
Relaxation Therapy and Mindfulness Meditation One-Day Workshop for Nephrology Social Workers: Exploring the Impact of This Training on Professional Practice

PART ONE

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Relaxation therapy techniques and mindfulness meditation are clinical intervention tools that have demonstrated benefits associated with the reduction of negative psychological states and the enhancement of positive states of mind critical to the alleviation of physical and emotional distress (Jain et al., 2007). Many mind-body therapeutic training workshops are offered in a one-day format; however, there is a gap in the literature examining the direct impact of learning relaxation therapy and mindfulness meditation specific to nephrology social work practitioners, and how, if at all, learning these techniques might assist a practitioner in his/her work. A study was undertaken to examine the influence of a one-day relaxation therapy and mindfulness meditation educational workshop on nephrology social workers' professional practice. Eight members of the Canadian Association of Nephrology Social Workers with limited previous exposure to mind-body therapeutic approaches participated in this project. Telephone and Skype participant interviews occurred following the workshop on three separate occasions over a period of four months. The key findings from this study suggest that 1) the workshop had an impact on professional practice, 2) the workshop had an impact on self-care, and 3) amid obstacles to implementation, nephrology social workers expressed their desire to expand their current scope of practice to include relaxation therapy techniques and mindfulness meditation with their clients.

INTRODUCTION

The term “kidney disease” encompasses a variety of diseases and disorders that affect the kidneys, usually starting slowly and progressing over a number of years. Chronic kidney Disease (CKD) is defined by the Kidney Foundation of Canada as “the presence of kidney damage, or a decreased level of kidney function, for a period of three months or more” and often requires psychosocial intervention in addition to medical care (2013). The effects of kidney failure and dialysis treatment are experienced amongst patients, family members, caregivers, and nephrology staff. Dialysis treatment is unique, because patients and families spend countless hours together with staff over several times a week for many years. It is easy to understand how the frequency of treatments, dependence on staff, and the close nature of the treatment impact the entire circle of care.

End-stage renal disease (ESRD) requires ongoing dialysis treatment or kidney transplant in order to sustain life. Hemodialysis, one treatment option, typically occurs thrice-weekly in an outpatient dialysis clinic setting or hospital and is designed to remove excess fluid and filter the blood of toxins because the patients' kidneys can no longer perform these functions. Dialysis patients require this treatment for the duration of their lives, unless they are candidates for kidney transplant. All members of the circle of care struggle with the manifestations, conflicts, and suffering that this illness evokes.

Working with ESRD patients can be difficult. Nephrology social workers are frequently exposed to patients who are frightened, suffering, and dying, and are therefore vulnerable to cumulative distress. “This accumulation of work related distress facilitates a quest for healthcare workers to

examine a deeper meaning of pain and suffering in their lives as well as in others, and repeated traumatization makes us vulnerable to burnout and vicarious trauma” (Schure, Christopher, & Christopher, 2008, p. 47). This unrelenting stress has negative ramifications for healthcare professionals, often illustrated with increased incidence of depression, decreased job satisfaction, disrupted personal relationships, psychological distress, and self-harm (Shapiro, Astin, Bishop, & Cordova, 2005). Stress negatively affects the healthcare professional's ability to concentrate. Stress also hampers sound decision making and deters healthy professional collegial relationships. Unmanaged stress disrupts patient/staff therapeutic relationships because healthcare professionals may become devoid of empathy, awareness, objectivity, and compassion (Shapiro et al., 2005). Segal et al. (2010) suggested that this constant influx of stress on healthcare professionals often contributes to burnout, exhibited by decreased attention, reduced concentration, compromised decision-making skills, and suboptimal relationships with patients.

This study examines how, if at all, learning mindfulness and relaxation therapy techniques in a one-day workshop format might assist the nephrology social worker both professionally and personally. This article is the first of two parts and will provide an overview of the literature in reference to mindfulness meditation, its use in social work practice, and the differences between mindfulness meditation and other mind-body interventions, such as relaxation therapies. The second article will describe the methodology used in this study and provide a detailed summary of the study results.

MOTIVATIONS FOR STUDY

Nephrology psychosocial therapeutic involvement follows the patient throughout the disease trajectory from pre-renal insufficiency (prior to the initiation of dialysis) to post-transplant and, in many cases, when the transplanted kidney fails. As a nephrology social worker for 13 years, I have provided frontline counseling and support to patients and families affected by chronic kidney disease. In my professional practice, I employ mind-body interventions that include relaxation, visualization, Autogenic Training, Progressive Muscle Relaxation, Guided Imagery, and mindfulness meditation as therapeutic interventions throughout the nephrology patient trajectory (definitions to follow). In my experience, I have found that these interventions appear to be beneficial for patients, caregivers, and nephrology health team members based on direct patient feedback, observation, and survey results (Petingola, 2010). I have come to realize that both relaxation methods and mindfulness are distinct, yet equally significant therapeutic modalities that may benefit the entire nephrology circle of care (Turk, Swanson, & Tunks, 2008).

Importantly, my own subjective experiences are reflected in the current burgeoning literature in this field. Many researchers are finding that mindfulness-based practices and relaxation exercises have benefits for a wide variety of people and problems (Jain et al., 2007). I was interested in learning more about how relaxation therapy and mindfulness meditation could help nephrology patients and become invaluable tools to assist nephrology social workers with the challenges of their everyday frontline practice.

WHY THIS RESEARCH IS IMPORTANT

This qualitative study explores the potential influence of a one-day relaxation therapy and mindfulness meditation educational workshop for nephrology social workers on their professional practices. Although mindfulness-based training workshops are frequently offered in a one-day format, there is little literature that explores the benefits of this type of training. As will be illustrated in the literature review, there is a gap in examining the direct impact of relaxation therapy and mindfulness meditation specific to nephrology social workers and how, if at all, learning mindfulness and relaxation therapy techniques might assist social workers in their practice.

The purpose of this study is to provide nephrology social workers with more information regarding the benefits of relaxation therapy and mindfulness meditation to professional practice. It is also my intention to stimulate the reader's curiosity, validate the efficacy of these mind-body therapies, and increase confidence to explore how these therapeutic modalities can be utilized within professional practice. A study of this nature may illuminate how the benefits of relaxation therapy and mindfulness meditation can assist the entire nephrology circle of care.

MIND-BODY INTERVENTIONS

Relaxation Therapy and mindfulness meditation fall under the realm of mind-body interventions. The National Center for Complementary and Alternative Medicine (NCAM) summarized that "mind-body practices focus on the interactions among the brain, mind, body, and behaviour with the objective to use the mind to influence physical functioning and promote health" (NIH, DHHS, & NCCAM, 2011). Carlson and Bultz (2008) suggested that mind-body interventions (hypnosis, imagery/relaxation, meditation, yoga and creative therapies) include all treatments that depict the interaction between the mind and the body. Cassileth and Deng (2004) highlighted that mind-body interventions strive to utilize a reciprocal connection between body and mind to assist patients in relaxing, reducing stress, and obtaining symptom relief.

Geffen (2004) described the dichotomy between Eastern and Western views of the mind-body relationship:

Western scientific thought regards the body as a machine. Doctors are the "mechanics" and the disease is viewed as a condition that springs from a flaw in the human machinery. In Eastern medical systems, the body can be seen as a garden. Doctors are "gardeners" who seek to discover and heal the roots of disease, planted in the past by a patient's heredity, food choices, daily activities, environment and ongoing mental process. (p. 95)

In his book entitled *When the Body Says No*, Dr. Gabor Mate (2003) reinforces the notion that there is a codependent relationship between the body and the mind and that treating stress or illness necessitates a consolidated approach to care:

People have always understood intuitively that the mind and body are not separable. Modernity has brought with it an unfortunate dissociation, a split between what we know with our whole being and what our thinking mind accepts as truth. Of these two kinds of knowledge the latter, narrower, kind most often wins out, to our loss. (Note to reader section, paragraph 1.)

Bertisch, Wee, Phillips, and McCarthy (2009) adapted the National Center for Complementary and Alternative Medicine definition of mind-body medicine, which incorporates a wide range of healing modalities, such as meditation, yoga, deep-breathing exercises, Guided Imagery, hypnotherapy, progressive relaxation, acupuncture, and tai chi, which all share a collective purpose aimed at enhancing the mind's capacity to affect bodily functions and symptoms.

Gordon (2008) suggested:

Mind-body approaches to healing are based on the understanding that our thoughts and feelings, our beliefs and attitude, can affect and

shape every aspect of our biologic functioning. Mind-body approaches also recognize that everything we do with our physical body—what we eat and how we stand, the ways we stretch our muscles and the tension that constricts them—can modify mental, psychological, and physical functioning. Finally, mind-body approaches are based on the understanding that the mind and body are, in fact, inseparable, and that the central and peripheral nervous system, the endocrine and immune systems, all the organs of the body, and all the emotional responses we have share a common chemical language and are constantly communicating with one another. (p. 683)

MINDFULNESS

Mindfulness may be defined as “paying attention in a particular way: on purpose, in the present moment, nonjudgmentally” (Kabat-Zinn, 1994, p. 4). The practice of mindfulness focuses on “being” as opposed to “doing,” and “observing one’s experience without trying to change” (Shapiro, Brown, & Biegel, 2007, p. 106). Mindfulness helps us wake up from this sleep of automaticity and unconsciousness, thereby making it possible for us to live our lives with access to the full spectrum of our conscious and unconscious possibilities (Lord, 2010). Mindfulness is simply seeing “what is” (Rock, 2006, p. 350). Riskin (2004) defined mindlessness as “lights on nobody’s home” (p. 80).

Carlson and Speca (2010) explained, “mindfulness is simple; pay attention to whatever comes up in the present moment; allow it all to rise and fall of its own accord, without trying to change anything; and be with things as they are” (p. 10). This essentially requires that the individual who practices mindfulness meditation will simply acknowledge and accept the present moment even if that moment, is defined by pain, sadness, or other feelings that challenge the human condition. Kabat-Zinn (1990, p. 6) refers to this as being able to accept the whole that life gives you—the art of embracing “the full catastrophe.” Mindfulness meditation reframes the experience of discomfort. Attention and awareness of discomfort or suffering is another part of human experience; rather than to be avoided, it is to be experienced and explored (Turks, Swanson, & Tunks, 2008). Caudill (2002) illustrates the concept of the mindfulness and pain paradox:

Simply observe the pain and the feelings you may have, such as fear or anger, without running away from those feelings or sensations. And say to yourself, “oh yes, that’s my pain and that’s my anger.” By staying focused on the pain you begin to realize how much fighting your pain or avoiding those feelings contribute to your feeling powerless. (p. 47)

Derived from Buddhist roots, mindfulness is achieved through the practice of employing meditation as a mechanism pivotal to enhanced awareness and acceptance of the present moment (Bishop, 2004). The Buddhist belief is that in order to become enlightened one must have wisdom to

recognize that there is suffering; there is a cause of suffering; and there is an end to suffering. The Four Noble Truths of Buddhism suggest that the practice of mindfulness helps one to be in the moment, devoid of desires, judgment, criticism, and worry. Essentially, Buddhists believe that the practice of mindfulness facilitates a catharsis that ultimately lessens one’s suffering (Gyatso & Ekman, 2008).

Gyatso and Ekman (2008) suggested that:

In the Buddhist meditation practices, one key method for cultivating this awareness is the development of mindfulness. The second one, which is thought to be more specific to the cultivation of this monitoring, is applying constant awareness to the actual processes of thought, just observing your mind and the thoughts as they arise, and being aware of what arises in the present. (p. 54)

Buddhist belief suggests that we embrace suffering rather than withdraw from it or make attempts to “fix” or get rid of it, which is typical of the Western medical model. Mindfulness is not a distraction technique but paradoxically strives to assist individuals to be fully aware of their feelings and emotions, to not label them as being right or wrong, and in doing so liberates the person to become emotionally intelligent and more reflexive than reactive. If one is experiencing pain, the individual accepts the pain and in doing so lessens its power to negatively influence the person’s well-being. Sumedho (2011) summarizes that we must be willing to accept:

The excitement and the boredom, the hope and the despair, the pleasure and the pain, the fascination and the weariness, the beginning and the ending, the birth and the death. We are willing to accept the whole of it in the mind rather than absorb into just pleasant and suppress the unpleasant. (p. 25)

Mindfulness facilitates a “fuller awareness” that promotes more “flexible, adaptive responses to events, and helps to minimize automatic, habitual, or impulsive reactions” (Bishop, 2004, p. 230). It is argued that the ability to do this helps us to be more patient and less reactive. Gyatso and Ekman (2008) term this as being more “emotionally aware.” “Emotional intelligence” is a concept that refers to being in sync with our emotional existence. Emotional intelligence is derived from increased awareness and equips us with more skill to handle emotional challenges, to be more responsive to the struggles of others and to have more compassion (Gyatso & Ekman, 2008, p. 1). Baer (2006) described these phenomena as follows:

A large part of mindfulness training is geared toward changing a stress reaction into a stress response, in which emotional arousal is effectively managed. Emotional arousal decreases present-moment awareness, and inhibits the ability to see the whole context of the situation and the options available. (p. 363)

Schmidt (2004) suggested that mindfulness fosters compassion, and this in turn connects the suffering of the patient with the healthcare provider's suffering, and that this emotional connection creates a healing synergy. Mindfulness may be viewed as being a cornerstone for increased self-awareness, greater insight, wisdom, enhanced compassion, connectivity, and equanimity (Baer, 2006).

The term mindfulness can be nebulous to a person who has not practiced or experienced it. Bell (2009) used the analogy of "trying to explain the Zen of a meditation experience as being similar to trying to explain color to someone who is color blind" (p. 128). This lack of a clear definition of mindfulness and consistency across studies has been detrimental to completing scientific research that is efficacious and validated. Bishop (2004) suggested that failure to have a consistent working definition of mindfulness negates the credibility of investigations and hampers the development of measurable tools. Thus, several researchers have worked to develop an operational definition of mindfulness. For example, Bishop (2004) suggested the following operational definition of mindfulness:

We propose a two-component model of mindfulness. The first component involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment. The second component involves adopting a particular orientation toward one's experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance. (p. 232)

Not everyone agrees that mindfulness can be operationally defined. Another school of thought is that the sheer ambiguity and complexity of mindfulness negates the possibility of actually defining or operationalizing the concept. Hick (2009) argued that since the mindful experience is so individual that it may be impossible to either capture it in words or accurately measure it, contrary to the positivist attempts to do so. Hick further argued that attempts to do so would be contradictory to a core concept in mindfulness of simply being without judgment. Gause and Coholic (2010) reinforced this notion, contending that the practice of mindfulness in a traditional context invokes a synergy that is extraordinary and immeasurable and that attempts to define it are counterproductive to the Buddhist traditional belief of non-striving. Gause and Coholic also pointed out that mindfulness is taught by people with diverse backgrounds, therefore the interpretation of what mindfulness is will be equally subjective and diverse. Rinpoche (2009) suggested that "Nonjudgmental observation is the basis of meditation, at least in terms of the Buddhist tradition. Many cultures, of course, have developed their own specific forms of meditation practice, each uniquely suited to the cultural environment from which they emerged" (p. 127).

Additionally, the profession of social work is engaging with mindfulness in a unique way that differentiates it from other behavioral sciences. Hick (2009) reinforced that the profession of social work implements mindfulness in keeping with the traditional Buddhist teachings, toward the greater good of society. This necessitates looking at person in their social environment, which means applying mindfulness system-wide as a proponent for justice and for social activism to facilitate change. Social work recognizes an interconnectedness that may be referred to as a "link," "kinship," and "wholeness." This interconnectedness encourages the social work profession to reach out rather than ignore: "And seeing suffering in others—though you do not experience suffering yourself—creates the feeling of personal unbearably. We are one family of human beings, so a person must take concern about the well-being of everyone in society" (Gyatso & Ekman, 2008, p. 196); "First, there was this perception of shared humanity. 'There is no concept of an in-group or an out-group. We are all one group.' All people have value" (p. 199).

This theme of being interconnected reinforces the instinctive desire for social workers to search for a deeper meaning of pain and suffering in their lives as well as in others. Awareness derived from mindfulness meditation can be a powerful equalizer.

MINDFULNESS INTERVENTIONS

Jon Kabat-Zinn and Saki Santorelli are two Western practitioners who sought to operationalize mindfulness as a targeted intervention that would be helpful for patients affected with chronic pain who might not be interested in subscribing to traditional Buddhist traditions or understanding the terminology, but who might benefit from many of the key concepts (Baer, 2006). In doing so, they laid the foundation for researchers and clinicians to explore a variety of interventions designed to teach mindfulness, and created the Mindfulness-Based Stress Reduction (MBSR) Program at the University of Massachusetts Center for Mindfulness. Kabat-Zinn and his colleagues successfully integrated mindfulness into conventional medicine and healthcare and it is now used to treat chronic pain as well as other ailments. The MBSR Program generally runs for eight weeks and incorporates formal practice of hatha yoga, body scan, walking meditation, and sitting meditation with informal practice (Baer, 2006). The MBSR program falls under the realm of social cognitive theory, focusing on interventions geared towards modification of behaviour. Baer summarized:

This theory contains a number of constructs that are important for understanding human behaviour and how it can be changed. These include reciprocal determinism (in which there is a dynamic interplay between the environment and the person's cognitions and behaviours), the importance of the person's perception of the environment, behavioural capability (an index

of the person's knowledge and skill to perform a given behaviour), anticipated outcomes of behaviour and the value a person places on the outcome, self-control, observational learning, reinforcement, self-efficacy, and emotional coping responses. (p. 363)

Mindfulness-based cognitive therapy (MBCT) is more of a prophylactic intervention that merges key concepts of mindfulness practice with cognitive behavioral therapy primarily used for depression relapse. MBCT is similar to MBSR, as it too incorporates meditation and yoga, but a key difference is that it also teaches participants preventative information and helps them to understand the links between thinking and feeling. MBCT was developed by Zindel Segal, Mark Williams, and John Teasdale (Baer, 2006; Bishop, 2004).

Dialectical behavior therapy (DBT), in brief, is a treatment intervention initially intended to treat borderline personality disorder. It blends key concepts of MBSR and MBCT, but emphasizes recognition and alteration of damaging thoughts, emotions, and behavior. DBT helps patients have a clearer understanding of reality so that they can learn to respond appropriately (Baer, 2006).

Lastly, acceptance and commitment therapy (ACT) strives to reduce potentially harmful thoughts and feelings by adopting a nonjudgmental approach to thoughts that fosters acceptance of the moment. ACT is not meditation-based like MBSR and MBCT (Baer, 2006; Hick, 2009).

Social workers are using many of these mindfulness interventions successfully in their frontline practices in health-care. Psychosocial oncology in particular has made strides in measuring patient distress and utilizing many of the aforementioned mind-body interventions (Carlson & Bultz, 2008; Gordon, 2008; Luebbert, Dahme, & Hasenbring, 2001; Shennan, Payne, & Fenlon, 2011). Nephrology closely parallels the area of oncology in many aspects, as both populations endure invasive life-sustaining treatment, survivorship, and fear of relapse. Although nephrology social work as a specialty is just beginning to explore mind-body interventions with patients, the time is ripe for more development in this area. We are on the cusp of a major paradigm shift in treating illness and it is exciting to see this emergence. The shift has been brought on by heightened consumer demand, patient frustration, and conventional Western-influenced medicine's inability to "fix" and promote healing. We are now witnessing the emergence of complementary medicine becoming more prevalent in hospital settings, not only addressing the physicality of the body but also embracing a multidimensional approach to care that moves towards treating the whole person (Geffen, 2004).

MINDFULNESS PRACTICES

Mindfulness is typically taught using formal practice techniques aimed to heighten awareness that will extend into everyday life so that one can eat, bathe, and write mindfully. Carlson and Speca (2010) described formal and informal mindfulness practice and reinforced that both practices complement each other and are codependent:

It helps to think of mindfulness in two ways, which we often call "big-M mindfulness" and "little-m mindfulness." The big "M" refers to mindfulness as a way of being in the world that spans all that you do every moment of your life; you can be mindful or not. It's not specific to any activity or situation. In contrast, little-m mindfulness refers to purposefully setting aside a chunk of time in your day to practice being mindful, just as you would practice the piano if you wished to learn that new skill. Mindfulness is a skill that you learn only through repeated doing. Essentially you practice little-m mindfulness to make it possible to be more mindful in the world (the big "M"). It's virtually impossible to achieve big-M mindfulness without a very strong and regular practice. (p. 35)

Mindfulness is typically taught using practice techniques that include sitting meditation, hatha yoga, walking meditation and body scan exercises. Carlson and Speca (2010) suggested that sitting meditation is often thought of as the gold standard means of achieving mindfulness. Sitting meditation can be done on a cushion or by sitting on a chair in an upright fashion with both hands resting on the thighs. This practice usually entails placing one's mind on the breath, and truly focusing on the moment. It implies acceptance of all feelings and thoughts that emerge and just "letting go."

Mindfulness walking exercises encourage people to slowly walk paying attention to the breath, heartbeat, and every associated movement that the function of walking necessitates. Carlson and Speca (2010) note that walking mindfully means walking with no agenda, no destination, and no expectations. Walking is usually done in a circular or back and forth motion.

Peel (2004) stated:

The labyrinth is an ancient symbol that works well as a therapeutic tool to encourage mental focus through meditation or prayer, which can be instrumental in releasing mental and physical tension. Many recognize the labyrinth as a metaphor for the path we walk through life, and as an appropriate symbol that creates sacred space for enhancing psychological and spiritual growth. As a therapeutic tool, the labyrinth provides willing clients an opportunity to examine problems, questions, or issues from various perspectives, while also affording time and space for personal reflection before making a decision. (p. 287)

Curry (2000) described "walking the labyrinth" as a powerful opportunity for contemplative walking meditation and clarified that a labyrinth is distinct from a maze in that it is comprised of a safe passage in and out, and its focus is on healing rather than trickery. Curry further emphasized that the labyrinth journey is comprised of three parts: a pathway into the center, the center of the labyrinth itself, and the pathway back out. Walking a labyrinth is done in a mindful,

meditative state that allows one to transcend excess worries, emerging empowered for life's challenges.

La Torre (2004) said:

Walking a labyrinth together, client and therapist, can be a powerful activity as the movement itself around the circular path provides a connection, and can lead to a deeper relationship... we came together again in the center and then walked out slowly, saying very little but feeling a quiet connection. (p. 121)

Eating mindfully helps to anchor one to be truly cognizant of the entire dining experience, using all senses and aware of the texture, smell, appearance, and taste of every bite. Mindfully eating truly entails the practice of using all of your senses to "be with" the food you are about to eat, while being cognizant about its origin and the stories to which it speaks. Additionally, mindfulness eating entails an examination of the body's reaction, both physically and emotionally to what one has eaten or is about to eat (Hick, 2009).

The practice of body scan is usually done by lying on one's back or sitting in a chair and sequentially moving the focus of attention through the different regions of the body, noticing sensations as they arise. Body scan invites participants to simply notice any sensations in the body with openness and curiosity (Baer, 2006).

Loving kindness is a practice that allows us to practice "metta." Salzberg (1997) stated:

When we practice metta, we open continuously to the truth of our actual experience, changing our relationship to life. Metta—the sense of love that is not bound to desire, that does not have to pretend that things are other than the way they are—overcomes the illusion of separateness, of not being part of a whole. Thereby metta overcomes all of the states that accompany this fundamental error of separateness—fear, alienation, loneliness, and despair—all of the feelings of fragmentation. In place of these, the genuine realization of connectedness brings unification, confidence, and safety. (p. 1)

Salzberg (1997) suggests that practicing metta allows us to practice gentleness towards one's self and to see the basic goodness in all. Carlson and Speca (2010) suggest that loving kindness meditation involves a series of cultivating good wishes for a loved one, for one who causes angst, one's self, and eventually outward to all living beings. Salzberg (1997) stated:

When we steep our hearts with loving kindness, we are able to sleep easily, to awaken easily, and to have pleasant dreams. To have self-respect in life, to walk through this life with grace and confidence, means having a commitment to non-harming and to loving care. If we do not have these things, we can neither rest nor be at peace;

we are always fighting against ourselves. The feelings we create by harming are painful both to ourselves and for others. Thus harming leads to guilt, tension, and complexity. But living a clear and simple life, free from resentment, fear, and guilt, extends into our sleeping, dreaming, and waking. (p. 41)

Schmidt (2004) described loving kindness as egoless, spontaneous and unconditional, and summarized that loving kindness is an act of a balanced mind that aims for genuine happiness for others.

Baer (2006) suggests that although there are variations in the teaching methods, techniques, and duration, there are basic core instructions common to mindfulness practices. When one practices mindfulness, the person is directed to focus attention directly on an activity (breathing, walking, and eating) and to observe it. If the mind wanders, the individual is assured that this is normal and this is what minds do—that is, think. The participant is then instructed to simply label all discursive thoughts but then to come back to the target being observed, which is most frequently, the breath. If the body reacts while meditating, the participant is instructed to take notice but to not to necessarily act on the pain, itch, and desire to shift positions, et cetera. When thoughts arise, the bearer is instructed to simply label the thoughts with a word like "thinking." He is to avoid falling into the reactive pattern of judging, evaluation or self-criticism. There is no requirement to quash those thoughts and feelings that emerge but to rather substitute a curiosity and freedom of briefly noting them and allowing them to come and go (Baer, 2006). "Rather than evaluating our cognitive and emotional experiences, mindfulness teaches us to simply notice them" (Allen et al., 2006, p. 288).

PHYSICAL AND PSYCHOLOGICAL BENEFITS OF MINDFULNESS

Research to date confirms the benefits of mindfulness meditation training for the client population with regards to amelioration of illness symptomatology. There is no specific research reported to support mindfulness for CKD that I am aware of, although there is support to substantiate the effectiveness of mindfulness post-kidney transplantation. Gross et al. (2004) validated successful use of mindfulness to reduce symptoms of depression, anxiety, and sleep disturbance post-transplant. Following a MBSR eight-week program, participants demonstrated improvements in all areas. CKD is often a secondary complication of comorbidities that include hypertension, diabetes, compromised cardiac health, trauma, and advanced age. There is ever-increasing scientific evidence to support the efficacy of mindfulness meditation to treat comorbid medical conditions associated with CKD, including chronic pain (Zeidan et al., 2011), rheumatoid arthritis (Zangi et al., 2011), type 2 diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007), and chronic diseases that include both multiple chemical sensitivity and cardiovascular diagnoses (Merkes, 2010). Furthermore,

there is a wealth of mounting scientific evidence to support the therapeutic effect of mindfulness meditation on medical conditions, including improvement of IBS (irritable bowel syndrome), related quality-of-life and gastrointestinal-specific anxiety (Kearney, McDermott, Martinez, & Simpson, 2011), chronic low back pain (Morone, Greco, & Weiner, 2008), attention-deficit hyperactivity disorder (Smalley et al., 2009), and myalgic encephalomyelitis/chronic fatigue syndrome (Dayes, 2011).

It has also been suggested that mindfulness may be beneficial for a number of psychological stress-related conditions that often unfavorably affect patient quality of life. Garland (2007) summarized that mindfulness might assist with the prevention of stress-related illness through a number of psychological, biological, and behavioral pathways. He suggested that mindfulness facilitates heightened clarity and insight, a more comprehensive understanding of stressor demands, as well as coping strategies alternative to catastrophizing and ruminating, which are all favorable to enhanced adaptive coping. Bränström, Kvillemo, Brandberg, and Moskowitz (2010) found that mindfulness assisted in psychological well-being in a stress reduction intervention for cancer patients. Völlestad, Sivertsen, and Nielsen (2011) concluded that MBSR is an effective treatment for anxiety disorders and related symptomatology. Segal et al. (2010) recently demonstrated that MBSR is valuable in deterring depressive episode relapse. Additionally, Bonadonna (2003) suggested that mindfulness has been proven to be an effective practice towards the amelioration of many physical and emotional challenges, including anxiety, pain, depression, mood, self-esteem, and stress.

Most recent research has begun to examine the actual effect of mindfulness meditation on the structure and understanding of the brain and this is a very exciting uncharted frontier for researchers. Hölzel et al. (2011) suggested that mindfulness is associated with changes in gray matter concentration in brain regions involved in learning and memory processes, emotion regulation, self-referential processing, and perspective taking. Hasenkamp and Barsalou (2012) examined the effect of the meditation experience on brain networks underlying cognitive actions employed during mindfulness practice. Westbrook et al. (2013) reported that mindful attention helped to reduce neural and self-reported cue-induced craving in smokers and might assist with smoking cessation and other addictive behaviors.

In summary, the literature suggests that mindfulness may be a valid treatment option for many physiological and psychological health challenges because it helps people to be more insightful, less reactive, less judgmental, and more tolerant.

MINDFULNESS AND THE HEALTHCARE PRACTITIONER

Of particular interest to me, researchers have also begun to explore how mindfulness-based practices might shape practitioner behavior and health. Researchers are express-

ing interest in how mindfulness meditation is of assistance to the healthcare counseling professionals who provide frontline service to patients on a day-to-day basis. Hence, amongst the chaos and the work stress of healthcare counseling professionals, there is the hope that mindfulness meditation may foster resilience, clarity, and a moment-by-moment appreciation of therapeutic relationships (Schure et al., 2008).

Bell (2009) validated that the practice of mindfulness meditation enhances therapist well-being and that this indirectly benefits clients during the psychotherapy encounter. Bell maintained that psychotherapists who practiced mindfulness meditative techniques became more in touch with their essence, more reflective, less judgmental, less reactive, more creative, more compassionate, and clearer in their thinking. Further, Bell suggested that this enlightenment allows for the psychotherapist to have a more heightened “therapeutic presence” with the client (p. 140). Mindfulness meditation enhances awareness and helps the therapist to appreciate and celebrate “interconnectedness” in the therapeutic relationship with enhanced awareness of all senses (Kabat-Zinn, 1994). Hence, mindfulness awareness may also promote increased professional fulfillment.

O’Driscoll (2009) reported how numerous qualitative and quantitative research initiatives have demonstrated that healthcare professionals who are engaged in mindfulness have more enhanced therapeutic interventions with clients. O’Driscoll painted an emerging theme that increased mindfulness practice parallels with positive patient clinical outcomes due to the therapist’s enhanced objectivity, comfort with silence in the therapeutic process, and comfort in a sacred space that the therapist and patient share. Both O’Driscoll (2009) and Brown and Ryan (2003) confirmed that counselling psychologists who practice mindfulness attest to more satisfaction and less rigidity in the therapeutic encounter and more positive outcomes reported by clients.

McCullum and Gehart (2010) examined the effects of mindfulness practice on beginning therapists and conclude that mindfulness meditation is a useful addition to clinical training, as it instills a calming effect, heightens therapeutic presence, and enhances compassion. Brenner (2009) confirmed that mindfulness meditation cultivates the therapist’s self-awareness, fosters a nonjudgmental response, assists in helping to see clients as they truly are, and enhances therapeutic presence.

Shapiro, Brown, and Biegel (2007) examined the concept of mindfulness and its application to assisting frontline mental health professionals who are susceptible to increased physical and emotional health difficulties directly attributable to their work environment. In a mixed method study, masters-level psychology program students who were in a “Stress and Stress Management” course that included Mindfulness Based Stress Reduction (MBSR) as a component, fared better than the control group counterparts in all regards and demonstrated reduced stress, reduced negative affect,

diminished vulnerability to rumination, and decreased anxiety. Participants also demonstrated increased positive affect and self-compassion.

Chan, Ng, Ho, and Chow (2006) addressed the ramifications of repeated traumatization specific to healthcare workers and promoted the embodiment of a “Body, Mind, Spirit” (BMS) Holistic Model of Care to assist both patients and healthcare workers in today’s specialized, compartmentalized and heavily bureaucratic hospital settings” (p. 822). The authors acknowledged the burden that many of today’s healthcare workers carry, repeatedly exposed to patients who are frightened, suffering, and dying. This accumulation of work-related distress facilitates a quest for healthcare workers to examine a deeper meaning of pain and suffering in their lives as well as in others. Their body-mind-spirit approach to care promoted the concepts of appreciation of the moment, immersion of body in movement, acceptance of pain and suffering, appreciation of life as it is intertwined with nature, and the ability to demonstrate compassion.

O’Donovan and May (2007) sought to validate that the mindful therapist (social workers, psychologists, and counselors) has the advantage of enhanced well-being, job satisfaction, diminished burnout and, as a result, correlated enhanced patient interventions and better outcomes. They further maintained that both therapist and client benefit when the practitioner has more clarity and an appreciation of the moment in a non-judgmental fashion, and confirmed that a mindful therapist is more compassionate and more present. In a quantitative study of healthcare professionals Galantino, Baime, Maguire, Szapary, and Farrar (2005) demonstrated that an eight-week program to teach healthcare workers mindfulness in an effort to combat work stress and burnout improved mood and lessened emotional exhaustion. Schmidt (2004) summarized:

Applying the ideas derived from the Buddhist mindfulness concept it is possible to add that an emotionally charged relationship can be established if the healer/therapist encounters the patient with his or her full awareness and presence. This means that the therapist is not hiding behind a professional stance, but shows his or her full personality in a genuine human way. Moreover, a therapist or healer who is practicing mindfulness toward his own person is likely to display an unconditionally accepting and compassionate healing intention toward the patient. (p. S-10)

In closing this section, Johns (2008) suggested that:

Mindfulness is fundamental to being a caring practitioner, because it is the root of all skillful action. Buddhadasa Bkikku describes mindfulness as “reflective awareness”; the mind’s ability to recall, know and contemplate itself. It allows us to be aware of what we are about to do. It is characterised by speed and agility. (p. 37)

MINDFULNESS MEDITATION AND SOCIAL WORK

When discussing the role of mindfulness in the social work profession, Hick (2009) suggested that social workers utilize mindfulness at three distinct levels. He first conveyed that the social worker utilizes mindfulness for self. In other words, the social worker who practices mindfulness meditation benefits because it fosters an inner peace, an appreciation of the moment, enhanced self-compassion and self-acceptance, clearer insight, diminished stress and enhanced gentleness with oneself as demonstrated through self-care. This is similar to the concept of therapeutic presence. O’Driscoll (2009) referred to therapeutic presence as a heightened awareness that permeates the therapist-client relationship during the therapeutic encounter, directly attributable to the practice of mindfulness. It is suggested that therapists who practice mindfulness have enhanced therapeutic presence, allowing for them to listen deeply, experience the fullness of the client’s experience, and share a sacred space. Wisniewski (2008) emphasized that mindfulness is vital to effective social work practice, because it allows the therapist the opportunity to truly be attentive to the moment. Wisniewski postulated that this heightened therapeutic presence assists the client in feeling more connected, less judged, and more akin to the therapist. Likewise, “mindfulness prevents the therapist from reacting in scripted, preconceived ways in favor of reserving judgment and reaction so that the patient, ultimately, feels more freedom to govern their own actions” (Wisniewski, 2008, p. 18).

Related to this, Hick (2009) defined what he refers to as “micro-practice influence.” He cited the practice of mindfulness meditation as being instrumental in contributing to enhanced client engagement and therapeutic presence. Ultimately the social worker who practices mindfulness is more attentive to the moment, has enhanced listening skills, exercises more objectivity, and possesses enhanced compassion for the patients they serve.

Hick also suggested that a social worker who engages in mindfulness practice is more in touch with the greater community, more open minded, attentive to process, and a strong advocate who has more awareness of societal issues and feels a connectedness to others more likely to foster social change.

RELAXATION THERAPY

Relaxation Therapy (RT) includes techniques which are targeted to induce a relaxed physical and mental state in the patient, usually obtained by the implementation of deep breathing; progressive muscle relaxation with or without Guided Imagery/visualization; hypnosis; and Autogenic Training (Luebbert et al., 2001). Relaxation Therapy techniques can effectively be used as a complementary therapy with conventional medicine towards the amelioration of anxiety, sleep disturbance, fear, and pain (Barnes, Bloom, & Nahin, 2008). Relaxation Therapy and Cognitive Behavioral Therapy (CBT) attempt to alter patterns of negative thought and dysfunctional attitudes in order to cultivate more

healthy and adaptive thoughts, emotions, and actions. Relaxation techniques are frequently included as a behavioral component in CBT programs (NIH, 1996). Relaxation Therapy began in 1934 when Edmund Jacobson developed a physiological means of reducing anxiety and tension through systematic tensing and releasing various muscle groups, assisting the client in achieving a state of deep relaxation (Bernstein & Borkovec, 1973). Barnes et al. (2008) defined Relaxation Therapy as a complementary therapy under the framework of mind-body intervention that, when used together with conventional medicine, can be helpful with the amelioration of anxiety, sleep disturbance, fear, and pain. Jain et al. (2007) clarified that although there are varied approaches, Relaxation Therapy instills a direct intention to invoke change. The intention of Relaxation Therapy is to use specific exercises or imagery techniques to help the participant relax. This is directly the opposite of mindfulness practice, which facilitates a nonjudgmental awareness observing one's experience without trying to change it (for instance, just noticing the tension of a muscle without attempting to alter it, or just noticing a thought as it arises as opposed to trying actively to modify it).

Allen et al. (2006) differentiated the practice of Relaxation Therapy from mindfulness meditation:

Mindfulness is not primarily a goal-directed activity despite the fact that the practice does have its secondary effects. For example, although mindfulness may bring about relaxation, it is not primarily a "relaxation exercise" in that bringing non-judgmental awareness to the state of body and mind is the practice without any expectation of results, no matter how desirable those results might be. (p. 286)

Turk et al. (2008) highlighted that there is a broad spectrum of approaches available to assist the client, and that the exposure of many different techniques is conducive to an informed decision as to which one is best suited to individual needs. No one method is more efficacious and no one technique is effective for all people all the time. In fact, knowledge of a wide array of different methods may be the best approach in arming the patient.

Gordon (2008) suggested that, when implementing any of the mind-body interventions with patients, it is imperative that the therapist assess the needs of the individual first, highlighting the benefits and consequences of the proposed action to the patient and then respecting the patient's preference and ability to give informed consent. Gordon also emphasized that in order to truly understand and, practice any of these techniques with patients, it is prudent for therapists to have experienced and made use of these techniques themselves. Knowing and then experiencing these techniques authenticates the therapist as someone who truly understands the practice being recommended, and, I would argue, validates their expertise and instills patient trust.

Relaxation Therapy is designed to invoke the "Relaxation Response." Stephen and Smith (2003) suggested that once a patient learned how to invoke the Relaxation Response, they could effectively invoke it thereafter when required in order to achieve a state of mental and physical tranquility. When the body moves from chaos to homeostasis, cortisol and blood lactate levels decrease, the heartbeat steadies, blood pressure diminishes, and lymphocytes increase. This institutes a sense of peace and well-being for the patient.

In summary, although Relaxation Therapy techniques and mindfulness meditation are distinct and equally significant therapeutic modalities that benefit both the patient and healthcare professional, they both facilitate the Relaxation Response.

RELAXATION THERAPY TECHNIQUES

The following section will describe four relaxation therapy techniques, including deep breathing, Progressive Muscle Relaxation, Guided Imagery, and Autogenic Training. Caudill (2002) describes diaphragmatic breathing as focusing on the rise and fall of the breath as one tightens the abdomen and expands the chest with each in-breath. A diaphragmatic breath is a fuller and more complete breath than the chest breath. During this technique, one is encouraged to focus on inhaling clean, oxygen-filled air while imagining all the tension in his body and mind dissipating with the out-breath. Additionally, one might direct the breath into areas of the body where there is tension, pain, or tightness and relinquishing with the out-breath.

Progressive Muscle Relaxation focuses on sequentially tensing and relaxing individual muscles of the body, usually starting from the feet upwards or vice versa. The participant is directed to clench the area tightly, hold it, and then release it. This modality promotes body awareness and the release of tension in response to anxious thoughts or stressful events (IDEA Health and Fitness, Inc., 2005). Progressive Muscle Relaxation has been extensively studied and shown to be effective for improving sleep in persons with insomnia (Ladas, Post-White, & Hawks, 2006). Progressive Muscle Relaxation assumes that it is possible to learn the difference between tension and relaxation (one cannot be both relaxed and tense at the same time), and that relaxing the body through decreased muscle tension will, in turn, decrease mental tension (IDEA Health and Fitness, Inc., 2005).

Guided Imagery can be an effective modality in bolstering one's sense of control and helping individuals to achieve a state of calmness. Turk et al. (2008) suggested that:

Guided Imagery involves the generation of different mental images, evoked either by oneself or with the help of the practitioner. It overlaps with different mental images, evoked either by oneself or with the help of the practitioner. It overlaps with different relaxation techniques and hypnosis. It is often used in conjunction with other treatment interventions such as relaxation and within the context of CBT. (p. 219)

Guided Imagery is often used towards achieving a life-enhancing goal with the connotation to heal, promote personal growth, heighten concentration, and alter body chemistry. Guided Imagery incorporates all the senses and focuses attention inward. Guided Imagery also focuses on a safe place or private sanctuary (IDEA Health and Fitness, Inc. 2005).

Finally, Autogenic Training consists of imagining a peaceful environment and comforting bodily sensations. Six basic focusing techniques are used: heaviness in the limbs, warmth in the limbs, cardiac regulation, centering on breathing, warmth in the upper abdomen, and coolness in the forehead (NIH, 1996).

PHYSICAL AND PSYCHOLOGICAL BENEFITS OF RELAXATION THERAPY

Helping and health professionals have been utilizing relaxation therapies since the late 1930s (Bernstein & Borkovec, 1973). Dr. Herbert Benson later popularized the Relaxation Response technique that sought to quiet the mind and diminish muscle tension (Weinberg & Gould, 2007, p. 280). The early research in this area examined the body's reaction to environmental stress in the 1960s; focused on the field of biofeedback and the body's reaction to stress in the late 1970s; substantiated the efficacy of support groups, changes in lifestyle, meditation and yoga in the 1980s; and provided impetus for the establishment of the National Center for Complementary and Alternative Medicine in 1992 (Finger & Arnold, 2002). More recently, researchers have focused their efforts on examining the effectiveness of relaxation therapy techniques for specific physical and psychological manifestations, often by using meta-analysis to facilitate evidenced-based practice acceptable to both professionals and a better-informed public.

Similar to the research on mindfulness-based practices, the literature supports Relaxation Therapy as an effective treatment for a variety of ailments that include depression, anxiety, and hostility (Luebbert et al., 2001; Uzma & Hasan, 2010); pain (Carlson & Bultz, 2008); blood pressure control (Dusek et al., 2008); and quality of life and sense of coherence (Fernros, Furhoff & Wändell, 2008). Specific to chronic kidney disease, Duarte, Miyazaki, Blay, and Sesso (2009) conducted a research study with 85 hemodialysis patients. It was demonstrated that those patients who underwent three months of weekly 90-minute sessions of CBT, including coping techniques, thinking and cognitive remodeling techniques, and relaxation activities, had a significant improvement in depressive symptoms, cognitive function, and quality of life scores. A meta-analysis that examined psychosocial interventions for anxiety and depression in adult cancer patients by Jacobsen and Jim (2008) highlighted relaxation training in randomized control trials and was found to be efficacious in preventing and relieving anxiety in patients undergoing chemotherapy. Manzoni, Pagnini, Castelnuovo, and Molinari (2008) examined 27 studies dating from 1997 to 2007 and said that results demonstrated

consistent and significant efficacy of relaxation training in reducing anxiety.

RELAXATION THERAPY AND THE HEALTHCARE PROFESSIONAL

Schure et al. (2008) examined the profound effect that elevated stress has both physically and emotionally on helping professionals responsible for treating persons with mental health challenges. In their study, 33 masters-level counseling students were enrolled in an elective course referred to as "Mind/Body Medicine and the Art of Self Care," where they were exposed to hatha yoga, sitting meditation, qigong (an ancient Chinese method combining gentle physical movement with meditation), and conscious relaxation techniques. Students identified profound changes to their physicality, emotional integrity, cognitive clarity, and concept of self. Students spoke of how this exposure to mind-body interventions then resonated into their practices in a positive manner, using themes of enhanced comfort with silence, reduced reactivity, more compassion, and increased empathy.

In 2008, I completed a survey with the National Kidney Foundation Council of Nephrology Social Workers (NKF-CNSW), a group of American nephrologists, and the Canadian Association of Nephrology Social Workers to determine if there was an interest in advanced relaxation therapy as a standard of practice in the overall treatment for persons affected with CKD (Petingola, 2010). Nephrology social workers reported that relaxation therapy techniques were not being utilized in their practices and clearly saw the need for their implementation. Eighty-four percent of American nephrologist respondents reported that they would like to see the implementation of relaxation therapy in the overall treatment plan. Overwhelmingly, nephrology social workers suggested the need for enhanced training to acquire more skill with using relaxation therapy techniques (Petingola, 2009). Learning relaxation therapy techniques, however, is not sufficient to guarantee successful integration of skills into professional practice with patients.

Finger and Arnold (2002) explored the use of mind-body interventions in social work practice and outlined that social workers can learn to integrate relaxation techniques into their frontline practice with additional training and a commitment to personally using the relaxation techniques. Furthermore, Finger and Arnold suggested that social workers who develop a personal practice of relaxation techniques gain a clearer and truer understanding of how these techniques can be used in stress reduction, thereby increasing their proficiency.

Adams, Camarillo, Lewis, and McNish (2010) examined the benefits of a Professional Provider Resiliency Training (PPRT) program aimed at providing military medical professionals the opportunity to significantly develop and enhance their resiliency skills. In this study, 172 medical professionals, including nurses, doctors and ancillary professionals, were taught mind-body interventions. Study participants found the deep-breathing exercise (95%), tai

chi (86%), and Guided Imagery (85%) to be the three most helpful mind-body resiliency techniques. Overall, 96 percent of the participants reported that they planned to use the learned mind-body techniques in the future.

Poulin, Mackenzie, Soloway, and Karayolas (2008) examined two mindfulness-based interventions designed to reduce stress and enhance well-being amongst human services professionals in the workplace. The first study compared mindfulness to traditional relaxation therapy for nursing staff. Results demonstrated that both of these interventions significantly improved relaxation as well as life satisfaction. In the second study, relaxation intervention focused on the impact of stress on the body, and utilized abdominal breathing techniques, progressive muscle relaxation, imagery and creative visualization, and incorporated relaxation exercises into daily life.

Gallant, Holosko and Gallant (2005) argued that working conditions, client demands, and heavy workloads exacerbated high levels of stress among social workers, thereby undermining their potential for self-fulfillment and productivity. These researchers introduced a model referred to as Bio-Spiritual-Music-Focus-Energetics (BSMFE), a focusing technique for social workers and addiction counselors, as a part of staff training and re-certification. BSMFE incorporated music, relaxing breathing techniques, body awareness, and breathing wellness. A study sample of social workers and counselors participated to heighten their awareness of inner-directed processes in their own spiritual quest toward personal fulfillment, professional growth, and transformation. The researchers argued that BSMFE was an effective tool that could be utilized to help social workers attain more personal and spiritual fulfillment.

So, while there is no doubt that researchers are finding that both mindfulness practices and relaxation therapies are beneficial for both patients and practitioners, we know little about how training in these methods is taken up by practitioners.

AUTHOR NOTE: *In this first of two articles I have provided a detailed description of relaxation techniques and mindfulness meditation definitions and practices, providing the reader with the necessary information to understand the topics covered in the workshop. In Part Two, I will discuss methodology and results of this study.*

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