

**Response to Commentaries on *Integrating Time-Limited Dynamic Psychotherapy*  
and a *Buddhism-Inspired Aversion/Attachment Model*  
of Client Suffering: The Cases of "Beth" and "Amy"**

**On the Skillful Integration of Buddhist Psychology  
and Short-Term Dynamic Psychotherapy**

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**ABSTRACT**

In this article, I respond to commentaries by Morgan (2016) and Schacht (2016) regarding my presentation of the cases of Beth and Amy (Samlin, 2016). Addressing the dialectic raised between Morgan's (2016) support for and Schacht's (2016) skepticism towards the integration of Time-Limited Dynamic Psychotherapy (TLDP) and the Aversion/Attachment Model of Client Suffering (A/AMCS), I organize my response into three broad sections. First, I provide context as to the type of Buddhist tradition from which the A/AMCS draws. In this section, I also address the current debate in Mindfulness-Based Interventions literature regarding the use of explicit vs. implicit Buddhism in treatment. Second, I address issues related to the technical and conceptual integration of the A/AMCS into TLDP. Finally, I re-examine the outcomes of Beth's and Amy's cases from the pragmatic standpoint and offer additional thoughts regarding the differing outcomes of the two cases.

*Key words:* Time-Limited Dynamic Psychotherapy (TLDP); Cyclical Maladaptive Pattern (CMP); Buddhist psychology; Aversion/Attachment Model of Client Suffering (A/AMCS); mindfulness; depression; anxiety; case studies; clinical case studies

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In my original set of pragmatic case studies (Samlin, 2016), I presented the cases of "Beth" and "Amy" wherein I integrated components of (a) Buddhist Psychology, organized into what I termed the Aversion/Attachment Model of Client Suffering (A/AMCS), within (b) an established, short-term relational psychodynamic treatment, Time-Limited Dynamic Psychotherapy (TLDP). My goal was to integrate the A/AMCS into TLDP at both the conceptual and intervention levels in order to illustrate a pragmatic integration of Buddhist concepts into modern relational therapy. Although both the cases of Beth and Amy were seen for a similar number of sessions using a similar treatment, the cases presented two different outcomes: whereas Beth evidenced clear reductions in self-reported symptoms using quantitative measures, as well as intra- and interpersonal improvements, Amy reported more modest

reductions in symptoms on quantitative measures, with less pronounced interpersonal and intrapsychic improvements.

I greatly appreciated receiving Morgan's (2016) and Schacht's (2016) commentaries on the two cases presented, particularly because each commentary elucidates a different viewpoint regarding the applicability of the integration of Buddhist psychological concepts into TLDP. In his commentary, Schacht (2016) sounds a note of caution regarding the integration of the A/AMCS and TLDP, raising potential points of theoretical and practical conflict between the two treatments. Approaching the cases from a more traditional psychodynamic background, he focuses much of his commentary on the potential for A/AMCS-focused interventions and conceptualizations to negatively affect both the therapeutic relationship and the therapist's ability to create a parsimonious formulation. Coming to the cases from a background more firmly rooted in Buddhist thought and practice, Morgan (2016) provides further context regarding the Buddhist roots of the A/AMCS, focusing on the Abhidharma and the Doctrine of Dependent Origination. Morgan (2016) also describes a more positive set of arguments for the integration of Buddhist concepts into TLDP, based on a perspective of pragmatism.

In the two commentaries, Morgan (2016) and Schacht (2016) highlight a dialectic between perspectives that lead to either an eager embrace of or a cautious skepticism towards the integration of the A/AMCS model into the TLDP model. In my response to these commentaries, I will address three broader issues that were raised. First, I will address the role of explicit and implicit Buddhism in the A/AMCS, highlighting current thought and disagreement in the Mindfulness-Based Interventions (MBI) literature. Next, I will examine issues of theoretical and practical integration brought up by Schacht (2016), with an emphasis on why I believe the A/AMCS can be effectively integrated into TLDP without leading to a denaturing of either treatment. Finally, I will re-examine the outcomes of Beth's and Amy's cases from the pragmatic standpoint, following the disciplined inquiry model of investigation (Peterson, 1991).

## **BUDDHISM AND THE A/AMCS**

While discussing issues related to client recruitment and selection, Schacht (2016) astutely points out that Buddhism such as it is contained in the A/AMCS was never explicitly brought up during the initial process of informed consent and initial assessment. He points out that this information, despite the secular nature of treatment, could have affected client participation and therapeutic alliance were it more explicitly discussed; Beth's and Amy's preconceived notions of what Buddhism is and represents may have impacted their engagement in treatment and therapeutic alliance.

Schacht's (2016) questioning regarding issues of explicitly discussing the Buddhist influences in the A/AMCS is particularly relevant if one views Buddhist-based psychotherapies as coming from a religious tradition (Tan, 1994). This raises the question, though, of what exactly the "Buddhism" is that is being discussed. Similar to other traditions that combine philosophical, spiritual, and psychological traditions, "Buddhism" is not a monolithic concept. When discussing informed consent within the context of this treatment, understanding the cultural and epistemological background of the tradition from which the A/AMCS was drawn is critical. Though I have already touched briefly on the Buddhist tradition from which many of

the concepts in the A/AMCS are drawn (Samlin, 2016), it may be worthwhile to delve more deeply into the type of Buddhist thought behind the A/AMCS.

The Buddhist tradition from which the A/AMCS draws has been largely classified as Buddhist Modernism, and this is a tradition that, though diverse, generally emphasizes lay, rather than monastic, teachings (Fronsdal, 1998; McMahan, 2008). Specifically, the A/AMCS is informed by the teachings of the Western Vipassana movement of Buddhism as taught by teachers such as Jack Kornfield, Joseph Goldstein, and Sharon Salzberg; although it should be noted that while these teachers are all Western, they each studied extensively with predominantly Southeast Asian teachers in the Theravada Buddhist tradition. The main set of teachings that are discussed in this tradition are the Pali Cannon, which comprise what are thought to be the earliest teachings of the Buddha (Batchelor, 2012).

The Vipassana tradition, as it is frequently practiced in the United States, is explicitly secular in nature and generally views teachings on topics such as Buddhist cosmology and ritual as allegorical, rather than dogma (Fronsdal, 1998). As an example, rather than the concept of *karma* explicitly being taught as related to future instances of reincarnation and the cycle of rebirth, it is framed as a method for addressing the cause-and-effect reality of life; Buddhism scholar Andrew Olendzki (2010) explains that, “[k]arma is primarily concerned with how we shape ourselves, and how we are shaped by ourselves, through action” (p. 146). Further, though the Western Vipassana tradition largely draws from the Theravada Buddhism practiced in Southeast Asia, concepts from traditionally separate schools of Buddhist thought such as Zen and Tibetan Buddhism can be incorporated into teachings (Fronsdal, 1998). This type of egalitarian, inclusive Buddhist teaching can be seen in established Buddhism-influenced psychotherapies such as Dialectical Behavior Therapy’s (Linehan, 1993) inclusion of Vipassana-informed mindfulness meditation and the Zen “middle path” concept to conduct.

There is evidence, then, of Westernized, secular Buddhist philosophical and psychological concepts being utilized in Western psychotherapies absent the related concepts found in classical Buddhist teaching. Nonetheless, this approach to the integration of Buddhist concepts into psychotherapy is not without controversy, and there is an ongoing debate within the Mindfulness-Based Interventions (MBIs) literature as to the appropriateness of integrating Buddhist concepts and practices, such as mindfulness meditation, into psychotherapy, out of their traditional Buddhist framework. Monteiro, Musten, and Compson (2015) elucidate the two sides of this debate by dividing mindfulness as practiced in Western psychotherapy into two broad camps: “contemporary” and “traditional” mindfulness meditation.

As described by Monteiro et al. (2015), contemporary mindfulness meditation is centered on the practice of mindfulness meditation and is the type of Buddhist integration practiced by most current established MBIs. In contemporary mindfulness meditation, Buddhist concepts are framed in terminology syntonetic with Western psychology and psychological science. Rather than incorporating Buddhist concepts into MBIs because of their traditional association with mindfulness, it is seen as necessary to operationalize and test said concepts in order to determine if there is any value added to interventions through their incorporation (Baer, 2015; Lindahl, 2015). As an example, Buddhist ethical foundations and concepts, such as right speech, right conduct, and right mindfulness, could be incorporated into established treatments, but only if

these ethical principles aid clients in achieving and maintaining favorable therapy outcomes (Baer, 2015).

In contrast, traditional mindfulness practice (Monteiro et al., 2015) holds mindfulness meditation as just one of many components of beneficial Buddhist thought. Therefore, this view maintains that it is necessary to incorporate other related and interconnected Buddhist concepts into treatment. Of particular emphasis in traditional Buddhism is the incorporation of the ethical principles found in the Noble Eightfold Path. These ethical principles—which consist of right speech, right action, right livelihood, right effort, right mindfulness, right concentration, right attitude, and right view—provide the framework from which mindfulness can be used skillfully, leading to reduced suffering and increased compassion for oneself and the world (Amaro, 2015). Using a classical example of how mindfulness without ethical practice can lead to increased suffering, one need simply imagine a sniper utilizing mindfulness practice in order to better execute a kill shot on a target; is this an example of right mindfulness, which would lead to reduced suffering, or an example of utilizing mindfulness techniques to engage in an activity that is antithetical to foundational Buddhist tenants? Besides explicitly teaching ethical practice as part of interventions, some proponents of traditional mindfulness have argued that mindfulness meditation actually acts as an embodied ethical practice whereby practitioners develop the ability to discern between wholesome and unwholesome qualities in their lives (Grossman, 2015). Additionally, traditional mindfulness advocates have also raised the question of whether informed consent can be given without talking about the Buddhist origins of mindfulness practice (Purser, 2015).

Rather than subscribing to either strictly contemporary or traditional views of mindfulness meditation, I find my viewpoint more in line with Compson and Monteiro's (2015) "middle path" between these two viewpoints. It is important to bring awareness to the ethical framework within which mindfulness meditation was developed, if for nothing else than because this ethical framework can provide guidance as to the skillful application and practice of mindfulness meditation. Further, while mindfulness meditation arose out of the Buddhist tradition, research has begun to show the universality of the Buddha's insights into the reduction of suffering: the pro-social, compassionate, and selfless stance encouraged through meditation practice has been found to have similarities with values found in other philosophical and spiritual traditions (Baer, 2015).

With the above dialectic between implicit and explicit Buddhism in mind, let us return to Schacht's (2016) comments regarding the impact of the lack of explicit Buddhism in the A/AMCS. As I was thinking about the appropriateness of including the explicit discussion of the Buddhist origins of the A/AMCS as part of the initial treatment process, I wondered if this might not lead to a case of *mis*-informed consent rather than informed consent. That is to say, if the A/AMCS uses a tradition that is explicitly non-religious, e.g., it's absent from a number of religiously laden concepts such as karma and reincarnation, would the client be provided with the accurate, nuanced information necessary in order to differentiate between secular and religious Buddhism? If there is a negative effect arising from not explicitly discussing the Buddhist origins of mindfulness practice, are we also not providing comprehensive informed consent if we do not inform clients of the empiricist, Western European origins of most current mainstream psychotherapies? I think the answer is no; we provide informed consent when we

accurately give a description of the type of services being provided and the potential effects of those services. In the cases of Beth and Amy, I provided information regarding mindfulness meditation and outlined the general concepts of turning towards experience and engaging with present events, giving what I believe to be sufficient context to the type of work that was to be done as part of the A/AMCS. Nevertheless, I think that Schacht's (2016) point does raise the importance and necessity of a clinician being aware of the context within which mindfulness and other Buddhist-informed concepts are introduced. In this way, the clinician can make his or her own skillful determination regarding the appropriate type of informed consent provided to clients.

### **CRITICAL REFLECTION ON THE INTEGRATION OF THE A/AMMCS AND TLDP**

In his commentary of my original two case studies, Schacht (2016) presents a number of critiques to my integration of the A/AMCS and TLDP. In discussing integration from the view of both interventions and case formulation, Schacht (2016) focuses on the potentially conflicting approaches of the A/AMCS and TLDP, and the ways in which A/AMCS interventions could work against the type of therapeutic process fostered in TLDP.

#### ***Integration Concerns Between the A/AMCS and TLDP Regarding Intervention***

First, as an aside, it would seem prudent to raise the possibility that my and Schacht's differing viewpoints regarding the integration of the A/AMCS and TLDP could in part be informed by the difference in the type of TLDP practiced by each of us. As Schacht (2016) mentions in his commentary, he practices a type of TLDP that is closer to the version first put forth by Strupp & Binder (1984); and thus Schacht's viewpoints reflect that relatively more traditional approach to TLDP. In contrast, I was working from Levenson's (2010) model of TLDP, which she differentiates from Strupp and Binder's (1984) version by TLDP's stronger focus on experiential, rather than interpretive, interventions. This difference in TLDP styles could account for the differing opinions Schacht and I present regarding the appropriateness of more active interventions, such as those found within the A/AMCS. Thus, whereas I put a premium on the experiential interventions in the A/AMCS, Schacht (2016) raises the possibility that these more experiential interventions overlook important transference enactments that can occur in treatment.

In his reading, Schacht (2016) goes further to wonder whether the type of integration done in Beth and Amy's cases might have negatively affected the therapeutic alliance through interventions that are potentially invalidating and not in line with the positive, strengths-based approach of TLDP. Schacht (2016) raises these concerns primarily through the case of Amy. In his commentary, he discusses one example of Amy's treatment in which she voiced frustration with mindfulness meditation training and I "challenged Amy's defenses" by engaging her in a role play in which she imagined what she might say to me if she were to accurately voice her frustration with her treatment. Schacht (2016) raises an alternative line of intervention wherein, rather than "challenge Amy's defenses" through the role play, I would re-state Amy's frustration as understandable and adaptive given her interpersonal history with her father. In this way, Amy's experience would be re-framed as one that is seeking out meaningful connection with her

father, rather than potentially leading Amy to feel “broken and defective” because of her interpersonal frustration. Through this example, Schacht (2016) frames mindfulness meditation and giving voice to Amy’s frustrations as interventions that could lead Amy to see herself as needing to overcome deficits, rather than couch her current experiences as logical and understandable given her interpersonal history.

The above example raises an interesting question regarding how to engage with enactments when integrating the A/AMCS into TLDP. Amy’s frustration with the process of practicing mindfulness meditation, and later with my questions about her experience (in session 12), could be seen as a reenactment of her experience with her father; Amy experienced me as the aloof parent who was either unconcerned with her experience or unable to accurately perceive her experience, and she was “not sure what [I was] ... looking for [her] ... to say” (Samlin, 2016, p. 279). Whereas Schacht (2016) appeared to be advocating for a more reflective, less active approach, this situation could offer an excellent example of how the introduction of the A/AMCS could add to TLDP’s ability to effectively address enactments.

If the A/AMCS is viewed as an active intervention, it provides a unique set of interventions that can address enactments in treatment through encouraging the client to experientially get their needs met in therapy (Gold, 2014a). In the above enactment, Amy was not getting her interpersonal needs met by me and not connecting and bringing awareness to her frustration, which could lead the clinician to wonder what might be done to begin helping Amy move towards her intra- and interpersonal goals. Using Levenson’s (2010) 25 general TLDP interventions, one could work towards increasing Amy’s emotional awareness (intervention 7); encourage Amy’s expression of feelings, thoughts, and beliefs (intervention 14); and provide opportunities for alternative experiences in relation to the therapist (intervention 23). In terms of the A/AMCS, the therapist would want to explore with Amy what internal experiences would be avoided and aid Amy in turning toward her experience so she could skillfully engage with her experience.

While both intervention strategies seem to value the experiencing of emotion, on the surface there does not appear to be a great deal of similarity. I believe that the interventions done in the treatment, though, illustrate the synergy between the two sets of interventions. In session 12, as Amy was expressing her frustration, I encouraged her to explore what prevented her from telling me more fully about her frustration, engaged in a brief role play in which Amy imagined what she might say to me were she to express her frustration more directly, and expressed my genuine appreciation that she would confide in me her experience of frustration with me. Mapping the A/AMCS interventions done in this example onto the TLDP interventions discussed, one can see that the A/AMCS interventions are clearly in alignment with TLDP interventions: I encouraged Amy to explore her reaction to me (intervention 23), turned the focus of our discussion towards her frustration at me with openness and curiosity (interventions 7, 14), and explored how Amy would give voice to her frustration while responding in a receptive, open and appreciative manner (intervention 23).

If Amy had responded to these interventions with skepticism or reticence, there could be a further case made for the inappropriateness of these interventions. However, Amy evidenced almost immediate behavioral change. In the next session Amy discussed a conversation she had

with her then-boyfriend during which she expressed to him her experience of frustration at their communication difficulties and ultimately chose to “take a break” from the relationship. Amy further said that she appreciated how turning towards and expressing her experience of her relationship with her boyfriend led to a resolution of the situation. Rather than having the negative effect on treatment that Schacht (2016) feared, the integrated intervention implemented in this example led to a shift in how Amy behaved in an important relationship and moved her closer towards her stated goal of interpersonal change. This example further illustrates how active interventions can lead to a swifter processing of enactments in treatment, particularly with clients who have a more intellectual defensive style (Gold, 2014b).

### ***Integration Concerns Between the A/AMCS and TLDP at the Case Formulation Level***

In addition to the five sections of the Cyclical Maladaptive Pattern (CMP) case formulation found in TLDP (Levenson, 2010), I added a section reflecting the theoretical viewpoint of the A/AMCS. This added section addressed the internal experience the client was attempting to either avoid or achieve through her or his established relational patterns. In Beth’s case, this section described how she tended to avoid her experience through rumination and self-criticism and maintained feelings of interpersonal safety through being polite, but distant in relationships. This section of Amy’s CMP described how Amy attempted to maintain feelings of safety through ruminative problem solving.

Schacht (2016), in his commentary, raises questions as to the necessity of this new section of the CMP. Referencing Beth and Amy’s cases, he points to the added section of the CMP predominantly addressing the clients’ experiences of rumination and wonders whether the type of data discussed in this section, in this instance rumination, could not have also been found in the established sections of the CMP. Specifically, Schacht (2016) wonders if the type of rumination discussed in these two cases might not be better placed in the “Acts of the Self Towards the Self” section, and he raises the possibility that the additional section unnecessarily complicates the CMP and was akin to “adding a new rule of grammar to a language.”

While Schacht (2016) raises a valuable point regarding the necessity of parsimony in case conceptualization, I believe that the additional section of the CMP adds value beyond the technical integration of the A/AMCS into TLDP. As discussed in my original article (Samlin, 2016), this additional section further elucidates the behaviors, both internal and external, that perpetuate maladaptive relational patterns. Though certain behaviors, such as the rumination discussed in both Beth’s and Amy’s conceptualizations, could be accounted for in established CMP sections, other behaviors that are even more interpersonal in nature (e.g., substance use following an argument) would more discretely fit with the additional section rather than the established CMP sections.

Further, the added CMP section facilitates cohesion between case formulation and interventions. When the patterns of aversion and attachment are elucidated as part of an integrated conceptualization, the clinician will be better able to make determinations regarding when and how to apply A/AMCS interventions during the course of treatment. Additionally, this section allows the A/AMCS to be incorporated into the client’s therapeutic narrative. If, as

Schacht (2016) highlights, the CMP is a therapeutic re-telling of the client's experience, the collaborative exploration of how the client interacts with introjects can help account for the recurring nature of the client's maladaptive relational patterns. While some of the information discussed in the "attachment/aversion patterns" section might also be placed in other sections of the CMP, the deliberate incorporation of these concepts in the CMP not only describes the intra- and interpersonal factors contributing to suffering, but goes further to highlight the importance of considering the role of aversion/attachment, and maximize synergy between conceptualization and intervention in this integrated model of treatment.

## **RE-EXAMINING OUTCOMES IN THE CASES OF BETH AND AMY**

The two previous sections have focused on potential theoretical issues related to integration. The case study method espoused here allows the unique opportunity to further examine the cases of Beth and Amy from a pragmatic framework. Considering the success of integration from a pragmatic perspective, one need simply answer a single question: did the integrated treatment lead to positive treatment outcomes (Fishman, 1999)? When examining the cases of Beth and Amy, that answer is less straightforward, as the two treatments evidenced two different treatment outcomes. Beth exhibited both quantitative and qualitative improvements in her life and, in addition to a marked decrease in quantitative symptom measures, she engaged in more skillful interpersonal behavior and experienced herself very differently at the end of treatment. Amy reported a slight decrease in quantitatively assessed symptoms (possibly due to her low initial scores on self-report symptom measures) and, while she evidenced an increased tendency to recognize her internal experience in relationships, she did not experience the change in her relationship with her father that was a primary goal at the outset of treatment. The potential reasons for these two different treatment outcomes were initially discussed in my original article (Samlin, 2016), but it would be useful to re-address different outcomes in light of the Morgan (2016) and Schacht (2016) commentaries.

### ***The Role of Validation in Treatment***

When thinking about differences in Beth and Amy's therapy experiences, one aspect that was present was Amy's relative reticence to discuss her internal experience during treatment, and particularly during the mindfulness practice sessions. As Schacht (2016) discusses in his commentary, the more active interventions of the A/AMCS could have negatively affected the therapeutic alliance, increasing Amy's discomfort in discussing her internal experience. He suggests interventions aimed at re-framing Amy's behavior as a "positive effort to adapt to circumstances as she experienced them," essentially validating Amy's experience of difficulty and her current behaviors as both understandable and normative, given her interpersonal history. Schacht (2016) rightly highlights the importance of validating and de-pathologizing Amy's experience.

Though Schacht (2016) discusses this type of validation intervention as more in line with TLDP, Morgan (2016), in his commentary, provides the rationale for actively utilizing validation and normalization from a Buddhist psychology standpoint. In his discussion of the Abhidharma, the doctrine of Dependent Origination, and its applicability to Western psychology, Morgan (2016) describes how an individual's thoughts, feelings, and behaviors arise and are maintained

in a conditioned manner whereby the individual's experience, reactions to this experience, and the effects of these reactions to experience interact through mutual influence. That is to say, it is completely logical and understandable that individuals could engage in a set of maladaptive behaviors given their past experience, their reactions to past experience, and how their reactions further shaped their experience.

Applying this approach to Amy's case, one could view her cautious and intellectual interpersonal style as logical, given her history of interacting with her father and brothers, her historical and current reactions to interpersonal interactions with her father and brothers, and how her reactions further influenced her relationships with her father and brothers. By re-framing Amy's experience as conditioned and arising through the completely normal and everyday process of being a person in the world, her difficulties are inherently de-pathologized and classified as an understandable, but unfortunate byproduct of trying to navigate her relationship with her father and brothers.

I suspect that the type of validation discussed above may have had a strong influence in the differing treatment outcomes between Beth and Amy. First, given Beth's relative comfort discussing and sitting with her internal experience in therapy, there was less of an overt need for validation and normalization in order to aid her in more effectively engaging with treatment. Amy's slight unease with the therapy process could have required more validation in order for her to feel comfortable experiencing vulnerability while engaging with her experience. In addition to the potential difference in amount of validation for each client, I think that the type of validation I provided could have contributed to outcome differences. Though I ended up engaging in more validation-based interventions with Amy, the type of validation I provided was different than the type of validation discussed above. When I provided validation to Amy, I generally used techniques such as reflection and restatement in order to underscore her experience; I generally did not use the normalizing, de-pathologizing type of validation discussed in different ways by both Morgan (2016) and Schacht (2016), and I suspect had I engaged in more of that type of validation Amy would have developed more comfort in sitting with her experience.

### ***Mindfulness and Transference in the A/AMCS and TLDP***

As used in the cases of Beth and Amy, mindfulness meditation was incorporated on both an implicit and explicit level. While there has been some discussion previously as to the implicit implications of mindfulness and related interventions, I would like to focus in this section on the explicit use of mindfulness meditation, specifically my actively teaching techniques to Beth and Amy both during pre-treatment sessions and during treatment. In his commentary, Schacht (2016) discusses the transference implications of explicitly teaching mindfulness in session; he points to Amy's treatment, wherein she appeared to exhibit a transference reaction in which, when teaching her mindfulness meditation, I was taking on the role of her aloof father, disconnected from Amy's experience and frustrations. Though Amy appeared more comfortable expressing some frustration toward me during her treatment, it did seem that this transference was never truly resolved, and Amy continued to view me as not being fully attuned with her experience through the end of treatment. Schacht (2016) addresses this aspect of treatment in raising a note of caution regarding the potential for explicit mindfulness instruction to lead to

harmful transference reaction, and it is worth noting that Schacht is not alone in expressing concern as to how the explicit instruction in mindfulness could affect psychodynamic therapy (Fayne, 2014).

Interestingly, Beth also expressed concern and some frustration as to my reaction to her practicing mindfulness, but expressed less of a direct response than Amy to the practice of mindfulness. Given that I engaged in roughly the same mindfulness instruction with each client, as well as used the similar technique of turning towards experience when interacting with transference reactions, what caused the differing transference resolution between Beth and Amy? I think the answer lies in the content of the specific transference reactions and how A/AMCS techniques either magnified or dissipated said transference. Though the Buddhist-inspired techniques found within the A/AMCS can be extremely valuable in addressing transference enactments (Stern, 2014; Gold, 2014b), I wonder if, by applying similar techniques to both cases, I was too focused on addressing the function, rather than the content of the transference reactions. The A/AMCS techniques utilized with Beth could have been sufficient in addressing her transference enactment with me because the nature of her enactment was not related to her instruction in mindfulness meditation; her enactment was related to her engaging in “crazy” behavior and me becoming too overwhelmed to help her.

In contrast, Amy’s transference enactment was directly related to her instruction in mindfulness, with me taking on the role of her father with whom she was unsure how to connect and who was unable to intuit her needs and desires. It seems a logical conclusion that addressing this transference primarily utilizing A/AMCS techniques would lead to less favorable outcomes. Perhaps the validation line of intervention suggested by Schacht (2016) would have better allowed me to address Amy’s transference and, ultimately, led to better treatment outcome. Certainly, the potential for A/AMCS interventions to have been the specific cause of different transference resolutions is a worthwhile reminder as to the importance of integrating treatments with intention and bringing sensitivity to how a specific set of interventions may affect the broader nature of treatment. In fact, these cases may be a valuable example of Messer’s (1992) caution to take into account how the nature and implications of interventions can change when put in different contexts.

### ***Iatrogenic Effects of Mindfulness and the Importance of Therapist Mindfulness Training***

As a final thought, I’d like to briefly address the potential for iatrogenic effects by practicing mindfulness. In his commentary, Schacht (2016) points to research that has suggested the potential for psychosis, de-personalization/de-realization, and addictive practice when practicing mindfulness meditation. While I think that it is incredibly important to keep in mind the client’s potential negative reaction to mindfulness meditation, it is also important to keep in mind the context in which the mindfulness is practiced. Many of the studies examining negative effects of mindfulness practice have looked at meditators on longer, silent retreats with minimal instructor interaction (Lustyk, Chawla, Nolan, & Marlatt, 2009; Dyga & Stupak, 2015). Besides the types of retreats in these studies having potential confounds (such as the lack of interpersonal interaction, silence, and sleep deprivation), the setting in which mindfulness is practiced in these studies is rather different than the rather more controlled setting in which it was introduced with Beth and Amy. Further, mindfulness-based interventions, when applied judiciously and with

sensitivity regarding the client's background and presenting problems, have been shown to be effective in treating some of the specific problems that Schacht raises, such as psychosis (Chadwick, 2014, Dyga & Stupak, 2015).

The potential for negative effects when incorporating mindfulness meditation into treatment, does raise the absolute importance of the clinician having a background and training in mindfulness meditation. Of particular relevance, having proper training in mindfulness meditation, and ideally one's own regular practice, will help the clinician manage any risk that arises from client practice (Lustyk, et al., 2009). Extending this logic further, it would seem important that, when integrating the A/AMCS into TLDP, the clinician have not just a solid foundation in mindfulness meditation, but also a background in the broader Buddhist concepts from which the A/AMCS draws. Beyond contributing to the clinician's ability to recognize and manage any adverse reactions of mindfulness practice, this knowledge and experience base will enable the clinician to more skillfully manage the integration of the A/AMCS into TLDP.

## CONCLUSION

I have greatly appreciated the chance to engage in dialogue regarding the integration of the A/AMCS and TLDP and believe that both Morgan's (2016) and Schacht's (2016) commentaries raised valuable and thought provoking questions that were worth examining further. It is my hope that this case series will spur other clinicians and researchers to more thoroughly examine the pragmatic integration of psychodynamic treatment and Buddhist psychology.

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