Contemplative Psychotherapy:

Clinician Mindfulness, Buddhist Psychology, and the Therapeutic Common Factors

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Abstract

Contemplative psychotherapy (CP) is a counseling discipline that integrates psychotherapy training, clinician mindfulness, and Buddhism. This review articulates CP as developed at Naropa University, contextualizes its core concepts and practices with regard to the common therapeutic factors, and briefly reviews the Buddhist frameworks, theories of pathology, and interventions that characterize CP.

The foundation of CP training is clinician mindfulness and compassion. Because of its integrative approach to developing these therapeutic traits in clinicians, aspects of CP have the potential to enhance the common factors and therapeutic outcomes across counseling disciplines. Future empirical research should investigate these claims, and if they are verified, explore best practices in clinician mindfulness and compassion training. Because CP thoroughly integrates clinician mindfulness and compassion into clinical training and practice, it is a notable field for research into psychotherapy practice, pedagogy, and outcomes.

Keywords: Contemplative psychotherapy, mindfulness, compassion, Buddhism, common factors

Contemplative psychotherapy (CP) integrates clinician mindfulness, Buddhism, Western developmental psychology, and counseling skills. This paper reviews the core concepts and practices of CP as developed at Naropa University, examines their relationship to the common factors movement in psychotherapy, and calls for more research on the impact of CP training on therapeutic outcomes. I argue that clinician mindfulness and the CP core concepts of *brilliant sanity* (intrinsic health), *maitri* (unconditional friendliness), and *exchange* (empathic resonance) may actualize clinician mindfulness within the therapeutic encounter and thus enhance the common factors. I articulate these CP terms below, in their respective sections.

It is one thing to be mindful and aware as a psychotherapist; it is another thing to be mindful, aware, genuine, friendly, sensitively attuned to interpersonal experience, and deeply confident in the intrinsic health and innate dignity of the client. The common factors research lends empirical support to the notion that therapists who embody these attitudes help their clients more (Baldwin, Wampold, & Imel, 2007). In CP, clinician mindfulness serves just that purpose.

Whereas mindfulness research has enjoyed exponential growth in the past two decades (Brown, Creswell, & Ryan, 2015), CP has been integrating mindfulness and Buddhism with psychotherapy for more than 40 years. The first CP degree program was founded in 1976 at Naropa University (then the Naropa Institute) in Boulder, Colorado, USA, and it continues there today (Lief, 2005). In CP, Buddhist views of mind and experience integrate with clinician mindfulness and compassion practices to provide an overarching, synergetic, and transformative context of practice. As such, CP's Buddhist-informed theoretical orientation may have important contributions to make to psychotherapy theory, research, and practice. Although the CP literature includes nine volumes of a journal and several professional books, this is the first review of the field to be published in a peer-reviewed journal.

Although the Naropa University stream of CP is a theoretical orientation in its own right, CP training may enhance therapists' ability to deliver the therapeutic common factors across different modalities. For that reason, I start this article by reviewing the research on the common factors and how clinician mindfulness helps cultivate them. After that, I explain CP's Buddhist theory base, and then I articulate the core theories of CP: brilliant sanity, maitri, and exchange.

Next, I explain the core practices of Naropa CP: clinician mindfulness-awareness, other contemplative practices, and CP interventions. I then propose some future directions for the field, including research and publication, developing new interventions, contemplative social justice, and more communication among various strands of CP. To wrap things up, I summarize that CP has much to offer to the conversation about mindfulness in psychotherapy, including the development of new interventions.

The Therapeutic Common Factors

The common factors model argues that the active ingredients in psychotherapy are factors common to all psychotherapies, rather than specialized ingredients that are unique to specific therapies (Frank & Frank, 1961/1991; Rosenzweig, 1936). This claim repeatedly has found empirical support in meta-analyses of psychotherapy outcome studies (e.g. Smith & Glass, 1977; Wampold, 2007; Wampold et al., 1997). Meta-analytical modeling of therapeutic factors has found that about 30% of the difference in psychotherapy outcomes are attributable to the therapeutic relationship, 15% derives from specific techniques, 15% of change derives from expectancy effects/placebo, and 40% of outcomes are attributable to factors outside of therapy such as client variables and extratherapeutic events (Asay & Lambert, 1999).

As for the approximately 60% of outcome variance that is attributable to therapy, there is robust research indicating that individual therapist factors and the therapeutic relationship are the

strongest predictors of treatment success (Miller, Hubble, Chow, & Seidel, 2013), and further research has investigated subcomponents of these therapist and relationship factors (Norcross, 2011). Because therapist factors and the therapeutic relationship are the strongest intratherapeutic contributors to outcomes, and because different therapy approaches are roughly equivalent in their outcomes (Wampold, 2007), increasing individual clinicians' therapeutic attributes and their ability to establish a beneficial therapeutic relationship should be the focus of psychotherapy research and clinical training. By learning and internalizing therapeutic attitudes, therapists can enhance outcomes across clients and interventions. Several authors, reviewed below, have argued that clinician mindfulness practice serves just this purpose.

Clinician Mindfulness

Mindfulness is the intentional cultivation of nonjudgmental, present-moment awareness through a variety of practices, including sitting meditation (Germer, 2005/2013). Mindful practices cultivate the ability to be present, attuned, curious, and aware, and over time these mindful states can evolve into mindful traits (Shapiro & Carlson, 2009; Siegel, 2010). Mindfulness can be applied in psychotherapy by teaching mindfulness to clients, by extending lessons from mindfulness to the theory and practice of psychotherapy, and by clinicians practicing mindfulness to enhance their clinical work (Germer, Siegel, & Fulton, 2005/2013). This section focuses on this last aspect of clinician mindfulness.

Several authors have examined the impact and integration of clinician mindfulness in professional psychotherapy practice (including Geller & Greenberg, 2012; Germer et al., 2005/2013; Hick & Bien, 2008; Pollak, Pedulla, & Siegel, 2014; and Shapiro & Carlson, 2009). Siegel (2010) argued that clinician mindfulness practice helps therapists cultivate interoception, attunement, self-awareness, and empathy, and gives rise to neurological correlates that are

strengthened with sustained practice. The neurobiological and neuropsychological mechanisms underpinning mindfulness also appear to be deeply related to therapeutic presence and interpersonal attunement (Badenoch, 2008; Geller & Porges, 2014; Siegel, 2010, 2012). These authors suggest that the capacities for mindful attention, social relatedness, and self-regulation are intricately interwoven at the neurophysiological level, and that mindfulness practice leads to lasting changes in the brain. These changes promote flow, choice, integration, connection, empathy, awareness, and freedom—desirable qualities in psychotherapy and in psychotherapists.

To date, only a handful of studies have investigated the influence of clinician mindfulness training on psychotherapy outcomes, and these offer initial support to the argument that clinician mindfulness improves counseling. Lesh (1970) conducted a study of the effects of *zazen* sitting meditation training on a small sample of counseling students (N=39), and found a significant increase in scores on an empathy measure among members of the treatment group. Grepmair et al. (2007) conducted a double-blind randomized controlled trial of 124 inpatients and 18 psychotherapists in training, and found that the 61 patients who worked with the nine therapists who practiced meditation daily during the course of the study gave better ratings to individual therapy and therapy as a whole, and had more improvement in symptoms between intake and discharge. A few qualitative studies have investigated the impact of contemplative practice in promoting beneficial traits and attitudes on counselors in training (McCollum & Gehart, 2010; Schure, Christopher & Christopher, 2008). These studies suggest that mindfulness practice may have a beneficial impact on therapeutic outcomes, and that more research is warranted.

In terms of the common factors, clinician mindfulness practice may function as a key clinical practice by enhancing therapeutic presence (Geller & Greenberg, 2012), which can itself be construed as a common therapeutic factor (Geller, Pos, & Colosimo, 2012). In a similar vein,

Shapiro and Carlson (2009) articulated mindful awareness as a way of being in the therapeutic encounter, and mindfulness practice as a way to cultivate it. Siegel (2010) argued that clinician mindfulness practice can help therapists train in and sustain attitudes of curiosity, openness, acceptance, and love, and integrate multiple brain systems to promote therapeutic presence and attunement. Thus, clinician mindfulness may help develop subcomponents of the common factors, such as attentiveness, openness, receptivity, and empathy (Norcross, 2011).

In a chapter on clinician mindfulness and research on the therapeutic relationship, Lambert and Simon (2008) argued that although many studies have measured improvements in the therapeutic alliance after teaching interpersonal skills such as empathic responding to psychotherapy trainees, the effects are short-lived, because "[interpersonal skills] training appears to increase the ability of novice therapists to be empathic, but not their inclination to use this ability in everyday practice" (p. 26). Rather, what is needed is cultivation of an empathic attitude, which can "[sustain] therapist behaviors of acceptance, understanding, warmth, respect, and the like across time" (p. 27). The authors continued: "In this regard mindfulness training may be an extremely promising addition to clinical training because it may indeed foster attitude change (internalization) toward greater acceptance and positive regard of self and others" (p. 26).

In contemplative psychotherapy, the view is that the therapist's genuine presence, attuned openness, and spontaneous warmth provide the ideal ingredients for a healing relationship (Podvoll, Fortuna, Montgomery, Novick, & Nagarajan, 1980; Trungpa, 1983/2005b; Wegela, 2008, 1996/2011). These qualities are precisely those called for by Rogers (1957) in his seminal formulation of the necessary and sufficient conditions of therapeutic change, and mindfulness practice may support greater therapist empathy, unconditional positive regard, and congruence (being fully and genuinely oneself, at least within the therapeutic encounter). Insomuch as

common therapeutic factors such as empathy, presence, attentiveness, and genuineness are cultivated by clinician mindfulness, the Naropa CP tradition has a wealth of tools to offer therapists and researchers who wish to strengthen their understanding of how to cultivate better therapeutic relationships and thereby deliver better clinical outcomes.

Buddhist Views of Mind and Experience

In addition to its emphasis on clinician mindfulness-awareness (discussed further in a later section), CP embraces Buddhist theories to understand how to reduce suffering. This Buddhist theory base serves as a conceptual framework to guide therapy, and helps to contextualize and deepen clinician mindfulness practice within a specific philosophical view. It also serves as a collection of therapeutic ideas that can be shared with clients as interventions.

CP integrates Buddhist frameworks to guide mindfulness-awareness practice; uproot, remedy, and transform cognitions, feelings, and behaviors that produce suffering; provide a developmental scaffolding for the development of prosocial states and traits; transform the self; and promote experiential integration of present-moment awareness in all of experience. Buddhism has been under development, refinement, innovation, and translation for 2,500 years. It can be viewed as a religion or a philosophy, a psychology or a metaphysics, a pragmatic life path or an esoteric spiritual tradition. Any of these views is accurate, yet incomplete, for Buddhism is all these things. CP emphasizes pragmatic Buddhist frameworks that reduce suffering and promote ethical behavior, gentleness, openness, freedom of choice, and growth.

Because of limitations of space, it is only possible to discuss briefly the Buddhist ideas that are integrated into CP's therapeutic orientation. CP's Buddhist theory base is grounded in the Kagyü and Nyingma schools of Tibetan Buddhism (Wegela, 1994), although it embraces a variety of Buddhist frameworks in an ecumenical manner. Briefly, then, I will sketch some of the

Buddhist frameworks that figure in CP's theoretical orientation.

In CP, the basic theory of pathology is that suffering derives from clinging to a solid and separate sense of self (Trungpa, 1994/2005g; 1973/2005h). In CP, the goal of therapy is not to destroy the self, but to recognize and relax into its fluid, open nature (Luyten, 1985), and thus to discover intrinsic wisdom (Ponlop, 2008). The three marks of existence— suffering, impermanence, and nonself— are a Buddhist articulation of immutable qualities of experience. As human beings, we suffer, and this just seems to be the way things are. Everything we see, have, or experience will one day dissolve, and no compound phenomenon lasts. Finally, what we take to be a self is not a solid and truly existing thing, but just a flow of experience that is born, matures, and eventually dies. These three marks are features of reality that we can choose to accept gracefully, or struggle against and thereby create more suffering for ourselves. In CP, each encounter with these three aspects of experience provides an opportunity to either turn toward openness, or to deepen our struggle with the way things are (Wegela & Joseph, 1992). This existential choice is the pivot between suffering and freedom from suffering (de Wit, 2008).

The four noble truths articulate the basic Buddhist logic of how to work with experience. The first of these truths is the reality of suffering, that suffering happens and is pervasive. The second truth is that suffering has its origin in the sense of separate and permanent self, which we attempt to protect and cherish at all costs, despite it not being a solid thing at all. The third truth is the possibility of an end to this suffering. The fourth truth teaches the path to end suffering in the form of the eightfold path of right meditation, right mindfulness, right intention, right view, right speech, right conduct, right livelihood, and right effort (Thrangu, 2003b), as well as all the rest of Buddhist practice. A major emphasis in Buddhism and CP is cultivating beneficial traits and activities, and abstaining from behaviors and thought patterns that lead to more confusion

and suffering (Hạnh, 1990).

CP and Buddhism articulate a collection of experiential-phenomenological models that analyze psychological functioning and its contribution to suffering, known as the *abhidharma*. The five *skandhas* or heaps are five layers of experiential processes that give rise to a confused sense of self, and these can be seen through in the process of meditation (Hạnh, 1990; Trunpga, 1973/2005h). Having cultivated steadiness and clarity through mindfulness practice, the therapist-meditator can bring awareness to bear on these processes and gain insight into their functioning, thus loosening habitual patterns, promoting choice, and clarifying distorted views.

Buddhism includes theories and practices to promote prosocial activities as a component of the path of awakening, and CP incorporates these to help cultivate therapeutic traits and attitudes such as compassion, gentleness, and kindness. The six *paramitas* or transcendent actions serve as a guide for cultivating wisdom and compassion through generosity, discipline, patience, exertion, meditation, and wisdom (Ray, 2000). Wegela (2009) explored the six paramitas as the path of the *bodhisattva* or awakening being and the practice of psychotherapy. The four *bramaviharas* or immeasurable qualities of loving-kindness, compassion, sympathetic joy, and equanimity are prosocial attitudes that can be cultivated through contemplative practice (Wallace, 2010; Wegela, 2009). Compassion practices are viewed as a powerful way to loosen self-clinging and open to the nature of reality (Ponlop, 2008), and are discussed in a later section.

Finally, an important component of CP's Tibetan Buddhist heritage is the Vajrayana view of intrinsic wakefulness as existing even within the most painful and confused states of mind (Ponlop, 2008). The Five Buddha Families are a view of the basic wisdom of the world and of emotions (Thrangu, 2011; Trungpa, 1981/2005i; Wegela, 1994), and they constitute a CP theory of personality, in different modes of wakefulness and confusion. The view of nondual

realization, in the Tibetan traditions of *mahamudra* (great seal) and *Dzogchen* (great perfection), serve as the theoretical and practical basis for going further along the path of brilliant sanity (Ponlop, 2008; Thrangu, 2003a, 2011; Traleg, 2003). Because they have thoroughly explored their own mind and developed the confidence that all states of mind and all situations are workable, the contemplative psychotherapist is able to help clients approach their own experience with curiosity, courage, and compassion. Again, because of space limitations, this is but a brief discussion of the Buddhist components of CP's theoretical orientation.

Core Theories of Contemplative Psychotherapy

Like many schools of therapy, Naropa CP embraces the broader literature on psychotherapy theory and practice. These include humanistic, existential, behavioral, cognitive, psychodynamic, intersubjective, transpersonal, and integrative psychotherapy. In addition to its Buddhist theory base, CP holds three core theoretical commitments, discussed below. The core theoretical commitments of CP are brilliant sanity, exchange, and maitri (explained below). These theories mutually inform and deepen each other. They also serve to deepen, orient, and actualize clinician mindfulness in the therapeutic encounter.

Brilliant Sanity

The core theoretical perspective of CP is *brilliant sanity* (Podvoll et al., 1980; Ponlop, 2008), the view that all beings are fundamentally sane and awake, and wisdom underlies and precedes all suffering and confusion. This is synonymous with the view of *basic goodness* (Trungpa, 1984/2005c), in which intrinsic wakefulness and dignity are the primordial nature of human experience and the basis for enlightened society. It is also termed *intrinsic health* (Trungpa, 1979/2005d; Wegela, 1988; Wegela & Joseph, 1992) or *buddha nature* (Ponlop, 2008), and it is characterized by openness, clarity, and warmth (Wegela, 1996/2011). Brilliant

sanity is the CP term for the innate wholesomeness, fundamental workability, and indestructible awareness that is said to pervade the mind of sentient beings and all of reality and experience (Ponlop, 2008). This view has profound implications for psychotherapy, health, and mindfulness-awareness practice.

The commitment to brilliant sanity as the ground, path, and fruition of therapeutic work is a unique characteristic of contemplative psychotherapy. The main practice of CP is to recognize and return to brilliant sanity in all its guises (Wegela, 1996/2011) through mind-body synchronization (Trungpa, 1984/2005c). This can be accomplished through a variety of contemplative disciplines, but the principal training for contemplative psychotherapists is sitting meditation practice (Wegela, 1996/2011).

The perspective of brilliant sanity plays out in therapeutic work by helping clients recognize their intrinsic sanity as it arises in the moment and in their lives (Wegela, 1994). Because the contemplative psychotherapist has trained in recognizing and resting in their own brilliant sanity, they can identify it in others, and thus can help clients recognize and rest in natural wakefulness (Wegela, 1996/2011). By holding the view that their clients are brilliantly sane and basically awake, therapists can help clients "shift their allegiance towards the history of sanity" (Podvoll, 1983/2002, p. 135) and thus take sanity, rather than their confusion, as their point of reference. Building from this foundation, a different logic of life becomes possible—one characterized by increasing trust, flow, curiosity, and appreciation, rather than fragmentation, conceptualization, distraction, and alienation from self and experience.

The view of brilliant sanity is a powerful antidote to notions of chronic pathology and innate neurochemical imbalance, and promotes a narrative of healing, resilience, and growth. It also serves as a guidepost for therapists to extend unconditional positive regard toward clients

and their own experience, and thus to develop more congruence in therapy and in their lives (Rogers, 1957). Based on developing a sturdy connection with brilliant sanity, therapists can bring attuned empathic attention, unconditional open awareness, and their experiential conviction in intrinsic health into the therapeutic relationship. Based on that, therapists gain confidence to open fearlessly to the flow of intersubjective information that arises in the therapeutic encounter.

Exchange

Another fundamental perspective in CP is exchange, which is based in the understanding that humans are interdependent, nonsolid, and deeply connected (Silverberg, 2008; Wegela, 2008). We subtly influence each other in nonverbal ways, and this phenomenon can be used to advantage in psychotherapy. Exchange is similar to other notions, such as resonance (Larson, 1987; Shaw, 2004; Watson & Greenberg, 2009), embodied empathy (Dekeyser, Elliott, & Leijssen, 2009), and resonance and attunement (Siegel, 2010).

A neuropsychological perspective on exchange comes from interpersonal neurobiology (IPNB; Siegel, 2010, 2012), which integrates mindfulness, attachment theory, and neuropsychology in its articulation of the neurobiological substrates of interdependent social nervous systems. In this view, empathic attunement, limbic resonance, and neural integration through mindfulness-awareness (or *mindsight*; Siegel, 2010) allow the therapist to be open to, aware of, and in touch with mutual dyadic regulation and empathic resonance, including implicit limbic arousal states of which the client may not be consciously aware. By cultivating mindsight, the therapist opens the door to experiencing themselves and the client fully, without rejecting or suppressing any aspect of the mutual dyadic experience (Siegel, 2010).

Exchange is the CP term for the phenomenon of mutual experiential resonance. Interpersonal connection allows for all kinds of information to be transmitted, including subtle

nonverbal emotional content. By bringing mindfulness, awareness, and compassion to the therapeutic encounter, contemplative psychotherapists practice opening to the exchange, and find ways to use the information thus gained to help clients. By cultivating openness and unconditional acceptance (or maitri*,* discussed in the next section) toward a variety of mental, affective, and existential states, the contemplative psychotherapist uses their mindfulness practice to offer their nervous system as an attuned reference point for mutual dyadic regulation. Based on the information gained in the exchange, the therapist can make informed interventions, including reflecting feeling, radiating genuineness (Trungpa, 1983/2005b), and the intervention of simply being with the client with an attitude of openness and warmth (Wegela, 1988). The therapist's own mindfulness practice is crucial in supporting an attitude of openness, warmth, and clarity toward the experience that comes through in the exchange.

For example, if the client is angry but does not put words to it, or does not even express it through overt cues, the sensitized therapist may be able to interpret their own in-the-moment experience of anger as possibly being subtly communicated by the client. The therapist could choose to use this information therapeutically, or simply practice self-awareness and self-regulation skills in order to extend their social nervous system's regulated state to the client's system. Similarly, the therapist's stance towards the client can also be subtly transmitted through the exchange. For example, by having confidence in the client's brilliant sanity and radiating an attitude of compassion and warmth, the therapist can nonverbally communicate this attitude to the client as a therapeutic intervention (Trungpa, 1983/2005b; Wegela, 2008).

In using exchange therapeutically, it is important for the therapist to distinguish it from other interpersonal phenomena that arise in therapy, such as transference, objective and subjective countertransference, and projective identification (Geltner, 2006; Gorkin, 1987;

Searles, 1979). This requires the therapist's thorough self-knowledge and self-acceptance, so as to identify and work with subjective countertransference (where the therapist's experience of the client is colored by the therapist's biographical/emotional history) and objective countertransference (in which the client provokes a similar experience in many people). Projective identification, in which the client projects disowned parts and emotions onto and into the therapist, can elicit intense feelings in the clinician, and, if wielded skillfully, can be used to therapeutic advantage (Auerbach & Blatt, 2001; Waska, 1999). However, none of these phenomena are exchange, and it is important that therapists gain a deep understanding of their own emotional and experiential make-up in order to discern the various emotional and intersubjective clinical indicators that can arise in the therapeutic relationship. It is also necessary to recognize that although the therapist's emotions can be a valuable source of information, any interpretations the therapist comes to from them should be held lightly.

A further safeguard from the CP perspective is the therapist's own connection to brilliant sanity, as cultivated in mindfulness-awareness practice. By returning to the experience of brilliant sanity again and again during the therapy session, the therapist uses it as a touchstone, and is able subtly to communicate their connection with intrinsic health to the client. Thus, clinician mindfulness itself can be used as a therapeutic intervention: the practice of sitting meditation helps the therapist to be unconditionally present with themselves, with the client, and with what unfolds during the session, and this may have a subtle impact on the client's awareness and experience (Wegela, 1988).

From an IPNB perspective, Siegel (2010) argued that the mindful therapist gains the capacity to foster greater mind-brain-body integration within clients via implicit communication (Siegel, 2010). In IPNB, within the subtle process of mutual dyadic regulation that takes place

during the therapeutic encounter, the therapist helps clients practice interoception, disembed from implicit trance states, and integrate the variety of affective, behavioral, mental, and experiential states that can arise (Siegel, 2010). This integration has the potential to extend to all the senses, implicit and explicit memory, bihemispheric integration, and all the possible contents of awareness, including mutual dyadic regulation (Siegel, 2010).

These interpersonal processes are core concerns of contemplative psychotherapy. Based on working with their own mind in mindfulness-awareness practice, clinicians can open to the exchange and use it therapeutically with clients. The capacity to welcome clients, with all their relational, conceptual, and affective complexity, is supported in CP by the development of kindness, gentleness, and unconditional acceptance. Based on developing these qualities internally towards their own experience through contemplative practice, the contemplative psychotherapist turns them outwards to bring warmth and positive regard to their clients.

Maitri

Maitri is a Sanskrit word meaning loving-kindness (Wegela, 2014). In contemplative psychotherapy, maitri means a sense of unconditional friendliness toward oneself, one's clients, and one's experience altogether (Trungpa, 1983/2005b; Wegela, 1996/2011, 2014). Such an attitude creates an environment of hospitality in which genuinely therapeutic interactions can take place and clients can connect with their own dignity (Trungpa, 1983/2005b).

Many other authors have investigated the value of creating an environment of gentleness, warmth and acceptance; just a few are mentioned here. Dan Siegel's (2010) mindful therapist cultivates the COAL qualities of curiosity, openness, acceptance, and love, toward themselves and toward their clients. In intersubjective psychodynamic terms, therapists can cultivate a combination of contact, allowing, and accommodation that provides a moment-to-moment

holding environment (Winnicott, 1965/2018) in which clients can experience relatedness without engulfment or abandonment. Attachment-informed interventions such as IPNB (Siegel, 2010) and sensorimotor psychotherapy (Ogden, Minton, & Pain, 2006) use the therapist's present-centered, open, loving awareness to modulate implicit limbic communications around contact, spaciousness, relatedness, and holding, and help foster earned secure attachment states and improved autoregulatory capacities in the client. In person-centered terms (Rogers, 1957, 1951/2015), unconditional positive regard is synonymous with client-directed maitri, and to the degree that therapists cultivate maitri towards their own experience, they increase their congruence and genuineness within the therapeutic relationship.

Sitting meditation cultivates openness and acceptance, and the touch and go technique in sitting meditation (Trungpa, 1991/2005j) is a powerful way to train in the unconditional warmth and acceptance of maitri. This technique has been extended into a form of clinician mindfulness practice during psychotherapy sessions (Wegela, 1988). This approach may promote clinician resilience, openness, and flow in session by training therapists to touch into their experience of the client, and then let go into the spaciousness of the present moment, again and again.

CP includes other meditation techniques that cultivate unconditional warmth and acceptance and support therapists in accessing and embodying compassionate attitudes, such as *tonglen* (Tibetan: taking and sending; Chödrön, 2001; Wegela, 2014) and the *four immeasurables* of loving-kindness, compassion, sympathetic joy, and equanimity (Wegela, 2009; also see Bien, 2008; Wallace, 2010). These are discussed below in the section on other contemplative practices. In addition to therapists radiating genuineness and acceptance toward clients (Trungpa, 1983/2005b), clinicians can help clients cultivate maitri toward their own experience, thus cutting through struggle and self-aggression, and promoting kindness,

acceptance, and self-compassion. These CP attitudes and capacities are echoed in other applications of mindfulness in psychotherapy, such as self-compassion (Neff & Germer, 2013), empathy (Shapiro & Izett, 2008), and acceptance (Brach, 2003; Linehan, 1993).

Maitri can be understood as a possible common therapeutic factor, and it may have multiple effects. Maitri likely improves the therapeutic relationship, and it may mobilize and enhance client strengths such as self-compassion, acceptance, and resilience. It could be conceived of as a therapist factor, and there is some overlap between maitri and therapeutic presence (Geller & Greenberg, 2012) and other relationship factors such as empathy (Norcross, 2011). The core practices of CP, described below, cultivate these core perspectives and integrate them into clinical practice.

Core Practices of Contemplative Psychotherapy

In CP, various practices serve to deepen and contextualize the theories, so that they become experientially integrated and are thus made available to guide clinical practice. As clinicians use these practices to cultivate states of connection with brilliant sanity, maitri, and openness to the exchange, these states become therapeutic traits. Core CP practices include mindfulness-awareness practice, other contemplative practices, and CP interventions.

Mindfulness-Awareness Practice

The core practice of CP is mindfulness-awareness, traditionally cultivated in sitting meditation (Trungpa, 1991/2005j; Wegela, 2014). While the benefits of clinician mindfulness have been explored in the literature on mindfulness in psychotherapy (e.g. Germer et al., 2005/2013; Hick & Bien, 2008; Shapiro & Carlson, 2009; Siegel, 2010), CP emphasizes a particular approach to mindfulness practice. This warrants some clarification.

In contemporary Western psychology, the term “mindfulness” has been applied to a

variety of different practices, states, traits, and dimensions of contemplative practice experiences (Dorjee, 2010). In CP and in this paper, the terms *mindfulness-awareness* and *shamatha-vipashyana* refer both to a specific approach to sitting meditation practice and to the mental capacities thus developed. *Shamatha* is a Sanskrit word can be translated as "dwelling in peace" or "calm abiding," and *vipashyana* means "superior vision" or "insight" (Trungpa, 1984/2005c, 1984/2005f). These practices are two important aspects of sitting meditation in the Buddhist tradition, and united they form the foundational meditative training of the contemplative psychotherapist (Wegela, 1988, 2014).

Western psychology has articulated multiple possible mechanisms of action of mindfulness, including attention regulation, body awareness, emotion regulation, and change in perspective on the self (Hölzel et al., 2011); reperceiving, continuation of developmental processes, self-regulation, values clarification, cognitive/emotional/behavioral flexibility, and exposure (Shapiro, Carlson, Astin, & Freedman, 2006); cognitive change, self-management, relaxation, and acceptance (Baer, 2003); neural integration (Siegel, 2010); and deconstructing and reconstructing the self (Dahl, Lutz, & Davidson, 2015). These postulated mechanisms of action are functional operationalizations of Buddhist descriptions of the meditative path. Although they do not describe all the ways that mindfulness-awareness practice transforms experience, these operationalizations convey meaningful aspects of how mindfulness practice can reduce psychological suffering.

From CP's Buddhist perspective, mindfulness-awareness practice can stabilize the mind and clarify, deconstruct, and transform cognitive distortion, dualistic clinging, emotional upset, and habitual patterns (Trungpa, 2013), and cultivate the nondual experience of the nature of mind (Ponlop, 2008). In this view, sitting meditation practice helps meditation practitioners, as well as

psychotherapists with a meditation practice, become less self-centered, more flexible, more attuned to themselves and others in the present moment, and less emotionally and conceptually reactive. The shamatha aspect of sitting meditation pacifies the mind and emotions, and the vipashyana aspect brings insight into the nature of the mind and experience.

Mindfulness-awareness practice in CP can also be understood as a way to synchronize body and mind and develop one's genuineness and self-awareness (Trungpa, 1984/2005c). This practice serves to clarify the nature of mind processes (Podvoll et al., 1980), cultivate greater kindness and acceptance toward experience (Trungpa, 1980/2005a, 1983/2005b), and foster a stronger connection with brilliant sanity (Wegela, 1994). Based on these strengths, contemplative psychotherapists can help clients foster these qualities in their own experience, through modeling, attunement, relatedness, working with the exchange, and teaching clients mindfulness-awareness practices (Trungpa, 1980/2005a, 1983/2005b).

Mindfulness-awareness in CP goes beyond cultivating helpful attitudes and capacities, as sitting meditation includes basic pacifying and clarifying of the mind all the way up to the pinnacle nondual practice of *mahamudra* (Sanskrit: "great seal"), in which shamatha and vipashyana also play an integral part (Thrangu, 2003a; Traleg, 2003). In this way, mindfulness-awareness practice in CP is not merely a set of tools for calming and clarifying the mind and increasing interpersonal sensitivity and empathy, but it also provides a vehicle for transforming one's relationship to oneself and the whole of existence. In terms of direct application to doing therapy, CP extends clinician mindfulness-awareness by using the "touch and go" technique of sitting meditation (Trungpa, 1991/2005j) to attend to the therapist's present-moment experience of the client (Wegela, 1988). In this way, being with clients itself becomes an embodied and relational contemplative practice. Whereas sitting meditation is often a solitary activity in which

the body and speech are stilled, in the therapeutic context, present-moment awareness becomes the anchor for engaging with clients within a spacious, grounded, responsive state of being.

The capacity to rest the mind in an open, accepting, and attuned way is a fundamental skill for psychotherapy. Rather than being lost in thought, mindfulness-awareness helps therapists attune with clients in the present moment and convey genuine empathy. Sitting meditation also forms the experiential basis for engaging in other contemplative practices in CP.

Other Contemplative Practices

CP includes additional practices for therapists, such as contemplations on the four immeasurables, tonglen, Maitri Space Awareness (MSA), and a contemplative group supervision approach. Because of space limitations, these topics will be discussed only briefly below. In addition to these practices, CP embraces other contemplative practices, including walking meditation, yoga, chi gong, nature hikes, and any practice that synchronizes body and mind.

The four immeasurables or brahmaviharas are the prosocial attitudes of loving-kindness, compassion, sympathetic joy, and equanimity (Wallace, 2010; Wegela, 2009). Loving-kindness is the wish that others be happy, compassion is the wish that they be free of suffering, sympathetic joy is to rejoice in others' happiness, and equanimity is to apply these attitudes to all beings without bias or reservation (Ray, 2000). These attitudes can be fostered through specific meditation practices that focus on thinking of the welfare of others, and generating a prosocial feeling state that can, over time, become a trait— that is, an embodied therapeutic attitude. Intentional compassion practice has been found to reduce empathic distress, increase positive emotions, and produce statistically significant changes in brain activity (Singer & Klimecki, 2014).

Tonglen (Tibetan: sending and taking) is a contemplative practice that entails visualizing

breathing in the suffering of others, and breathing out one's strength, health, and happiness (Chödrön, 2001; Trungpa, 1993). This practice is reputed to reverse self-centeredness and foster gentleness and compassion. In CP, it is used to increase sensitivity to the exchange and to help therapists cultivate an attitude of compassionate attention to the client's well-being.

MSA entails taking special postures in five different colored rooms, and is meant to evoke the confused and wakeful qualities of five different emotional states, in order to strengthen the practitioner's recognition that brilliant sanity is the basic nature of all emotions. Naropa CP trainees attend multiple meditation retreats where they undertake this practice. Space limitations prevent a full presentation of MSA here, and interested readers are referred to other authors (e.g. Casper, 1974; Evans, Shenpen, & Townsend, 2008; Lief, 2005; Trungpa, 2005e).

The body-speech-mind supervision group is a unique contemplative practice developed in Naropa CP (Walker, 1987/2008; Wegela, 1996/2011, 2014). In these groups, therapists use mindfulness-awareness and clinical description to provide an experience-near case presentation of clients and the therapist's relationship with them, in a sensitive, spacious, and reflective atmosphere. Clinician mindfulness, openness to present-moment experience, willingness to experience the exchange, and tolerance of ambiguity may be beneficial therapist capacities, and body-speech-mind groups offer a context for practicing these skills among peers.

The goal of contemplative practice in CP is to help the therapist connect with all of these: the therapist's experience and their own brilliant sanity; the client, their experience, and their brilliant sanity; and whatever is happening in the exchange. Because contemplative psychotherapists use these practices to develop awareness, stability of mind, maitri, a strong connection with brilliant sanity, and openness to the exchange, they are well suited to working with clients in a variety of states of mind. The next set of practices are therapeutic interventions,

which are informed by the other CP theories and practices.

Interventions in CP

In general, CP views specific techniques as being of minor importance. Rather, brilliant sanity, maitri, exchange, and the clinician's contemplative practice lay the groundwork for improvising interventions adapted to each client. In a sense, CP interventions arise from being fully human in the moment and providing what the client needs:

> In one sense there are few Contemplative Psychotherapy techniques. We are encouraged to be present in the moment and to make use of our richness, our creativity and our resources. As in many psychotherapeutic traditions, we each find our own style.… While we may draw upon many different psychotherapeutic techniques, some general principles have developed in working with clients to uncover brilliant sanity and to cultivate mindfulness and maitri. (Wegela, 1994, p. 45)

Despite Wegela's (1994) ambivalence about specific technical interventions, I will articulate a few techniques drawn from the CP literature, including the "general principles" she mentions (p. 45). As discussed earlier in this paper, the core intervention of CP is to help clients turn toward, recognize, align with, and cultivate a connection to their brilliant sanity (Wegela, 1996/2011). This intervention can take place throughout therapy. The clinician can emphasize the client's history of sanity (Podvoll, 1983/2002) throughout the therapy, from initial intake to the final session. By aligning with and supporting clients' natural impulses toward health, therapists can help clients set aside unhelpful habits, go beyond a limited sense of self, and move toward discipline, compassion, clarity, and courage (Podvoll, 1983/2002).

Rather than analyzing a client's problems, CP emphasizes helping clients cultivate healthy behaviors (Hạnh, 1990; Trungpa, 1983/2005b). These behaviors include physical,

emotional, and cognitive patterns. In addition to cultivating habits that support health and body-mind synchronization, CP is eager to use clients' existing life activities as an opportunity to cultivate mindfulness and awareness. Wegela (1994) discussed helping a client extend the mindfulness they experienced in rock climbing into the rest of their life, thereby decreasing discursive thinking and promoting body-mind synchronization. Other everyday examples include shopping, exercise, sports, applying makeup, cooking, and dressing— anything that clients can use to come into their bodies and notice what is happening right now (Wegela, 1994).

Another category of intervention involves transforming "mindless practices" into mindfulness practices (Wegela, 1994, p. 47). Many clients have unconscious automatic behaviors, including smoking, fidgeting, thumb twiddling, hair twirling, nail-biting, TV watching, drinking, compulsive phone checking, and so forth— "anything that splits our attention is potentially a mindless practice" (Wegela, 1994, p. 47). The technique here is to encourage the client to get interested in the behavior, and then notice all the aspects of their experience— What is happening in their body while they engage in that behavior? In their emotions? In their thoughts? What does it do for them? How does paying attention change the experience? Usually these mindless practices are skills that clients unconsciously use to cope and self-soothe. The goal of the intervention is not necessarily to stop the behaviors, but rather to transform them into opportunities to cultivate mindfulness and awareness.

CP also supports a number of relational interventions, which boil down to being a genuine human being. By "providing a gentle, nonaggressive, warm environment [and] feeling a fundamental connection to others," the contemplative psychotherapist creates a setting of basic hospitality and warmth (Trungpa, 1983/2005b, p. 148). In Trungpa's (1983/2005b) view, this entails the therapist telling clients the truth, genuinely liking them, and being honest and

straightforward. In general, CP views any intervention that distances, pathologizes, and attempts to fix the client as countertherapeutic. Rather, CP emphasizes the development of an authentic human relationship between client and therapist as the bedrock of therapy.

The ability to forge such a basic human connection derives in part from the CP training in mindfulness-awareness and kindness toward oneself. By cultivating maitri toward themselves and their own experience, the contemplative psychotherapist gains the capacity to be "fully human and inspire full human being-ness in other people who feel starved about their lives" (Trungpa, 1980/2005a, p. 137). This attitude informs all the subsequent work of therapy, and bolsters the relationship and therapist factors. Trungpa argued:

> The approach to working with others that I would like to advocate is one in which spontaneity and humanness are extended to others, so that we can open to others and not compartmentalize our understanding of them. This means working first of all with our natural capacity for warmth. To begin with, we can develop warmth toward ourselves, which then expands to others. This provides the ground for relating with disturbed people, with one another, and with ourselves, all within the same framework. This approach does not rely so much on a theoretical or conceptual perspective, but it relies on how we personally experience our own existence. Our lives can be felt fully and thoroughly so that we appreciate that we are genuine and truly wakeful human beings. (Trungpa, 1980/2005a, p. 138)

In the CP approach to unconditional friendliness, the therapist embodies and radiates wholesomeness, compassion, gentleness, and genuineness, both in their person and in the physical and emotional environment of therapy (Trungpa, 1980/2005a). This derives chiefly from contemplative practice. In a sense, an attitude of maitri is the fundamental skill of CP.

CP also supports specific interventions for working with emotions. On the basis of understanding the emotions and styles of the Five Buddha Families, therapists can help clients recognize the sanity inherent in their emotions, and relax self-clinging so that their wisdom can emerge. The therapist's prior practice of sitting meditation, MSA, and other contemplative practices provide a crucial foundation for helping clients cultivate acceptance and understanding of their feelings. By treating emotions not as problems to be solved, but rather the intelligence of the body-mind manifesting as life energy, CP helps clients cultivate a sense of respect and appreciation toward their emotions, and the confidence that every state of mind is workable.

Other interventions derive from Buddhist frameworks, including the six paramitas (Wegela, 2009), the three marks of existence (Wegela & Joseph, 1992), impermanence (Podvoll, 1991/2003), the Five Buddha Families (Wegela, 2014), the six realms of existence (Podvoll, 1991/2003), and the mandala principle (Wegela, 2014). Another notable CP intervention is basic attendance, a set of practices developed in the Windhorse home recovery model (briefly discussed below) to promote unconditional friendliness while accompanying individuals who experience extreme states (Podvoll, 1991/2003). Because of limitations of space, these interventions can only be mentioned here. In addition to the techniques discussed in the CP literature, others can be improvised for different contexts by integrating client preferences, therapist training, clinical judgment, and the common factors.

Future Directions

As a field, CP has a robust theoretical orientation and a unique training model. While no empirical data are available on its therapeutic outcomes as a model of psychotherapy, based on the accumulated research evidence supporting the *dodo bird conjecture* that all psychotherapies are roughly equally effective (Asay & Lambert, 1999; Rosenzweig, 1936; Smith & Glass, 1977;

Wampold, 2007; Wampold et al., 1997), it seems reasonable to anticipate that CP, in terms of its specific ingredients, should be about as effective as other bona fide psychotherapies. This supposition remains to be investigated through outcome research, and providing evidence for CP's efficacy is an important direction for the field. Moreover, CP may have a special contribution to make in promoting the common factors and helping clinicians train in therapeutic attitudes, including empathy, presence, and warmth. To that end, empirical studies should be conducted to answer these questions: Does clinician mindfulness training help people become better therapists? Does clinician mindfulness training supported by CP theory improve therapeutic outcomes? Does CP outperform other types of clinician mindfulness training? Future studies should use client-rated measures of outcome and alliance as the principal criteria in investigating these questions.

A needful future direction for CP is the development of more literature and training programs. To date, the major descendants of Naropa CP are a 2-year certificate program (Karuna Training, 2019) and the Windhorse approach to recovery from severe mental disturbance (Fortuna, 1987, 1994; Knapp, 2008; Podvoll, 1991/2003; Windhorse Guild, 2019). Apart these two strands, nine books, a few dozen journal articles, and a few hundred graduates of Naropa's CP program, little exists in the way of applications of Naropa CP. Given the richness of CP's theoretical orientation and its unique integration of clinician mindfulness into therapist training, further dissemination is needed. A first step in that direction is to get CP literature on the map by articulating existing models in peer-reviewed journals. Future publications should address topics that are outside the scope of this article, including a more extensive consideration of Buddhist views of mind and reality, advanced contemplative practices, assessment approaches, group training, CP pedagogy, and the Windhorse approach.

Another significant future direction for Naropa CP is the development of new mindfulness-based interventions (MBIs) that integrate mindfulness, Western psychology, and Buddhist ideas. Insomuch as Buddhism is a set of ideas and practices designed to relieve suffering, its psychological, phenomenological, and philosophical frameworks have great potential for helping clients find lasting happiness. New MBIs could incorporate adaptive explanations for experience (Wampold 2001, 2007) drawn from CP's Buddhist theory base. Brito (2014) argued that mindfulness practices embedded within a contextualized set of Buddhist attitudes and views have the potential for transforming consciousness, experience, and psychotherapy in a way that surpasses the Westernized mindfulness goals of stress reduction and self-care. On the other hand, Buddhist meditation practice in the Western context often fails to address significant psychological problems among meditators (e.g. Aronson, 2004; Engler, 1986; Treleaven, 2018). CP has the potential to create new MBIs that teach mindfulness practices to clients in a contemplative framework that integrates Buddhist and Western theories of healing and transformation, hopefully bringing out the best of both traditions, and providing a rich store of practices and ideas to help clients find healing and peace. In sum, the time is ripe for new MBIs based in CP.

Another growth area for CP is the elaboration of contemplative approaches to social justice and multiculturalism. Because of its non-pathologizing views of brilliant sanity and maitri, CP may benefit clients who have experienced therapeutic violence in other clinical contexts, including members of oppressed groups generally. However, like much of the rest of psychotherapy, CP remains primarily a white, privileged, and cisheteronormative discipline. To the degree that social conditions, systemic and structural oppression, minority stress, and internalized oppression contribute to client distress, CP frameworks as presently elaborated will

not provide adequate relief, because they do not provoke consciousness-raising around social justice concerns. In terms of reducing clinicians' risk of enacting social injustice, because bias and oppression arise in social contexts and are largely implicit, unconscious, and automatic (Greenwald & Banaji, 1995), merely didactic approaches to multiculturalism and antioppression fail to address the problem, as they do not provide the opportunity to learn new attitudes and behaviors that can be encoded in procedural memory. Thus, a needful future direction for CP is the experiential integration of critical and antioppression strategies into clinical training and practice. This could include contemplative approaches to social justice and antioppression pedagogy (e.g. Berila, 2019; King, 2018; Williams, Owens, & Syedullah, 2016) and training in antioppression skills and perspectives (Nieto et al., 2014).

A final promising move is further communication and collaboration among CP's different strands. CP is not unique to Naropa, and other approaches have also made significant contributions (e.g., De Silva, 2014; Karuna Institute, 2019; Loizzo, Neale, & Wolf, 2017; Nalanda Institute for Contemplative Science, 2019). A *big tent* vision of CP, supported here, would foster interaction, integration, and crosspollination. This could enrich and renew the Naropa CP tradition, and spread its theories and practices to a wider audience.

Summary

In sum, CP is a rich field at the intersection of psychotherapy, Buddhism, and mindfulness, with much to contribute to the wider field of psychotherapy. Based on a thorough self-understanding borne of mindfulness-awareness practice, clinical training, and coursework that integrates Buddhist views and psychological theory with lived experience, contemplative psychotherapists develop familiarity with their own brilliant sanity, and gain confidence in the intrinsic health of their clients. Because contemplative psychotherapists have developed maitri,

they can attune fearlessly to the mutual dyadic resonance of the exchange, and extend unconditional friendliness to themselves and their clients, in all their wisdom and confusion. CP is a theoretical orientation, a promising field for research on clinician mindfulness, and a corpus of teachings and practices for developing new MBIs. May this article serve to disseminate CP, promote healing and harmony, and dispel the suffering of beings.

Conflict of Interest: The author holds a master's degree in Contemplative Psychotherapy and conducts a psychotherapy practice based on the theoretical orientation discussed here,
The manuscript does not contain clinical studies or patient data.

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