).

Within the arena of providing individual therapy to patients once a week, it must be stated that this in itself is a limitation, given that the patient has an entire week to fall back on his/her normal maladaptive patterns compared to seeing their therapist for only one hour, if at all, where they could sit down and ask questions about the MG or discuss their treatment and go over their symptoms. This adds even more pressure on the proper adherence to the intervention, which again relies heavily on the presence of a solid therapeutic alliance and rapport building between both parties, i.e. patient and clinician. Therefore, the comprehension of the patient in the proper applicability of the intervention is indispensable to the success of this intervention.

The patients' level of adherence to the steps of the MG and their openness to practicing this technique, or lack thereof, could itself be a limitation. The instruction guide for the MG was given to each patient who were being administrated this intervention by the subjects, as an added support. However, much like with a prescription medication, a person taking it might not follow its instructions properly, or might not take it at all, both of which are outside the range of the

physician's or in this case, the clinician's recommendations and thus, may very well end up not having the desired effect on the individual. Therefore, the willing participation of the patient to pursue using it, whenever they have an escalation in their symptomatology outside the session period is inherently connected with its successful outcome.

Further, if the clinician is not able to trust in the intervention itself, the patient is not going to "buy in," as is the case with any intervention. To gain the trust of the patient, it was clear early in the study that clinicians needed to have practiced the intervention on their own first. This is where the experiential understanding of mindfulness for oneself, of knowing how it feels to be centered and being in the moment by the administering clinician, was a variable that could not be ignored, hence its absence could also be considered a huge limitation.

Given that both the quality of administering the MG, as well as the patient's openness to applying it are variables in the context of any therapeutic tool or intervention, it takes us back to the clinician and their observation skills to notice the tiniest little things that take place during sessions. For example, when the patient is pausing at a certain point in following the steps of the MG, as when they get to a body part and are suddenly stuck or avoid it completely; if the clinician is not fully present, i.e. unable to observe this very crucial piece of information, then the intervention will soon come to an end, without bearing any positive fruits or outcomes. In thus pausing during the grounding process, the patient is providing a large piece of information by not being able to proceed further given the psycho-somatic factors taking place, in relation to a possible trauma that has been "caged inside" that body part (Levine, 2010; Van der Kolk, 2015).

At this juncture again, the patient's trust toward the clinician has everything to do with the latter being present and observant. To this end, the clinicians' observational skill is enhanced by and largely stems from an empathic attitude towards the patient. Here, empathy has direct

correlation with the capacity of the clinician to build those strong and invisible bridges between oneself and the patient, and in fact with the whole family unit, because the family will get to see the results of the intervention, all of which present as the reduction in symptoms within the patient.

4.9 Summary. In Buddhism, one of the key principles we learn about is that of *anicca* or impermanence, which happens to be the first of the Three Declarations the Buddha made during the night of his Awakening, with the other two being *dukkha* (suffering/dissatisfaction) and *anattā* (non-substantiality) (Rahula, 1974). In learning about the principle of impermanence or change, we see how it is intrinsically connected with the aforementioned two, and especially to that of suffering. As is the case with many of us when faced with change, so did the patients seen throughout this study who, when presented with the MG as an intervention to address their symptoms, were found to resist it, at least initially due to their propensity to hold on tightly to the pain that was familiar, even if that meant they were holding onto suffering as they burn themselves (Dhammananda, 1992).

Heraclitus once stated: "*Man cannot step into the same river twice*," but as Buddhists, we can make an even more existential statement: *"The same man can never enter the same river twice."* This is the case because life is always unfolding and changing and with it, we too must learn to adapt in order to grow. Instead of engaging in mental or philosophical acrobatics, the Dhamma is designed from its very discovery to be a tool that is to be used to remove suffering. However, this is accomplished through understanding of certain principles, which when followed grant one the wisdom, given the unfolding that occurs within oneself of the layers of ignorance and habitual tendencies that keep a person chained to negative i.e. *akusala* or unwholesome states of being. Therefore, Buddhism offers us understanding through effort in the three trainings

(*sīla, samādhi, paññā*), and the gift of experiencing the Dhamma through meditation for oneself, which itself is a process of constant discovery (Tejaniya, 2010; Vimalaramsi, 2012). It is here that the teachings become fully applicable and immediately effective in one's life, due to their usefulness in delineating the role that one's attachment or craving has in one's life; the glue that keeps one yoked to the endless cycles of suffering and rebirth.

Forgiveness and tolerance are often talked about in connection to moving forward in one's life; however, hardly anyone can challenge the saying: "easier said than done." This is especially the case with those of us dealing with past trauma, as we try to face each day without being bogged down by the negative influence of cognitive distortions that tinge each of our thoughts with fear and anxieties, thereby pushing away from us the very possibility for a healthier life. Thus, many of us remain emotionally dysregulated throughout most of our lives, even though we may have found ways of suppressing our symptoms or resorting to various "tricks" to numb the symptoms that are on a wide spectrum of influence, as they come to disrupt our major life functions, and peace of mind (Van der Kolk, 2015). Often this is manifested through the disconnect that occurs with one's own physical body, which can easily be seen as the anchor that can help us be secure in the present moment, divorced from whatever took place in our past or might happen in our future, given the presence of anxiety and dread towards its uncertainty.

It has been shown that as an intervention in the clinical setting, the MG demonstrably was adaptable in bringing peace and a sense of balance into the lives of patients from various backgrounds, regardless of age or gender. Through its application, patients became aware of their bodies, as the quality and nature of their attachment to anger or other negative emotions (related to their past trauma) changed, leaving them with a sense of freedom and autonomy. The MG

helped patients gain a steadiness of mind that was thus far unprecedented for them, granting them insight into the nature of their suffering.

Finally, therapists also worked closely throughout the treatment with the family, addressing the many latent causal aspects of symptoms, which went beyond the local symptoms (those uniquely involving the patient) to those of the system's, i.e. the family's (Minuchin & Fishman, 1981; Whitaker, 1989). Therefore, parents often shared details as to how their child had "changed" by improving at school and at home, ever since starting therapy a few months earlier. One such remark was made when a parent stated how their child began teaching his family the intervention, given their experience of its benefits.

Chapter 5: Conclusion

Conclusion

In a culture that is becoming more and more able to normalize traumatic events, it is no surprise that many in our population are beginning to manifest the subversive effects of these experiences, where today, we have become adept at trying to somehow hide the magnitude of trauma underneath thickly ornate terminology. With as many syllables as may be necessary to numb the full affect of loss, of suffering, or of trauma as we try to do our best to avoid confronting the harshness of reality that has invaded the feeble security of a fictional sense of permanence, it is no wonder that suffering and trauma abound in our technologically advanced time in history. Now, as a culture we are no longer needed to be in the front lines or a bottle zone, per se, to experience trauma. Trauma has come to our doorstep; no longer does it exist in a far-off country that we cannot even pronounce. Although suffering remains prevalent, we somehow have lost connection to finding out the most efficient and practical means of addressing it, let alone healing or even treating it. Mindful Grounding (MG) represents that tangible hope, the very doorway to reconnect with and therefore address the wounds and the suffering within and to do so through the body itself.

5.1 Background to the MG. The knowledge that here is an intervention which helped patients overcome symptoms that had been with them for as long as they could remember, was something that kept me excited long after I walked off the school campus after a long day's work. I was able to report to my supervisor the experiences I had in sessions with patients, who became equally excited given that they were quite familiar with many of the patients in question, having assigned them to the other therapists in previous years. Using the progress notes where I had documented the progress of patients over time and the interventions used, I was able to trace

the changes taking place in patients' behaviors, as well as their newfound ability to self-regulate their emotions. Soon, my supervisor suggested that I share my results with fellow clinicians on site, and later I was asked to present my findings to the agency's headquarters to formally introduce them to the MG.

This project that has taken me over a decade to complete given many challenges and obstacles, aside from being beneficial to my field of knowledge about the mechanism of trauma in those who survived it, has also become the culmination of a personal journey. Through this project, I often found myself having to face my worst fears, even the ones that had remained imperceptible to my sphere of awareness, hidden in some subconscious region of the mind. Beyond the arduous and tedious academic journey that I have trodden, picking myself along with the pieces of whatever hope I could muster, the research always seemed secondary to what was taking place within me, as I observed my emotions, feelings, and thoughts, in their interplay within this body that was inevitably, sooner or later manifesting these traumatic experiences which the mind wanted to relinquish and move away from.

During this research, I collaborated with fellow clinicians who were the subjects of this project. Here, I found myself engaging with fellow psychotherapists on a daily basis as we worked with trauma patients, whereby I discovered how, whether in my clinical work with patients or collaborations with the subjects, there was no difference in the fabric of who I was and what I was doing. This, I did not realize at first. However, as the days and months came and went and patients progressed in their treatments, I saw how crucial it was for patients to have a human being in the room with them. This meant for me the inseparability of one's own kindness, warmth, empathy, and love in *all* of one's relationships, whether with patients or subjects, i.e. fellow clinicians. These of course I had already previously identified in my life as none other

than the integration of the *brahmavihāras* with what I did and how I lived, but through this project I saw how the *brahmavihāras* were crucial for the MG and its success in helping trauma patients, including in making the principles of the *Dhamma* more perceptible through lived experience. Therefore, in order to bring about the regulation of emotion within another, attuning with another human being was essential, which meant that connections needed to take place. Here, I saw how the project had made me become more patient with myself, with my patients, as well as with the subjects, not to mention navigating through the tedious research, other logistical factors, and unforeseen obstacles involved before, during, and after the project was completed.

Perhaps, it was meant that I would find a way to incorporate my training as a student of Dhamma, in order to apply the principles of my Buddhist practice in trying to help those who had never attempted meditation but had seen the worst that humanity could throw at them, that of childhood trauma. It was in such a turn of events that in coming up with the topic of this dissertation, which I was struggling with, during a conversation with my doctoral advisor Rev. Jitsujo Gauthier, I suddenly recalled the work I had already started doing with patients at my Marriage and Family Training Traineeship site. This was none other than the already very important work I was doing with patients, who had come to me for help as they grappled with symptoms of anger outbursts, negative social interactions, drug addictions, and many with self-harm and suicidal ideations.

Working with this population engendered within me a curiosity to delve deeper into my own past trauma, something I thought was long resolved. Introducing these patients, who came to me with scars of abuse, childhood sexual trauma, broken families, and severe anxiety levels, to a practice that combined mindfulness, compassion, loving kindness, acceptance, and forgiveness was no easy task. Many of these patients had been in therapy for many years, so the

prognosis for sudden and radical shift was something that although hoped, nevertheless remained unrealistic for most of them. I knew I had to try something different. The answer to my problem came as the culmination of incorporating the above qualities in Buddhist practice, with the inclusion of body awareness (*kāyanupassanā*), while using it as a systematic and progressive un-layering of awareness through the various body parts.

The effect of this was rather sudden, at times observed even in the session that MG was first introduced, in the form a distinct level of relaxation where anxiety patients were witnessed becoming serenely aware and calm, displaying prosocial behavior, a drastic drop in violent encounters or anger outbursts, increased academic performance, and the ability to mend broken parent-child relationships. Unlike what the cases had been in the past, here was a group of tormented young human beings, who although having lost hope in mankind or in a safe and loving future, were now witnessing the wondrous experience of integration within themselves as they applied the MG. Starting with the body, which to that point had been looked at by these patients as a "dirty" or "ugly" part of themselves to be severed from, my work involved helping them discover otherwise, and with the insights to construct a new and healthy paradigm.

5.2 Author's personal experience as part of this research. Applying mindfulness in therapy in a fuller capacity finds itself indelibly connected to this author's own experience of trauma and lifelong symptoms of post-traumatic stress disorder. With trauma's historicity buried in the sands of time, it remains alive and well in the very heartbeat of each moment lived since the occurrence of the traumatic event. Our minds are trained, research says, to think and dwell on whatever is negative, even if it happens to be something that we experienced a long time ago, in hard-to-remember foggy past. However, this research and the life I have lived thus far, indicate this past not to be so foggy after all, at least as it relates to its ever-present witness in our lives:

our bodies. Therefore, it is no surprise to find how even the slightest comment leaves its mark on the mind, given the triggering effects of everyday situations whereby the individual helplessly stands alone to relive the horrors of the past and anxieties of what's to come.

My own experience of trauma and the limitless life-changing role of the Dhamma with its meditative practice in my life, both as a meditator and a teacher, placed me in a unique position to understand my patients, their circumstances, and the impact their traumas have had on their entire family. I knew I could use that as a fuel to develop a bigger heart, a prime characteristic for an excellent therapist. Knowing how trauma holds a person hostage, therefore, with every patient I found myself considering as to what might be the best method of help that they needed.

Looking back at my life, I have come to realize that if life has taught me anything, it has been the factuality of impermanence, which makes it urgent to clean one's heart with faith and love along with actions that reflect them in the world around us. This became crystal clear for me through my Dhamma practice and studying with various meditation teachers, including Ven. Havanpola Ratanasara, Ven. Henepola Gunaratana, S.N. Goenka, Sayadaw U Pandita, Sayadaw U Vimalaramsi, and Sayadaw U Tejaniya. Studying under these teachers helped me become more present, as they each brought me back to what mattered most, i.e. that *dukkha* or suffering exists, and unless I take on the reins of my own life now, this precious human birth may slip from underneath me at any moment.

- ***Applying insights gained through personal challenges and mental illness faced throughout life.*** The major trauma that I experienced as a child left its indelible mark on my life. I found myself fighting demons of PTSD, major depression, while being plagued daily by a series of painful obsessive-compulsive symptoms. Although going to an art therapist helped greatly in the early stages, it did little to alleviate the ever-growing ripple effects of trauma and

other major events in my life to follow. It was only years later, through my understanding of therapy, modalities, loving kindness meditation, the Seven Factors of Awakening, (Bodhi, 2000) and finally the Four Foundations of Mindfulness (*Satipaṭṭhāna*) that things began to make sense, on a deep level. It may be true that all things faced in life come to congregate into seemingly disparate experiences, yet suddenly conspire to make sense after all. At least that is how things have turned out to be for me, especially as it relates to the work that I do with patients who have dealt with traumas of all kind.

- ***Communicating with mettā.*** Practicing *mettā* under Sayadaw U Vimalaramsi, I felt the power of loving kindness the Buddha discussed in the *suttas*. For the first time, I was able to feel the expansiveness of what love truly is; tasting the fruits of the Dhamma, I realized that it is in fact sweeter than my own Mother's milk. It was this love, which later allowed me to go to my sessions in the capacity of a clinician, and help my patients face and work through their challenges. It was thus that I encountered patients, who came to me while tenderly carrying in their palms the remnants of what used to be a loving heart.

I realize how life makes it necessary for us to be compassionate first towards ourselves, in order to better assist others. I know now that this is undeniably important to myself as well as my patients, as I see them transform their pain to a life-changing and enriching experience. Working as a therapist has everything to do with my mission in life; whether it is my personal or professional life, in both the common denominator happens to be the Dhamma, as I promote Lord Buddha's Teachings through my life and practice as a Dhamma teacher to alleviate suffering. This has always been the main *modus operandi*, whether I wore the hat of a High School Teacher, a fitness trainer helping the elderly and those recovering from injuries, or as a college and university professor.

Although these various positions allowed me to function within a certain capacity, they often also meant that I was to operate within the limitations dictated by each of these positions I was entrusted with, although they did not deter my function (albeit incognito) as a Dhamma teacher. This can be challenging many a time. However, the assumptions of many of my students or patients who came to receive education or mental health services were soon replaced by an understanding, given the tools they received, which enabled them to look at their own lives differently than before. This meant looking at their own faculty of freely making choices versus being led by tendencies or habitual patterns, as they started experiencing a sense of ease and comfort with less strife now that their attachment was not as strong. From the aforementioned careers I have had over the last two decades, I was able to see the value of communication throughout the process of change while engaging and sharing *mettā* via actions. The pedagogical methods applied also used imagery, analogies, and examples from students' own lives that they shared with me, as I showed respect and appreciation for the world they came from. This was no different while I worked with the population of children and youth at my clinical site, as I developed the MG.

- ***Appreciation of the sense of urgency and the 'two arrows' mentioned by the Buddha.*** This intervention has a quality of urgency (*saṃvega*), as it forces the person to stop delaying action in the moment for the sake of hoping for something in the future or dwelling in memories of the past. This urgency works beautifully while relating it to the "poisoned-arrow" simile (Bodhi, 2000), which the Buddha explained to motivate action and change (from the status quo), something that many patients suffering from various traumatic symptoms are desperately seeking (Punnaji, 2001). We are informed in the *suttas* that the arrow, which is explicit, comes to us from the outside, i.e. via the external sense bases, entering the body through our six senses in

the absence of an aware mind where wisdom is lacking (Tejaniya, 2011). In my work with patients, I have seen the reality of their pain, which has the flavor of immediacy to it. Here, one realizes that relief cannot be delayed, nor the experience of pain argued. Hence, using this as a springboard, patients have appreciated the quick effect of the MG, due to the value of directly experiencing it.

- ***Making room for loving kindness (mettā), compassion (karuṇā), altruistic joy (muditā), and equanimity (upekkhā) in patients.*** The MG has the capacity to lead one into preparing to experience the four *brahmavihāras* or 'divine abidings' (Walshe, 1995; Ñāṇamoli & Bodhi, 1995). Here, I realized early on in my own work with patients that this was needed for MG to hold any value in patients' lives. However, to have these qualities manifest in patients, therapists needed to develop these within themselves first, thereby making this truly a "healing profession." This is especially relevant, as it relates to caregivers within the helping professions, something that Western psychology has come to acknowledge and promote due to the influence of these Buddhist concepts within the field of therapy (Gauthier, 2013). After all, "responding with the same emotion to another person's emotion" is referred to as empathy within therapy (Gladstein, 1983, p. 468). Having personally used the *brahmavihāras* as my main objects of meditation over the last six years, I was able to not only develop these qualities within myself (Vimalaramsi, 2012), but also have them permeate my therapeutic work with patients.

Similarly, the integration of these qualities into the practice of therapists has been identified as a measure of success in treating patients. While incorporating the *brahmavihāras* into the administration of the MG throughout the sessions, soon I noticed how these patients were able to grasp the MG in a quicker manner and benefit from it, while they too began exhibiting the qualities of the *brahmavihāras*. These took the shape of new constructive choices

they were now making, and the happiness that followed. In addition, during our clinical meetings I often found opportunities to encourage my colleagues to explore the *brahmavihāra* by openly discussing them, but most importantly through my behavior with them *vis à vis* our therapeutic work, i.e. in practice (Lewis & Haviland-Jones, 2008). Working at my site or studying alongside other clinicians at the university, I saw how it was not only patients we were serving that needed help but we, therapists, as well (Ñāṇamoli & Bodhi, 1995). Here, I recall a conversation with a group of clinicians, when I saw how the consensus among the majority was that while it is so easy for us to give interventions to patients, when it comes to our own issues, however, the fact is, we often avoid or blame others, situations, etc. Here, I was reminded of the words of Lord Buddha to Cunda from the *Sallekha sutta* in the MN 8: *"Cunda, that one who is himself sinking in the mud should pull out another who is sinking in the mud is impossible; that one who is not himself sinking in the mud should pull out another who is sinking in the mud is possible."* (Ñāṇamoli & Bodhi, 1995).

- ***Relationally lived life: a life worth living.*** In our therapeutic work and in our own personal lives, we cannot divorce ourselves from being social, which adds a different dimension to the experience of living. The Buddha himself, after his awakening, did not live in isolation but always made himself available to the society that he happened to be in, whether it was the community of monks and nuns, or the laity (Bodhi, 2000). Being inspired by this example and those of teachers I have come to respect and love, I have always looked at ways to share whatever insights I may have come to experience in my practice, be it in my capacity as a Dhamma teacher or a mental health provider. As a Dhamma teacher, I saw how the experiences I went through as a child of war, living in and with trauma, losing loved ones from a young age to death, all enabled me to come to see and understand the teachings of the Buddha with clarity,

due to a deep appreciation of suffering (*dukkha)* and the ever-present possibility and certainty of death. These also made me feel the sense of urgency (*saṃvega*) in learning and practicing what the Buddha taught in order to break the bonds of cyclic existence (*saṃsāra*), while being yoked to the three defilements of greed (*lobha*), aversion (*dosa*), and delusion (*moha*), (Tejaniya, 2010).

Interestingly, these relational attributes are dovetailed into the qualities that I have come to learn and develop as a psychotherapist, as I help patients who may not come to session in order to break from *saṃsāra*, but nevertheless are there for the alleviation of suffering. After all, as I have come to understand the work I do with patients, it is inseparable in its spirit from the work that I do in disseminating the Dhamma (Ireland, 1997). This trait, therefore, has helped me expand beyond the confines of my immediate personal life by opening up and developing a deeper sensibility of what it means to be alive. This also led me to trust in the limitless joys of trying to live a selfless life, as humanly as possible, in a society. The work I do as a Dhamma teacher, which during the past year seamlessly weaved itself into my clinical work, showed me layers of relational living I once only imagined (Ñāṇananda, 1971). I found this not to be something that remains hidden from those whose lives we touch, however, but something that shines through as it can give them the trust in their own capacity to rise out of their suffering.

5.3 An opportunity to share the Dhamma. Given my experience with mindfulness, both as a practitioner and a meditation teacher, especially during my clinical practicum work with patients, I saw how mindfulness could in fact be a truly powerful intervention in addressing various emotional, cognitive, or behavioral disorders, despite its initial failures in addressing certain patients' mental health symptoms. However, there is a stipulation to the success of mindfulness as an intervention: it needs to be administered appropriately, while considering the patient's individual disposition. This also needs to be done in the knowledgeable clinical hands

of the competent therapist whose therapeutic toolbox includes certain key Buddhist traits, i.e. empathy, loving-kindness, compassion, level-headedness or equanimity, etc. Within a therapeutic setting that includes such conditions, patients have been observed to become more self-regulated in their emotions, while simultaneously developing the ability to become self-aware and thus, less prone to fall victim to habitually negative or maladaptive cycles (Conway, 2014).

Through this research, my goal was to clarify how mindfulness itself is not designed as a "cookie-cutter" technique to address problems. Instead, to ensure its success as an intervention, it needs to consider a series of variables that become clearer in the ongoing assessment of the patient throughout their treatment. Here, the trust between patient/therapist needs to first be established, which makes room for the safety necessary for the patient to become encouraged enough to stay within the body while reconnecting with their emotions, therefore developing the tools to emotionally self-regulate. This method of administering mindfulness given the relationship between therapist and patient is not so different from the way mindfulness was first taught by the Buddha 2600 years ago (and continues to be taught today by certain Buddhist meditation teachers), as it was reflective of the individual capacities of listeners (patients) being "prescribed" the intervention (Tejaniya, 2010; Vimalaramsi, 2012).

- ***Bringing the Satipaṭṭhāna into view.*** Mindful Grounding applies the principles of the *Satipaṭṭhāna* by bringing about the contemplation or awareness of the body, feelings, the mind, and mental states, through the following questions: *"Where am I? Am I in the body? Am I here, right now? Or am I living in the past or the future? What is happening to me?"* This develops the skillfulness of awareness where the mind is seen as the 'knower' of that which it observes, including the body or feelings, which are objects "to be known" (Tejaniya, 2011).

Understanding that all phenomena are nothing more than *dhammas* to be processed and contemplated upon, a relaxed and gladdened mind comes to experience the freshness of the present moment, nowhere else but here (Vimalaramsi, 2012). Conversely, this state of a relaxed body/mind with full awareness, allows one the experience of a gladdened mind, i.e. giving the individual a glimpse of what the Buddha mentioned in the Dhammapada: 'We are the Happy Ones' (Dhammananda, 1992). This works in conjunction with developing wisdom.

As we approach the MG thus, we may see how this becomes one method of applying Right Effort (or Harmonious Exercise) of the Eightfold Path (Punnaji, 2010), shown in the *Satipaṭṭhāna sutta* as an outcome of a relaxed and tranquil observation of one's own living experience (Ñāṇamoli, & Bodhi, 1995; Walshe, 1995). Here too, neuroscience agrees that pain is inevitable in life, yet suffering is seen as optional (Hanson, 2013). Following this rationale, therefore, we ease the tension in the mind through the promotion of a relaxed state throughout, (Ñāṇamoli, & Bodhi, 1995), which allows the body to follow suit, and does in fact reduce suffering (in the form of stress, tension, strife both in the body and the brain), as one arrives at a greater state of peace (Vimalaramsi, 1997).

For a practicing Buddhist, working with these patients meant that I was in a rare and privileged position to be offering them tools such as the Four Noble Truths, as I tried to share Dhamma using the principles of the Eightfold Path. Of course, given my limited function as a mere trainee working in the capacity of a mental health clinician at a public site, a school setting, serving a non-Buddhist population also meant I had to share the Dhamma without naming it as such, applying practical life examples, especially ones that patients could relate to. In doing so, I found myself sharing my understanding of meditation and the *Satipaṭṭhāna* (Ñāṇamoli & Bodhi, 2001; Walshe, 1995) to devise an intervention, the Mindful Grounding (MG), as I addressed the

behavioral, emotional, and mental disorders patients suffered from, by the medium of bringing awareness to their body.

- ***The cost paid for the popularity of mindfulness.*** Having tried the interventions I was taught in the Marriage and Family Therapy program, I found myself frustrated at times, given the fact that patients' symptoms were often exacerbated or temporarily suppressed, until the next emotional outburst took place, thereby indicating clearly a failed means of intervening to alleviate their suffering. Using mindfulness techniques, as those listed in therapeutic manuals or Mindfulness-Based Stress Reduction (MBSR) training guidebooks, I quickly saw how these were often inadequate at best in addressing patients' symptoms. Such interventions, albeit "mindfulness-based," often came to separate patients from their experience, whether through falling asleep by removing themselves from re-experiencing their trauma via their accompanying negative feelings or worsening their symptoms. It was here that I extended my therapeutic resources by bringing into them my understanding of the Dhamma, practice of meditation, and the fruits gained from it. Thus, I began incorporating core principles of the Dhamma, such as mental cultivation (*samādhi*) along with its other branches, i.e. virtue or moral discipline (*sīla*), and discernment or wisdom (*paññā*) (Rahula, 1974; Tejaniya, 2010).

In today's world of materialistic approaches in looking at life, it is often no surprise that even in the midst of Buddhist research, it is difficult for some to see that the very tools used by Lord Buddha and his disciples in removing the "second arrow", i.e. alleviating the suffering of continued existence in *saṃsāra*, still stand in their effectiveness to address our modern-day *dukkha*(s) (Ñāṇamoli & Bodhi, 2001). The length of time spent trying to deal with pain often allows a person to remain stuck in the pangs of suffering. This truly difficult state is often perpetuated due to lack of information or curiosity, which may come to be seen as none other

than holding to wrong views (*micchā ditthi*), which the Buddha warned against, and for which he devised the very first of the eight steps he formulated in the Noble Eightfold Path. In addition, looking at the structure of the Four Noble Truths, and how they address the removal of ignorance and thereby that of suffering, due to craving, is at the base of eradicating our attachment to the way suffering lingers from the past, as it is caught and kept lodged inside the body. This entails looking at our relationship with pain itself, as we reevaluate moment to moment our attitude towards our experiences, both good and bad.

Much like failure teaches us what success miserably fails to, similarly with having a scarred past with equally tormented memories; here introducing patients to ways with which they can become more cognizant of their bodies has a tremendously valuable role to play, and on so many levels. These include but are not limited to (a) becoming more forgiving of themselves and their bodies, (b) gaining the understanding to see through negative tendencies and disruptive patterns that sabotage their therapeutic progress, and (c) the capacity to develop healthier boundaries with others but without sacrificing the potential for developing deep and meaningful interpersonal connections. Thus, by witnessing the changes taking place within, these individuals discover that it is the absence of what is needed that is most important, i.e. reconnecting their living experience with their bodies using mindfulness or *sati*.

Evolving from our past trauma requires the relinquishment of unhealthy attachments, including our past hurts, and here the skillful use of the principles found within the Eightfold Path and the Ten Perfections (*pāramī*), such as Right Thought, Right Effort, Patience, Renunciation, etc. can make patients understand their role in the perpetuation of negative symptoms, as seen in Buddhist pastoral work (Yetunde, 2011). Working as a conscientious therapist inevitably involves (and necessitates) an understanding of mindfulness and its role in

producing positive experiences for patients, while also playing a major role in the reduction of suffering, the cultivation of compassion, in addition to maintaining a solid foundation of ethics within the practice. With the introduction of positive experiences onto the sphere of awareness, patients undergo a state of freshness while increasing the release of dopamine, a key neurotransmitter responsible for feeling good (Hanson, 2013). The same effect takes place given the outcomes of other researchers, such as Peter Levine's seminal work in helping patients with PTSD, as achieved in using the body through movement while having the patient sound "*voo,*" which may be described as an unintelligible mantra. It has been proven that no matter the traumatic weight one bears, such techniques are able to bring patients' attention back into their viscera as they breathe out, in turn producing a leveling of oxygen and carbon dioxide, manifesting as a balanced state of wellbeing while using the mindbody connection (Levine, 2010). Developing such new and higher capacities that warmly open one up towards self-appreciation through the practice of mindfulness of the body, offering the mind and body an authentic sense of caring, inevitably moves one to a state of loving balance (Cope, 2000).

5.4 Finding the Dhamma in our therapeutic work. Modern secular treatment of mindfulness being mostly based on cognitive approaches, causes it (mindfulness) to become different from what the Buddha originally intended in teaching it, nearly 2600 years ago. For the Buddha, rationally understanding something was one thing, experiencing it for oneself through practice was quite a different matter. It is this experience that is lacking in many of the modern-day pedagogical approaches in the field of mindfulness meditation.

- ***Issues with teaching mindfulness as an intervention.*** Much like in any line of specialized study that prepares individuals to properly apply that skill, so too mindfulness meditation requires individuals to have proper training and sufficient first-hand experience in it

as monitored by experienced meditation teachers (Tejaniya, 2010). This is lacking in the modern mindfulness pedagogy. The lack of adequate training in meditation with a clear understanding of the subtle workings of the mind can do more damage than good (Vimalaramsi, 2012). Teaching mindfulness after having attended a weekend retreat and being certified in it can hardly be considered sufficient training for oneself to be called an "expert" or someone trained in it. Yet, I have witnessed numerous therapists today attending such workshops and in turn offering their own mindfulness retreats for other therapists, while charging exorbitant amounts of money. Lacking a core understanding of the Four Noble Truths, or what the main purpose of introducing this 2600-year old science of mindfulness training truly entails, many of todays "experts" invariably are unable to appreciate its various nuances *vis à vis* helping patients. This makes it necessary for us to raise the following simple yet important questions: What *is* mindfulness? Can *anyone* do mindfulness? Does it cost anything? Does one have to be an expert at it, to gain from its benefits? Etc. etc. All of these are valid questions. Thus, in our efforts to explore the beneficial qualities and practice of mindfulness as such, we need not merely look at the technique itself, i.e. in isolation, but to start with the persons wanting to engage in it, either as teachers or practitioners.

When we speak of mindfulness, often as a public we have become used to taking its meaning for granted, whereas many practitioners and even "experts" are left speechless and unable to define "mindfulness" in clear and simple terms. Some have defined mindfulness as "remembering to remember" or "being aware of the present moment", etc. The definition provided by the meditation teacher Ven. Vimalaramsi, of 'mindfulness being the ability to be aware while observing the mind as it moves from one moment to the next' (Vimalaramsi, 2012), seems to be more apt given the objective and clinical outcome offered through the MG. What

was being observed, therefore, was not just the momentary state of mind but also the overall condition of the mind, i.e. the process of thinking, feeling, which led to action through the body, that which can be called one's true behavior (Cohen, Mannarino, & Deblinger, 2008). Unlike the common way of understanding or defining mindfulness, what we understand as mindfulness therefore is not necessarily about feeling good, or relaxing, or having things be a certain way. Mindfulness is the wide and accepting way of observing the living experience with nonattachment. It is working towards gaining wisdom in order to see through the negative habitual patterns of living that disconnect us from living every moment consciously, with fresh eyes.

What is often worse than a lie is misrepresenting (or partially revealing) the truth or "pruning" it to fit the palate of a public that is becoming ever so mesmerized by the fashionable theme of "mindfulness." This presents an ethical issue that needs to be addressed, especially when we are discussing the possible benefits of an intervention while leaving out its proper scrutiny, which includes the method of delivering and administering it to the public. As a comparison, one may think of the way prescription medication is offered to patients as an intervention. First, the individual prescribing it needs to have had extensive training and experience, and secondly their needs to be proper assessment of the patient about to receive it. The same is the case with using mindfulness as an intervention. If we are coming from the same premise as that of the Buddha, i.e. relieving suffering in the world, unavoidably this very well includes the ethical basis within the practice of mindfulness (Moffitt, 2016), beginning with non-harm towards oneself.

As teachers of the Dhamma, we do have a responsibility to keep it both unhindered and undiluted, and even more so, not to dumb it down from its core principles so that it fits the

capacity of our readers or listeners, and the times we live in. This also applies to trying to follow current trends of teaching the Dhamma *vis à vis* the attempts at "secularizing" it. Furthermore, there must be a sense of gratitude and humility in one's approach in teaching any subject to others, let alone the Dhamma brought forth by the Buddha, something that seems to be lacking today. For a teacher of Dhamma to come up with their own interpretation of key concepts without any consideration as to how that may eventually affect others on the path as they continue on their journey, is similar to someone reaching a crossroad on their journey and looking at a signpost, such as the road to Kathmandu or Paris, and deciding to change it to a different name, just because it fits their own interpretation of how it "should be." This not only confuses those traveling on the path, but may even make them lose their way, or even worse, have them give up on their quest.

- ***Reconnecting with the body to settle the mind.*** For MG to be effective, once the therapeutic alliance has been established, the therapist needs to allow the space for the patient to bring up any feelings or thoughts about the intervention. This means helping the patient identify any sensations arising in the body while going through the steps of the MG. This is especially the case with the MG and its emphasis on incorporating the body through pacing and empathic listening; in other words, the very way one is teaching or showing the intervention *is* essential. Slowing things down instead of rushing helps patients to pay close attention to their emotions, as they begin noticing how these emotions (generated by their habitual thoughts) are interrelated with specific areas of the body, much like two ends of a string, whereby when one is pulled, the other is affected too.

The MG urges us to consider how the separation between body and mind need not be further perpetuated. As we look at the role of stress and how it influences the everyday functions

of our lives, be they emotional or physical in nature, one soon realizes how easily they impact one another. Thus "mindbody" have the hyphen removed from their midst, making the two inseparable from each other. No wonder that in Buddhism we see the body and mind as *nāmarūpa*, put together as one aggregate within the collections of aggregates/factors that make up an individual.

- ***A sustainable way for self-regulating the emotions.*** The MG allows its user to monitor the successive moments of experiencing taking place through the six sense doors (eye/vision, ears/hearing, skin/touch, tongue/taste, nose/smell, mind/thoughts), i.e. the body. Similarly, it helps one look at feelings, especially in terms of our tendency to run away from the painful into the arms of the pleasant, as we identify the entirety of this process and attribute it to an illusory sense of "mine," "my pain," "my past," etc. Meanwhile, the mind gets flooded through hyper-arousal, as negative reactionary tendencies keep one stuck in their maladaptive cycles of becoming. Thus, the MG intervention remains independent of happenstance or speculative thinking, as it gives the patient a sense of responsibility, control, strength, and confidence of knowing what is taking place within. This is done by enabling patients to self-regulate their emotions, whether in facing bouts of anger, irritation, anxiety, sadness, or debilitating thoughts, which now become understood and seen for what they are as outcomes of the intervention.

- ***Experiencing the Third Noble Truth, in the here and now.*** Being caught in the grip of the fears of a future or trapped in the torture chambers of the past, while sacrificing the miracles taking place in the present, can hardly be called a life worth living; that is truly a proper synonym for *dukkha.* However, hatred or ill will, which many of my patients dealt with, cannot function on its own; it requires the fuel that only craving could supply. Through psychoeducation,

patients developed the curiosity to find out as to why this is so as they became more comfortable to see themselves being rid of the anger or anxiety. Further, they saw the clingy nature of the desire in holding on to something or wanting things to be different than what they are, which was accomplished by breaking down the conditionality of phenomena in terms they could understand. Here, they began feeling comfortable with their past as they felt the power of having control over something else: their next move, their next response, as opposed to reactions to situations that would normally bring sorrow for them and their loved ones. This was liberating for them, as patients' anxiety levels dropped exponentially, and they began choosing their new life.

5.5 A malleable technique fitting different dispositions. Whether we are teaching the Dhamma or anything that can change one's life to the better, we need to always consider the capacity of the person to process the information being granted. This also means that not all listeners have the same mode of grasping the ideas, hence the same chance to benefit from the guidance. In the *suttas* we come across the differences in the ability of individuals to learn as they are being taught (Bodhi, 2012), i.e. one who learns by taking hints (*Ugghatitaññña*); one who understands after learning all the details through an expanded clarification (*Vipacitaññña*); one who learns through guidance and systematic instruction (*Neyya*); and finally those who learn by rote (*Padaparama*). To this end, in teaching and communicating the MG, I tried to incorporate all levels of comprehension after carefully assessing my patients.

This intervention has the capacity to be individualized according to the needs and emotional-cognitive level of patients. For example, with a patient who is hyper-alert and overly obsessed with being scrutinized by their peers, the MG in its original presentation of being administered while standing up may be a problem. So, to accommodate for this, clinicians have been advised to encourage their patients to apply the intervention even while seated or lying

down, where they can mentally or through touch scan and go over each body segment. This way, patients would still benefit from the usefulness of the MG no matter the circumstances or their unique needs and dispositions. Here, the personal experiences in having applied the MG on themselves, therefore witnessing its potential effectiveness, enables the therapist to conduct the MG with conviction.

- ***Effectiveness of intervention is dependent on its delivery method.*** It all starts with *how* we talk to people. While the malleability of the MG enables it to become effective, this is greatly dependent, however, on *how* the intervention is delivered. The very manner of how I presented the MG to my subjects was crucial in whether subjects (be it patients or therapists) would "buy into" the validity or promising nature of the intervention. To this effect, examples from actual cases where this tool had worked successfully were used to indicate precedence. Also, the more a therapist used this MG, the easier it became to administer it, with little room for it to become stale or monotonous because it required full attention while conducting it. This applied to both the administrator of the intervention, as well as their subjects.

As has been the case with patients I have administered the MG to, for this intervention to bear fruit, the administrator needs to "deliver it with guts," by describing and modeling it with conviction. In doing so, one must not omit here the importance of tone of voice, body language, silence, and pacing used along with the crucial relational approach of therapists in helping patients benefit by this intervention. If we are to agree with sociologists and researchers exploring how 93% of the way we communicate happens to be non-verbal, leaving only 7% verbal, then we see the importance of *how* we need to convey those words (Mehrabian, 1981). Although the value in becoming skillful in our reflective listening, body language, tone of voice,

eye contact, etc. is paramount for any therapist wanting to connect with their patients, the importance of being genuinely caring eclipses *all* other skills.

Other reasons why this MG works can be seen in its simplicity, immediately useful application, along with it being relevant irrespective of the contents or specific details of the trauma experienced by patients, given its adaptability. As mentioned earlier, the MG can be easily applied whether the patient is standing or sitting, such as in a classroom, for example, as in the case with patients using it to self-regulate during intense moments of anxiety while being in social settings. I discovered this ease of application while sitting versus standing, for example, to be quite helpful for those patients who have situational or other forms of anxiety, such as being in public settings where they can get severely self-conscious in applying the intervention. Thus, by quickly applying the steps while being seated in their classroom seat, unbeknownst to anyone, they can reap the benefits equally and gain a sense of peace while calming down, enabling them to have a full experience of the present moment, with a calm mind. While using the MG, patients began experiencing courage in themselves as they faced their fears, while being rooted in the now. This instilling of newfound courage that does not rely on anything outside, has granted the MG an element of spontaneity in the practice, as it brought the person to the present moment.

- ***Allowing latent symptoms of trauma to surface, while working through them.*** A point worth exploring is that sometimes, deeply hidden anxiety-causing trauma may be allowed to come out while doing this intervention, as in the case of one of the patients, who having experienced childhood sexual abuse, while doing this intervention was unable to point to her left side and say the words: “this is my past,” while turning to her body and state “this is my present.” This allowed the therapist to explore further the mental and emotional blocks that brought out the patient’s aversion towards letting go of the past (traumas), while becoming afraid of taking in the

freshness of being present in their body, rendering her severely anxious. By utilizing loving kindness and compassion, while staying equanimously with what was taking place with the patient, this clinician applied the *brahmavihāras* successfully, as they were described during the presentations that I had done prior and during the period of this study. Here is yet another perfect example where making room for practicing the *brahmavihāras* can be indispensable in inculcating and redirecting the patient, when unexpected scenarios occur to derail interventions, including the MG. Interestingly enough, this clinician was later able to take her patient back through the steps of the intervention yet again, only this time, the patient was able to go through the entirety of it without any challenges, and eventually was able to terminate her services having reached her treatment goals. When asked as to what she enjoyed the most from her time in treatment, this patient was reported to have told her therapist that it was the "becoming familiar for the first time with her body, in the present moment," as she hinted to the MG, and that it is her "new go-to trick," whenever her thoughts of the past "creep back up."

Through the means of this research project while using the MG with patients and their loved ones, given their traumatic pasts, strong emotions were given space and allowed to be acknowledged, instead of fighting or pushing them away through guilt or hurt. Thus, patients began to heal in their bodies. Furthermore, they were encouraged to carefully and compassionately allow these emotions to come out and through the use of eye contact, voice, and body expressions they began to open up and share deeply held powerful feelings with family members, who in turn came to develop the compassion to allow the patients to have the safety to do so (Gehart, 2014).

5.6 Contribution to the field of mindfulness and engaged Buddhism. Buddhism, not being a teaching that focuses on suffering alone, but on its alleviation by looking at its causes,

helps its practitioners look at themselves and the choices they make. Once understanding of the process has taken place, one then makes the choice to intentionally live the kind of life that moves them away from creating more suffering. Similarly, this MG teaches patients to stop being victims to their own suffering through considerate compassion while teaching them to be gentle with themselves, as they gaze at their feelings of hate, pain, anger, or depression, with tolerance and kindness, observing the effect of these through the sensations taking place in the body. This removes the patient from being at the mercy of the noisy thoughts that are remnants of past trauma or anticipated dread, hence no longer keeping them victims of their past or future. This is a recipe of success and a freedom that cannot be taken away by the outside world, which is important given the harsh environmental conditions that many of my patients come from where there is great lack of resources. Thus, becoming self-sufficient by accessing the inner reservoir of their own happiness through resilience, can be seen as a wealth that keeps enriching them and their families.

- ***Healing the family from within.*** As a therapist using different mindfulness techniques, my emphasis has been on including the entire patient family of origin and patient's current network of support. This has been possible due to staying closely attuned to overt and covert emotions within each session, and most importantly, responding directly and immediately to emotions (Gehart, 2002). To gain the trust of these patients and their families, I knew I could not just be one of the many therapists who have gone before me, without doing my very best to find a way to connect with them on a deep level, to help them come out of their suffering (Keith, 2015). Whether one is struggling with sexual dysphoria (trying to come out to their parents), major depression (leading them to cut themselves or having suicidal ideation), panic disorders, severe anxiety, ADHD, or a slew of other disorders, building a relationship is always key (Van

der Kolk, 2015). Hence, to look at healing, we see how this is what the nature of our work is all about: healing of relationships, both the one we have with ourselves and with others (Yalom, 2002).

Many of the patients I was assigned to came from poverty, belonging to a minority population that were usually undocumented, which also meant that in many cases, their parents (if they were present) barely spoke any English. These patients were often underserved Hispanic community members, belonging to a low socio-economic status (SES). Unfortunately, many of them have had little to no proper adult role models in their lives, being raised in unsafe environments with many risk factors. These risk factors are always what we look for as therapists while case conceptualizing and in the formulation of our treatment plans in addressing not only the symptoms, but the causes for the negative emotional and mental cycles being perpetuated. Therefore, at times, the risk factors seemed quite insurmountable for patients. Often my work involved staying for much longer hours than officially needed, in an attempt to find ways to accommodate families and their needs while working with them. This extra time spent was necessary for me to explore various interventions as I tried applying them in my work. Because the patient or IP (identified patient) is often considered by the family as the "weakest link" where the family breaks down, in my work I tried to show to the families how, at the same time, this IP/patient happens to be the unifying "glue" that has the potential to bring them together, and in a way stronger than ever (Keeney, 1983). The patient, therefore, in being the most sensitive or vulnerable member of the family, bears the "bottleneck effect" in becoming the meeting point of the family's problems, which in Family Systemic Therapy is referred to as homeostatic disruption (Winek, 2009).

Not having the proper guidance that is essential in growing up, several of the parents of my patients I closely worked with often had a skewed understanding of what is good versus what is bad. In other words, a state of affairs had been the norm for the family, such as raising the children in unwholesome conditions or having them follow a mode of behavior that only sustains an overall harmful and at best unskillful way of developing and maintaining relationships with each other. This usually came down to one's lack of understanding of how to self-regulate their emotions, especially in controlling their anger, by first understanding, appreciating, and then processing instead of the usual *modus operandi* of reacting to their loved one(s). This itself served as a primary first step to help the family from within, beyond helping the patient gain insights just through attending therapy sessions.

Therefore, when parents attended therapy sessions wherein the MG was taught in a step-by-step manner, they were shown ways to become the very healthy role models their children needed, especially in heated moments. Many relationships took birth in these sessions, where tears flowed freely, and discoveries were made and, instead of the usual negative reactions, both child and parent witnessed completely different interactions taking place, with bridges being built where there were none. This new understanding of what is wholesome (*kusala*) versus unwholesome (*akusala*) came to represent an entirely new emotional vocabulary for the child (as well as adults) growing up in the family, by allowing them new and healthier ways of relating to their own and others' emotions, given the stimuli received from their environment.

When we consider our contemporary culture, we see how diseases, be they mental, emotional or physical, are promoted in the mass media while the attention and responsibility for oneself is constantly being removed from the person *vis à vis* their actions. This gives us the opportunity to introduce a new paradigm that challenges the perpetuation of the model of

lifelong therapy, by looking at the very root of the problem and addressing it systemically (Keeney, 1983). Here, the presence of the patient in our therapy room means, at the same time, that the family has the opportunity to cut itself from the negative cycles it has been caught in, thereby making our work involve not only the individual child, but also the parents (if available), and herein true gains are possible through new connections (Dattilio, 2014).

- ***Assessing patient progress through the Mindful Grounding intervention.*** As the noted therapist Irvin Yalom states, often therapists happen to be the only audience to great discoveries and acts of courage taking place in patients, occurring in front of their eyes (Yalom, 2002). One such moment took place with one of the patients of the clinicians, a victim of childhood sexual trauma. Having used the MG as her primary intervention, whenever this patient came to the part where she was to say the words: "This is my *beautiful* body," she would pause and become unable to speak. However, one day, after making sure she was comfortable with repeating the steps of the MG, the clinician empathically proceeded through the intervention, and suddenly, even though she anticipated the patient to stop at that critical point, however, to her utter delight, the patient calmly raised her hands and pointed them towards her body, smiled, and while touching it she uttered: "This is *my beautiful* body!" Becoming speechless, therapist and patient were both moved to tears experiencing the enormity of that moment. The therapist here reported how she was so happy for her patient and proud of her ability to have come thus far in her treatment, overcoming so many obstacles as she recalled the fact that this young woman had been carrying this burden for the last twelve years, as a child, with a silent tormenting pain that had been tearing up her family for all those years. Here, the Buddha's Dharma was so alive and effective as ever in helping this young woman and her family overcome years of torment. The MG thus gave this patient and her family a new life by making the Dhamma accessible through

the language of family psychotherapy (Keith, 2015).

The palpability of positive expectation through living in and experiencing the authenticity of the now, is something that modern-day children are less and less inclined to know and enjoy. This is largely due to the dissociation that often takes place in them as a result of being enamored by all the sensory stimuli overload, that is inputted into a continuous stream of newer experiences promising them a juicier next moment. Thereby feeling inadequate at best, many of these children are in a constant state of rushing through their lives while having fully accepted the status quo of strife and emotional stagnation that they find themselves living in. The patients who have applied the MG intervention became able to feel alive, to involve their bodies and most of their senses, thereby becoming connected to the world around them and responsive to their environment. By doing so, they were able to change their behavior, body gestures, as they chose to process and respond to the incoming stimuli, as opposed to being victims to reacting automatically given their hyper-vigilance.

5.7 Mindfulness as a way to reclaim responsibility for one's own life. In the Dhammapada's 277 verse, the Buddha says: 'When one sees with wisdom that all things are conditioned, one turns away from suffering. This is the path to purity' (Dhammananda, 1992). Seeing the conditioned nature of things brings us face to face with suffering as we realize how everything around us is impermanent. If we use interventions to avoid our emotions, therefore, what we would be doing is trying to run or turn away from impermanence (Gunaratana, 1992). This would only sustain our suffering because deep down we know full well that permanence is not possible. What we can prevent and what we are turning away from in using the MG is our *attachment* to impermanent things, as we look for that state of purity that remains within, given a calm mind (Ñāṇananda, 1974). This is what I observed in patients I worked with while using the

Mindful Grounding intervention.

Through the MG intervention, patients are invited to see how we are responsible for our own thoughts, that essentially, what we put in front of our mind becomes our reality, whereby 'what one feels, that one perceives, and what one perceives, that one thinks about and ponders often, and what one thinks about, that one conceptualizes and proliferates, turning this whole process into the very flavoring and inclination of one's mind,' to which one constantly returns in an endless cycle of suffering (Bodhi and Hecker, 2003). In using the MG, the narrative of suffering is thus encouraged to be re-framed and allowed to come into the patients' purview, to redirect one's inclination and therefore, the hermeneutical understanding of one's very existence. One of the greatest attributes of this intervention can be seen in the way it enables one to stand firm and learn from trauma versus making the trauma one's own identity.

Here, the application of the most concrete aspect of one's existence is that of experiencing the body in the present moment as opposed to seeing it in another time/place, i.e. past or present. In therapy, as we work with our patients, it is generally accepted that every action has and brings with it its own details, thoughts and feelings. To this end, it is essential for one to be grounded while these facets of oneself become unraveled and explored further (through the body); otherwise the experiencing of the present moment may very well be sacrificed if one ignores or relinquishes these details, as in disconnecting or dissociating from the body.

5.8 Summary. Given the unproductive outcomes I received from working with patients as I taught them the usual belly (or nostril) mindfulness breathing techniques (which most often led the patient to either fall asleep or remove oneself from the present moment), I had to devise the MG as an answer. The results obtained from using the MG have been quite remarkable, with therapeutic goals being met to the point where treatment had to be terminated much sooner than

originally anticipated for many of the patients. At times, this took merely one or two sessions, while with others a few months, where they came reporting how they did not react to aggravating situations as before, and did so with a sense of elation, something that was not observed before. This has been not only my experience but that of other therapists working with this population, as observations were made and collected of our patients' behavioral improvements. This was further augmented by reports from patients' family members and peers. The greatest incentive experienced by patients, however, was their own observation as to how the level of anger or depression is dramatically reduced while applying the intervention daily.

No matter what intervention or theoretical model we use in treating patients, what ultimately matters every single time and with every single patient is for them to see that we as therapists, care about them, and especially that we are *listening* to them. This is at the heart of loving kindness or compassion, as it is also with this MG in changing the lives of patients. Mindfulness when taught and practiced in such a dedicated fashion, has within it the inescapable quality of loving kindness, in addition to compassion, altruistic joy, and equanimity felt towards oneself, which can be synonymous with a fully lived experience of the moment.

The goals of MG included improving the quality of patients' lives, increasing positive interactions, activities with peers, developing and maintaining a healthy attitude towards oneself and the world. In addition, the MG helps in the development of self-control, which allows one to stop trying to control others and outside circumstances in order to be happy inside. Thus, one realizes how one's reality is not defined by the actions of others outside of oneself. This itself engenders a strong sense of confidence from within, despite external conditions, as one realizes that everything one does has consequences (the Eightfold Path). Thus, we begin to see clearly

how true freedom is in the choosing of our actions, instead of living by default, lacking control over our lives.

- ***An engaged, Buddhist individual and family therapy.*** Working with MG to bring awareness to the body neutralizes the human drive to crave and hold on to the pleasant, even to the desire to be free from suffering. By becoming centered through reflectively connecting with what is going on in the body, one loses (or loosens at least) the grip and clinging to the concept that this is "my pain," and starts to see what is truly taking place and being experienced in the here and now. This step is not an independent one, for it involves first identifying (a) the fact of suffering (First Noble Truth), then, (b) the reason one is suffering (Second Noble Truth), i.e. the clinging to an idea of a state that is 'other than' what is in front of oneself (Vimalaramsi, 2012; Tejaniya, 2010); when this is understood, (c) the patient experiences the cessation of suffering (Third Noble Truth), as one realizes that there is in fact safety to be experienced as an outcome of loosening of one's tight grip on pain and past trauma. This brings patients to the threshold of the realization that they themselves have been contributing to the perpetuation of their suffering (*dukkha*). This understanding truly launches the process of their healing as they (d) tread the path (Fourth Noble Truth) with healthy understanding or Right View (*sammā diṭṭhi*), which inevitably allows them to see their role in choosing between the wholesome and unwholesome when it comes to thoughts, words, and actions. Thus, by 'seeing the way things are' (*yathābhūtaṁ pajānāti*) in the presence of a trustworthy and qualified guide using a workable and simple tool, (d) the patient undertakes the Right lifestyle that adheres to Right intentionality, Right communication (including one's self-talk and mental commentaries), Right activities, while applying Right effort through mindfully reflecting on one's body via Right mindfulness, as the

patient settles in the calmness of Right concentration in full awareness of what is happening in the present moment (Anālayo, 2017).

- ***Yet another glance at Right View.*** One cannot underestimate the role of having the Right View or *Harmonious Perspective* (as two of my teachers, Vens. Vimalaramsi and Punnaji have termed it), wherein the patient is able to look at their own participation in choosing to continue their suffering due to their hold on to how things "should be" as opposed to how they "truly are within the present." Using the MG, it was observed how patients were able to see and experience the tightness in both the body and the brain, as they visually witnessed and physically experienced suffering when overtaken by memories of trauma. This created a state of restlessness, which indicated the absence of the calm and concentrated mental state mentioned above, highlighting the fact that when we become restless in the mind (and the body), we lose our sense of restraint, which takes one back to re-experiencing sorrowful states. After all, the mind of one without restraint is far from *samādhi* (Ñāṇamoli & Bodhi, 2001). This understanding eventually allowed patients to lessen their attachment to painful experiences and reactionary behaviors that had become familiar symptomatic scenarios, instead of being swept away by strong and negative emotions as before.

Within the study, as subjects were able to relate to me the reduction in symptomatology of their patients as they reported on the changes taking place in patients' behaviors, we were able to clearly observe aspects of the Eightfold Path as an outcome of the proper practice of the MG. Furthermore, given the testimonials of the clinicians, it was evident to the subjects of this study that the MG teaches courage and honesty in patients, as it encourages a spirit of investigation in order to undo negative tendencies, while at the same time looking for better ways of thinking, communicating, and acting in the world, despite outside circumstances.

- ***Caring for ourselves.*** Today, as a population we have to relearn the differences that exist between needs and wants, developing in the meantime the urgency to take care of ourselves, as we work on refining our ethics of intention to move forward in life. In addition, it is paramount to learn to exercise generosity towards ourselves, our bodies, and our minds through love and forgiveness. This is the domain for healing the individual that can also permeate outward and thus heal our society at large. True safety can only be found within; it can be experienced not by looking outside of oneself, but within the tranquility of mind that sustains itself despite external factors. This calm and equanimous mental state can become the litmus test by which we can know whether we are established in a state that is not prone to turmoil or further suffering, even though our circumstances and outside conditions might say otherwise. In other words, it is the peacefulness spreading within that one comes back to for the experience of lasting safety and true refuge.

Looking at the body as the way into bringing about a sense of ease into the lives of patients, I formulated the MG by mostly keeping my focus on the body mindfulness aspect of the *Satipaṭṭhāna*. This enabled patients to look at their bodies, "both internally and externally with energetic effort, right mindfulness, and clear comprehension" (Ñāṇamoli & Bodhi, 2001). This allows one to move away from fervently desiring a complete self-eradication from their painful past, while also not dreading a worrisome and anxiety-filled future yet to come.

- ***Mindful Grounding and the "two arrows" (mindbody).*** The body and mind are not necessarily two distinct and unrelated phenomena, given the experiences one undergoes in life, and how influencing one of them has a direct bearing on the other. The body always seeks the path of least resistance. This is yet another quality that it shares with the mind, because as is the case with lethargy produced in the body as a result of inactivity and the muscles getting to

move less, so it is when we do not introduce new and challenging concepts for the mind to become better able to cope with situations and not to reproduce maladaptive and symptomatic behaviors of the past. In the case of the body, this leads to decrepitude, atrophy of muscles, and other forms of physical ailments and inflammations requiring exhaustive processes, including surgeries and expensive treatments. Similarly, when the mind is forced to become less active, one is less prone to develop behaviorally and to process new information, which leads a person to be stuck in old patterns, unable to face new challenges or even overcome negative patterns of behavior.

So, what can we do? We can challenge ourselves. In the case of the body, this would mean gently pushing oneself beyond its comfort zone or beyond what is usually termed as the path of least resistance. In the case of the mind it is not so different, where instead of just relying on the negative biases that the mind (through evolutionary biology and psychology) has been using by always pondering the worst possible scenarios, one can be making room for new potentialities to take root within. The latter is especially relevant with patients struggling with mental health disorders, where they are trapped and unable to see for themselves a better future, or even a state of normalcy without pain.

The transformation to the better, however, does not happen overnight, and it does not happen without the necessary effort, and of course without also having the right view and understanding, while imaging oneself in the mind as capable of breaking away from the negative cycles to which one has been sentenced. The downward spiral of being a victim to symptoms does not have to be the case for these patients. There is freedom. After all, Lord Buddha did not just teach *dukkha* or suffering, but also the way out of suffering, i.e. cessation or *nirodha,* which also means the 'opposite of prison' ("*ni"* + "*rodha"* = "non-prison").

The body will get old, and that is one of the two arrows that the Buddha talks about in the *Māluṇkyāputta sutta*, but the other arrow does not need to be there, i.e. the poisoned arrow of ignorance, the one we have some control over in completely eradicating (Ñāṇamoli & Bodhi, 2001). After all, that is what the Buddha taught us, that is what he gave us a hope for through his life and the lives of all his monks, nuns, and students over the course of millennia, who also experienced what he himself had attained, which is a testament that we too can taste this very quality of liberation from suffering.

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Appendix A

"Mindful Grounding"

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Research Study Questions

1. Before using the intervention, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say described you best?
2. Could you describe how you administered the intervention?
3. What has (have) your experience(s) been like while using this tool?
4. How often would you say you remembered to use the MG when other interventions did not seem to work?
5. How often would you say the MG actually worked in reducing symptoms?
6. Have you used the MG on yourself? What was (were) the outcome(s)?
7. What disorders or symptoms did you try to address while using this tool?
8. How often have you used this as an intervention in your treatment plans?
9. Have you noticed any differences overtime in your patients' behavior or mental state since using the MG? How would you describe these differences?
10. Would you prefer using this MG with any other interventions? Why? Why not?
11. How would you describe patients' treatment outcome after using this intervention?
12. Do you see yourself using this intervention in your treatment plans in the future? With which populations?
13. Do you recommend this intervention to others? Why?

14. What is your critique about this intervention? Do you have any recommendations on how to improve the intervention?
15. Now that you have been using the MG, on a scale from 1-10 (with "1" being very anxious, doubtful, skeptical, etc. and "10" being completely relaxed, open-to, and positive in using the MG), what number can you say describes you best?

Appendix B

"Mindful Grounding"

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Participant Consent Form

You are being asked to take part in a research study that incorporates Mindful Grounding (MG) as a therapeutic intervention. By signing this document, you express your agreement to participate in this study and incorporate MG in your therapeutic toolkit, as a clinician.

This study is part of a research project conducted by Garbis J. Bartanian, a graduate student in pursuant of a Doctorate in Buddhist Ministry, at the University of the West. MG was designed to address the need for an intervention that applies principles of body-mind connection while maintaining the patients' awareness of their thoughts, feelings, and behaviors within the present moment with a calm and balanced state of mind. The reason for this intervention is to help those clients, who are unresponsive to other forms of therapy and have had a multitude of other therapeutic measures used in the past by several other clinicians, but without obtaining positive outcomes.

Taking part in this study is completely voluntary. Participants have the right to refuse to participate, decline to answer questions, and to withdraw at any time from the study without penalty.

While working with patients during a span of one-year, participating therapists will apply different interventions in addressing various disorders presented, as per the information gathered from the assessments from patients. By choosing to administer the MG to their patients, clinicians will be integrating it with their individual treatment goals within the timeframe allotted.

So long as participants are practicing under supervision, there are no potentials for risk. Each therapist utilizing the MG would be enhancing their interventions toolbox by adding other interventions, as they see fit. Mindful grounding is a potentially more detail-oriented intervention than the mindfulness practices hitherto introduced in the graduate program and trainings of the participants. In addition, the practical approach in the application of empathy through the mindful grounding practice has a potential of enhancing their Self of therapist and deepening their understanding of empathy *vis-à-vis* all the interventions they might have in their repertoire of tools to bring into the sessions.

The data for this study is completely anonymous. Information pertaining to the therapists' administration of MG to their patients will be collected via interviews, journal entries, and transcripts (if available), wherein Q & A sessions with participants will help understand the rate of success in using the MG in sessions. The questionnaire includes 15 items that will be asked of

the therapists participating in this study. By the time of terminating with clients, and before the end of the school year, final individual Q & A sessions will be conducted with the participants of this study, addressing the same questions.

The data collected will be accessible by the individual clinicians working within the PUC agency and their supervisors. The information gathered verbally and through journals, as well as the list of questions given at both the beginning and end periods of this study will be provided by the case-carrying clinicians, who are the subjects of this study. The journals that will be shared only during the data collection period with this author will be handed back to the contributing subjects once done. The records of this study will be kept private.

No identifying elements regarding the clients themselves will be included in the data pool. Only the clinicians themselves, the holders of their own caseloads – meaning the actual clients that they conduct therapy with – will know the names of the individual clients. When data is being collected and shared with this author, the clinician may use the initials of the first and last name of clients to discuss individual cases.

The same agency-enforced and legal protocols of confidentiality are to be abided by the subjects, as well as the author of this study.

Statement of Consent: I have read the above information and have received a copy of this form. I consent to take part in the study.

Your Signature _____ Date _____

Your Name (printed)

_____

Signature of person obtaining consent _____ Date _____

Printed name of person obtaining consent _____Date _____

Appendix C

Parent Consent Form

Date:_____

To the Parent(s) / Guardian(s) of: _____

Partnerships to Uplift Communities (PUC) offers free clinical counseling services to the students at all PUC Schools. All of the clinical counselors at PUC are Master's level Trainees/Interns. They are supervised by Christine Sartiaguda, Director of Clinical Services at PUC, a licensed Marital and Family Therapist (LMFT) and Registered Art Therapist (ATR), Nicole Nardon, a licensed Marital and Family Therapist (LMFT), or Promla Singh, a licensed Clinical Social Worker (LCSW), or Claudia Cobos, a licensed Marital and Family Therapist (LMFT), or Richard Bonhama, a licensed Marital and Family Therapist (LMFT). The clinical counseling Trainees/Interns change each academic year. Clinical counseling services may continue for your child throughout the time your child is in a PUC School. The clinical counselors meet with student individually, with their families, and/or in small groups in order to help students get along better with others and feel better about themselves. In their work, clinical counselors are to use various interventions and therapeutic modalities to address the behavioral, emotional, and mental health needs of students, as dictated by their clinical and medical necessity.

PUC would like to provide counseling services to your child. In order for the counseling services to begin. **Please sign below and return this form to the school office as soon as possible. Consent can be revoked at any time.**
Thank You.

_____

Christine Sartiaguda, Director of Clinical Services

STUDENT: _____
SCHOOL: _____

I give permission for my child to participate in the PUC Clinical Counseling Program.

Parent Name: _____ Signature:_____

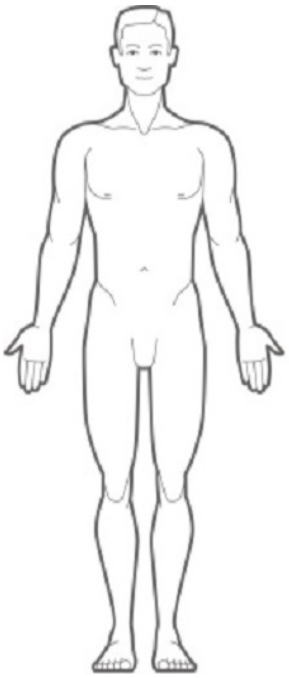
Phone Number: _____ Emergency Contact: _____

Please return to the school office as soon as possible.
(PUC Clinical Counseling Revised Fall 2015)

Appendix D

"Mindful Grounding" Intervention

(11/11/2016)



1. Stand up with arms slightly to the side
2. Looking down to one foot, tap it twice with the toes
3. Sweep in an alternating or zigzag motion, by one limb/section of the body at a time (ex. left foot, right foot, left knee, right knee, etc.)
4. Each time you look at the location you are mindful of as you say:

• **this is my left foot** (tapping it)
• **this is my right foot** (tapping it)
• **this is my left knee** (or the entire leg)
• **this is my right knee** (or the entire leg)
• **this is my left hand** (touching it gently with a finger)
• **this is my right hand** (touching it gently with a finger)
• **this is my left arm** (touching it gently with a finger)
• **this is my right arm** (touching it gently with a finger)
• **this is my torso** (touching it gently with a finger)
• **this is my face** (touching it gently with a finger)
• **this is my body** ("…my beautiful body" for past trauma)

5. Looking to the left as you point in that direction, say:

• **this is my Past**

6. Looking to the left as you point in that direction, say:

• **this is my Future**

7. Looking at the body by pointing with both hands to the torso, say:

• **this is my Present**
• **where am I?**
• **I am safe**
• **I am here**
• **I am now**

- Depending on the time you have to do the intervention and how deep you want to experience its effects, you may choose to isolate the body into further sections, as you mindfully allow yourself to sink into each of the parts, while taking your time. An advanced of this intervention can be applied by incorporating breathing into each of areas "scanned" as we zigzag our way up, while we gently gaze at them, "breathing" into each area at a time.
- Yet another form of this would include reversing the motion by moving backwards once we completed the upward motion, as we go over each area and finally end up back to the beginning body part.