



Meditation and Psychotherapy: A Case Study—James S.

 THE FOLLOWING case studies in Chapters Two and Three exemplify in practical ways how the issues raised in Chapter One can be applied. Both cases are guided by the framework laid out in that chapter and attempt to further help us answer the question, "What effect does the teaching of meditation have on an individual who practices, and why?" The first case study, James S., (Chapter Two) is a clinical case illustrating the use of meditation as a self-regulation strategy; the second case, Deane S. (Chapter Three) illustrates a potential methodology for researching meditation as an altered state of consciousness. Since I am the therapist in the case in this chapter, it is important to include here some remarks on my therapeutic orientation and style. I present my own views within the context of the general issues of "teaching" which need to be addressed in any clinical/therapeutic endeavor. Specifically, these issues, mentioned in Chapter One, include the orientation, beliefs and preconceptions of the teacher and his/her role, the role of the relationship process, and the actual method of teaching.

2.1 *The Orientation of the Therapist*


 I REMEMBER being asked my religious orientation in a religious studies class at Stanford. I wrote: a Jewish existentialist with Zen Buddhist inclinations. My clinical orientation is similarly complex. It is behavioral, insofar as that implies belief in the importance of carefully evaluating the efficacy of my clinical work (rather than adherence to a specific body of techniques). It is also behavioral in that it involves an emphasis on action-oriented therapy, a setting of goals with the client, the collection of data, working on change—behavioral or cognitive—i.e. new ways of acting, thinking, feeling about the world and oneself. It is insight oriented insofar as that means that a client's understanding of his/her behavior, thoughts, actions, habit patterns is important, rather than *a priori* assuming historical insight into psychosexual stages is needed. It is relationship oriented—I believe trust, empathy and understanding provide a critical context for therapeutic change. However, I do not believe, in general, that relationship is sufficient, and do not believe it should be the focus of therapy, except as it facilitates changes the client is trying to make outside of the therapeutic context. Finally, it is religious, spiritual, transpersonal, insofar as this means I am committed to my own personal growth and work, believe in working toward developing myself toward the farther reaches of my potential, desire to find a core connection between myself and others, and have experienced feelings of unity and oneness with nature, myself, and others. It does not mean I believe all clients should experience this; that there is only one path to its experience; or that it is an *a priori*, true reality, but rather one which I believe to be true, part of my path of heart: a belief system that, for now, *works* to nourish and sustain me.

Thus my orientation is really a combination of personal, clinical and religious. Interestingly, at the risk of being an overly “general” armchair philosopher, it appears to me that for many, there is a large overlap between the psychological and religious. Scientists and psychotherapists have, for many in our culture, become a type of guru: priests of a technological and secular age.

To label my orientation, we could say I am an applied pragmatic behaviorist who believes in relationship, insight, and spiritual growth, all with appropriate reservations!

Perhaps, true to the behaviorist/existentialist within me, more important than the label, is how I act. So, let us now turn to two different cases, to discuss in more detail the issues raised in the first chapter.


2.2 *Therapist's Belief in the Efficacy of the Strategy*

 I BELIEVE meditation to be a useful self-regulation strategy for certain clients with certain clinical problems. I do not believe meditation to be any more (or less) effective than other self-regulation strategies for a client who wishes some type of stress-management strategy. My decision to use it (rather than other strategies) would depend upon the client's belief system, values and expectations. Further, I do not feel a particular need to call a cognitive focusing strategy “meditation” if a client has a resistance to that term either because of prior religious training, or dislike of its “mystical” association. I am also not convinced, at the level of actual behavior, how different meditation is from other cognitive strategies. As Ted Barber noted, on reading a previous draft of this manuscript (personal communication, January 23, 1979),

The overlap between self-hypnosis and meditation is tremendous. In fact it seems to me that the variability within self-hypnosis and meditation is almost as large as the variability between these procedures. There seems to me to be so many parallels so that it appears possible to at least conceptualize self-hypnosis as one type of meditation, or vice versa, meditation as one type of self-hypnosis.

It should be noted, however, that for me we are talking here only about meditation as a self-regulation strategy, and its use for clients who wish some form of training for a stress-related problem.

2.3 *The Client, and Presenting Problem*

 JAMES SIDNEY, an Australian male in his mid-thirties, was a short, rather unassuming individual, with a kind and sensitive face. When he introduced himself to me

at my private practice office in Portola Valley, California, he shook my hand, but didn't directly make eye contact. Although he had a pronounced accent, his speech was clear and lucid, but his voice was often so soft that I could not hear his words. When we sat down, he said, "I have a problem with insomnia, and wondered if you could teach me meditation." He said he knew of my clinical interest in meditation, and on the recommendation of a mutual colleague on the East coast, presented himself to me to learn an approach to meditation that was not immersed in "cultic" paraphernalia: incense, pictures of gurus, candles, etc.

I told him that yes, I would be glad to teach him meditation and work with him on the issue of insomnia. As one way of doing this, I told him it would be helpful for me to get to know him a bit better—his background—and to learn what he had heard about and expected from meditation.

CLINICAL NOTE

I have three goals in obtaining this information. First, before teaching a technique to a client, it is important to gather information about the client's expectations, hopes, motivation for learning a particular technique. Second, I interact with this information in a way which attempts to build a trusting relationship (cf. Rogers, 1951, 1961; Truax & Carkhuff, 1967) between us. I believe this relationship provides an important context for the teaching of technique and skill training (Shapiro, 1976). Without the trust, the teaching of any technique, whether meditation or a behavioral strategy is more difficult (G. Davison, 1973). Third, I want to obtain some initial background information about the client, as well as a broader profile of what other issues may currently be going on in this client's life that may be relevant to therapy.

OVERVIEW OF THERAPY DURATION

This client was seen for ten months. The first six months we met once a week; the next two months, once every other week, and then I saw him twice at three week intervals. There was a six-month, written follow-up. The sessions were face to face in the office; and involved homework assignments and data collection outside the office.

2.4 Client Expectations

THE CLIENT noted he had heard and read in the newspaper about the scientific experiments showing meditation's effectiveness for stress and felt it would be helpful for him. He said that he was not particularly interested in the "spiritual mumbo-jumbo" that went along with the technique. He noted that although raised a Catholic, he had had no formal religious affiliation for several years. "I consider myself more interested in down-to-earth human concerns than metaphysical issues."

2.5 Client Background

THE CLIENT noted he used to sleep about eight or nine hours a night, but that a couple years ago, for no reason he was aware of, he began to wake up during the night. He began to awaken with increasing frequency per night during the next six months, and finally decided to go into therapy. He noted that he was in therapy for the next six months, and that the therapy focused almost exclusively on trying to understand his dreams. The therapist indicated that the sleep disturbance was only a "symptom." After six months of dream analysis and no improvement, and even some deterioration in sleep, he left therapy. The therapist told him he was not giving the process long enough, and was only leaving now out of fear of confronting the really deep, true material.

Client then began taking valium (5-10 mg. nightly) and had been doing so for the year prior to our first meeting. He came in now because the insomnia problem seemed quite bad, he felt tired and tense at night from fear of going to sleep; and during the day from lack of sleep. He also had read and been told that it was not good for him to continue to use valium every night.

Over the next few therapy sessions, I learned the following information. In addition to the issue of insomnia (Concern #1), he was quite shy and unassertive. He noted that he had almost no contact with either his own or the opposite sex. Further, it was hard for him to be assertive, particularly with his family. He had two brothers, and both parents were living. He felt quite pushed around, "bullied" by the older brother, and ignored and not

attended to by the father. The mother was somewhat distant and he had never really felt too close to her. The issue of shyness and assertiveness became Concern #2. The client also noted he was quite self-critical, frequently noting in the session how poorly he did almost everything (Concern #3); felt stress a high proportion of the time during the day (Concern #4), and finally that he was an administrative assistant in business, currently out of work and having difficulty finding a new job, partly because of a poor recommendation from his previous employer (Concern #5).

2.6 Client Motivation

THE CLIENT felt his general weariness and stress from lack of sleep had reached "crisis proportions" and something needed to be done. He noted he was quite willing to learn and practice the technique of meditation.

The client initially appeared highly motivated to me and this was borne out in the course of therapy. Initial concurrent evidence of this motivation and ability to adhere to self-regulation practice was a special diet he was put on by his physician for a phosphorous imbalance. He had to be extremely careful about his eating behavior and monitor closely his intake. He followed this diet meticulously.

During therapy he maintained accurate and complete records of the homework assignments of areas monitored, practiced meditation exactly as instructed, and put a great deal of personal effort and energy into each concern we worked on.

2.7 Baseline Data

BECAUSE OF the behavioral part of my orientation, I felt it important to have the client gather data (i.e. monitor) in diary and/or chart form, on each of the areas of concern: i.e. the frequency, nature, duration of the target behaviors. This baseline data for each of the areas of concern is discussed below.

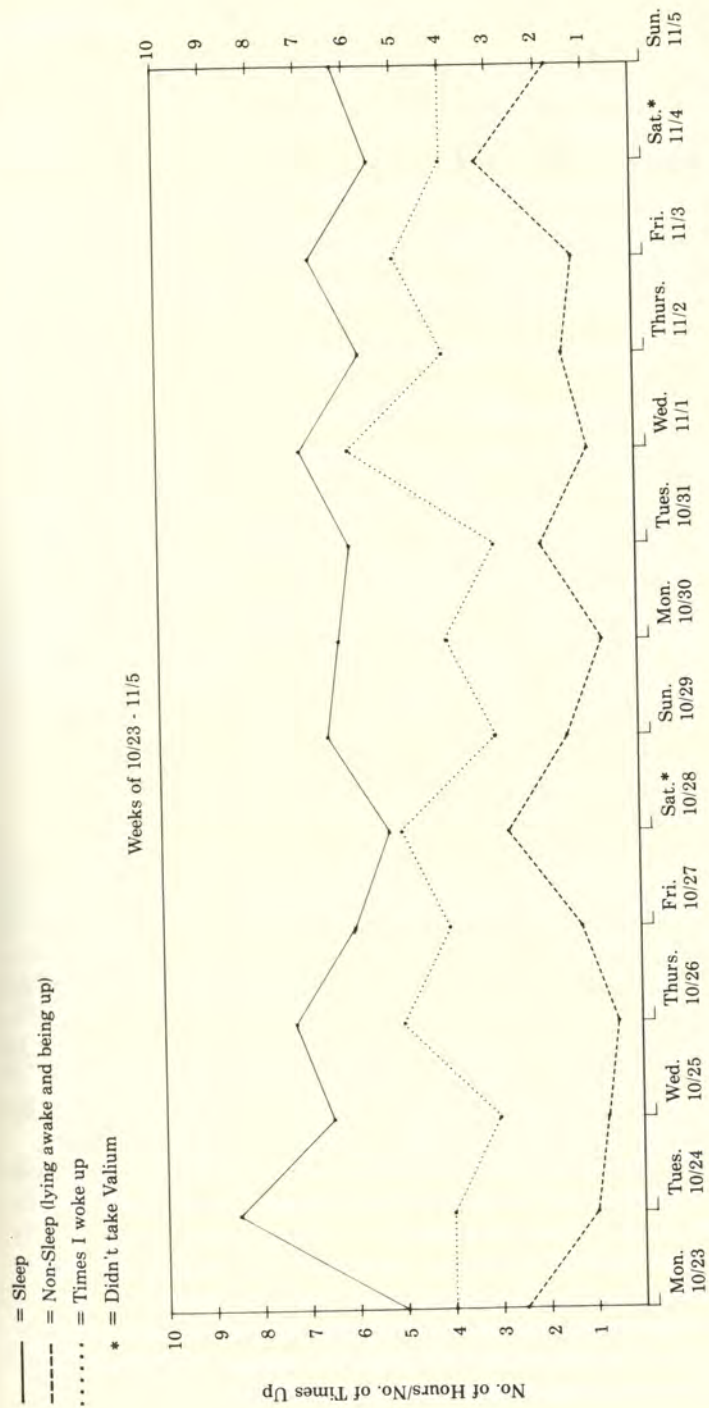


FIGURE 2.1
Sleep: Baseline Data Weeks One and Two

CONCERN NUMBER ONE:
SLEEP BEHAVIOR

As noted, the client stated that he used to sleep seven to eight hours a night, believed he currently was getting only three to four hours of sleep per night, if that; and felt he needed at least six to seven hours. To assess current sleep patterns we monitored length of night, amount of time asleep, number of times awoke, length of time awake, and whether or not he took valium that night.

From a two-week baseline (2.1) we found that this client on an average was sleeping a mean of 5.8 hours, was waking about 4.14 times, and was up 1.53 hours (i.e. twenty-seven minutes per time). The kinds of things that awoke him were: a) anticipation of a noisy neighbor coming in; b) actual noise from a neighbor (e.g., jogging upstairs, loud music); c) a bad dream; d) no actual incident. We also noted that Saturday nights were particularly difficult, partly because of the general noise in his apartment complex. During each week of the two-week baseline, the client took valium on six of seven nights.

CONCERN NUMBER TWO:
COMPANIONSHIP/ASSERTIVENESS SKILLS

The client was asked to monitor the amount of his social interactions not related to job searching. The first week, he noted that his only companionship was a hitchhiker to whom he gave a ride. The next week, it was his brother on the phone, the one he felt nagged him too much—about his health, about not having a job. When asked how he responded, he said he didn't say anything to the brother about the nagging. We discussed the client's fear of being pushed around, being taken advantage of and used both by his family and by potential acquaintances.

The client also noted that he really didn't want to have people back to his apartment because others might think it was sterile and unattractive, "just because it is neat, clean, and totally bare." He said he didn't feel any need to fix it up and artificially put "his stamp on it." He also noted that he seemed to have a response of ignoring (or pretending to ignore) insults or put-downs of other people and then all of a sudden to "snap" (his word) and become aggressive and verbally angry.

CONCERN NUMBER THREE:
POSITIVE AND NEGATIVE SELF-THOUGHTS

The first week of monitoring positive and negative thoughts, the client noted that his thoughts were primarily negative and that every time he had a positive thought (e.g., my piano playing sounds good), he followed it with a negative statement (e.g., who cares?).


CONCERN NUMBER FOUR:
STRESS/RELAXATION EXPERIENCES

A fourth area of monitoring was stress—times when he felt stress (antecedents, behavior consequences). He felt he was always pushing himself—what's going to happen next; how will I cope with tomorrow? Stress for him included physical symptoms of tight jaws, back, and shoulders. Mentally, he would block everyone out and ignore them. Stress frequently occurred for him when he felt there was too much to do with too little time. We also looked at times when he felt relaxed: when he was walking alone, sometimes when reading.

CONCERN NUMBER FIVE: JOB

The final area of monitoring was to look at behaviors he did toward finding a new job and how that process felt to him.

2.8 Interventions

 **THUS, AFTER** the first few weeks, a more complete picture of this person began to emerge, and we began to work together to set goals in each of the areas of concern and develop appropriate intervention strategies to help him meet these goals.

MEDITATION

In structuring a treatment intervention, I try to relate the client's concern to the research literature, to see what interventions have and have not been effective with this type of problem.

To my knowledge there is only one study in the clinical literature on meditation and insomnia. (Concern Number One). Although there are methodological problems with the study (measuring sleep onset and sleep duration) meditation was shown to be as effective as progressive relaxation in treating insomnia, and both were more effective than a non-treatment control (Woolfolk, et al., 1976). Further, as there are problems with drug dependence (Coates & Thoresen; 1978) and as the client requested to learn meditation, it seemed to be the treatment of choice for the sleep problem. Further, it was hoped, with appropriate cueing and practice, that the relaxation aspect of meditation would generalize to other high-stress times in this client's life (Concern Number Four: Stress).

CLINICAL NOTE:

CLIENT BACKGROUND INFORMATION

Before actually teaching meditation, the therapist should have made a careful assessment of the client's feelings, hopes, and expectations. Why did the client come into therapy? What is his/her concern? Is the client willing to take responsibility for that concern? How committed is the client (i.e. how motivated to change)? What is the client's vision of what might (can) happen if he or she does try to change? Does the client fear failure? Why? What are ways the client might sabotage his or her own efforts to change? Does the client fear success? Why? What are the client's reactions to "meditation"? Is there a fear of it, e.g., as mystical? Why? Does the client fear being controlled or losing control? Is there an attraction to meditation? Why? Is the client motivated by the idea of learning to yield and let go of thoughts? A cognitive avoidance? Or a hope for growth? Is the client willing to trust him or herself with an essentially non-analytical technique?

After this assessment, the therapist should determine whether meditation is indicated or contraindicated.

CHARACTERISTICS OF THIS CLIENT WHICH SUGGEST INDICATION FOR MEDITATION

First, the client requested meditation. Second, the research

literature suggests its effectiveness for insomnia (Woolfolk et al., 1976) and stress management (Shapiro & Giber, 1978). Third, the client's anxiety was primarily cognitive (Schwartz, Davidson & Goleman, 1978). The client was highly motivated and once he made a decision would stick to it and therefore would probably score high in internal locus of control (Beiman et al., in press, 1980); and also fit a personality profile of inward directed, relatively neutral affect (one which correlates with success in meditation; cf. Smith, 1978).

POTENTIAL CONTRAINDICATIONS

The client seemed shy and of low affect. Meditation as a sole strategy might merely reinforce that behavior pattern. Further the client was a "perfectionist" and might apply these same standards to the technique, perhaps being too self-critical.

If an individual has negative association to the term, "meditation," I feel no need to try to convince the client that it is an effective strategy and that they should change their beliefs. Rather, as noted earlier, I would rather change the label—e.g., a relaxation technique, a cognitive (attention) focusing strategy, etc.*

Assuming the client does want to learn meditation, what do I then tell them in terms of outcome results and practice?

CLINICAL NOTE: "DEMAND" CHARACTERISTICS OUTCOME RESULTS AND PRACTICE

In Chapter Five we discuss in some detail the research literature on meditation's effects. Because I believe it therapeutically beneficial to create positive expectancies, I often find it useful to share in lay terms these results. In this particular case I noted, "I think your choice of meditation for dealing with insomnia and general stress is a good one, for it has in fact been found to be effective for these types of concern."

*Earlier, before I would screen clients for their reactions to meditation, I had an interesting experience teaching meditation as part of a relaxation group in a psychiatric ward at the V.A. Hospital. A patient leaped up and ran out of the room shouting, "You're trying to steal my mind with Eastern witchcraft."

However, I also feel it important to state that meditation is not a magical panacea, and that the effects from meditation are a result of practice. I ask if the client is willing to give it a chance to work. "Normally, you should begin to feel a significant reduction in stress and anxiety within four to ten weeks (e.g., Smith, 1975). Are you willing to practice the technique on a regular basis for at least that period of time?" If the answer is yes, I spend some time talking about, planning when, and visualizing where the person might have an opportunity to practice on a daily basis. If the answer is equivocal, I spend some time on this issue, again stressing the importance of practice and talking with the client about how much effort they are willing to expend to deal with their concern. Before teaching a strategy, I do try to get some form of commitment from the client.

RELATIONSHIP ISSUES

By this time there should also be at least the initial development of trust and rapport between the therapist and client. As noted, the therapist should be aware that techniques appear to be more effective if offered within a context of trust and support (Davidson, 1973). Because exploring one's self, with any strategy, can be frightening, the therapist's gentleness and encouragement in this process, I believe, are crucial.

SELECTION OF A MEDITATION TECHNIQUE

The research literature on this point is not yet very helpful. For example, we do not yet know whether individuals with certain strong perceptual representational systems (e.g., visual, auditory, tactile, etc.) would be better off with an object of meditation which either is or is not in that same representational system (e.g., should an "auditory" person utilize a mantra or a mandala?). The biofeedback literature indicates that relaxation is facilitated if the feedback is in the non-preferred mode: i.e. biofeedback is more effective for an auditory person receiving visual feedback than for an auditory person receiving auditory feedback (Branstrom, Note 7). However, Davidson and Schwartz (1976) suggest that an object of concentration in the same mode as the problem is preferred. If a person has too many thoughts,

they should attend to verbal focus such as mantra, koan, etc. Further, there is some question about whether individuals would be better off learning concentrative versus mindfulness meditation, or both; and if both, in which sequence. The classical literature says first concentration, then mindfulness (e.g., Goleman, 1972). But what about beginning clients? We do not yet have any data which speak to this issue.

INSTRUCTIONS

This client was initially instructed in breath meditation, including counting one through ten, and asked to practice twice a day, twenty minutes each session. Why breath meditation? There is no empirically valid rationale for choosing this particular meditation technique over any other. Personally, it is the one I was taught in the Orient, and clinically, it is the one with which I am most experienced. I hope that further research, as suggested in Chapters Eight, Nine, and Ten of this book, will allow for a less personally biased determination of treatment choice. However, at this point, there seems no clear cut reason not to utilize the meditation technique with which a clinician feels most comfortable.

I generally spend part of two or three sessions instructing the client and having them practice the technique in the office. There are particular signs of "correct" practice I look for, and particular areas of the "teaching" that I believe important to emphasize. These are discussed in detail in Chapter Four where practical instructions for a breath meditation technique are given.

Another question often raised is when in relation to the therapy session should the person meditate? Carrington and Ephron (1975) have described having individuals meditate right before a treatment session so that whatever material may surface would be available for that therapeutic session. I have a meditation room next to my office where individuals can meditate prior to the session, for reasons similar to Carrington and Ephron's, as well as after the session, as a way of attempting to make sure that anything which is dealt with in the therapy session, which may be painful, might just be observed for a certain period of time during the meditation session without undue analysis. Meditation sessions before and after, even though brief, seem to

serve also as a helpful transition, both preceding therapy and following therapy before returning to the "real world."

WHY A TAPE, TOO?

In addition to the verbal instructions and practice in the office, I also often give clients a tape to utilize at home. The tape follows the instructions in the office and provides a time frame of twenty minutes. I do this as a way of facilitating practice at home. There are two potential advantages to the tape. 1) The tape repeats the office instructions, and thus provides clients an opportunity to re-check in case they feel they have forgotten or are not practicing correctly. This helps avoid the statement the following week of "I didn't remember exactly how to do it so thought I would wait till our next appointment." 2) The tape is structured with a successive approximation to silence. The first part contains dialogue of instruction followed by a thirty-second silence, then re-instructions to keep focused on breathing, followed by a ninety-second silence; then briefer re-instructions, followed by a ten-minute silence. Many people find this gradual approach to silence more comforting than just abruptly sitting down and counting breaths. Some people, however, find the instructions a disruptive, external intrusion. Therefore, in my instruction to the use of the tape, I note that some people find the tape helpful to facilitate their practice, by keeping them from having to worry about time boundaries, etc. I ask them to try it and if they find it helpful initially, to continue to use it. I note, however, that once they feel comfortable they can practice on their own schedule and time, using the tape only as a checkup when and if they feel it appropriate.

JAMES S's EXPERIENCES DURING MEDITATION

A general description follows of the issues that occurred during the nine months of meditation practice and how they were dealt with.

FIRST MONTH

After the first week of practice, he noted tension in his face that

he had not realized was there and also how hard it was for him to be attentive and relaxed. In the morning he felt his heart beat slowly and heavily, but not in the evening—then he got restless. He noted that the tape kept him sitting. This points out one of the potential initial issues in working with a client in meditation: that initially a certain discipline is necessary to give it a try. Generally, he said, by the end of the tape, even though he was not aware of the process by which it happened, he felt more relaxed and refreshed. He noted, "It's easier with the tape than without it." Without it he said he felt too time conscious.

Several times in the first month he noted that he felt "energetic" during meditation—a positive contrast to the lethargy he often felt during the day. The nature of the thoughts that occurred were generally of a "planning ahead" nature, such as people he had talked to or he was planning to talk to. Nice images included flowers, trees, mountains, birds. Sometimes he said he felt sad, lonely and withdrawn.

CLINICAL NOTE

The above comments raise several important issues. First, what should you instruct a client to do with thoughts—either positive ones or aversive ones? I agree with the recommendation of Glueck and Stroebe (1975) that when ideas that seem important to the therapeutic session come up during meditation, the meditator is to treat them like any other thought and return to the meditation focus or "anchor."

In other words, the client is instructed to merely observe the thought, notice any feelings associated with it, watch it and when s/he is ready, to return the focus to the breathing. In the therapy session, we then would spend time discussing issues or insights resulting from meditation. For example, the client's strong awareness of his/her feelings of loneliness became part of the incentive and motivation for him to decide to risk practicing social skills. The positive images gave us helpful information about useful competing responses to the aversive, fearful images in the evening of not being able to fall asleep.

It should be noted that the East says we should let go of thoughts when we meditate. They criticize the Western approach of thinking about thoughts and say that many Westerners believe they are meditating when in fact they are only performing

therapy on themselves. My feeling is that a balance is needed. During meditation I believe, as noted, that it is best to let the thoughts go. In meditation as a clinical self-regulation strategy, we can learn to see what issues come into awareness, feel how salient they are (i.e. how attached we are to them); watch them with equanimity and then let them go. However, I believe that after meditation, in therapy, the talking about, discussing, analyzing the issues, antecedents, consequences, etc., is important to facilitate change. The East would say let it all go. The West would say analyze it when it comes up. I think, sequentially, both are possible and useful.

A second important issue is the "anxiety about anxiety" that often can occur when a person initially meditates. They become aware of how tense they are (e.g., face tension for this client); how restless, how inattentive their mind is. Here therapist reassurance that "this is part of the process" is important.

Third, it should be noted that there is a certain discipline needed for the practice of meditation. For this client the tape helped, i.e. kept him sitting, so that by the end he felt more relaxed.

NEXT FOUR MONTHS

These were generally positive sessions for the client in which he experimented with a variety of cognitive strategies—self instructions, imagery, etc. The client noted that the best way for him to let go of thoughts was an image of a window in his mind's eye. He meditated on one side of the window in the room (in his mind); outside the window was a pasture with cows. He opened the window and let the thoughts fly out to pasture to graze with the cows, or let the thoughts "drift away" like kites without a string.

He also said he generally looked forward to the meditation practice, felt it refreshing, that it gave some structure to his days, and to him, a sense of competence. He learned about his thought process, realizing which thoughts he felt were more important (i.e. he was more attached to) because these thoughts had a higher emotional charge and it was harder to let them go.

SIXTH TO NINTH MONTH

At the start of the sixth month of meditation he said he was

attaining deeper levels of meditation; that he liked it, in general, and yet he was noticing more thoughts and he felt he was more distracted than when he had initially begun. After six months of meditating, we shifted from counting one through ten to just counting one after each out-breath. He said he did not like this as much as there was too little structure and so we returned to counting one through ten. He noticed, however, that there was still a constant stream of thought and he was becoming angry at himself for this, feeling a failure every time a thought occurred.

We discussed the importance of acceptance. I re-emphasized that "if thoughts come, that's okay, if they do not, that's okay, too." I tried to get the client to view meditation as a process of acceptance of what is and help him become aware how he was bringing "old" behavior patterns to the practice, applying "perfectionist" (goal oriented, accomplishment oriented) standards to meditation. We explained how this could, in fact, just be a way of setting himself up for failure. The image he liked was one which recognized the discipline it takes to practice meditation while trying to stay calm: "A fighter who meditates acceptingly." After two more months, he noted that he was fighting the meditation less and becoming more accepting of where he was with the process. He still noted that at times he felt inundated by his mind, "I can only turn it off...so seldom, it feels keyed-up, planning, worrying, finding chores to do." During the positive times he said his hands felt warm and good. They turned into furry, soft, heavy paws.

At this point I suggested he choose his own length of meditation. If he felt distracted and not able to meditate well, not to force it. It was all right to just stop after a few minutes. Again, it was a process of acceptance, not a goal of "reaching the end of the tape." He found this helpful, and sometimes he meditated more, sometimes less, "Not to fight it, to give up if thoughts get away from me."

CLINICAL NOTE:

It is important to note the issue of balance involved here. Initially, as noted earlier, I believe a certain discipline is necessary to give a self-control strategy like meditation a chance. However, we need to be careful that the discipline does not turn into a compulsive

rigidity: "I must practice twenty minutes or I'm a failure," etc. The therapist needs to be sensitive to when to encourage the discipline, when to encourage the letting go, of "rigid" standards, i.e. you "should," "it is 'better' if you can practice twenty minutes twice a day." Further, as noted, the therapist can utilize this information to explore with clients their psychological patterns and style as an aid to therapeutic learning.

NON-MEDITATION INTERVENTIONS, BY CONCERN AREAS

Let us now turn to each of the five specific concerns of the client and note how other interventions, in addition to meditation, were utilized to help this client accomplish his goals.

CONCERN NUMBER ONE: INSOMNIA

The client's general insomnia-related goals, on coming into therapy, were to lose his dread of going to sleep at night, increase sleep to at least six to seven hours per night, stop taking valium, and as a by-product, feel more relaxed and rested during the working day.

After the two-week baseline, the client realized he was getting much more sleep than he had thought. This self-observation in and of itself, therefore, became an intervention, and helped the client to feel more confident about his sleep problems. A second intervention was my telling the client, "When you are lying in bed, either initially or after awakening, you should remember that resting quietly is as good as sleeping. So don't worry about being awake. Just let yourself lie there and relax." The client noted that it really helped him to say this statement. (This cognitive restructuring was a strategy taught to me by my father when I was a child!) As the client noted, "I'm not dreading going to sleep as much. It's good to know I'm getting an adequate amount of sleep."

In addition to the regular meditation practice twice a day, the client used the focused breathing and counting as a general relaxation strategy while lying in bed beginning to go to sleep. Besides meditation, the baseline observation and the cognitive

restructuring strategy, this client also used humming, listening to an ocean record, and pep-talks (self-instructions) to deal with the anxiety and fear associated with sleep and the racing future-planning thoughts that would keep him tense and lying awake.

Another sleep-related issue the client had which we monitored during the initial few weeks was the amount of valium that he took. The first two weeks he went one night each week without it; the third week, two nights; the fourth week, three nights. The fourth week of three nights without valium was quite difficult for the client and in the following few weeks he resumed taking it every night. However, since the client was sleeping between five and six hours per night and felt comfortable with this, the sleep issue faded into the background and, with only minor spot checking (weeks six through ten, week fourteen), we turned to the other areas of concern (see Figure 2.2).

At week twenty-one, we returned to the sleep issue, particularly in relation to valium consumption. The client was feeling quite confident about his sleep patterns and wanted to work on stopping the valium. We decided to take a "successive approximation approach," beginning by not taking it two nights of the week.

While going off valium he gave himself the following self-instructions, "I am practicing relaxing, meditating, so I'm getting pretty good at this. I am not taking that much valium anyway; don't force it; let it go. If I can't get to sleep right away, it's not a big thing. Practice and be gentle on yourself as you try something new."

Weeks twenty-one through thirty-one involved working on increasing the amount of evenings in which no valium was taken. Figure 2.3 shows that he gradually tapered off valium, until in the last two weeks, he took it only twice.

This felt like a comfortable level to the client—to take it if he needed it, or felt in trouble but to first practice the strategies mentioned above.

Interestingly, the sleep data (Table 2.1, Figure 2.4) revealed that often the client slept as well with or without valium. These data charts helped him realize that in many ways the valium was merely a "psychological" aid, one which in fact did not seem to help him on a regular basis—many nights he would sleep better (i.e. more sleep time, less awakenings, less time up per awakening) without valium than with it. However, we agreed that

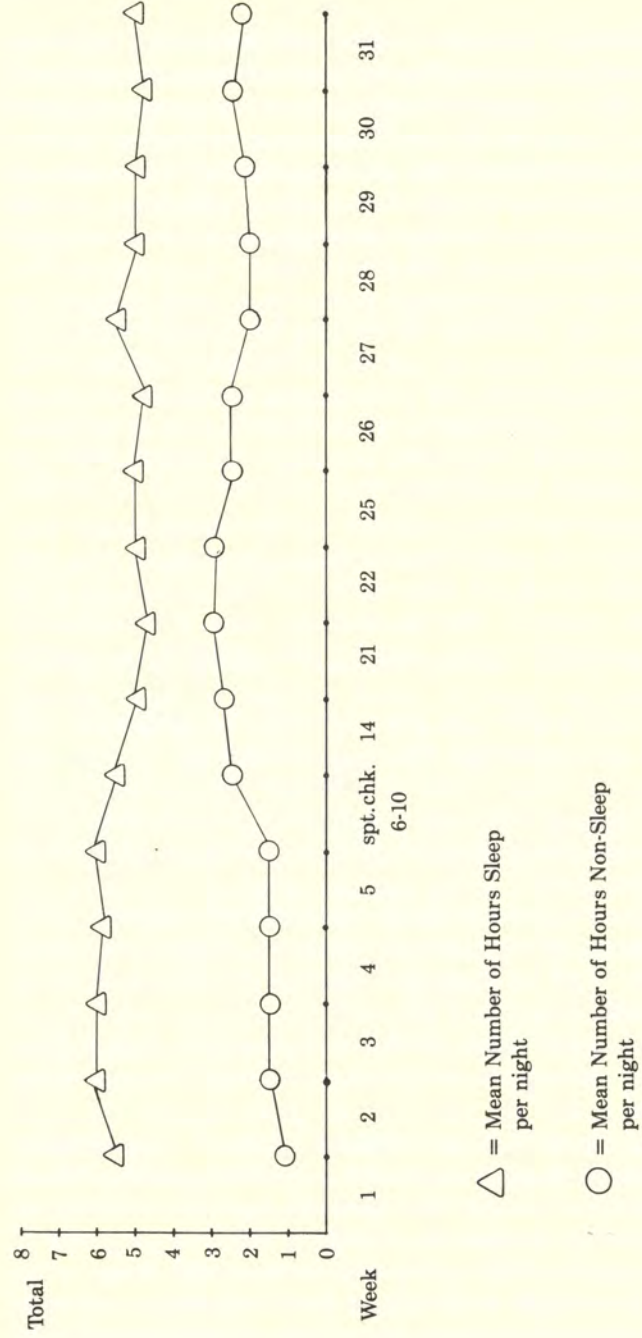


FIGURE 2.2
Weekly Mean of Sleep and Non-Sleep
(Hours)

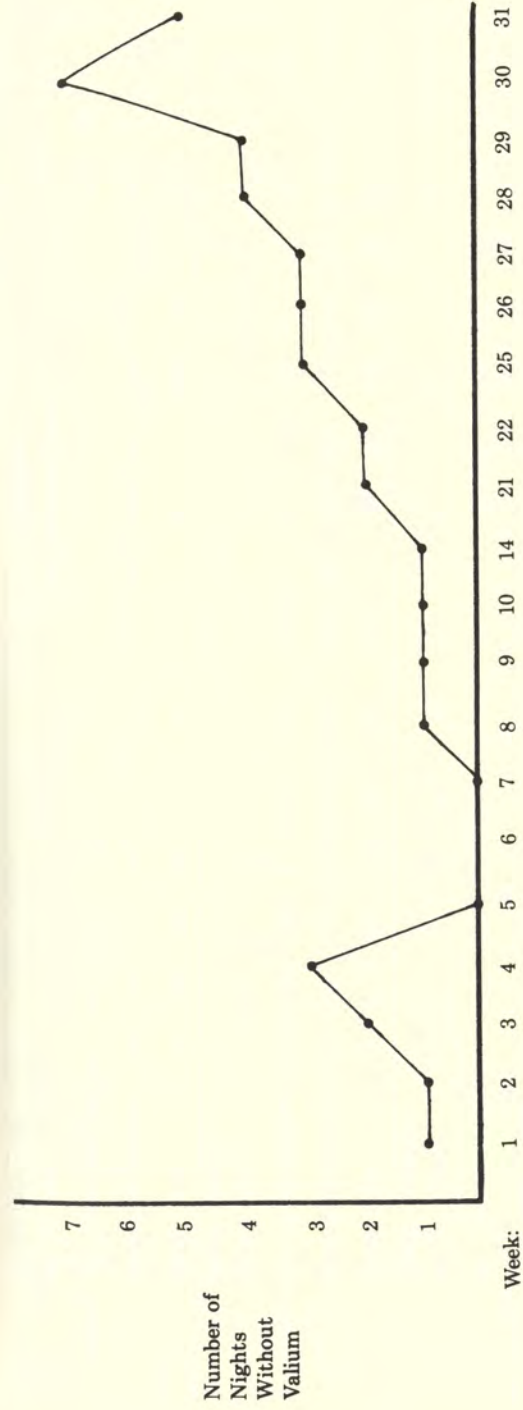


FIGURE 2.3
Nights Per Week Without Valium

TABLE 2.1
*Weekly Mean of Sleep, Non-Sleep, (in hours) and Number of times Awoke
 Total, With Valium, and Without Valium*

WEEK	1	2	3	4	5	6-10	14	21	22	25	26	27	28	29	30	31
Total																
Sleep (hours)	5.6	6.0	6.2	5.8	6.3	5.5	5	4.9	5.2	5.3	4.8	5.5	5	5.1	4.9	5.2
Non-Sleep (hours)	1.5	1.6	1.5	1.7	1.6	2.5	2.9	3.1	3.2	2.3	2.6	2.3	2	2.3	2.5	2.4
No. Times Awoke	4	4.3	4.9	4	4.7	3.8	4.3	5	5.7	5	4.8	4.7	4.4	3.6	4.3	4
No. of Nights Mean Based On	7	7	7	7	7	14	7	7	7	7	7	7	7	7	7	7
With Valium																
Sleep (hours)	5.6	6.1	6.1	6.2	6.3	5.6	5.2	5.3	5.4	5.4	4.9	5.5	4.8	5.1	—	5.2
Non-Sleep (hours)	1.3	1.4	1.1	1.1	1.6	2.5	2.9	2.9	2.8	2.4	2.5	2.3	2.1	1.8	—	2.5
No. Times Awoke	3.8	4.3	4.8	4.5	4.7	3.7	4.5	5	6	5.5	4.8	5	5	4	—	4
No. of Nights Mean Based On	6	6	5	4	7	11	6	5	5	4	4	4	3	3	0	2
w/o Valium																
Sleep (hours)	5.3	5.5	6.4	5.4	—	5.4	4	4	4.6	5.3	4.8	5.5	5.1	5.2	5.0	5.2
Non-Sleep (hours)	2.8	3.3	2	2.4	—	2.3	3	3.5	3.9	2.2	2.8	2.1	2	2.7	2.5	2.4
No. Times Awoke	5	4	5	3.3	—	4	3	5	5	4.3	5	4.3	4	3.3	4.3	4
No. of Nights Mean Based On	1	1	2	3	0	3	1	2	2	3	3	3	4	4	7	5

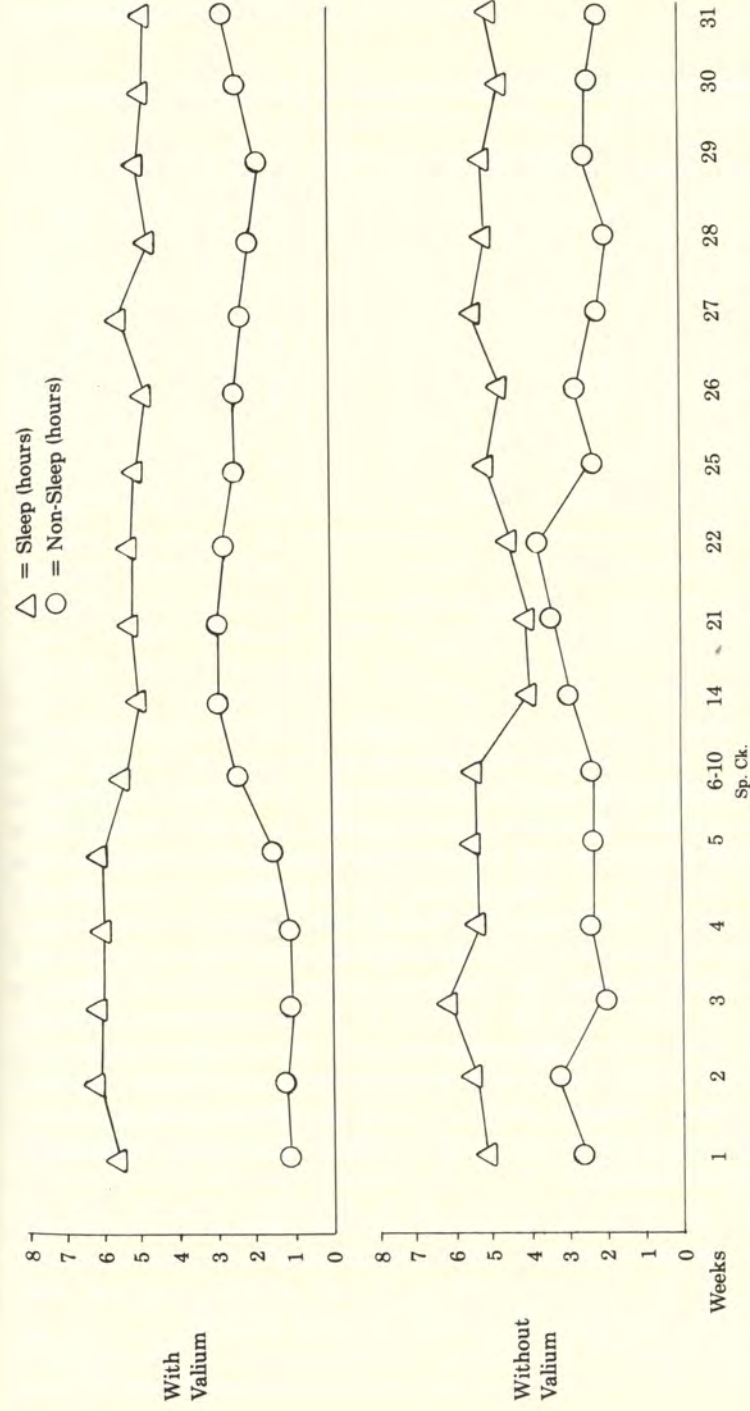


FIGURE 2.4 Mean Hours of Sleep and Non-Sleep: With and Without Valium

sometimes, when needed, there was certainly no problem with taking it.

In summary, for this client in the area of concern about sleep, the following observations are in order. The actual amount of sleep per night, on the average, did not change throughout the course of therapy, ranging from a low of $\bar{x} = 4.8$, week twenty-six, to a high of $\bar{x} = 6.28$, week five. If anything, visual inspection of Figure 2.2 suggests that there is a slight, though non-significant downward trend in the data indicating slightly less sleep per week. However, the client reported feeling quite pleased about this area of concern, noting his fear of going to sleep had lessened, his ability to stay relaxed when he woke up during the night improved, and he was able to substantially reduce his valium intake.

CONCERN NUMBER TWO: ASSERTIVE-COMPANIONSHIP

After several sessions of not dealing directly with this issue because it was too anxiety provoking, we began to talk about companionship and meeting other people. The client got in touch with the "dread" of meeting other people, the fear of being taken advantage of, the fear of getting into hassles with other people, and not wanting to snap, and yet not wanting to be passive either. Yet, he acknowledged that he did have a desire to meet new people. Therefore, we made lists of places where there would be the opportunity of meeting new people. He refused to go to bars, so we came up with the YMCA, a dance-movement class, a singing and music appreciation class. After exploring several options, he did join a music appreciation class. There he noted that he had a "freedom reflex," i.e. if somebody approached him, his "gut response" was to hide, to feel trapped, and to abruptly end the conversation.

Over the course of the music class, he was able to approach and initiate conversation with several people of both sexes. In addition, he was able to stand up in front of the group and sing, a risk-taking behavior he had not believed possible.

Another issue he raised was his feeling that all the people he seemed to meet were merely acquaintances (superficial)—E level

on Lazarus' inner circle* (Lazarus, 1971). He also realized how lonely, depressed, and withdrawn he felt and decided it was worth the risk to try to meet other people.

Our goals for companionship were two-fold: 1) to increase the number of people (quantity) from the baseline of zero to three or four, and 2) a later goal was added of increasing the depth of intimate experience (quality) from an E level of self-disclosure to a C or even B level of self-disclosure and closeness.

We made weekly tasks, beginning with inviting one acquaintance to lunch. We made a list of current acquaintances—there were three—and several times in the office we role-played asking each of them out to lunch. After three months he had gone out with each several times and felt comfortable about it. However, he felt the conversations were still too superficial, so we began, at least "loosely," to operationalize what was meant by a "more intimate conversation." We started by discussing how he had heretofore avoided B-level conversations: "I just say nothing about myself; be super-polite and super-cooperative." In order to have a B-level conversation, he and/or his partner would have to share some intimate, less comfortable part of themselves—a vulnerability or fear (or affection).

It should be noted that at the same time I agreed to work cooperatively with this client on the goal of developing "deeper" relationships I also requested that we spend part of our sessions acknowledging the enormous progress that had been made over baseline in even asking people to lunch!

The client felt, by the end of therapy, that he was able to improve the depth of sharing with two of his "acquaintances," and felt a B-level intimacy was occurring with greater frequency in their conversations.

Toward the end of the therapy session he noted that in general he felt more natural being with people, although he still had a gut feeling that he did not contact people very well and they would not really be interested in getting to know him. He admitted that although he could do it, he still did not enjoy taking the initiative and felt it an enormous strain on him. The

*Lazarus' inner circle is a concentric circle of A to E on which one can plot the "intimacy" of a conversation. E represents the most superficial conversation, B a self-disclosure of great intimacy, and A an area so sensitive that it is never revealed.

reason he was willing to take the risk is that he balanced strain against the fear and the dislike of the isolation. He also noted that he did feel *more* confident and more able to non-defensively take criticism than before.

Finally, on the issue of assertiveness, he confronted his parents and expressed his feelings of hurt and not feeling cared for; and was able to tell his brother tactfully please not to nag him about his health problems, his job, or lack thereof, and to explore other areas to communicate about. Although he noted relapses, a falling back into "my old docile, trying-to-please self," he generally was able to behave much more assertively, both with his family, and at work, to "not be afraid to say what I feel."

CONCERN NUMBER THREE: POSITIVE AND NEGATIVE SELF-STATEMENTS

This was a theme that ran throughout this client's life. His critical perfectionistic standards got in his way whether trying to learn to meditate, meet new people, or perform a job correctly. Here we worked on increasing positive self-thoughts, in particular, and on "sprucing up" his appearance and environment.

He agreed to "fix up the apartment" for himself—a candle, a couple of green plants, flowers, a Sierra Club calendar. He also decided to take more pride in his appearance: new clothes, getting his hair cut stylishly, grooming himself. He noted, "I am beginning to feel more confident more often although it is so hard for me to justify 'pampering' myself, am I really worth it?" We worked on catching the "critical" self and using these statements as cues for positive ones. We made a list of the positive qualities he had: intelligence, sense of humor, thoughtfulness, musical, with a good sense of rhythm. Homework for a while was at least one positive thought per day more than the number of critical thoughts.

He also realized a need to be gentler on himself—not to be always pushing for meeting new people. Sometimes it was all right to feel comfortable being alone, a self-retreat or a self-nurturance; to walk, to swing, to play the piano, or to read. Or, as we discussed earlier with meditation, not needing to have a *perfect* "empty" mind.


CONCERN NUMBER FOUR: STRESS/RELAXATION

Because the general strategy of this area has been covered in detail elsewhere (Shapiro, 1978b, 1978c) only a few comments are necessary. First, we worked on generalizing the relaxation from formal meditation to other times throughout the day. We did this by recognizing antecedents to stress, and also by using the behavior of stress as a cue for relaxation (focused breathing, coping self-instructions, and imagery).

CONCERN NUMBER FIVE: JOB

He did get a job in May after eight months of conscientious searching. It included several different simultaneous demands: phoning, typing, filing. His perfectionist side rebelled. We worked on generalizing the "accepting" attitude of meditation, and stress-management strategies of focused breathing, coping self-instructions, etc. At work he found it easier to set limits on what he could accomplish by being more assertive with others and more accepting of his own limits. He found that people did not reject him when he did set the limits.

2.9 *Did Meditation and Therapy Work Effectively for this Client?*

 THE CLIENT noted at the end of therapy that he was smiling more, seeing more colors in the world, holding his head higher, hearing the wind, taking the time to look at things. A six-month *follow-up* revealed that the client still felt good about his sleeping patterns; was using valium only infrequently (once every two or three weeks); continuing to see the friends he had made on a weekly or more frequent basis; practicing meditation at least once, and generally twice a day; and still feeling much less stress throughout the day.

WHY?

He attributed this success both to meditation and to his excite-

ment at working on the companionship area. Yet I could also, with a certain justification, add the issue of dealing assertively with his familial relationship, increased pride in his appearance, finding a job. Meditation did seem a useful and powerful therapeutic tool for this client. However, we must recognize it as one technique among many. On an applied clinical and empirical level, we do not really know too much more than that.

However, some clinical speculations and observations may be worthwhile. These observations are refined and discussed in more detail in Chapter Nine, *Mediating Mechanisms*.


First, let us look at meditation. The client learned the skill of being able to observe thoughts, watch them with relative equanimity and eventually let them go out to pasture. In this way, high affect issues were diffused. This is a mechanism involved in many therapeutic approaches. For example, the task of the therapist, as Freud noted, in his *Studies in Hysteria* (Breuer & Freud, 1893), is to help the patient assume objectivity to his own dilemma, a crystal ball attitude by the patient toward himself. This was done by making the patient into an intellectual collaborator, by showing the patient that he had nothing to fear by revealing the true memories. And Rogers (1957) noted that by fulfilling certain conditions of interpersonal warmth and acceptance, the therapist creates an interpersonal situation in which material may come into the client's awareness and in which "the client can see his own attitudes, confusions, ambivalences and perceptions accurately expressed by another, but stripped away of their complications of emotion. This allows the client to see himself objectively, to see that these feelings are accepted and are acceptable, and paves the way for acceptance into the self of all these elements. The therapist helps the client to see that the client is a person who is competent to direct himself and who can experience all of himself without guilt" (p. 41). From a behavioral perspective, classical systematic desensitization (Wolpe, 1958) involves having a person observe, in a relaxed way, issues that normally cause distress. This results in extinction of the maladaptive affective charge associated with the fear or phobia.

Similarly, meditation helped give this client a perceptual clarity on events in his life, and with a lessened affect. This may have allowed him to face so many aspects of himself as quickly as he did. As Vahia stated, (Vahia et al., 1973), emphasis on meditation therapy is on detachment (objective assessment) and not a manipu-

lation of environment. This increased equanimity may have helped in the decrease of negative thoughts (Concern Three); the reduction of stress (Concern Four); and the ability to deal more calmly and acceptingly with the number of job-related inputs. This affect-reduction and acceptance might have also been helpful in giving the client the inner strength to be more assertive with others. Further meditation in many ways seemed to help give this client a sense of mastery and control, a sense of increased self-esteem at his success. It also afforded him a "portable" relaxation technique to help him cope with his "generalized anxiety," and a technique which he could use any place at any time (i.e. contingent informal meditation—see Chapter Four).

But I believe meditation was only part of the reason for the therapeutic success. Another part was that the client, feeling more confident, was willing to have his affect *raised* and to take risks. He was willing to be assertive with his family, take the initiative to invite people to lunch or to talk with them. The social-skill and assertive-skill training also seemed a critical element in this case. Further, the baseline data and goal-setting seemed to help with his perfectionist style. It showed him the progress he had made so that he was literally forced to acknowledge improvement, even though his preference would have been to ignore (forget) improvement and only focus on the next mountain. Finally, the client himself was very highly motivated, the therapeutic relationship was an accepting one, and the therapist seemed to be both trusted and respected.

2.10 Summary Clinical Notes

 IN THIS CASE there were several areas of concern, individual strands of this person's life. They were not all tackled simultaneously. Sometimes more time in a session would be spent on one issue, sometimes another. However, all of the areas of concern together were important in the fabric of this person's life, and to have had the focus of therapy exclusively on only one would, I feel, have done a therapeutic injustice to this individual.

The following points, illustrated by the case of James S., need to be kept in mind when using meditation as a self-regulation strategy with a client.

The client initially presented a problem area of insomnia and requested meditation; however, meditation was not offered as a technique until the context of his life was better understood and his reasons (expectations) for wanting to learn it were made clear. Clinicians need to gather such contextual information to insure that they understand the full scope of the problem and that there are not reasons why meditation might be contraindicated. Second, meditation was not taught as a unimodal strategy for insomnia, but one technique among many. Third, meditation was taught within a therapeutic context of trust. Fourth, additional techniques, which seemed useful for other areas of this person's life (ranging from assertiveness training to role-playing social skills) were also utilized. I do not believe that meditation alone would have been sufficiently therapeutic for this client. Clinicians need to be careful in matching therapeutic interventions individually and as appropriate to the presenting concerns. Finally, careful evaluation and assessment seem important to determine whether the technique-therapy is having its desired effect. If not, why not? What changes can be made? The above comments are standard operating procedures for all good therapists. If meditation is to be considered as a therapeutic treatment, the same guidelines need to apply.