

# The Sisters of Mindfulness

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This article introduces the issue of *Journal of Clinical Psychology: In Session* entitled “Beyond Meditation: Mindfulness-Related Clinical Practices.” In the article, I describe how the “sisters of mindfulness”—forgiveness, gratitude, loving-kindness, compassion, acceptance, and best-self visualization—are each interconnected and important forms of mindfulness as well as tenets of Buddhist psychology. Each of these practices reflect mental strengths that are being integrated into the brain’s neuroplastic development as a function of modern day psychotherapy. © 2013 Wiley Periodicals, Inc. *J. Clin. Psychol.* 69:793–804, 2013.

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*“You can’t always get what you want . . .”*

*The Rolling Stones*

“Can you teach me some mindfulness techniques?” asked Ashton, my patient of 3 months. We were in the middle of a session, talking about how much he dreaded the upcoming time he would be spending with his father. I thought about it. Ashton had asked me the week before to refer him to a dialectical behavior therapy group. A highly educated and expressive young man, Ashton was up on the latest techniques in psychotherapy. He and his boyfriend had just broken up and he was simultaneously let go from his full-time job in marketing for executives. He had also gained 30 pounds over the past year. As a result, he was in a state of near-emergency when he started therapy and he very quickly began to reap the benefits.

In that particular session, Ashton, who sported shoulder length, wavy blonde hair and large, dark brown eyes, was complaining that his father would not let him drive when they were in the car together, and that he ended up always feeling like he was not “good enough.” I guided Ashton to consider thinking about his father from a different perspective, that he was a man with flaws who was trying his best in this lifetime. I suggested that it was very possible that his father did not realize what a terrible effect he had on his son with his stinginess and extremely controlling attitude. His father was a Holocaust survivor’s son. My hunch, based on the stories Ashton told, was that he sincerely and deeply loved Ashton, his only son. I believed that he wanted what was best for him, but had absolutely no capacity to effectively communicate those feelings. Ashton felt judged and unrecognized his entire life despite his considerable intellect, charm, and talent.

When I shared my beliefs about Ashton’s father with him, he was profoundly moved. He said that it was such a relief to let go of how much anger and hurt he was carrying around and to see his father as just human, a man who has weaknesses and blind spots (as so many of us do). In re-training his mind to focus on accepting his father and developing compassion for him, Ashton was already practicing mindfulness techniques, even if he was not doing meditation. To see his father’s humanness, Ashton needed to figure out how to muster up compassion for him and to forgive him for the ways in which he had failed as a parent.

At that time, I was a recent initiate into the study of Buddhist techniques in psychotherapy. Affected by my long-term devotion to the practice of yoga, I found myself applying the tenets

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of Buddhism and the corresponding yogic belief system, outlined in Patanjali's Sutras (Prabhavananda & Isherwood, 1981), more and more to my formulation of cases. I found that the Buddhist perspective added another crucial layer of understanding, beyond patients' history of experiences in their families and the surrounding culture.

### *The Story of the Buddha*

According to Buddhist legend, 2,500 years ago the Buddha, Siddhartha, a prince living in Nepal on the Indian border, left his family and their luxurious lifestyle to search for an understanding of human suffering. Despite having everything he could have wanted—palaces, dancing girls, a wife he loved, a newborn son—Siddhartha asked himself, "Is this all there is?" When he was 29 years old, he went to live among ascetics and teachers for 6 years in Northern India to seek the answers to his questions about the meaning of life. He came to realize that both extremes of opulence and asceticism led him nowhere, so he turned to what he called the Middle Path. On the night of his 35<sup>th</sup> birthday, he sat for many hours meditating under the Bodhi Tree. When he awoke, he was "awake," and he began to teach the path toward enlightenment.

Buddha spent the next 45 years teaching about the utter pervasiveness of suffering in life (Dukkha); that attachments and cravings for what we do not have are the causes of suffering; that the end of our suffering is possible; and that an explicit path can lead to the end of suffering (the Eight Fold Path). These teachings are widely known as the Four Noble Truths.

The practice of mindfulness is a crucial mile along this Path toward Awakening. Mindfulness is "a way of paying attention: on purpose, in the present moment, and nonjudgmentally" (Jon Kabat Zinn, 1995, p. 4). While mindfulness is often associated with meditation, the mental strengths described in the articles in this issue are also forms of mindfulness practice. According to Buddhist tradition, these are some of the basic mental strengths that require cultivation in order to achieve "pure awareness."

This issue of the *Journal of Clinical Psychology: In Session* is devoted to describing the work that is currently being done on the development of these types of mindfulness-related mental strengths as a function of the clinical practice of Buddhist psychology. The "sisters of mindfulness" included here are as follows: compassion, acceptance, forgiveness, gratitude, loving-kindness, and best-self visualization. There is an article on each of these "sisters" in this issue. Each of the articles demonstrates how these tenets of Buddhist philosophy have been integrated into the western paradigm of psychotherapy and researched distinctively. The sisters each reflect a form of mindfulness and a tenet of Buddhist philosophy that has been adapted into our Western psychotherapy culture and cultivated in the service of meeting therapeutic goals. Although there are certainly other mental strengths that can be considered a sister (or brother, or maybe a cousin) of mindfulness, the ones that are discussed in this issue have received considerable attention and been subject to formalized development in current psychotherapy research and practice.

Mindfulness meditation caught fire in the psychotherapy world over the past decade and is now a fairly mainstream practice used for the treatment of anxiety, depression, stress-reduction, sleeping problems, ADHD, and many other disorders. It has also been taken up in the scientific community and studied rigorously over the last decade. The brains of meditators have been studied with fMRIs, MRIs, and EEGs. The findings have consistently demonstrated substantial neural plasticity in response to this practice (Barnhofer, Chittka, Nightingale, Visser, & Crane, 2010; Hölzel et al., 2011).

According to the Buddha's Eight-Fold Path, the practice of mindfulness meditation is integral to skillful living. The Path also outlines a system of directives for living life without harm or judgment in addition to conducting oneself according to a clear system of ethics, in terms of both self-care and relationships with others. The Buddha told his disciples that "whoever practices the Four Immeasurable Minds together with the Seven Factors of Enlightenment, the Four Noble Truths, and the Noble Eightfold Path will arrive deeply at enlightenment" (Thich Nhat Hanh, 1996, p. 4). The sisters of mindfulness described in this issue are a Westernized extension of the Buddhist conception, the Brahmaviharas or "The Four Immeasurables," which are loving-kindness, compassion, sympathetic joy, and equanimity. The Buddha believed that

learning and practicing these qualities led to an awakened heart and comprised the very nature of an enlightened person (Thich Nhat Hanh, 2009).

### *Human Suffering (Dukkha)*

This issue offers a Westernized version of how these types of “immeasurables” are now being measured as well as cultivated in the practice of psychotherapy as a means of healing human suffering and pain. Recent research proposes that these types of mindfulness-related practices create long-lasting neuronal networks that are involved in top-down processing. Specifically, with practice, the brain develops neuronal pathways that become the default modes of processing and integrating stimulation (Kok & Fredrickson, 2010; Lutz et al., 2008). The development of our abilities to practice these alternative forms of mindfulness is easier if we learn to approach the notion of human suffering from a different angle. As opposed to expecting that the work of psychotherapy will heal our suffering, the Buddhist perspective recognizes that the experience of suffering is universal and unceasing (First Noble Truth). Although it seems paradoxical, it is how we relate to the experience of suffering that we need to change to release ourselves from the pain associated with the human condition. As Ron Siegel (2013) described:

We humans are in a terrible situation. We want to enhance our lives and feel happy in life but we also know we are going to get sick and die. This is difficult. Mindfulness helps us to live at peace with these realities. As human beings, we are designed to evolve for survival. We are wired to focus on what is not working for us, what we want to change, how to move forward and keep developing. Our brains keep going back to the past and re-imagining the future and scheming how we can feel better. This is how we are wired, for survival, but not for happiness.

Another master of Buddhist psychology, Jack Kornfeld (2009), describes this paradox as well:

In popular Western culture we are taught that the way to achieve happiness is to change our external environment to fit our wishes. But this strategy doesn't work. In every life, pleasure and pain, gain and loss, praise and blame keep showing up, no matter how hard we struggle to have only pleasure, gain and praise . . . . More than anything else, the way we experience life is created by the particular states of mind with which we meet it. (p. 49)

According to these masters of Buddhist philosophy, as opposed to running from painful emotions, experiencing them even more vividly and recognizing their temporary nature will better serve us. Ashton wrote me a desperate e-mail one weekend. It had only a subject line:

Paul is driving me crazy. I don't know what to do. I can't stand him right now. What do I do?

My response to him:

Try to breathe. Watch yourself being upset. Focus on your internal experience with complete Acceptance. Let me know how it goes.

At our next session 3 days later, Ashton did not even remember what it was that Paul had done that made him so upset. My response to Ashton reflected that he had a choice: to try to fix the cause of the discomfort or change his relationship to the discomfort.

Despite the prevalent findings regarding the positive effect mindfulness meditation has on its practitioners, introducing meditation into the arsenal of therapeutic techniques is not embraced by as many clinicians as one might expect. The shift in modalities and the guiding directiveness involved in meditating with patients may be off-putting to some therapists. Leading patients in

meditation typically involves creating an atmosphere in the office conducive to meditation and slowing and softening the voice. Sometimes bells and chimes get used. While the purchase of a Tibetan singing bowl and attending silent retreats may feel mind-expanding and educational to many in this field, these types of methods may not appeal to most. No matter how consistently research findings point to the effectiveness of mindfulness meditation, this type of shift in therapeutic modality may represent an orientation that strays too far against the dominant paradigms or worldviews of Western psychotherapy.

However, guiding patients in the practice of these related forms of mindfulness, such as gratitude, forgiveness, or compassion is quite simple and a less obvious transition from East to West. The Buddha did say that to do these practices skillfully, we must come from a place of mindfulness, or nonjudgmental attention. It seems that these concepts are inextricable and interdependent. To practice mindfulness, we must approach ourselves with great gentleness and generosity of spirit, exactly the type of qualities that the sister skills embody.

In this next section, I will describe each of the sisters of mindfulness, the articles that will be discussing them in this issue, and their inter-connections with Buddhist psychology.

### *The Sisters*

*Acceptance.* When you are “awake,” you accept what is. Our survival brains tend to focus on the negative. To succeed, we need to remember the bad things that have happened, learn from them, and adapt accordingly. As a result, the good things do not get as much attention. Our brains are filled with how we want things to be different. Our thoughts naturally go to what is bothering us over and over. That is why we need acceptance.

In the psychotherapist seat, we are met with constant challenges. Often, we blame ourselves for not getting it quite right and we struggle to find the point of connection with some of our patients. Kornfield’s (2008) approach to accepting our mind’s travels during meditation is to think of ourselves as puppies. Even if we are frisky or make mistakes, we should approach ourselves by saying, “It’s okay, sweetheart, don’t worry.” You need the capacity for loving acceptance to do psychotherapy treatment well: both the acceptance of others and, to a degree, the acceptance of suffering. Tara Brach’s radical acceptance, Steven Hayes’ acceptance and commitment therapy, and Marsha Linehan’s dialectical behavior therapy (which espouses radical acceptance techniques) are but a few of the psychotherapy treatments that have focused upon acceptance as being integral to healing.

The second Noble Truth is that we suffer because of our tendency to cling to our habitual ways of acting and feeling in the world. We believe we need for things to be a certain way to feel contentment. Our Western culture teaches us that we need markers of our success in life: material possessions and traditional family configurations. We are taught not to accept our circumstances but always to keep striving. Conversely, Williams and Lynn (2011) describe how in Taoist thought “the sage accepts the world, and the ebb and flow of things, without holding on” (p. 9). Being nonjudgmental, a crucial aspect of therapeutic practice, is also a pivotal factor in acceptance. The Zen concept of fushizen-fushiaku, literally “not thinking good, not thinking bad” (Fischer-Schreiber, Ehrhard, & Diener, 1991, p. 74) tells us that we need to let go of the trappings of what modern society teaches us and learn to find peace within ourselves, no matter the circumstances.

In this issue of *In Session*, Schwartz’s article on acceptance in Internal Family Systems (IFS) is in sync with this philosophy. He describes how acceptance emerges naturally as you clear away the clouds of other internal voices. In his treatment modality and theoretical self system, there are different parts of the self that are brought to awareness and understood in the process of psychotherapy. After they are acknowledged, these different selves get cared for and attended to like they never have before. As a result, the different parts dissolve and re-emerge into a more unified self. He describes how the process of acceptance is key to the transformation and integration of self. According to Schwartz, “IFS posits the inherent existence of a spacious essence in each person that, when accessed spontaneously, manifests leadership qualities which include mindfulness, loving-kindness and compassion. This essence is also characterized by a profound sense of calm, confidence, clarity, connectedness and creativity.”

*Forgiveness.* Ashton was worried that if he practiced forgiveness, he would be opening himself up to mistreatment and victimhood. He was no stranger to confrontation and had a history of being verbally aggressive with both his parents and his mild-mannered partner, Paul, on a fairly regular basis. He was initially furious with me as well for bringing up these types of “sister” ideas instead of validating his belief that he should confront Paul even more when he felt disappointed or hurt by his behavior: “You want me to just let myself be abused by him?”

The word, “abuse” was not appropriate to describe the circumstances in this situation. (Paul failed to respond to Ashton’s e-mails for an entire day.) However, the dramatic use of that word did accurately describe how badly it made Ashton feel. As the treatment progressed, we worked on developing his ability to take a moment of space before reacting. As Victor Frankl taught, “Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our happiness” (Pattakos & Covey, 2010).

Paul (now his fiancé) had come to conjoint sessions a few times and revealed how frightened he was by the force of Ashton’s anger. I watched many times how Ashton’s incredible ability to articulate the depth of his hurt feelings would have the effect of silencing Paul completely. He admitted that he would typically respond to these verbal assaults by withdrawing, which of course would enrage Ashton further. Ashton did find great freedom and a marked improvement in their relationship when he became more selective about when and how to confront versus when to forgive Paul for his failings in the relationship.

There are mixed feelings that revolve around the concept of forgiveness being incorporated into psychotherapy treatment. Therapists may approach forgiveness as being counter to the goals of self-empowerment and asserting one’s needs. Yet fostering this quality has been associated with increases in mental and physical health and decreases in psychological distress, negative affect, depression, and anxiety. Lawler et al. (2005), for example, found a significant correlation between forgiveness and decreased physical symptoms (lowered blood pressure, heart rate, and cortisol production). Murray (2002), in reviewing the clinical forgiveness literature, concluded that forgiveness can enhance the well-being of the forgiver, improve the resolution of relationship issues, and promote the healing process. Letting go of anger and hostility also promotes better sleep quality (Stoia-Caraballo et al., 2008).

Overall, researchers and theorists seem to agree that forgiveness is a process, not a singular occurrence. It involves a reduction in “un-forgiveness,” or in maintaining negative feelings towards the transgressor. These investigators also agree that forgiveness is an intrapersonal process, not an interpersonal one (that is, it does not involve reconciling with the offender or condoning the offense). Instead, the process is focused on the victim’s own healing.

According to Luskin and Rosen (in press), “forgiveness does not mean that a person becomes a doormat, condones poor behavior, or reconciles with his or her offender. Forgiveness only means that we choose to let go of our role in the hurtful offense. We relinquish our victim status.” Buddhism does not espouse a concept that directly corresponds to common conceptualizations of forgiveness. However, the Buddhist notion of *forbearance* includes both enduring an action done against you and the renouncing of anger or resentment towards someone who has offended you. It involves refraining from reacting to the offense, decreasing one’s sense of vengeance towards the transgressor, and reducing resentment (Rye et al., 2000).

Menahem and Love’s article for this issue describes how the Buddhist concept of Anatta (No Self) needs to be worked on so as to master the capacity for forgiveness. This is one of the most challenging Buddhist principles for modern day clinicians to buy into. One way to understand this concept is to envision ourselves within the vastness of the universe. As Ron Siegel (2012) described: “A teaspoon of salt in a glass of water is very salty. But if you pour it into a pond, it won’t matter at all. Turn your mind into the pond.”

Menahem and Love’s spiritual take on the role of forgiveness in psychotherapy involves seeing life “as a lucid dream from which we must ‘wake up’ and perceive that reality is really our connectedness to each other.” In their article, they describe their use of a cognitive/spiritual form of therapy that involves reframing negative events into opportunities, and harnessing the power of forgiveness to assuage anger and access a more peaceful mode of existence for their patients.

*Loving-kindness.* Developing the sister skills leads toward a healing and transformation of what we now recognize to be pervasive human suffering. The Broaden and Build research model, developed by Barbara Fredrickson (2011), demonstrated the powerful effect of working on developing these strengths in psychotherapy. Loving-kindness, also known as Metta, is one of the Four Immeasurables. It refers to directing unconditional kindness and friendly attention toward all beings (including oneself). Buddhist psychology master Sharon Salzberg (2002) explained that there are infinite ways of doing a loving-kindness practice. It involves any way you pay attention that has your heart feeling open and warm and tender. As the Buddha described:

As a mother would risk her life  
to protect her only child,  
even so should one cultivate  
a limitless heart  
with regard to all beings . . .  
(The Buddha, *Sutta Nipata 1.8*)

Fredrickson's research has shown that the practice of loving-kindness makes people significantly happier. Furthermore, the momentary positive emotions that emerge from doing the work of loving-kindness result in an increased flexibility of thought, which over time leads people to behave and think with more available personal resources—physical, social, intellectual, psychological. The benefits of loving-kindness mindfulness work have even been demonstrated to alleviate the negative symptoms of schizophrenia (Paulson et al., 2009).

In their article for this issue of *In Session*, Hinton, Ojserkis, Jalal, Peou, and Hofmann describe the effectiveness of their use of loving-kindness in the treatment of traumatized ethnic minority (Latino) and refugee (Cambodian and Vietnamese) groups, as compared with a waitlist condition, and applied muscle relaxation. The authors explain how the treatment protocol they developed (culturally adapted flexibility-focused therapy, CA-CBT or CA-FT) incorporates the practice of loving-kindness and mindfulness states more generally to reduce trauma-related stress. Furthermore, they describe the thoughtful adaptations they have made to their treatment protocols to increase their suitability for and effectiveness with these different cultural groups. Siegel (2013) pointed out the wisdom of applying cultural adaptations to our treatment approaches:

Our bio-psycho-social models also help us step out of our own perspective to appreciate how radically different the world can be for someone with another familial, cultural, or biological history. While the wise sages of old may have had an intuitive understanding of these matters, they didn't have the maps and data that we have today. (p. 22)

*Compassion.* Compassion or "karuna" in the Buddha's language of Pali, can be described as "the quivering of the heart in response to another's pain." This sister of mindfulness is inextricably linked with loving-kindness and they are often tied in together when discussed. There is one story wherein the Buddha was asked by his personal attendant, Ananda, whether it is true that the cultivation of loving-kindness and compassion is an important part of their practice. The Buddha is said to have replied, "No. It would not be true to say that the cultivation of loving-kindness and compassion is part of our practice. It would be true to say that the cultivation of loving-kindness and compassion is *all* of our practice." Buddhists also link compassion with wisdom. Wisdom and compassion are likened to the two wings a bird needs to fly or to the two eyes one needs to see deeply. Compassion is considered to be at the heart of Buddhist practices—compassion for both others and one's self.

In this issue of *In Session*, the pioneers of self-compassion, Germer and Neff, give us a detailed description of the structured yet flexible 8-week group training program they have developed called Mindful Self-Compassion (MSC). Their focus on MSC involves teaching their clients

to habitually approach themselves and their struggles in just the same way a compassionate therapist would for 1 hour once a week. They describe it as follows:

Self-compassion training may be considered “portable therapy” insofar as it is a self-to-self relationship that mimics the compassionate self-to-other relationship of psychotherapy, providing inner strength *between* sessions and, hopefully, tools for the rest of one’s life.

The MSC program actually makes use of many of the sisters of mindfulness—forgiveness, loving-kindness, and acceptance, for example, in addition to compassion. MSC entails helping clients to develop these mental strengths and to apply them when experiencing the inevitable challenges in life. This treatment modality has been demonstrated to be highly effective. Germer and Neff attest that their clients’ satisfaction in life improves after the program is over and provide evidence that life satisfaction continues to increase between 6 months to 1 year after the program ends. The continued and ongoing increase in life satisfaction after the completion of this treatment program suggests, like the Broaden and Build model has found, that the development of this sister skill results in a snowballing enhancement of patients’ lives.

### *Best-Self Visualization*

Ashton was having trouble deciding whether to lie to his new employer about needing to take a week off so he could go to a weight loss spa before he and his fiancé got married. He asked me, “Should I lie to them and keep calling in sick for the entire week?” What to say? I asked Ashton to visualize the version of himself that represents all the qualities he would most like to embody—in terms of how he both looked and behaved. Then I asked him to ask that version of himself, his “best self,” the question he had just asked me. He got the point.

The Buddha said, over 2,500 years ago, “All that we are is the result of what we have thought. The mind is everything. What we think, we become.” This idea has been supported by recent neuroscience research findings—that visualization of an activity or an image activates and enhances similar neuronal pathways (Pascual-Leone, 2004). Visualization techniques are integral to the Buddhist canon of practices that evolved in the first millennium (Lutz et al., 2007). For example, focusing on the breath or the body scan visualization are practices that have been widely integrated into mainstream, Buddhist-influenced, psychotherapy treatments. In their article for this issue of *In Session*, Schussel and Miller describe the treatment modality they developed which makes use of the best-self visualization. They incorporated this mindfulness-related practice into their work with inner city high-risk youth and reveal the powerful affect these techniques have had on the lives of the young people in their treatment program.

*Gratitude.* Gratitude is an antidote for the poisons of greed, jealousy, resentment, and grief. When we are grateful we do not wish for more than we have, but appreciate that which is already present in our lives. We do not chafe at the good fortune of others, or resent or mourn that which is missed, lost, gone, or never had. The desire for more can be boundless and endless. There is always one more thing to want. (Segall, 2010, para. 1)

Emmons and Stern’s article for this issue of *In Session* illustrates the powerful influence of incorporating gratitude into the work of psychotherapy. They describe how this mindfulness-related sister can be fostered in therapeutic settings and draw attention to the manifold benefits of keeping a gratitude journal. To keep a gratitude journal, you perform the following task: Pay mindful attention to the gifts that you receive in life and write them down each evening. They could be “simple everyday pleasures, people in your life, personal strengths or talents, moments of natural beauty, or gestures of kindness from others.” In the process of recollecting

the instances of receiving these types of gifts and then writing them down so that we will not forget them, we enhance our “psychological, physical, spiritual, and relational well-being.”

These authors suggest that the intentional cultivation of gratitude nourishes an affirmative life stance and that the practice is associated with increases in both hours of nightly sleep and hours per week spent exercising. The Dalai Lama’s expression of appreciation to the Chinese for their brutal occupation of his nation is the ultimate acknowledgement of the importance of this sister skill. “I am very grateful to the Chinese for giving me this opportunity,” he said. “The enemy is very important. The enemy teaches you inner strength.” It does require considerable mental strength to learn to approach all situations, whether they bring us pleasure and gain or pain and loss, with such inspirational humility.

## Case Illustration

### *Presenting Problem and Client Description*

Laura first came for treatment to deal with a severe case of bulimia. She was bingeing and purging on her comfort foods after she came home from work, nightly. She was 38 years old, very attractive, whip-smart, and incredibly successful at her job on Wall Street. A regular people pleaser, Laura had a winning smile and used it regularly. She took to therapy instantly. Within months, she recognized that her bulimic symptoms were developed as a way of communicating conflicted feelings. Laura was an expert at taking care of others’ needs but very rarely expressed any of her own. She grew up too afraid to express her anger toward her controlling and physically abusive father. The one time she did, during high school, he punched her so hard in response that he broke her nose. She learned to keep her mouth shut and smile through her anger to protect herself from his violence. Her family was quite wealthy and they hired a plastic surgeon to fix it so that at school she was able to play off the broken nose as though it were intentional. Laura’s mother did nothing to protect her from her father’s rages. She was ineffectual, depressed, and childlike, spending most afternoons on the couch watching her shows.

### *Case Formulation*

Once Laura understood how her bulimic symptoms were tied in to expressing her anger and disappointment, she was able to work them down to one to two times a month and then struggled to fully give them up about 2 years into the work. We initially focused on developing her ability to recognize her internal states and then to decide whether and how to communicate her needs. We were also working on mood management. Once she developed her skills at recognizing and identifying how she was feeling, then she and I explored alternative methods of coping with her internal states beyond bingeing and purging.

### *Course of Treatment*

While her bulimia improved steadily, the treatment began to focus on the breakup with her long-term boyfriend. She had to end the relationship because he wanted to play out sadomasochistic fantasies with her in the bedroom and she felt defiled by the role he expected her to play. Besides that, he was “perfect” and they were very compatible buddies for the course of their long-term relationship. She realized that in maintaining her relationship with this boyfriend, she felt herself to be continuously replaying the dynamic in her relationship with her father, with whom she was great “friends” even though she was terrified of his anger.

Once she broke up with the boyfriend, she went on a spree of dates from Match.com. She treated finding a romantic partner like a second job and she was just as focused and determined at this one as she was in her work on Wall Street. Finally, she met Jay. He was just as successful as Laura but in a different business. They felt they were meant for each other and quickly got engaged and married a year later. He called her his little “snuggle bunny” and they loved each other very much.



Laura's eating disorder was all but ancient history, except for her dysmorphic body disparagement. She was exceedingly concerned about being three to five pounds overweight and never felt very attractive. While Jay wanted to start making babies, Laura wanted to lose five pounds first. I suggested to her (having just had my own babies and being fairly experienced in the matter) that a few extra pounds would not matter as she could manage her weight throughout her pregnancy by eating healthfully. The next month, she was pregnant. They had tried only once.

Laura did not feel ready to become a mom, nor did she want to go off her beloved antidepressant medication or her Ritalin. Given that the research on women taking certain antidepressants in pregnancy is scarce and inconclusive, I countered her psychiatrist's blessing to continue with it. If the baby ended up having any types of illnesses or developmental delays in the first few years, she would very likely wonder whether it was because she took the antidepressants. Women regularly blame themselves for whatever problems their children have and Laura would most certainly have been one of those women. I suggested that we would work hard on mood management to get her through whatever detox rebound might occur. She went off the medication. Unfortunately, her rebound reaction was much worse than I expected.

She became obsessed with the fact that she was not going to lose the five pounds after she had her baby, and she was absolutely furious with me for not having warned her that in the beginning of her pregnancy she would look "fat" instead of pregnant. I offered the possibility that she was focused on weight gain as opposed to her concerns about becoming a mother given that her own mother had had absolutely no nurturing capacities. She was still furious. She dictated to me that what she needed from me was to acknowledge the validity of her weight concerns. I remembered that she had felt so relieved and understood when one of her friends told her that she could lose the weight easily if she wanted to by going on a juice fast. She needed her reality to be validated. I did not necessarily agree with that reality, but was pleased that she was being so clear about expressing her needs.

Meanwhile, Jay had lost his job. He began to spend his days lolling around the house, presumably job hunting, but there was no money coming in and they had a mortgage to pay. She was livid with him for this, and still in a rage toward me, blaming me for her pregnancy as well. Laura's only focus in our work together was on how angry she was and how helpless she felt in the face of it.

Heretofore, Laura had been my star patient. She had a totally idealized transference to me and had made enormously positive changes in her life. Now, she was treating me as though I was as ineffectual as her mother was and she dramatically regressed emotionally. I spoke with her about her shifting attitude toward me. I spoke with her about having a strong reaction to the medication detox. She could no longer make use of the mood management skills we had worked so hard to develop. She was in a perpetual state of fury—toward me, toward Jay—and it was eating her up night and day. I asked her to consider what the Buddha said about this topic: "Holding onto anger is like picking up a hot piece of burning coal with the intent of throwing it at someone. You are the one who gets injured along the way."

Then I introduced the idea of acceptance. I suggested to her that there was actually nothing she could do to fix what she was angry about—gaining weight during her pregnancy and Jay's joblessness. I told her that all she could do at this point was work on her own reaction as opposed to actually changing these situations. The truth of our suffering we cannot change, but we can change the way we relate to that suffering.

But she was relentless about trying to get Jay to be more productive in his job hunt. She was terrified that they would not be able to afford the nanny on just her income alone. Yet the reality was that her income was quite high and they both had families with significant funds. I also suggested that she attempt to approach Jay with compassion, to understand that he too was having a hard time and that he must have felt immense shame at being out of work for so long after having always been so professionally successful. She balked at all of my ideas and became even more incensed.

I asked her to imagine what her anger felt like, to envision its shape, its color, its texture. She reluctantly described a gray, oblong shape located in front of her chest, throbbing. I interpreted that her anger looked like a shield, and that she was using it to protect her from how vulnerable

and fragile she felt being pregnant, uncertain about her mothering skills, concerns that she had brought up earlier on in our work together. She thought this was nonsense.

I began to fume. Whereas in the early part of our treatment, she made use of my interpretations and worked with them to help her improve beautifully, now she refused to even consider my ideas as relevant. My countertransference to her was becoming very strong and I was preoccupied by what was happening in her treatment. I could not get the idea out of my mind that she could release herself from her suffering and anger if she practiced acceptance and was able to develop compassion for her husband who was becoming quite depressed himself. When I brought these ideas up to her, her fury hit an all-time high and she told me that she wanted to end our treatment, that I was no longer helping her.

Her words jolted me and my face burned for the rest of the evening after our session. I consulted with a close colleague and tried to understand my role in provoking her anger. All I could think about was how ineffectual she found me and about her comment that I was trying to get her to accept a situation that she could actually have control over and change. My take was the reverse: that her situation would change only once she accepted her circumstances instead of constantly focusing on how she was pregnant and needed her husband to start working again. He wanted to be a stay-at-home dad and she loathed that idea. To me, it sounded nice. She loved her job and did not want to stay home, so why should he not? Regardless, I at least prevented myself from telling her my thoughts about this.

Finally, I came to realize that I was the one who was not practicing mindfulness. I was treating her just like she was treating her husband—coming up with suggestion after suggestion to change how she was feeling instead of acknowledging her struggle and her pain. I was not feeling compassion toward her, only her husband. She presented with so much strength that while I frequently told her that we needed to work on expressing her own needs, I realized that I had been guilty of neglecting her needs as well. She needed me to at least validate what she was worrying about and give her this time to feel it before I tried to help make her feelings go away. I realized that I was not accepting her feelings in a way that mirrored her experience of her mother. I wrote her a letter requesting that she come in for another session to talk about what happened and that I would not charge her for it. Reluctantly, she agreed to come in.

In the session, I told her how I realized that I had not been giving her the compassion and acceptance that she needed and that I was sorry for having participated in getting her more agitated at a time when she most needed to have her feelings validated. I also told her that it was hard for me to not have been able to help her all this time. My (misattuned) suggestions were given because of how much I cared about her and that it was hard for me to see her having to cope with so much anger and pain. She decided that it was not a time for her to be without a relationship with her therapist and that she wanted to keep working together until the baby was born.

### *Outcome and Prognosis*

Laura's pregnancy was quite difficult. She had a lot of physical pain and pregnancy-related illness throughout, but she managed to start feeling calmer. As she moved into her third trimester, her mood settled considerably. Then she gave birth to a healthy baby girl. She told me in one of our follow-up sessions that she had actually been practicing the techniques I suggested to her and that they had helped her recognize there was only so much she could do about her husband's work issues. She still expressed herself to him regularly, occasionally getting to a point where her frustration with him bubbled over, but in between those times, she tried to practice acceptance and compassion and to forgive him his weaknesses. She gained a lot of weight during her pregnancy but had been able to take that in her stride and was just determined to be as healthy and fit as she possibly could while she adapted to her new maternal role. She also enrolled in a "Mindful Mama" support group to work on developing her mindfulness skills to make sure she was as conscious as possible so as to not repeat the mistakes of her own parents while raising her baby girl.

## Clinical Practices and Summary

One of the important points from the case example is the value of mindfulness training for the practitioner. There is much written about the value of having an established meditation practice before working with patients in this realm (Davis & Hayes, 2011). “Just as a person mired in quicksand cannot help another until he has himself reached firm ground, our ability to help others depends chiefly on keeping our own balance” (Olendski, 2006, para. 6). It is equally valuable for the practitioner to develop a practice for implementing the sister skills. It was only my recognition that I was not practicing the very skills I was espousing that allowed me to move past our stalemate in this case.

It is also important to note that these skills are somewhat controversial and patients may not respond to them as immediately and positively as they might to other therapeutic interventions. When I suggest approaching a situation with compassion or forgiveness, to practice gratitude or any of these ancient yet somehow modern ideas (especially to patients like Laura and Ashton who are searching for validation of their emotional experience), I might preface it by saying, “I’m not sure you are going to like what I am going to say . . .” This often works well to let them know that we are veering from more traditional forms of psychotherapy into the Buddhist realm and prepares them to receive the intervention from a more open-minded perspective.

The following articles in this issue of *In Session*, “Beyond Meditation: Mindfulness Related Clinical Practices,” includes a description of how each of the sisters of mindfulness—acceptance, gratitude, compassion, loving-kindness, best-self visualization, and forgiveness—are being incorporated into modern day psychotherapy treatments. They are Westernized versions of the Brahmaviharas and other important tenets gleaned from Buddhist psychology. The list of sisters included here is by no means exhaustive or exclusive. There are certainly brothers and cousins as well. Each of these sisters were chosen because of their growing position of importance in current psychotherapy treatment, their inextricable connection to the practice of mindfulness in psychotherapy, as well as their indissoluble bonds with one another.

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