

## INTRODUCTION

Our journey teaching, researching, and organizing mindfulness programs did not begin with a focus on trauma or posttraumatic stress disorder (PTSD). Instead, my (David Kearney's) aim nearly 15 years ago was to offer mindfulness programs with the hope that teaching mindfulness would mitigate the suffering of patients with chronic medical conditions. Although the system in which I practice medicine, a large academic Department of Veterans Affairs (VA) hospital, was adept at providing state-of-the art testing and an up-to-date array of medications, surgeries, and procedures to treat symptoms and ailments, what seemed needed were more avenues to help people take a more active role in caring for themselves, especially when faced with difficulties that could not be cured or made to go away.

I had been introduced to meditation practice in the 1980s as a medical student, when I sat in on a group led by some ahead-of-their-time therapists who encouraged people with substance use disorders to meditate. I recall at the time being immediately struck by how setting aside a few minutes each day for meditation practice helped me to maintain a sense of centeredness throughout the day, and how the practice felt intuitively healthy and

---

<http://dx.doi.org/10.1037/0000154-001>

*Mindfulness-Based Interventions for Trauma and Its Consequences*, by D. J. Kearney and T. L. Simpson

Copyright © 2020 by the American Psychological Association. All rights reserved.

## Copyright American Psychological Association

important. From that point forward, over many years, I attempted to gradually educate myself about meditation practice in parallel with my efforts to continually deepen my knowledge of the practice of medicine and my specialty of gastroenterology.

Over the course of several years practicing as a physician, as I listened to patients talk of their symptoms, their worries, and their difficulties, I began to wonder why we were not teaching mindfulness. Teaching mindfulness to people with medical problems seemed logical and important, given not just my personal understanding but also knowledge gleaned from the research literature that psychological factors, including daily life stress, fear of symptoms, catastrophizing and beliefs about the meaning of symptoms often worsened conditions such as irritable bowel syndrome and chronic pain. As a clinician I sensed an unmet need for patients, and as a researcher I noted gaps in the scientific literature I could help to fill. With these goals in mind I established a mindfulness program in our hospital and set about coleading, alongside an experienced mindfulness teacher, the initial mindfulness groups for people with medical conditions such as chronic pain and irritable bowel syndrome (IBS).

What I did not expect were the frequent comments by participants about how mindfulness practices seemed to help their symptoms of PTSD. In fact, many patients with PTSD have reported to us that they found the 8-week mindfulness course to be among the most helpful interventions in which they had participated. It is also not uncommon for individuals with PTSD to take the course multiple times so that they can learn more about mindfulness with the support of a group and a teacher. The mindfulness programs at our site gradually expanded to two campuses of a hospital system that serves a population of over 100,000 veterans with a high prevalence of trauma, PTSD, depression, chronic pain and substance misuse. At the time we started offering mindfulness-based stress reduction (MBSR), reports of outcomes for people with PTSD had not yet been published. Given the profound impact of PTSD on individuals across the lifespan, investigating these unexpected reports of benefit for PTSD became a primary focus, and it led to a partnership with Dr. Simpson to further investigate the impact of mindfulness on PTSD.

In many ways my (Tracy Simpson) journey to investigating the potential of mindfulness practice for treating psychological disorders, such as PTSD and their common physical comorbidities, parallels that of Dr. Kearney's. As a clinical psychology graduate student, I initiated a personal meditation practice in an effort to cope with the pressures and stress associated with graduate training and the attendant weight of responsibility I felt being a

## Copyright American Psychological Association

novice therapist to people with significant distress. Formal meditation time became something of an emotional sanctuary that allowed me to ease up on my expectations of myself and to be more patient with others; generally, it was a quality-of-life saver. I did not yet, however, have the tools needed to bring what I was learning on my own into my clinical work and specifically chose to take a postdoctoral position in the late Dr. Alan Marlatt's lab at the University of Washington to gain exposure to therapeutic applications of mindfulness practices in the addiction realm, my general area of inquiry. From there I transitioned to the Seattle VA and directed the then Women's PTSD Outpatient Clinic. I had the good fortune to begin working with Dr. Kearney at the Seattle VA on formally evaluating whether courses in mindfulness meditation practices could address the psychological, emotional, and social challenges, including PTSD and chronic stress-related physical conditions, that our veteran patients were bringing into our clinics daily.

Together, our interdisciplinary work has sought to understand how mindfulness-based interventions (MBIs) influence conditions commonly borne by people with trauma. Over the past decade we have facilitated thousands of clinical encounters teaching mindfulness to individuals with a history of trauma and enrolled several hundred individuals with PTSD in quantitative and qualitative research studies. Much of the material in this book is based on sharing this extensive clinical and research experience, along with an effort to summarize and make sense of the broader research literature on this topic. From a clinical perspective, what became clear is that given the multiplicity of clinical challenges faced by many people with a history of trauma, an optimal treatment strategy would not only address symptoms of PTSD and depression but also favorably impact physical health problems that commonly co-occur (e.g., chronic pain; Kearney & Simpson, 2015). What can be considered a common factor for many people with these overlapping conditions are experiences of trauma, which can lead to a host of life challenges.

Most people experience traumatic events over the course of their lives. The majority recover and heal from trauma without specific treatment, but a substantial proportion develop persistent and sometimes disabling symptoms, including PTSD, depression, chronic physical symptoms, or substance misuse. The impact of trauma and PTSD on individuals and society is profound. In addition to distress caused by hallmark clinical symptoms, PTSD disrupts interpersonal relationships; increases the risk of depression, anxiety, and substance use disorders; increases the likelihood of high school and college failure, and teenage childbearing; and reduces the ability to work

## Copyright American Psychological Association

(Davidson, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Moreover, PTSD frequently results in severe reductions in quality of life (Rapaport, Clary, Fayyad, & Endicott, 2005) and is associated with increased suicidality (Panagioti, Gooding, & Tarrier, 2012); those with PTSD have been shown to be 6 times more likely to attempt suicide as compared with matched controls (Kessler, Borges, & Walters, 1999). Research also indicates that physical health problems occur in excess for people with PTSD, including coronary artery disease, arthritis, asthma, and gastrointestinal symptoms (Boscarino, 1997, 2006). As a result, a high proportion of those with PTSD must simultaneously cope with other psychiatric diagnoses in addition to chronic pain or other symptoms because of medical problems. For people with PTSD, comorbidity is the norm rather than the exception.

To help individuals with PTSD, treatments have been successfully developed, studied, and refined over the past 3 decades. As a result, therapies with proven efficacy, such as cognitive processing therapy (CPT), prolonged exposure therapy (PE), and eye movement desensitization and reprocessing (EMDR), are now available to help treat symptoms of PTSD.

So, why are improved or additional strategies needed, despite significant advances in the field? They are necessary because many individuals continue to experience PTSD symptoms after taking part in evidence-based approaches (Bradley, Greene, Russ, Dutra, & Westen, 2005; Steenkamp, Litz, Hoge, & Marmar, 2015) or they have other symptoms not adequately addressed by existing treatments. As discussed in Chapter 1, the spectrum of clinical manifestations in PTSD is broad, and a one-size-fits-all approach is unlikely to meet the needs of all people (Cloitre, 2015). In addition, the range of available treatments does not necessarily match the range of preferences of people with trauma, which could affect the level of engagement in care, which in turn could influence outcomes (e.g., some people may prefer to start treatment with an approach focused on their trauma, whereas others may prefer a non-trauma-focused approach). The complexity of needs and wide spectrum of symptoms of people with PTSD has spawned efforts to develop new treatment approaches, driven by interest among both clinicians and patients. The purpose of this book is to explicate one category of additional treatment for PTSD that holds the potential to meet some of the challenges faced by individuals with PTSD—interventions based on teaching mindfulness.

In MBIs the emphasis is on changing the *relationship* to thoughts, emotions, bodily sensations, and associated behaviors. MBIs attempt to enhance the ability to attend to experience with an attitude of nonjudgment, curiosity, openness, acceptance, and kindness (Kabat-Zinn, 2009; Siegel, 2007).

## Copyright American Psychological Association

By shaping how and where attention is placed, and by providing a framework for understanding the nature of thoughts, emotions, and sensations, increased mindfulness is theorized to foster more adaptive responses to stress and pain (Baer, 2003). In MBIs, group leaders or therapists do not explicitly attempt to provide techniques or guidance to change thoughts, beliefs, or behaviors. Instead, the sessions focus on bringing nonjudgmental attention to present-moment experience with an attitude of curiosity and openness. The core method of bolstering these abilities in most MBIs is through mindfulness meditation practices, such as breathing meditation, body scan meditation, or mindful movement (e.g., walking meditation, Tai Chi, yoga). The meditation practices in MBIs are framed as self-care practices, which participants are encouraged to utilize on a regular basis after finishing the course.

Examples of MBIs based on teaching mindfulness meditation include mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT) as well as many other meditation-based approaches adapted to specific conditions (Bowen et al., 2009; Duncan & Bardacke, 2010; Kristeller, Wolever, & Sheets, 2014). We focus on MBIs that emphasize meditation practices, although we recognize that other interventions with a strong evidence base for conditions other than PTSD, such as acceptance and commitment therapy (ACT) and dialectical behavioral therapy (DBT), teach mindfulness through techniques other than meditation (Hayes, Strosahl, & Wilson, 1999; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). The book is not focused on a specific MBI, such as MBSR; instead, we discuss general principles that we think are applicable to all interventions with a core focus of mindfulness meditation. Our goal is to provide the reader with a working knowledge of how mindfulness can be applied to conditions that commonly occur following trauma, including PTSD, depression, chronic pain, and substance use disorders. We provide a synopsis of the conceptual framework for MBIs for each of these conditions, review the current state of the literature, and offer practical suggestions aimed at helping clinicians to effectively offer MBIs to people with trauma.

For PTSD, the literature on MBIs is still in a nascent state, and the evidence base does not allow us to draw firm conclusions on the efficacy of MBIs for PTSD. However, there is some evidence of benefit for PTSD and other conditions that commonly occur following trauma, and to date there is little evidence to suggest harm. So, why write a book now? One reason is that, despite the need for definitive clinical trials, MBIs are increasingly offered to populations with PTSD. For example, 77% of specialty programs for PTSD in the VA now offer some type of mindfulness training (Libby,

### Copyright American Psychological Association

Pilver, & Desai, 2012). Also, the application of MBIs to PTSD by clinicians has been buoyed by the recognition that—at least in theory—mindfulness practice provides gentle, gradual techniques that run counter to deeply ingrained symptoms of chronic PTSD. For example, in mindfulness practice, rather than avoiding distressing situations, a person is encouraged to notice reactivity and regard such experiences with curiosity and openness. Rather than ruminating and attempting to problem-solve difficulties, a person is encouraged to learn how to set those habits aside and “be with” perceived problems. Rather than reacting to distressing stimuli, a person is encouraged to recognize and disengage from habitual patterns. Rather than suppressing unpleasant feelings, a person is encouraged to feel what they feel—even if it is difficult to bear. And rather than being discouraged by shame and guilt, a person is encouraged to acknowledge and allow these experiences with an attitude of kindness and nonjudgment. Whether MBIs can fulfill the above potentialities remains to be seen, as we discuss in the chapters that follow.

Our clinical experience tells us that the upsurge in interest in MBIs for PTSD and trauma is in part driven by the fact that patients with PTSD are often seeking help for multiple challenges, including chronic pain, depression, and substance use disorders, on top of other life difficulties such as poverty, isolation, and fractured family relationships. If, as the evidence suggests, MBIs simultaneously provide some measure of benefit for multiple areas of difficulty (e.g., chronic pain, substance misuse, depression, and possibly PTSD), the MBI can play an important role helping a person with PTSD gain a foothold in their struggle to cope with very challenging circumstances (Holliday et al., 2014; Kearney & Simpson, 2015). In the words of one participant with PTSD who recently completed MBSR:

I don't feel like I'm circling the gutter now, I feel like I'm getting better and that I have a life ahead of me. So I don't attribute that all to [the mindfulness teacher], it's also [my therapist] who does the triggers and coping skills CBT course that's been incredibly helpful, but I think first and foremost, it's the combination of all three.

As this quote illustrates, we view MBIs primarily as a complement to other treatments for PTSD. In our experience, many people who have already participated in established PTSD treatments choose to participate in a MBI as a way of working with persistent difficulties, such as a loss of meaning, feelings of disconnection and alienation, or persistent emotional numbing. Others may not feel ready to participate in a trauma-focused PTSD treatment and may choose to participate in an MBI as an initial step toward working with the consequences of trauma. An enhanced ability to tolerate distressing

## Copyright American Psychological Association

feelings and thoughts, with an attitude of openness and kindness, may in theory be of help to them in the future if they engage in therapies specifically focused on alleviating PTSD symptoms.

In our experience, some people come to class desperate to get off their medications or at least minimize the number of medications they take. Some want an alternative to medications because they are concerned about side effects or becoming addicted. Others are interested in mind–body approaches because they understand the link between their stress and pain. Many have never tried meditation before and are open to anything that can help them, whereas others may have pursued integrative medicine approaches in the past and found them beneficial. Most individuals continue to pursue other treatment modalities (e.g., medication management, psychotherapy) while taking part in mindfulness groups and see them as a complement to their other treatments. In addition, some may be looking for help with social isolation and want a group format. Some wish to learn to deal with problems more independently. Others seek insight about their suffering related to PTSD. One participant summarized the reasons for seeking out mindfulness classes:

I think ultimately I was looking to gain some insight and peace on the suffering that I endure from PTSD. I mean, ultimately that was the goal. I've been moderately successful managing pain through meditation on my own so I hoped maybe to get a better tool to do that with. But really the primary reason for going was because PTSD . . . the feeling of remorse, kind of depression, sadness . . . *guilt*, that's the key word. *Guilt*. And just kind of a purposeless existence.

Our intention in writing this book is to provide a resource designed both to help clinicians understand the landscape of trauma more fully and to provide practical suggestions to help group leaders effectively teach mindfulness to those who have sustained trauma. In Part I we begin by providing an overview of the landscape of trauma. Each chapter in Part I is designed to provide a working knowledge of clinical conditions that commonly occur following trauma. Chapter 1 focuses on PTSD. It provides an overview of the clinical manifestations of PTSD and discusses how mindfulness is theorized to counter many of the hallmark symptoms of PTSD. A review of the extant literature on the safety of MBIs for PTSD is provided, along with an overview and discussion of outcome studies of MBIs for PTSD. Chapter 2 reviews other posttrauma sequelae: depression, chronic pain, substance use disorders, and functional somatic syndromes. An overview of the clinical manifestations of each condition is provided along with a discussion of the theoretical basis for applying MBIs. The overarching goal of Part I is

## Copyright American Psychological Association

to provide readers with a working knowledge of the most common clinical manifestations of trauma and an understanding of how mindfulness can be taught in an effort to benefit these symptoms.

Part II of the book focuses on practical considerations. Chapter 3 provides tips and advice on forming and managing groups, with an emphasis on how best to teach mindfulness to individuals with PTSD, chronic pain, and depression. Suggestions for managing group dynamics are provided. In Chapter 4, specific mindfulness practices are discussed, including the body scan practice, breathing meditation, yoga, and loving-kindness meditation. Suggestions are provided about how to guide each meditation practice, including commentary on tone, content, and use of language when working with populations with PTSD. Advice and suggestions are also provided for teaching individuals with chronic pain. Chapter 5 provides a synopsis of the rationale for understanding key mechanisms involved in maintenance of posttrauma sequelae by MBI teachers and therapists, and it discusses issues surrounding teacher experience and qualifications.

It is our hope that the material presented in this book will lead to a greater understanding of how mindfulness can help mitigate factors that maintain or worsen conditions commonly experienced by trauma survivors, and that this greater understanding will translate into more effective teaching and improved outcomes for patients.