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Pepperdine University
Graduate School of Education and Psychology

A MINDFULNESS-BASED ART THERAPY CURRICULUM FOR PARENTS IN
UNDERSERVED COMMUNITIES

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Jennifer Brown, M.A., ATR-BC

October 2012

Shelly Harrell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Jennifer Brown

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly Harrell, Ph.D., Chairperson

Thema Bryant-Davis, Ph.D.

Janet Osimo, Psy.D.

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DEDICATION

“...Who looks outside, dreams. Who looks inside awakens.”
Carl Jung

For Donna Elizabeth Lacy
In this life and beyond.

ACKNOWLEDGMENTS

A deep bow to my to my daughters for their endless, enduring patience and love. Much appreciation to my friends and family for motivation and encouragement over these years. Thanks to the communities of Boston for the inspiration to create this dissertation. A special thank you to the committee members for their intelligence, wisdom and guidance.

VITA

EDUCATION

- 2005-2012 Pepperdine University Los Angeles, CA
Graduate School of Education and Psychology
Doctor of Clinical Psychology (Psy.D.)
- 2000-2002 New York University New York, NY
M.A., Art Therapy
- 1995-1998 San Francisco State University San Francisco, CA
B.A., Psychology
Minor, Human Sexuality Studies
- 1995-1996 University of Amsterdam The Netherlands
Human Sexuality Studies

HONORS

- 2005-2008 Diversity Scholarship – Pepperdine University
- 2000-2002 Deans Scholarship – New York University

EXPERIENCE

- 2012-present Lesley College Cambridge, MA
Psychology and Social Sciences Division, Adjunct Faculty
 - Instructor for Lifespan Development
 - Instructor for Research Methods in Social Sciences
- 2011-present Lesley University Cambridge, MA
Graduate School of Arts and Social Sciences
Adjunct Faculty of Research Evaluation and Thesis
 - Lecture on research process and methods
 - Assist students in planning research projects
 - Thesis advisor for graduate students
- 2010-2011 Boston University Medical Center Boston, MA
Center for Multicultural Training in Psychology, Pre-doctoral intern
 - Led multidisciplinary wraparound services team
 - Conducted therapy and crisis counseling for families
 - Clinical assessments and treatment planning
 - Assisted in program development for clients and staff
- Jan-June 2010 Cambridge Health Alliance Cambridge, MA
Victims of Violence Program, Center for Homicide Bereavement
Bereavement Counselor/Victims Advocate
 - Counseled families of homicide victims
 - Conducted information sessions
 - Assisted in crisis response counseling
 - Collaborated with providers of homicide services

- | | | |
|--------------|---|-----------------|
| Fall of 2009 | Lesley University <i>Professors Assistant</i> | Cambridge, MA |
| | <ul style="list-style-type: none"> ▪ Researched literature for curriculum ▪ Assisted in planning course assignments & lectures ▪ Presented on multicultural competencies in art therapy | |
| 2009-2010 | Rogerson House for Alzheimers/Dementia <i>Art Therapist</i> | Boston, MA |
| | <ul style="list-style-type: none"> ▪ Conducted art therapy groups ▪ Conducted spirituality group ▪ Assisted in treatment planning ▪ Provided individual therapy | |
| 2008-2009 | Long Beach Memorial Hospital - Rehabilitation <i>Doctoral Practicum Trainee in Neuropsychology</i> | Long Beach, CA |
| | <ul style="list-style-type: none"> ▪ Assisted in treatment of patients with neurological trauma ▪ Conducted neuropsychological testing and evaluation ▪ Clinical interview and assessments and evaluations | |
| 2007-2008 | Jewish Children and Family Services <i>Art Therapy Supervisor</i> | Long Beach, CA |
| | <ul style="list-style-type: none"> ▪ Supervised art therapy interns ▪ Planned treatment and interventions ▪ Evaluated art therapy interns | |
| 2006-2007 | Long Beach Job Corps Wellness Center <i>Doctoral Practicum Trainee</i> | Long Beach, CA |
| | <ul style="list-style-type: none"> ▪ Led psych-educational training sessions for staff ▪ Conducted psychological testing for adolescents/young adults ▪ Provided individual therapy utilizing treatment interventions | |
| 2006-2007 | The Rita Project <i>Art Therapist</i> | Los Angeles, CA |
| | <ul style="list-style-type: none"> ▪ Led community outreach for suicide prevention ▪ Conducted art therapy open studio sessions ▪ Supervised art therapy interns | |
| 2005-2006 | Union Rescue Mission for the Homeless <i>Doctoral Practicum Trainee</i> | Los Angeles, CA |
| | <ul style="list-style-type: none"> ▪ Conducted assessments for clients with drug abuse histories ▪ Provided individual therapy utilizing treatment interventions ▪ Collaborated in assessment and diagnosis with treatment team ▪ Implemented individual treatment plans with clients | |

- 2003-2004 Cedars-Sinai Medical Center Los Angeles, CA
Art Therapy Fellow/Primary Therapist
- Primary therapist for groups and individual patients
 - Trained with multidisciplinary team of clinicians
 - Led clinical presentations in treatment team meetings
 - Documented treatment plans and patient progress
- 2002-2003 Brooklyn Community Counseling Center New York, NY
Art Therapist in New York Public Schools
- Conducted group and individual art therapy sessions
 - Documented treatment plans and progress of client
 - Led clinical presentations in team meetings
 - Performed crisis counseling for parents and teachers
- 2002 Summer Partnership for After School Education New York, NY
Personal Development Teacher/Art Therapist
- Conducted art therapy lessons
 - Created a curriculum for youth arts program
 - Documented program goals and progression
- 2001-2002 Mapplethorpe Residential Treatment Facility New York, NY
Art Therapy Intern
- Conducted art therapy sessions
 - Documentation of charts
 - Planned treatment and discharge for residents
- 2000-2001 Children and Family Services, Safe Space New York, NY
Case Manager
- Conducted therapy sessions
 - Performed intake and assessments
 - Planned treatment and discharge
 - Performed client outreach services

RESEARCH EXPERIENCE

- 2005-2008 Pepperdine University Los Angeles, CA
Research Assistant for Dr. Daryl Rowe
- Researched journal article databases
 - Edited and organized documents
 - Created referencing index for literature

PROFESSIONAL PRESENTATIONS & CONFERENCES

- 2011-Spring Mindfulness in Medicine, Healthcare & Society Boston, MA
Center For Mindfulness Annual Scientific Conference
- Attended Training for Mindfulness in Psychology
 - Attended lecture for Mindfulness in Communities
 - Participated in Silent Retreat with Jon Kabat-Zinn

- | | | |
|-------------|---|-----------------|
| 2011-Summer | Mindfulness-Based Stress Reduction In Mind / Body Medicine ▪ <i>Seven Day Training for Healthcare Professionals</i> | Rhinebeck, NY |
| 2011-Summer | Meditation & Psychotherapy: <i>Helping Our Patients, Helping Ourselves</i> ▪ Attended lectures on current mindfulness studies ▪ Attended training sessions on meditation and self-care | Cambridge, MA |
| 2011 Spring | Skills for Psychological Recovery (SPR) ▪ Completed FEMA crisis counseling training | Boston, MA |
| 2010 Summer | Meditation & Psychotherapy: <i>Refining the Art</i> ▪ Attended lectures on current mindfulness studies ▪ Attended training sessions on meditation and movement | Cambridge, MA |
| 2009 Spring | International Neuropsychological Society Annual Meeting ▪ Attended lectures on current topics in neuropsychology ▪ Attended training sessions for doctoral students | Atlanta, GA |
| 2006 & 2008 | Pepperdine University <i>Expressive Therapies Presentation</i> ▪ Led art therapy studio experiential for doctoral students ▪ Discussed client concerns in sample artwork ▪ Provided educational information on expressive therapies | Los Angeles, CA |

ORGANIZATIONAL MEMBERSHIPS

- American Psychological Association (APA) Student Affiliate
- American Art Therapy Association (AATA)
- Art Therapy Credentials Board (ATCB)
- International Art Therapy Organization (IATO)
- Society for the Arts in Healthcare (SAH)

ABSTRACT

Mindfulness Based Stress Reduction (MBSR) an empirically effective method of promoting psychological health and wellbeing. But access to MBSR is lacking in underserved urban communities. This is due in part to the limited research focus on urban communities – MBSR studies have primarily focused on measuring symptom reduction in middle-class – and in part to cultural concerns that diverse urban communities tend to have about mindfulness.

To address the needs of diverse urban communities, this dissertation develops a culturally responsive mindfulness-based art therapy curriculum (MAT-C) as a resource for clinicians to teach adapted MBSR techniques to parents. Developing MAT-C had 3 phases: (a) a comprehensive review of current literature on mindfulness and art therapy methods; (b) participatory research in mindfulness communities and community mental health agencies; and (c) an evaluation by experienced community-based clinicians of MAT-C's cultural relevance, quality, and effectiveness. Implications and future considerations of this study are discussed based on the evaluators' critiques and participatory research experiences.

Chapter I: Introduction and Literature Review

Mindfulness has demonstrated effectiveness in the promotion of psychological health and wellbeing (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Brown & Ryan, 2003; Kabat-Zinn, 1990, 1994, 2005; Santorelli, 2000). Mindful awareness practices – MAPs¹ – cultivate the capacity for attention and awareness (Brown & Ryan, 2003), and one’s capacity for awareness is essential in being able to respond to stress without adverse psychological or physical outcomes (Mendelson et al., 2010).

Mindfulness is also connected with self-compassion – the ability to tolerate difficult emotions such as fear, anger, sadness, shame, and self-doubt without stress (Germer, 2009). Holding onto negative emotions can forestall good mental health and wellbeing. While negative thoughts or emotions are unavoidable in life, a mindful practice can adjust the way one relates to those thoughts and emotions.

Psychologists conceptualize mindfulness as the practice of increasing awareness in order to respond successfully to thoughts and reactions that would otherwise increase emotional distress (Shapiro & Carlson, 2009). Stated simply, mindfulness training cultivates the ability to respond in the moment, instead of habitually reacting to the moment.

Research evidence suggests that MAPs can positively change the brain’s structure and chemistry. By altering brain activation, mindfulness increases

¹ MAPs, mindful awareness practices is a termed used by the Mindful Awareness Research Center at the University of California Los Angeles.

positive affect as well as bolstering immune system functioning (Davidson et al., 2003).

Other studies also found that MAP improves cardiac functions, endocrine functions and cultivates empathy and compassion (Siegel, 2007). Siegel (2007) describes the act of paying attention as an important task that assists in the creation of new synaptic connections in the brain. Synaptic growth and new patterns of neural activation can aid in positive brain changes. Research has found that structural changes in the brain increased positive brain functions when participants completed a meditation course. Areas of the brain responsible for emotional balance, empathy, body regulation, fear, insight and other states, have been found to adapt positively after a mindfulness instruction course (Hölzel et al., 2011a; Hölzel et al., 2011b; Lazar et al., 2005; Siegel 2007).

Attention to mindfulness continues to grow. In 2004, there were an estimated 10 million meditation practitioners in the United States, and over 100 million worldwide. It may be the single most practiced and researched psychological discipline (Duerr, 2004). Although the studies have widely focused on measuring symptom reduction in middle-class and working-class populations (Roth & Stanley, 2002), a few studies now include underserved inner-city communities. These studies suggest that mindfulness-based approaches may be beneficial in improving adjustment among chronically stressed, disadvantaged populations (Mendelson et al., 2010; Samuelson, Carmody, Kabat-Zinn, & Bratt, 2007).

Mindfulness based stress reduction (MBSR), a particular type of mindfulness instruction course, has been found to reduce stress effectively in underserved inner-city populations for those who participated in the program. In an underserved area of Boston, Massachusetts, mothers in recovery from drug addiction and at risk for contracting HIV / AIDS improved resistance to drug use and lowered their chances of contracting the virus after a mindfulness course (Vallejo & Amaro, 2009). In another low SES neighborhood in Massachusetts, an MBSR clinic served the community for 7 years by attending to the socio-economic and cultural barriers that participants faced and supporting them through other additional challenges (Kabat-Zinn, personal communication, 2011). A clinic in Connecticut created an English and Spanish MBSR program to address the needs of the ethnically diverse, low income community they served (Roth, 1997; Roth & Creaser, 1997), and in a continuation of the study, demonstrated that health problems and healthcare costs diminish for participants who complete an MBSR course (Roth & Stanley, 2002; Roth & Robbins, 2004).

Despite this increasing focus on mindfulness, a limited number of studies have engaged inner-city and disadvantaged populations; its use and effectiveness in the community remains relatively unexplored. The goal of this dissertation is to develop a mindfulness based art therapy curriculum – MAT-C– that is responsive to the needs of parents in underserved communities.

MBAT: The Integration of Art Therapy with MBSR

Art therapy has long been considered a useful treatment in disorders of self-regulation (Carolan, 2007). Early art therapy research, similar to the beginnings of MBSR, mainly studied patients suffering from chronic pain and medical illnesses (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001; Monti et al., 2006; Nainis et al., 2006). This particular kind of art therapy practice became known as medical art therapy; and MBSR in its beginnings in the Stress Reduction Clinic, provided assistance to suffering and terminally ill patients as well. MBSR and medical art therapy interventions both aim to alleviate suffering. Both are also the subjects of increasing research. And now both disciplines are being studied and used successfully in other therapeutic situations.

In an outcomes-based art therapy research project with pediatric patients, art therapy interventions aided in the reduction of symptoms associated with PTSD (Chapman et al. 2001). A unique art therapy intervention was implemented, the Chapman Art Therapy Treatment Intervention (CATTI), which is designed to help reduce PTSD symptoms in pediatric trauma patients. Symptoms of PTSD were assessed at 1 week, 1 month, and 6 months after discharge from the hospital. The evidence supported the finding that children who received the art therapy intervention showed reduced acute stress symptoms.

A study by Nainis et al. (2006), utilized a quasi-experimental design to find evidence for art therapy's efficacy in cancer symptom control. The

Edmonton Symptom Assessment Scale (ESAS) and the Spielberger State-Trait Anxiety Index (STAI-S) were used to measure physical and mental symptoms in 50 patients pre- and post-art therapy intervention. Pain, stress, and tiredness decreased significantly for the 50 patients in the study (Nainis et al., 2006). Researcher has shown that art therapy can help significantly to reduce symptoms for suffering patients and increase their quality of life overall.

Current research integrating art therapy with MBSR has culminated in a new approach: mindfulness based art therapy (MBAT). MBAT utilizes the concepts of self-regulation theory developed by Howard Leventhal (as cited in Monti et al., 2006), a theory that analyzes the ways in which people confront health issues and trauma, and adjust to make meaning of their experience.

Recent studies of MBAT demonstrate the method's potential. In an experimental MBAT study, an 8-week intervention with patients suffering from cancer showed significant symptom reduction. The researchers, moreover, reported that it was easy to integrate art therapy interventions with MBSR (Monti et al., 2006).

MAT-C is similar to MBAT – both integrate art therapy with MBSR and both focus on self-regulation of emotional states – but there is an important difference. MBAT utilizes a medical art therapy model, while MAT-C is not medically-based, but a skill-based alternative approach to psychological health and wellbeing. The MBAT study does show the successful integration of MBSR with evidenced based art therapy interventions.

Statement of the Problem

MAPs are ways of promoting a stress-reduced lifestyle, good health and wellbeing – they are not simply interventions to be utilized in psychological treatments. The holistic health focus of mindfulness may yield positive effects such as the reduction of stress and decreasing disorders of the body and mind in urban, low-income communities. Residents of low-income, urban communities could potentially benefit from practicing mindfulness in their daily lives. Though there is promising research that promotes the utility of a MAP for improving the lives of those in underserved inner-city populations, access to learning a MAP is lacking in these communities.

A few reasons that inner-city communities have not benefited from mindfulness practices are (a) religio-cultural bias against mindfulness practice, which is often perceived as a non-Christian religious practice, (b) the cost of developing and implementing a program and (c) that few studies are implemented in underserved communities. The curriculum in this study utilizes empirically-supported mindful awareness interventions in the community while maintaining sensitivity to cultural considerations. The program also takes into account the guidelines for reimbursement for the mental health clinics that utilize MAPs.

People in underserved urban communities are at risk for a range of negative outcomes related to stress, including social-emotional difficulties, behavior problems, and poor academic performance (Waite & Ramsay, 2010). Low socioeconomic status brings with it a level of stress involving

environmental, institutional, and mental health concerns (Baer, 2006). This includes stress due to economic issues, housing problems, lack of resources, and other systemic issues that plague inner-city communities.

In the United States, racial inequality is reinforced through segregated residential areas for minorities (Massey & Denton, 1993) and for immigrant populations (Rosenbaum & Friedman, 2007). Due to these inequities, low SES groups often suffer from poor diet, substance abuse, lack of exercise, and disparities in health care (Baum, Garofalo, & Yali, 1999). Higher rates of violence, homicide, and incarceration are other factors that are reinforced in society, structurally, and institutionally (Baer, 2006). The literature shows that psychological and physical health can be damaged due to effects of discrimination (Baum et al., 1999) and that chronic stress associated with low SES adversely affects health.

The goal of MAT-C is to respond to these problems by integrating mindfulness and art therapy techniques that have been utilized in low-income, urban communities; and by synthesizing mindfulness techniques with art therapy to develop a course for parents experiencing stress and other related issues. An example of such an agency, referred to throughout this study is Children's Services of Roxbury in the Boston, Massachusetts area.

This study will: (a) Review the literature on mindfulness interventions and art therapy interventions utilized in low-income, urban communities; (b) Develop a course for parents involved with outpatient services that synthesizes

mindfulness techniques with art therapy; and (c) Preliminarily evaluate the curriculum developed.

The remainder of this dissertation will present a review of the literature supporting the development of the MAT-C including: definitions and operationalization of mindfulness; research on the Mindfulness-Based Stress Reduction (MBSR) program established by the Center For Mindfulness at the University of Massachusetts Medical Center, the foundation for the MAT-C; and information about art therapy interventions to be utilized in support of the mindfulness curriculum. A description of the methodology of the development of MAT-C and evaluation methods will follow.

Definition of Key Terms

Mindfulness/ Mindful Awareness. The definition of mindfulness for the purpose of this project integrates operational definitions from several theorist. The function of mindfulness practice in a psychological context is the increasing of awareness in order to respond successfully to thoughts and reactions that would otherwise increase emotional distress (Shapiro & Carlson, 2009). One very standard definition from Kabat-Zinn (1994) is “Mindfulness means paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally” (p. 4). However, the term nonjudgmentally is avoided in the key terms for this project in an effort to utilize language that cannot be misinterpreted. Judgment is a central component of some Christian traditions, therefore to suggest non-judgment could be interpreted as antithetical to Christian practices and beliefs. Mindfulness will be defined here as a process,

that can be utilized independent of religious, spiritual, or cultural beliefs, of engaging in moment-to- moment observations of one's internal experiences (mental and emotional) and one's physical experiences that involves the capacity for attention and awareness and paying attention on purpose, in a particular way (Kabat-Zinn, 1994).

Self-Regulation. An individual's ability to modulate thoughts, emotions, behaviors, or attention by deliberate, automatic use of specific mechanisms through cognitive and mental skills (Karoly, 1993).

Attention. The sustained focus that an individual cultivates by attending to a particular stimulus (Siegel, 2007). Intentional focus for the enhancing of sensory awareness; (Baer, Smith, & Allen, 2004); and receptive attention to and awareness of present events and experiences (Brown & Ryan, 2003).

MAP(s). Mindful Awareness Practice(s) is any practice such as art activities, meditation, yoga, body scan or walking meditation that incorporate mindfulness.

MAT-C. The proposed curriculum in this study will be named MAT-C, Mindfulness Based Art Therapy Curriculum. In this study the curriculum is designed for use with parents.

Cultural Competence. A mental health professionals awareness of their own bias, prejudices and assumptions while encountering culturally diverse clients; the process of obtaining knowledge about culturally diverse groups and creating an environment sensitive to their needs. A practitioner's willingness to

obtain skills, awareness and knowledge for working with diverse clients and populations (adapted from Campinha-Bacote, 2002).

Underserved Communities. Groups that have documented minimal access or use of mental health services, face barriers to participation in public mental health, the policy making process, have non-existing or minimal health care insurance coverage and/or have been identified as having a need for mental health services (Snowden & Cheung, 1990; CDC Public Health Practice Program Office, 1997). In this study the terms underserved, inner-city and urban communities will be used synonymously.

A Brief History of Mindfulness

Mindfulness is a term whose origins are in Eastern contemplative traditions that began over 2500 years ago. “Mindfulness” is an English translation of circumspection, awareness, discernment and retention in the Pali language (Black, 2011; Shapiro & Carlson, 2009). Mindfulness is derived from the Sanskrit word *dharma*, or “the way things are,” (Kabat-Zinn, 2003, p. 145), to recollect, (Brown, Ryan & Creswell, 2007), and is said to signify a state of consciousness (Bodhi, 2000). It has also been described as a receptive attention to and awareness of present events and experiences (Brown & Ryan, 2003; Kabat-Zinn, 2003). Some consider it “the heart” of Buddhist meditation (Thera, as cited in Shapiro, Carlson, Astin, & Freedman, 2006) as well as other contemplative disciplines (Kabat-Zinn, 2003).

Contemplative Christian Practices

It is important to note that contemplative practices have existed for many religions and are not exclusive to Eastern practices. Many Western religious traditions, including Christianity, include some form of contemplative or silent practice such as prayer, walking, nature observance, and meditation (Duerr, 2004; Siegel, 2007). Christian religions include Catholicism, formal Protestant denominations (e.g., Baptist, Methodist, Episcopalian, etc.), as well as non-denominational Christians (e.g., evangelicals). In the United States, most African Americans and Latinos who live in low-income communities practice some form of Christianity and religion is often a central aspect of their lives (Moll, 2006). It is important to address the issue of utilizing a practice that may be perceived as non-Christian in these communities where many people may have concerns about mindfulness and its association to Buddhism.

While teaching MBSR in an underserved community in Boston, a meditation practitioner experienced a resistance from participants due to their cultural and religious beliefs (Vallejo, personal communication, July 2011). Another MBSR instructor reported the same experience in another underserved area of Boston (de Torrijos, personal communication, July 2011). MAPs for some Christian participants can seem antithetical to their religious beliefs. Rather than circumvent the idea of spirituality in MAPs, MAT-C is developed to address religion-based unease, as well as give participants different avenues for personal focus and intention by raising their awareness of contemplative practices.

One such avenue is the Christian practice of the centering prayer. The centering prayer is drawn from ancient Christian contemplative heritage and can be traced to early Christian monks in the third century C.E. Centering prayer is practiced much in the same way as mindfulness meditation with a strong emphasis on silence, but the focus of centering prayer is to deepen one's relationship with God. The prayer consists of responding to the spirit of Jesus by consenting to the internal presence of God. A word or symbol connected to the sacred such as divine, Jesus, Lord, God or Savior can be the focus of silent prayer (Ferguson, Willemsen, & Castañeto, 2010).

Christian meditation differs slightly from Eastern practices with its focus on Biblical scriptures and the Divine. In her book *Breathe, Balance and Stretch* (2006), Reverend Stephanie Butler proposes mental meditation and physical exercise as a source of connection with the Divine. Butler points to scriptures in the King James version of the Old Testament that prescribe meditation as a source of religious practice. Butler's works offer a way to incorporate Christian religious and spiritual beliefs into every aspect of MAPs. The curriculum will use a similar approach to help participants overcome religion-based unease; by offering participants the opportunity to include their spiritual and/or cultural beliefs into the practice. The MAT-C program will also emphasize the science-based definitions of mindfulness as involving the general capacity for attention and awareness that can be utilized independent of religious, spiritual, or cultural beliefs.

The Culture of Buddhist Psychology

The origin of the use of mindfulness in psychotherapy is most directly tied to Buddhist psychology. Buddhist psychology is based on translations of ancient Pali texts of India 2,500 years ago and mindfulness practices are a part of the discipline (Kelly, 2008; Siegel, Germer, & Olendzki, 2009).

A Buddhist Manual of Psychological Ethics, published in 1900, set forth psychological tenets based on Buddhist practices introducing Buddhist Psychology to the West. Some main psychological theories are presented, *motivation, perception and cognition* alongside traditional Buddhist teachings. One core practice of Buddhist psychology is personal development through meditation. Modern Buddhist psychologists describe mindfulness practice an intuitive, conceptual, personal journey of self-discovery. Buddhist psychology is similar to the therapeutic application of mindfulness with its focus on attention and awareness of moment-to- moment experience. Khong (2009) views Western psychological implementation of mindfulness as an acceptance of Buddhist practices, however, other Buddhist psychologists find therapeutic applications of mindfulness diluted and simply a derivative of Buddhist practice and tenets (Siegel et al., 2009; Shapiro & Walsh, 2003; Walsh & Shapiro, 2006; Walsh, 1980).

Much has been said about mindfulness interventions and their relationship to Buddhist religious practices. Buddhist psychologist on the other hand caution that contemporary mindfulness interventions such as MBSR, extrapolate from Buddhist practices (Walsh & Shapiro, 2006; Walsh, 1980). One concern that Buddhist practitioners raise is that mindfulness studies are limited

to one focus, attention regulation. These practitioners contend that this limited focus leads to a disregard of mindfulness meditation as a discipline, practiced in Buddhist religions.

Definitions for Mindfulness and Meditation in Psychology

Prior researchers have defined “mindfulness” in a variety of ways. Kabat-Zinn’s widely-cited definition of mindfulness is “paying attention in a particular way: on purpose, in the present moment and non-judgmentally” (Kabat-Zinn, 1994, p. 4). Other definitions include: attending to the present in a sustained and receptive fashion (Brown & Ryan, 2003); and voluntarily bringing mental processes into conscious awareness while intentionally attending with openness and acceptance to the present moment (Shapiro & Carlson, 2009; Shapiro & Walsh, 2003). The authors concur that a mindfulness stance or attitude of non-judgment, acceptance, trust, and patience is essential for the practice.

In 2004, Bishop in a consortium of psychology researchers and mindfulness practitioners, gathered to establish a consensus for an operational definition of mindfulness. They proposed that there are two components to mindfulness.

Per Bishop (2004) mindfulness’ first component is self-regulating one’s attention. This gives researchers a way to measure mindfulness’ efficacy: studies can measure improvements in sustained attention and switching (Bishop, 2004) after mindfulness interventions.

Bishop’s (2004) second component of mindfulness is orienting one’s experience of the present moment. This too allows researchers to measure the

effect of mindfulness practices: studies can examine changes in coping styles and the way individuals experience distress after mindfulness interventions (Bishop, 2004).

Shapiro et al., (2006) proposed three components in mechanisms of mindfulness – (a) intention, (b) attention, and (c) attitude (IAA) – that do not occur independent of each other but rather are concurrent processes. These “axioms” of mindfulness are described as the “building blocks” from which other factors arise (Shapiro et al., 2006, p. 375). Intention is said to “...set the stage for what is possible” (Kabat-Zinn, 1990, p. 32) and it indicates the reason for practice. Attention involves the awareness of one’s experience in the moment as an observer. Attitude refers to the quality of attention brought to that experience.

Shapiro et al., (2006) attempt to construct a way of understanding the process involved in mindfulness interventions, and so they propose four other related factors for evaluation: self-regulation, values clarification, cognitive-behavioral flexibility, and exposure. Walsh and Shapiro (2006) posit that if psychology incorporates only one aspect of meditation (i.e. mindfulness), psychology may overlook and exclude the value that Eastern disciplines have for psychological and physiological health. Their concern is that a specific focus on one area of contemplative practice – mindfulness – could diminish the utility of the practice as a whole.

While more rigorous research yields evidence for the value of mindfulness in psychology, Walsh and Shapiro (2006) caution that the broader utility of other

contemplative practices may be overlooked. They assert that, in order to feel the full benefit of mindfulness meditation, Western investigation into the processes and mechanisms involved should proceed with sensitivity and respect for the traditions from which they arrived (Kabat-Zinn, 2003; Walsh, 1980; Walsh & Shapiro, 2006).

Walsh & Shapiro (2006) explain that there are many types of meditation and ways of meditating but all have mental training as a common theme. The authors contend that Western perspectives is viewed as a self-regulatory practice aimed at cultivating attention and wellbeing; and that Eastern perspectives have a similar aim, cultivating positive emotions and decreasing negative emotions for daily living and self-regulation of emotions. Walsh and Shapiro (2006) offer a combined definition of meditation:

...a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and or specific capacities such as calm clarity and concentration. (pp. 228-229)

Shapiro & Carlson (2009) explains that mindfulness has two parts: “an outcome, mindful awareness and a process, mindful practice” (p. 556). The former, mindful awareness, is a deep knowing that arrives from escaping delusional thinking. The latter, mindful practice, is the practice of intentionally paying attention in a specific way. The quality of attention in mindfulness is focused, yet broad and sustained, with the ability to shift attention between

stimuli (Burke, 2010); or intentional, self-regulating, directing, and/or switching attention simultaneously (Bishop 2004; Kabat-Zinn, 1990; Shapiro et al., 2006).

Other Mindfulness Constructs

It is necessary to specify the type of mindfulness construct that this project will examine. Earlier researchers examined a variety of related concepts such as cognition, self-awareness, and concentration. While these concepts bear similarities to mindfulness, there are differences in aim and intention.

Eastern contemplative disciplines receive wide credit for mindfulness practices, but some Western ideas have similar principles. Husserl's concept of "bracketing," which involves the attempt to set aside assumptions about a matter being studied, is similar to the mindfulness concept of suspending judgment (Brown & Cordon, 2009).

Self-awareness is another area of psychology and psychotherapy that is distinct from the type of mindfulness to which this study will refer. For example, Duval and Wicklund's objective self-awareness theory, Buss's self-consciousness theory, and Carver and Scheier's control theory (as cited in Brown & Ryan, 2003) all involve self-awareness that is related to but distinct from the type of mindfulness that this project will study. Shapiro et al. (2006) contend that this form of highly focused self-awareness to internal states is a construct that differs from mindfulness; a broad attention to what is taking place in the present moment and acceptance of that moment without attempts to make it something other.

Langer's (1989) research examines the relationship between mindfulness, health and the consequences of mindlessness. This research has participants focused on goal-oriented activities in order to increase cognition. Langer's conceptual definition of mindfulness resembles that of contemplative disciplines (i.e. intentional attention, awareness in the moment, mental flexibility). But Langer and fellow researchers are more specifically speaking of one's cognitive ability and capacity to problem-solve external stimuli as opposed to the construct of mindfulness as defined by other mindfulness practitioners, which involves non-striving and non-judgmental observation of one's inner experience. Langer's construct of mindfulness "has been conducted entirely from a Western scientific perspective," and moreover Langer herself cautions drawing similarities between these two distinct forms of mindfulness.

Mindfulness through Langer's (2009) framework is devoid of meditation and other methods in which the aim is to let go of thoughts, without any attempt to discern the various stimuli that come to mind. Langer's concept is almost the opposite, in that mindfulness is comprised of focus and concentration in the moment, and the cognitive ability to process stimuli.

Mindfulness Processes and Mechanisms

A common thread in the literature on mindfulness practice is its salutary effect on the mental health of those who practice it. To fully understand and support such findings, researchers are beginning to look more closely at mindfulness mechanisms and processes – the ways that mindfulness practices

work. In particular, the neurobiological processes involved in mindfulness are becoming a central focus in the current literature.

In a blind randomized trial study, Jensen and colleagues compared the level of attentiveness of four groups: (a) an MBSR experimental group, (b) an active control group receiving a non-mindfulness stress reduction (NMSR), (c) an inactive group receiving a monetary incentive for attention tasks, and (d) a non-manipulated inactive group. They found that selective attention improved more for the MBSR group trained in mindful practice than for the untrained group. Increased levels of mindfulness, moreover, were related to improved visual and working memory and less perceived stress (Jensen, Vanglilde, Frokjaer, Hasselbalch, 2011).

Baer (2003), in an effort to explain how behavior change and symptom reduction occur through mindfulness, outlined five distinct mechanisms: (a) exposure, (b) cognitive change, (c) self-management, (d) relaxation and (e) acceptance. Similarly, Brown et al. (2007), described mindfulness mechanisms as (a) insight, (b) exposure, (c) nonattachment, (d) enhanced mind-body functioning, and (e) integrated functioning.

In a longitudinal study, 16 non-meditators who participated in an 8-week MBSR course showed positive changes in the concentration of gray matter in their brains when compared to a control group (Hölzel et al., 2011a). Gray matter concentration increased in the areas of the brain responsible for learning, memory processes, emotional regulation, and perspective-taking. A decrease in age related cortical thinning was also discovered. The implications of this study

are that specific brain regions with an increase in gray matter show a greater capacity for an individual's awareness and experience of internal stimuli; thereby improving integration of emotion and cognition and allowing for a flexible and adaptive approach to stressful events (Lazar et al., 2005).

In a second longitudinal study Hölzel and colleagues (2011b) studied 26 participants suffering from stress as measured by the perceived stress scale (PSS) participated in an 8-week MBSR program. Participants reported reduced stress after the intervention as measured by the PSS, and this was in correlation to structural changes in the amygdala. The study indicated that neuroplastic changes are connected with improvements in psychological states. After the meditation intervention, participants showed an improvement in prioritizing tasks in particular areas of the brain. The research suggests that mindfulness meditators benefit from improved conflict monitoring in their executive functioning; the area of the brain responsible for planning, organizing and paying attention, among other tasks.

In a neuroimaging study, Farb et al., (2007) measured the brain activity of MBSR participants after they completed an 8-week course with a control group who had not completed the program. The researchers investigated two forms of self-referential activity: experience across time (narrative) and experience first centered in the presence (momentary). The control group participants, during experiential focus, exhibited reduced activity in self-referential areas of the brain (the medial prefrontal cortex) that involved narrative focus.

In contrast, participants trained in mindfulness showed a more marked reduction in activity in the medial prefrontal cortex (mPFC) during experiential focus. The experienced meditators exhibited increased insula activation when they focused on a momentary experience.

The brain activity change in these areas indicates that individuals trained in meditation are more able to separate the distinct experiences of self, and to differentiate momentary experience from narrative experience. This type of perspective-taking is associated with greater self-awareness.

Siegel (2007) describes three mechanisms of attention and their role in enhancing receptive awareness: “(1) *exogenous*, when an immediate stimulus such as a loud noise drives attention; (2) *endogenous*, a sustained attention that an individual cultivates by focusing on a particular stimulus; and (3) *executive*, a flexible mode of attention not governed by external or focused attention.” (p. 124). The integration of these three mechanisms is essential for self-regulation of emotional behavior, response to stress, and social skills, which are in turn associated with the anterior cingulate cortex (ACC) and prefrontal cortex (PFC). Siegel posits that the brain’s central regulatory system assists in the development of self-awareness as well as flexibility of attention to others and ourselves, both of which can happen without the awareness of an individual, but both of which are essential components in mindful awareness.

The processes involved in mindfulness continue to receive greater consideration in the literature. A consensus seems to be forming that the anecdotal mental health improvements that those who practice mindfulness

report are supported by scientific study in measurable, biologically-manifested ways. The benefits of mindfulness practice are real.

Hölzel's and colleagues neurobiological bases of four mindfulness processes. One of the most recent and thorough examinations of the neurobiological underpinnings of mindfulness practice's processes is the work of Hölzel et al., (2011b). Their research connects theoretical findings about four distinct mindfulness processes with neurobiological mechanisms.

Mindfulness practices improve attention regulation. One process in mindfulness that gains considerable focus is attention regulation. Attention-sustaining is associated with the ACC. Neuroimaging studies have found that the ACC's executive functioning is responsible for planning, judgment and attention (van Veen & Carter as cited in Hölzel et al., 2011b). Posner and Peterson (as cited in Hölzel et al., 2011b) refer to focusing on an object of attention while ignoring distractions, and conflict monitoring as key elements of executive attention. ACC activation, together with the fronto-insular cortex (FIC) is thought to maintain and regulate attention through "top down processing" that involves rapid switching between multiple areas of the brain. (Hölzel et al., 2011b, p. 540).

During meditation, the ACC and FIC work to recognize distractions, both external and internal, and then engage neuronal networks to multiple areas of the brain. Hölzel et al., (2011b) used fMRI to compare meditators to a control group and found that meditators showed greater activation in the ACC. Lutz, A., Brefczynski-Lewis, Johnstone, & Davidson, (2008) found that ACC activation

decreases when meditation practice is cultivated, when focus of attention becomes more stable and distractions less noticeable. In MRI studies, brain gray matter analysis showed cortical thickness in the dorsal ACC of experienced meditators as compared to a control group (Grant, Courtemanche, Duerden, Duncan, & Rainville, 2010). These findings suggest that mindfulness practices can enhance attention regulation by conditioning the ACC. This has promising implications for using a mindfulness curriculum to decrease deficits in attention due to disorders.

Mindfulness practices improve body awareness. Body awareness is the internal experience of sensation and emotion and is an important component of MAPs. Psychologically, body awareness is an essential part of regulating emotional states. Body awareness is also thought to be crucial for empathy and compassion (Hölzel et al., 2011b; Siegel, 2007). Being able to recognize one's own affective states is a key element in recognizing these states in others. And being able to accurately assess one's own internal state is necessary to one's ability to understand another (Decety & Jackson, 2004).

An individual's body awareness is mediated through the temporoparietal junction (TPJ). Structural changes in the TPJ are associated with increased body awareness.

Hölzel and colleagues (2011a) studied the brain regions of participants in an 8-week mindfulness course, finding a correlation between mindfulness practice and an increase in TPJ gray matter was found.

Mindfulness practices improve emotional state regulation. The regulation of emotional states is another area that mindful practice seems to help on a biological level. Hölzel and colleagues (2011b), divide this process into two parts: reappraisal and exposure.

Emotional state reappraisal – the experience of emotional reactions with acceptance – is linked to the PFC. The PFC is essential to voluntary emotional regulation, inhibition (Garland, Gaylord, & Fredrickson, 2011), attention regulation, and other executive functioning tasks (Lezak, Howieson, & Loring, 2004).

Emotional state exposure – an open, receptive attention to whatever is in the field of awareness – is associated with the hippocampus and amygdala and a decrease in reaction to inner experience. Santorelli (2000) describes exposure as turning towards unpleasant emotions.

Imaging studies have shown that mindfulness improves prefrontal control over the amygdala, essential in arousal and reaction and affect regulation. Physiological studies show that meditation training decreases emotional reactivity. Individuals who practiced mindfulness have shown a decrease in reactivity and rapid return to baseline after receiving aversive stimuli (Hölzel et al., 2011b). During emotional regulation, pre-frontal neural systems, including the PFC and ACC, regulate areas (such as the amygdala) that are responsive in detecting arousing stimulus (Ochsner & Gross, 2005). The studies have found that the ACC is also involved in emotion activation (Hölzel et al., 2011b) and the distribution of thought content (Siegel, 2007).

It is a possibility that this is the way in which mindfulness can positively affect one's emotional wellbeing. MAPs, consequently, may yield positive results in treating mood and personality disorders as well as other similar psychological disorders.

Mindfulness practices improve self-perception. Changing one's perspective on one's sense of self, including identity detachment from a static sense of self, is associated with the posterior cingulate cortex, the insula, temporoparietal junction and changes in self-concept (Hölzel et al., 2011b). Mindfulness leads to changes in brain regions responsible for self-perception. The self-concept styles of mindfulness-practicing individuals are thought to be associated with fewer pathological symptoms.

There is strong evidence that mindfulness practice can lead to neurological and structural changes in the brain that are associated with healthy psychological functioning. The studies on how brain functioning is affected by mindfulness have sparked research interest in mindfulness measurements.

Measuring Mindfulness

While attention to the utility of mindfulness in psychology has grown over the last decades, so has the rigor of research investigation into mindfulness's properties and processes. In 1998, Santorelli & Kabat-Zinn counted 240 programs in the United States alone utilizing MAPs (personal communication, June 18, 2011) and the number has continued to grow worldwide (Duerr, 2004). With this growth has come the need for instruments to understand, measure and replicate effective mindfulness interventions.

The Mindfulness Attention Awareness Scale (MAAS) is a 15 item, 7 point-scaled self-reporting questionnaire that measures a single factor; one's open receptive attention to what is taking place in the present moment (Brown & Ryan, 2003). A clinical intervention study utilizing MAAS found that mindfulness states increased over time for cancer patients who received mindfulness-based stress reduction training (MBSR), and that the increase was related to a decline in mood disturbance and stress (Carlson & Brown, 2005). The purpose of the research was to investigate the correlation between mindfulness and wellbeing, and to support the reliability and validity of MAAS as a measurement tool. The results showed that higher levels of mindfulness after MBSR training were related to lower levels of stress and mood disturbance. Further, MAAS predicted a stronger relationship between "implicit" and "explicit" emotional states. In 2007, Mackillop and Anderson further examined the validity of the MAAS thereby establishing reliability of the scale as a measurement tool for mindfulness.

The Toronto Mindfulness Scale (TMS) was developed using two studies in order to design and evaluate the psychometric properties of the instrument (Davis, Lau, & Cairns, 2009; Lau et al., 2006). Utilizing the operational definition composed by a team of mindfulness researchers and practitioners, researchers found strong internal validity, criterion and incremental validity. TMS is a 13 item, two factor questionnaire that captures Curiosity (investigation of one's own experience) and De-centering (a switch from personalizing one's experience to a broader awareness of that experience).

The Kentucky Inventory of Mindfulness (KIMS) assesses mindfulness by self-report (Baer et al., 2004). Utilizing a study with a sample of undergraduate students and a sample of outpatients diagnosed with borderline personality disorder, Baer et al., (2004) examined four mindfulness skills; observing, describing, acting with awareness and accepting without judgment.

The Five Facet Mindfulness Questionnaire (FFMQ), a revision of the KIMS that is used to assess the mindfulness construct (Baer et al., 2008; Van Dam Earleywine, & Danoff-Burg, 2009). Carmody and Baer (2008) examined the mindfulness practices of 174 participants in an 8-week MBSR program utilizing the FFMQ scale. Participants had varying issues such as stress related illness, anxiety, and chronic pain. The researchers recorded pre- and post-test measures of mindfulness (Baer, 2006), psychological symptoms, medical symptoms, and wellbeing. They found that increased mindfulness through formal meditation practices improved health and reduced physical symptoms of stress and illness.

Other scales include the Philadelphia Mindfulness Scale (PHLMS) which assesses present moment awareness and acceptance (Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008); and the Freiburg Mindfulness Inventory (FMI), a 30 item questionnaire that measures mindfulness (Buchheld, Grossman, & Walach, 2001; Kohls, Sauer, & Walach, 2009; Walach, Buchheld, Buttenmüller, Kleinknecht, & Schmidt, 2006).

Mindfulness-Based Stress Reduction

Mindfulness techniques have been incorporated into several empirically based interventions in medical and mental health settings. One of the most

researched is mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982, 1990) that was developed at the University of Massachusetts Medical Center in 1979 for patients experiencing chronic pain. Kabat-Zinn (1990) states that the development of MBSR had two intentions: (a) MBSR as a way to reduce physical discomfort and pain and (b) as a model in other healthcare environments as a preventative method of coping with stress-related events.

MBSR is part of a branch of behavioral health known as integrative medicine. Integrative medicine focuses on the whole person in context of their social and cultural environment (Kabat-Zinn, 1990). The practice puts emphasis on the collaboration between the client and the practitioner with the belief that the client can affect their own health in a positive way (Kabat-Zinn, 1990). Integrative medicine also promotes self-care for the practitioner.

An MBSR curriculum consists of weekly group sessions and regular home practice. The practitioner teaches participants techniques such as body scan, sitting, movement (yoga), and walking meditation. Group sessions include guided meditation practices and education about the nature of mind, the role of perception, the mind/body connection, and ways to develop coping mechanisms to handle stress and enhance health (Kabat-Zinn, 1990). The goal of group practice is for participants to learn mindfulness skills such as focus, attention awareness, breathing techniques, and accepting the experience of the present moment. A description of mindfulness techniques follows.

Body Scan. To practice body scan in traditional MBSR one must be lying down, but this exercise can also be practiced standing or sitting. The leader will

guide participants to evaluate their breathing and different areas of their bodies for tension and discomfort. This prepares participants for mindfulness meditation by helping them to calm and focus their minds. It also helps participants to relax and begin to relieve stress and chronic pain.

Meditation. In MBSR, participants practice sitting meditation daily. Meditation often extends into participants' other activities such as walking and eating. Meditation cultivates a state of mindful awareness. It turns one's focused attention toward whatever one is feeling, thinking, perceiving, or doing.

Yoga. Hatha Yoga, also referred to by some MBSR practitioners as mindful stretching, is a traditional part of MBSR. Participants will engage in stretching, gentle movements, and mindful (or "conscious") breathing to heighten their capacity for body regulation. The literature is overwhelmingly in support of many forms of yoga for treating mental illnesses, health issues, and cultivating a healthy lifestyle (Kabat-Zinn, 2003; Pilkington, Kirkwood, Rampes, & Richardson, 2005; Young, 2001).

Adapted Models of MBSR. Other interventions created from the MBSR model have similarly been shown to be effective in numerous studies. These include:

1. Mindfulness-based cognitive therapy (MBCT), (Segal, Williams, & Teasdale, 2002). MBCT is a technique for preventing relapse of major depressive episodes (Baer, 2006; Segal et al., 2002). MBCT promotes an attitude toward depression where the individual views thoughts as "mental events" (Baer, 2003, p. 127) rather than reality.

2. Dialectical behavior therapy (DBT). DBT can help clients to accept themselves as they are, while they learn new ways of reacting to their environment (Linehan, 1993).
3. Acceptance and commitment therapy (ACT), ACT encourages clients to observe their thoughts and change behaviors in constructive ways (Hayes, Strosahl, & Wilson, 1999).
4. Relapse prevention for substance abuse (RP), (Marlatt & Gordon, 1985; Parks, Anderson, & Marlatt, 2001). RP uses mindfulness techniques to help clients cope with urges by accepting them as normal responses to bodily cues.

Clinicians and Mindfulness Practice

Mindfulness practice can provide important benefits to mental health clinicians – both for their ability to perform effectively as clinicians, and for their personal mental health. Practitioners and clinicians who implement mindfulness strategies and interventions with their clients should also have a mindfulness practice of their own (Kabat-Zinn & Santorelli, personal communication, 2011).

Professional stress takes a toll on clinicians, which leads to job dissatisfaction, interpersonal difficulties, and decreased productivity (Shapiro, Astin, Bishop, & Cordova, 2005). A capacity for empathy is essential for mental health workers engaged in treatment of clients (Bohart & Greenberg, 1997). By practicing mindfulness a system of mirror neurons is actively engaged in empathic response (Siegel, 2007). Mindfulness interventions have shown to increase loving-kindness to self and others (empathy), increase life satisfaction,

reduce stress, anxiety and depression for health care professionals and clients. Practitioners teaching mindfulness skills to others must not only understand mindfulness intellectually, but also embody mindful awareness (Kabat-Zinn & Santorelli, personal communication, 2011).

Studies show that meditation and mindfulness training assist clinicians with secondary trauma and have the potential to assist in post-traumatic growth (Berecli & Napoli, 2006; Napoli & Bonifas, 2011). Berecli & Napoli (2006) proposed a mindfulness-based trauma prevention program for health care professionals such as caregivers, social workers, and physicians as a necessary intervention for preventing secondary trauma. Napoli and Bonifas (2011) further developed and evaluated a 16-week course for social work students in an effort “toward empathic self-care” (p. 635). “Empathic relationships stem from mindful reflection that activates the prefrontal cortex,” responsible for executive functioning, “creating a mind that is adaptive and flexible” (Siegel, 2007, p. 262).

Napoli & Bonifas (2011) administered the Kentucky Inventory Scale of Mindfulness (KMS) before and after the 16-week course to assess changes in clinician trainees use of mindfulness skills in four areas: acting with awareness (intentionally paying attention), observing (enhancing sensory awareness), accepting without judgment (accepting experience as it is) and describing (empathically acknowledging). Describing did not increase for the student practitioners, indicating that personal descriptions of trauma are uncomfortable to discuss for the mental health practitioners (Napoli & Bonifas, 2011). Social work students and educators in the study were described as more attuned and

authentic with one another after the mindfulness course, and that type of empathic awareness seemed to have increased with greater mindful practice.

In another study, health care professionals' levels of exhaustion were measured before and after an 8-week mindfulness program, finding a decline in exhaustion for the practitioners (Galantino, Baime, Maguire, Szapary, & Farrar, 2005). Similarly, Chopko and Schwartz (2009) found a relationship between mindfulness and post-traumatic growth using the Kentucky Inventory of Mindfulness Skills and the Post Traumatic Growth Inventory. Post-traumatic growth seems to aid in "meaning-making and coping" during traumatic situations and may minimize symptoms of PTSD (Chopko & Schwartz, 2009, p. 372). The researchers studied the response and reactions to traumatic events experienced by a large sample of police officers; and the findings were that acceptance without judgment or exerting psychological control over the traumatic experience – a mindfulness technique – facilitated post-traumatic growth.

Mindfulness Studies with Children

There is strong evidence that mindfulness programs have the potential to greatly benefit parents and children in underserved communities. Although this dissertation focuses specifically on parents, the studies suggest that children benefit from learning MAP concurrently and consecutively with their parents.

A significant portion of the literature supports mindfulness meditation for adults, but in recent years some mindfulness research has focused on children and adolescents – and their parents (Burke, 2010). A program that integrated

behavioral parent training (BPT) with mindfulness interventions showed positive results for disruptive children. Dumas (2005) proposed a method of addressing maladaptive parent-child interactions, helping them become more adaptable to change by combining mindfulness practice with BPT. These studies have important implications for MAT-C.

Three key elements of Mindfulness Based Parent Training (MBPT) are: (a) parent-facilitated listening, while therapist listens non-judgmentally; (b) distancing, in which parents learn to separate themselves from their implicit ways of coping and emotional states; and (c) motivated action plans, in which therapist helps parents choose effective goals for themselves and their children, and devise and implement specific plans to reach those goals (Eyberg & Graham-Pole, 2005).

In another successful parent training program, Duncan, Coatsworth, and Greenberg (2009) combined a structured family skills training program (SFP) with mindfulness to develop a family focused preventative intervention for adolescence.

Inattention has been a significant problem for children and adolescents in recent history as well as a problem for their parents. ADHD is a common neurodevelopmental disorder among school-aged children that generally has a genetic component. According to the diagnostic and statistical manual, between 3% and 7% of school-aged children receive an ADHD diagnosis. An ADHD diagnosis is also given to about 4% of US adults, with only about 11% of them receiving appropriate treatment.

In underserved communities, many children are diagnosed and treated for attentional issues (Waite & Ramsay, 2010). Children in these communities are often diagnosed with attention deficit/hyperactivity disorder (ADHD), oppositional defiance disorder (ODD), and other disorders of self-regulation. Despite this, cultural issues in underserved communities concerning both ADHD and mindfulness practices can be a barrier to appropriate treatment and education about the disorder (Waite & Ramsay, 2010). But because (a) an ADHD diagnosis is so widespread in underserved communities, and (b) mindfulness interventions are so effective in improving attentional ability, mindfulness interventions are ideally suited for the children in underserved communities – and their parents.

Research supports this idea. Among youth, sitting-meditation interventions have positive outcomes physiologically, psychosocially, and behaviorally. In a meta-analysis study with primarily African American youth participants with various medical conditions, ADHD and learning disabilities; sitting meditation proved to be effective in the reduction of their physiological, psychosocial and behavioral conditions. The intervention modalities assessed were mindfulness meditation, transcendental meditation, mindfulness-based stress reduction, and mindfulness-based cognitive therapy. Mindfulness-based approaches showed positive results in enhancing self-regulatory capacities for underserved and disadvantaged youth (Black, Milam, & Sussman, 2009).

A Boston public middle school implemented an MBSR and Tai Chi program for children that resulted in positive outcomes and encouraging

implications for similar curriculums to be used in other schools (Wall, 2005). The study's goal was to help the participants learn emotional regulation and identify emotional triggers. The children's self-reports suggest that they experienced wellbeing, calmness, relaxation, improved sleep, less reactivity, increased self-care, increased self-awareness, and a sense of interconnection with nature.

In a multiple-baseline study (Adkins, Singh, A., Winton, McKeegan, & Singh, J., 2010) researchers used a mindfulness-based technique –*Meditation on the Soles of the Feet* – to target the aggressive and disruptive behaviors of three cognitively disabled adults in a residential setting and of adolescents with conduct disorder in a middle school setting. *Meditation on the Soles of the Feet* proved to be an effective mindfulness directive promoting self-regulation for that community. Unlike MAPs that have a succession of learned skills, *Meditation on the Soles of the Feet* is a “single component” technique. The technique requires individuals to focus their attention on “an emotionally neutral part of their body” during times of heightened arousal (Adkins et al., 2010, p. 176).

In a separate multiple-baseline study (Singh, N., Singh, A., Lancioni, Winton, & Adkins, 2010), children diagnosed with ADHD and their parents underwent a 12-week mindfulness training course. The parent participants in the study were selected due to concerns over their child's poor behavioral compliance, defiant and oppositional behaviors. The parents first underwent a 12-week mindfulness course, which was then followed, by a 12-week course for their child. As a result of both mindfulness courses, children participants' compliance increased.

The researchers further observed that mindfulness training for parents without a particular focus on decreasing their child's non-compliant behaviors facilitates more positive interactions between parents and children. Parents may learn through mindfulness training, the ability to respond rather than react to their child's behavior (Singh, N., et al., 2007). The research suggests that mindfulness training with parents and their children may yield positive results for the health and wellbeing families.

Both studies of the latter studies showed a significant decrease in aggressive or disruptive behaviors. Participants in these studies were able to learn, integrate, and utilize techniques to regulate their own behavior.

A Brief History of Art Therapy

Art therapy methods have been utilized with diverse populations since its inception. In 1934, Dr. Edith Kramer, who studied art in Europe, began this tradition in Prague alongside her teacher and mentor Frederika Dicker-Brandeis (also known as Friedl Dicker-Brandeis), working with children whose parents were political refugees (Junge & Wadeson, 2006). Kramer developed a theory that the process of creating art is a culturally universal during her work in Europe and traveling abroad.

Fleeing Nazi occupation, Kramer would eventually live and work in the United States as an art teacher. Kramer became instrumental in utilizing art therapy techniques with disadvantaged African American boys. During 1950-1957 at the Wiltwycks School for severely disturbed adolescents, Kramer developed art therapy techniques that would continue to define the discipline

(Kramer, 2000). Art therapy had previously been mainly practiced in psychoanalysis, a method of psychotherapy unavailable to many at that time (Kramer, personal communication, 2001). Kramer's work at the Wiltwycks School showed the utility of art therapy across cultures.

At the same time as Kramer (1972) was conducting her pioneering work, other art therapy theorists developed their own methods for practice, which started to solidify the discipline through "a priori knowledge" and later "methods of science"². While working with hospitalized, severely emotionally ill patients in inner-city Chicago, Illinois, in the 1960s, Harriet Wadeson adopted strategies for art therapy to engage this population. Wadeson (Junge & Wadeson, 2006) went on to develop the art therapy program at the University of Illinois at Chicago (UIC), a program instrumental in supporting art therapy research, methods, and training.

While Wadeson's program primarily focused its attention on art therapy research, Kramer's curriculum emphasized cultural competence as well as artistic competency in training art therapists. The programs at UIC and NYU both created a culturally competent framework for how a trained art therapist should practice in the community (Junge & Wadeson, 2006). Art therapy programs today continue to train art therapists in addressing their own cultural influences when working with clients (Cattaneo, 1994).

² Charles Pierce -Four methods of determining truth; tenacity, authority, prior and the scientific method (1867).

Currently, the American Art Therapy Association (2012) describes art therapists as:

...Professionals trained in both art and therapy. They are knowledgeable about human development, psychological theories, clinical practice, spiritual, multicultural and artistic traditions, and the healing potential of art. They use art in treatment, assessment and research, and provide consultations to allied professionals. Art therapists work with people of all ages: individuals, couples, families, groups and communities. They provide services, individually and as part of clinical teams, in settings that include mental health, rehabilitation, medical and forensic institutions; community outreach programs; wellness centers; schools; nursing homes; corporate structures; open studios and independent practices.

(<http://www.arttherapy.org/aata-aboutus.html>)

Art Therapy and Self Regulation

The aim of incorporating art therapy interventions within this curriculum is to provide methods of mindfulness practices that are culturally competent. Art therapy is recognized for its cross-cultural utility and makes use of the universal language of art-making through the process and production of artworks.

Carl Jung (1963) suggested that creative art represents a synthesis between the subjective inner world of the creator and the outside reality. Artwork is an effective medium for transforming unconscious material to conscious awareness.

Naumburg (1966), a pioneer in the field of art therapy, viewed the unconscious material of the process and the product of art-making as paramount. She found art-making particularly apt to uncover unconscious material through the analysis of a patient. According to Naumburg, this was the source of art therapy's effectiveness, to release subconscious material in order to regulate and tolerate difficult emotions. For Kramer (1972), the process of sublimation is the aim of art therapy, assisting in impulse control and emotional regulation; and if addressed according to art-therapy principles it helps initiate the psychological forces that facilitate the individual's better psychological and social adjustment.

Lachman-Chapin (1987) point out that the power of art-making to help one reach self-awareness and change stems from the direct line that reaches from art-making to the core of self-awareness. Dalley and colleagues utilizing Winnicott's concept of potential space (as cited in B. Moon, 1990), argued that like play, artwork also takes place in the protected free realm of potential space. According to B. Moon (1990), the use of art in therapy with clients can serve as a metaphor to explore meaning and purpose.

Yalom (1980) views a creative life as meaningful unto itself and contends that "the creative path to meaning" relieves, prevents, or counteracts meaninglessness through the person dedicated to its creation (p. 10). He argues that since artwork in and of itself entails therapeutic agents, the patient's act of creation and its products are the essence of the therapeutic process in art therapy (Yalom, 1980). Waller and Mahoney (as cited in Malchiodi, 2003) discuss four primary areas where art therapy can play a pivotal role in treatment: expression

and communication of emotion, loss of control, low self-esteem, and isolation. It is that awareness that mindfulness interventions aim to cultivate. The evidence suggests that mindfulness and art therapy in underserved communities can promote positive health and well-being.

Art Therapy Approaches

The two dominant models of art therapy, historically speaking, are (1) dynamically oriented art therapy and (2) art as therapy (J. Ulman as cited in Vick & Sexton-Radek, 2009), which seems to be more of a pathology-based approach in mental health (Vick & Sexton-Radek, 2009). A third approach, studio art therapy (often referred to as “open studio”), developed out of a need to have a more flexible approach to art therapy that allowed for non-clinical approach to treatment. A more contemporary approach, Focusing-Oriented Art Therapy (FOAT, Rappaport, 2009) is intended for use with MAT-C.

The studio art therapy method is an intentional art-based art therapy practice in which art is the central component to understanding clients in a created therapeutic or calming environment (Moon, 2002). The use of studio art therapy in MAT-C avoids using art as simply a tool in the meditation course and instead utilizes the art process for its own personally therapeutic and meditative value. The therapeutic open studio space is not the same as a space where therapy takes place. MAT-C’s use of art therapy techniques is not intended to be therapy but psychoeducational.

Focusing-oriented art therapy is a term used to describe a bodily experience of a situation or event that is experienced by the client through the

art-making process. Focusing is a therapeutic idea adapted by psychologist and philosopher Eugene Gendlin and psychotherapist Carl Rogers as a way to assist clients in accessing a “felt sense” or “inner place” (Gendlin as cited in Rappaport, 2009).

Rappaport (2009) further extends the focusing concept with Focusing-Oriented Art Therapy (FOAT). In FOAT the emphasis is placed on the process not the product created. The art product is simply to engage in the moment, a sensory experience. FOAT encourages the participant to enter into the creative process non-judgmentally allowing whatever emerges with acceptance. Like mindfulness, a beginners mind is encouraged in order to allow a playful interaction with the art process.

Together, FOAT– which emphasizes an individual’s inner experience of the art process – and MAPs form the basis of the art therapy methods formulated for MAT–C. FOAT and MAPs seem to be a compatible process and the MAPs framework is closely analogous to FOAT’s five tenets:

Table 1

Focusing-Oriented Art Therapy and Mindful Awareness Practices

| FOAT | MAPs |
|-----------------------|------------------------|
| Therapeutic Presence | Presence |
| The focusing Attitude | Attitude and intention |
| Clinical Sensitivity | Self Awareness |
| Grounding | Body Awareness |
| Reflection | Empathy |

An aspect of the focusing process that differs slightly between the two approaches is that MAPs uses concentrated, introspective self-reflection as the basis of focusing. In MAT-C, mindfulness approaches do not attend to “self” in the same manner as FOAT which utilizes psychotherapeutic self-reflection. Further, mental attendance on any particular object or theme is not a part of MAPs practices. Though FOATs particular self-focus is appropriate for therapy, the focus on self for MAT-C differs; MAPs are skills taught in an 8-week course with a psychoeducational component, not therapy sessions. It is necessary for the practitioner of mindfulness to be aware of the subtle difference in the construct of self-awareness in mindfulness practice versus self-awareness in therapeutic terms. The MAT-C will utilize the FOAT method in implementing art therapy, but will adapt the concept of self-focus in a mindfulness framework.

The Aims of MAT-C

The curriculum is an 8-week course with weekly mindfulness and art therapy activities, aimed to integrate the complementary techniques of mindfulness practices and art therapy. By adapting MBSR techniques and studio art therapy, the curriculum will be unique in the field of mental health practices.

The activities comprising the curriculum are intended: (a) to enhance personal development; (b) to increase awareness of self and others; (c) to cultivate the capacity for attention; and (d) to assist in self-regulation of emotional states. This course aims to teach these four skills to parents in

underserved communities in order to give them the ability to “respond to stress without adverse psychological or physical outcomes” (Mendelson et al., 2010).

It is vital that the curriculum be conducted by practitioners sufficiently familiar with mindfulness and art therapy. While there are education and certification standards for teaching MBSR they are not as rigorous as the process of becoming a board certified, licensed art therapist. The Center for Mindfulness at the University of Massachusetts medical center promotes the idea that MBSR teachers should have appropriate training, and states that:

Teaching MBSR requires an intellectual understanding of the scientific, medical, and educational roots of MBSR, and the capacity to articulate these aspects of the teaching. For that reason, it is essential to pursue a graduate degree in a field connected to MBSR. Psychology, education, and medicine are typical fields of study, but any program that emphasizes an understanding of the mind and body, and includes service as a component, may be acceptable. You do not have to have a graduate degree to teach MBSR, but if you wish to receive certification, you must have completed a graduate program (Santorelli, personal communication, June 20, 2011).

Mindfulness in the Communities: Existing Research and Programs

According to Roth and Stanley (2002), more than 200 MBSR programs in the United States model themselves on the Stress Reduction Clinic at the University of Massachusetts created by Jon Kabat-Zinn. Most of these programs are taught among middle-class and working-class populations. But there have

been successful adaptations of MBSR that address the needs of the low-income, urban communities. Though these studies are few in numbers, the results are promising.

For example, the Mind Body Awareness Project in Oakland, California, assists at-risk and incarcerated youth with impulse control, aggression management, and stress reduction. The Attention Academy in Arizona completed a randomized controlled trial of a mindfulness intervention in a sample of elementary school aged children. The students showed significant increases in attention and social skills and decreases in test anxiety and ADHD behaviors (Napoli, Krech, & Holley, 2005).

Inner Kids in Santa Monica, California, assists underserved children, teens, and families using mindfulness interventions. Inner Kids is a program that promotes age-appropriate games and activities as a vehicle in teaching mindfulness to children and teens. The inner-city curriculum is divided into three sequences: (a) short introspective sitting practice; (b) a longer introspective lying down practice; and (c) activities and games to support the session objective (Flook et al., 2010).

A randomized controlled study of elementary school aged children found that MAPs increased positive executive functioning in children who participated in Inner Kids. Outcome measures given by parents and teachers further supported the findings with positive changes in the behaviors of children who participated in the study. A local Boston newspaper featured an article about the success of the program (Jackson, 2008).

Strong support for the use of mindfulness practices in underserved communities is found in an unpublished study by Kabat-Zinn, Mumford, Levi-Alveraes, Santorelli, and Skilling (F. de Torrijoes, personal communication, July 2011). In 1993, this study was done in collaboration with local community health centers and agencies. Kabat-Zinn and colleagues adapted MBSR in both English and Spanish for use in an inner-city clinic in Worcester, Massachusetts. The researchers received funding from a grant from the National Institutes of Health (NIH) that enabled them to address barriers for participants to attend the 8-week course. Childcare was available for participants while they attended classes, and participants received transportation to and from the clinic.

During the first year of the program, there were several no-shows from the start of the course, beginning with the initial individual interview with the instructor. The researchers addressed cultural concerns regarding the interview process. They discovered that the participants in the underserved clinic were more likely to attend the 8-week course if others in their community were attending, therefore a group format for orientation was created (Santorelli, personal communication, June 19, 2011; de Torrijoes, personal communication, July 2011). When asked specifically about how the researchers addressed the participants' religious objections to MBSR, Fernando de Torrijoes, former director of the clinic, explained that MBSR instructors were "very prudent in the language and how everything was presented" (personal communication, July 2011). For some, the idea of yoga created a religious issue that was addressed by teaching participants 'mindful exercises' (de Torrijoes, personal communication,

2011). Kabat-Zinn and Santorelli explain that “languaging” is essential to keeping the secular nature of MBSR available to everyone.

The clinic ran successfully and was funded for 7 years with a program’s completion rate was 60%. The 40% of participants who did not complete cited socio-economic, psychosocial, or environmental issues such as a homicide in the family or loss of employment (Santorelli, personal communication, June 19, 2011).

Another study that indicated the great potential that mindfulness practices have in the inner-city underserved communities was the study that Beth Roth (1994) conducted at a Community Health Center in Meridian, Connecticut. The study showed that Spanish- and English-speaking medical patients in the underserved community who completed the MBSR course exhibited fewer psychological symptoms and an increase in self-esteem. Roth and Stanley (2002) measured healthcare utilization of participants who completed the Spanish language MBSR program before and after the 8-week MBSR intervention. They reviewed participants’ charts from the year before and the year after. They found that participants’ healthcare utilization and visits to their primary care physicians both decreased as compared to the year before the MBSR intervention.

Roth and Robbins (2004) reviewed the changes in 68 English-and-Spanish speaking patients at the changes who completed MBSR reported. Through analyses of self-report questionnaires and a quality of life surveys, the 68 patients were compared a comparison group of 18 patients not receiving the MBSR

intervention. The researchers examined health-related quality of life and healthcare status of both the comparison and intervention group pre-and post-MBSR intervention (Roth & Robbins, 2004). Statistically significant differences were found between the comparison group and the intervention group indicating that the intervention group showed more improvements in most areas of the quality of life surveys and the self-report questionnaires.

In 2000, an MBSR program was successfully integrated in six drug units of Massachusetts correctional facilities. The course was adapted to the environment of each facility (for example, some maximum security facilities did not allow recorders or tapes for homework). A total of 1,350 inmates participated and self-reported levels of hostility, self-esteem, and mood disturbance, both pre- and post-MBSR course (Samuelson et al., 2007). The study showed that a meditation practice could assist inmates in emotional regulation and reduce their use of illicit substances.

Vallejo and Amaro (2009) adapted MBSR for a community-based addiction treatment setting. They designed their program, MBRP-W (mindfulness based relapse prevention–women), to meet the specific needs of African American and Latino Women in recovery from addictive drugs and at high risk of contracting HIV/ AIDS. The researchers' rationale was that cultivating the ability to cope with stress for the participants would decrease the risk for relapse and possibly reduce the risk of HIV infection.

The practitioners were met with barriers during the initial stages of implementing MBSR within the inpatient program located in Mattapan, an

underserved area of Boston. At the onset of the study, clinic staff and participants were resistant to the mindfulness-based program being instituted. Staff and participants questioned the relevance of MAPs for recovery. Vallejo & Amaro (2009), in response, adapted MBRP-W from MBSR to meet the needs of women in recovery. Certain components of MBSR such as daily practices outside of class (homework) were less emphasized. Yoga practice was changed to “mindful stretching” (de Torriejos, personal communication, July 2011) to alleviate the participants’ religious and cultural concerns. Some Latina participants felt that yoga practices were of “the devil” (de Torriejos, personal communication, July 2011).

The adaptation took many forms. Particular stretching movements were eliminated from the curriculum because they reminded some women of traumatic experiences (pelvic yoga movements). Vallejo & Amaro (2009) also added more educational components to the curriculum. MBSR is typically more experiential than the adapted version for this community. Vallejo (personal communication, July 2011) expressed the necessity for self-disclosure as a way of facilitating trust and identification the instructor for participants and staff.

Cultural Considerations

Mindfulness, meditation, and art therapy approaches must be applied in a culturally competent manner when utilized in culturally diverse communities. This presents a challenge: as suggested earlier, MAPs and art therapy may be viewed as antithetical to religious practices and beliefs. Although mindfulness is most often associated with Buddhism, most cultures and major religions

worldwide include some type of meditation or contemplative practice (Walsh & Shapiro, 2006). Mindfulness, as a cognitive skill, may be practiced outside of religion and modified for cultural appropriateness (Brown & Ryan 2003; Kabat-Zinn 1990, 1994; Vallejo & Amaro, 2009). Mindfulness practices that focus on the psychological processes of attention and awareness have proven to be an empirically valid intervention for psychological and medical wellbeing; and can be used across cultures separate from any particular theology or religion.

According to Kabat-Zinn (1982), mindfulness techniques can be taught independently of spiritual or religious origins. He addresses the religious or spiritual concerns that meditative disciplines sometimes evoke by offering a program of secular mindfulness and meditation while simultaneously holding the universal essence of what contemplative disciplines offer. Often described as simply a specific way of paying attention, Kabat-Zinn's MBSR is a secular program and can be utilized cross-culturally.

Another important cultural issue is providing mindfulness programs in the appropriate language. In many underserved urban communities, there is a need for more Spanish-speaking practitioners and services. Spanish-speaking MBSR programs in the community have shown successful outcomes, but these programs have been limited in number (Baer et al., 2006; Kabat-Zinn personal communication, June 2011; Roth 1997; Roth & Creaser, 1997; Roth & Stanley, 2002; Roth & Robbins, 2004; Vallejo & Amaro, 2009).

Reimbursement for MBSR

One particular advantage and appeal of MBSR for underserved populations is that MBSR is a legitimate, evidence-based health care intervention and thus is a billable service. Baer (2006) states that billing and reimbursement are critical factors in effectively implementing MBSR in inner-city communities. How third party insurers will cover MBSR is dependent on the profession of the provider. Kabat-Zinn and Santorelli (personal communication, June 2011) noted the trend of large medical insurance companies, such as Harvard Pilgrim, to reimburse for MBSR services provided by certified Center-for-Mindfulness-trained, MBSR instructors.

Licensed mental health care providers can typically bill for individual or group treatment. Medical health care providers can use Preventative Medicine Group Counseling code "99412" for patients without an illness or diagnosis and "99078" for those with an illness or diagnosis. In 2002, additional codes were created for mental and medical health care professionals called Health and Behavior Assessment/Intervention (codes 96150 through 96155) and are useful through Medicaid in most states, though these codes remain under-utilized due to a lack of knowledge about them (Baer, 2006; Roth, 2005). Appropriate reimbursement for MBSR is necessary to implement the program more broadly and effectively in underserved, low-income urban communities where access to health care is limited and under-funded.

Chapter II: Methodology

This chapter outlines the research procedures used to design the curriculum for a mindfulness meditation course integrating art therapy for parents in underserved communities (MAT-C). It will then review the training that practitioners who wish to use the curriculum will need. The chapter concludes with a brief overview of the curriculum's elements and evaluation procedures for MAT-C.

Finally, this chapter will discuss the proposed curriculum itself. The curriculum's goal is to effectively develop an integrated course of mindfulness meditation and art therapy skills for parents involved with underserved community mental health centers. The chapter will also address the importance of integrating evidenced-based practices for multi-cultural clients.

Literature Review Methods

In Chapter I, this dissertation reviewed the literature that formed the basis of this study from a variety of relevant resources. Resources were identified through Internet searches and other credible sources of mindfulness meditation training. The literature search included peer reviewed journal articles, books, educational curricula, and manuals derived from following databases: PsycInfo, PsycArticles, EBSCOhost databases, LexisNexis, MEDLINE, PubMed, and mindfulexperience.org. The individual searches consisted of combinations of the following keywords: mindfulness, underserved communities, low-income, poverty, community mental health, African American, Latino, Hispanic, ethnic minorities, meditation, MBSR, stress management, relaxation response,

contemplative practice, art therapy, art therapy approaches and mindful art therapy. The date parameter of each search was limited to 1990 to the present for inclusion in this study.

Participatory Research Methods

In addition to an extensive literature review, the research that supports this curriculum utilized participatory methods. In this context, participatory research was an immersion within the meditative disciplines and the mindfulness community.

To be specific, participatory research for this project includes: (a) giving presentations on mindfulness and conducting information sessions in urban community health care centers with question and answer sessions for clinicians; (b) participating in conferences and events that focus on meditation, mindfulness, and art therapy in psychotherapy; and (c) consulting with mindfulness practitioners on the success of various methods, and with mental health agencies to discuss their needs and viewpoints on mindfulness.

Presentations with question and answer sessions were essential to develop an understanding of how mindfulness interventions may best serve the community. Interaction at conferences and events supports a more collaborative research process. Conversations with program directors of various agencies were essential in understanding the barriers to mindfulness and meditative disciplines within the community.

It is also worth noting that the literature supports active interest and involvement in meditative practices before becoming a practitioner of MAPs.

Clearly, it will be important to have a method of qualifying the potential MAPs practitioners. Each of these participatory methods – presentations and information sessions, conferences and events, and consultation with practitioners and agencies – were an opportunity to further investigate meditation and mindfulness training and teacher certification. One such agency that assisted in forming the inspiration of this project is Children’s Services of Roxbury.

Mindfulness in the community of Roxbury. The community of Roxbury, Massachusetts has been a majority African-American neighborhood since 1960, with a growing Puerto Rican population. As of the 2000 census Roxbury was 5% Non-Hispanic White, 63% Non-Hispanic African-American or Black, 24% Hispanic or Latino (a group varied in diversity), 1% Asian-American, 3% from other races and 4% from two or more races (Boston Redevelopment Authority Research Division, 2011).

Children’s Services of Roxbury, a community-based agency, expressed interest in bringing preventative holistic care to this community. That has culminated into their own proposal for a new entity, the Center for Successful Living. The proposed mission statements for the Center’s newly formed mental health clinic and the to-be-developed mindfulness program are as follows:

The Mission for the Mental Health Clinic: To provide effective, progressive, and compassionate mental health services that incorporates proven mind-body practices in the treatment of trauma recovery. The Center will bring the benefits of mind-body practices to our mental health professionals and our clients. The Center will hold regular classes and trainings for our

clinic staff in order to increase their skill set with clients, increase their effectiveness with clients, and reduce stress and burn-out of the clinicians. The Center will train staff to incorporate mindfulness and yoga practices and the domains of playfulness into their therapy, when appropriate. The goal is to use the transformative powers of a holistic approach to wellness, which has proven to reduce stress, cultivate the wise mind, and improve health and bring them to our underserved community in an authentic, meaningful, and accessible way. (Children's Services of Roxbury Staff, personal communication, 2011).

Mindfulness Program Mission: To bring the benefits of mind-body practices to the greater CSR community. The Center will bring yoga, mindfulness, and the domains of playfulness (including dance, drumming, and chanting) through classes and workshops to the children and families we already serve, our employees, and the broader Roxbury, Dorchester, and Mattapan communities. The intention is to provide access to transformative holistic approaches to wellness to our underserved and marginalized community in an authentic and meaningful way. The goal is to reduce stress, cultivate the wise mind, and improve health and bring them to our underserved community in an authentic, meaningful, and accessible way. (Children's Services of Roxbury Staff, personal communication, 2011).

Mindfulness and wellbeing are part of an active, ongoing dialogue at the agency. But they are not yet part of an evidenced-based practice.

A meeting with the agency's director and clinicians raised the questioned about the empirical basis for the development of a mindfulness program at CSR. The possibility of creating a mindfulness program grounded in current research for parents in underserved communities became the basis for MAT-C. The APA's ethical guidelines require that psychologists must not practice outside of his/her areas of competence, based on education, training, supervised experience, or appropriate professional expertise (Richards & Bergin, 1997). There are many mindful awareness programs that claim effectiveness but have not been clinically proven or validated (Kabat-Zinn, personal communication, 2011). Thus developing a mindfulness program requires evidence based interventions and support from rigorous research.

Presentations and information sessions. To date, two presentations were delivered, both to directors of a local community social services agency. Each included an informational question-and-answer session.

CSR presentations April 5 and June 10, 2011. This researcher presented a Power Point presentation to community program directors at Children's Services of Roxbury. The presentation consisted of an analysis of the current mindfulness studies and mindfulness-based community programs across the country.

One question of concern from a program director present, "Name it!" meaning, to be more explicit about any religious connotations of MAPs and to address questions regarding religion and culture directly. People within the

community are hesitant, if not suspicious about participation in programs that claim to be secular (according to the agency program directors). One director expressed concern that a MAP would interfere with her and her clients' Christian values and beliefs. Another director spoke about Christian prayers and how meditation in particular was written in the Bible, "...But his delight is in the law of the LORD; and in his law doth he meditate day and night" (Psalms 1: 2 King James Version). While most directors present thought that this would be valuable for their community, it was evident that religious and cultural beliefs would need to be addressed.

Other questions included:

- Can mindfulness practices happen in office settings, at meetings, with clients where they sit?
- Can mindfulness be a way of life as opposed to driven by pathology?
- How can a mindfulness program be funded in a nonprofit setting?
- What are the current thoughts about mindfulness in the education of young children?

Participation in meditation and psychotherapy conferences. The researcher took a participant observer stance while attending professional conferences. To date the research has included 3 multi-day conferences on the interplay between meditation/mindfulness and psychotherapy.

Meditation and Psychotherapy Conference, May 7 and 8, 2010. Each year Harvard Medical School's Department of Continuing Education, in collaboration

with the Department of Psychiatry of Cambridge Health Alliance, presents the Meditation and psychotherapy conference. The conference included multiple lectures on current research in the field of mindfulness and psychotherapy.

Ellen Langer (personal communication, May 2010) presented her current research on mindfulness as viewed under her cognitive definition. At the start of her presentation, Langer was clear to separate her construct of mindfulness from that which includes mindfulness and meditation (discussed earlier).

Jan Willis (personal communication, May 2010), a professor of religious studies at Wesleyan University in Connecticut spoke about the psychic wounds of racism and the potential for meditation to assist in healing those wounds. Dr. Willis also shared her personal narrative of being an African American woman growing up in “the Jim Crow South,” and her journey from Baptist to Buddhist. Dr. Willis spoke about dharma (the natural order of things) as universal for all beings without religious or cultural barriers.

Dr. Britta Hölzel (personal communication, May 2010), instrumental in MBSR neurobiological research, presented two studies that utilized neuroimaging of the brain (discussed earlier).

Meditation and psychotherapy conference May 6 and 7, 2011. Melissa Myozen Blacker (personal communication, May 2011), director of professional training and associate director of the stress reduction program at the Center for Mindfulness, University of Massachusetts Medical School, described MBSR as “standing in two fields:” mindfulness-based stress reduction and Buddhist tenets. Blacker’s concept of mindfulness came from its use in the Sati (Pali)

language: “to recollect, remember, come back into the body” (personal communication, May 2011).

MBSR is a secular, psycho-educational intervention, but MBSR teachers are expected to know the roots of Buddhist meditation practices, due to the utility of teaching this way of meditating. Teachers also learn yoga, stress physiology, group psychology, neurobiology, and experiential education. Blacker emphasized that the course does not teach or train participants in Buddhist practice, and no direct Buddhist teachings or vocabulary is used in the course. MBSR teachers judiciously use poetry and quotes to facilitate guided meditations. Overall, Blacker stated that MBSR is a curriculum that is respectful of individual differences and needs, experiential, scientific, sensory-based, not faith-based, and responsive to what arises.

Also lecturing at this conference was Dr. John Christopher, presenting research from a program at Montana State University; this program integrates mindfulness-based self-care into the curriculum for master’s level counseling students. Florence Meleo-Meyer, director of Oasis-Institute for Mindfulness-Based Professional Education and innovation and senior instructor in the stress reduction program at the center for Mindfulness, presented on an MBSR program targeting youth, Cool Kids. This 8-week MBSR adapted program, for adolescents ages 14-18, consists of 8 weekly 2-hour classes with a core lesson each week, a home meditation practice, and meditation CDs.

Other lecturers included Carolyn Jacobs, director of the Contemplative Clinical Practice Advanced Certificate program at Smith College School of Social

Work, who spoke about her book *Exploring Spirituality and Religion in Clinical Practice*; Susan Gere, interim dean of the Graduate School of Arts and Sciences the director of the Division of Counseling and Psychology and Co-director of Mind, Body and Spirituality at Lesley University, who lectured on the differences between meditation and psychotherapy; Dr. David Vago, instructor in psychology and functional neuroimaging at Harvard Medical School, who provided an overview of models of self-awareness and regulation related to meditative training using functional MRI studies; and Dr. Ronald Siegel, professor of psychology at Harvard Medical School at Cambridge Health Alliance, and faculty at the Institute for Meditation in Psychotherapy, who presented on the therapeutic utility of mindfulness interventions in psychotherapy, and distinguished between concentration and awareness.

MBSR Retreat for healthcare professionals – Omega Retreat June 17-24, 2011. The MBSR program presented at the Omega Institute Center for Holistic Studies, through the Center for Mindfulness in Medicine Healthcare and Society (CFM), is an initial requirement before pursuing teacher training in MBSR. Jon Kabat-Zinn and Saki Santorelli (personal communication June, 2011), the retreat's instructors, assert that an interest and intensive experience in mindful awareness practices is essential to teaching others. Over 200 professionals from varying disciplines of health care participated in this course, as well as a small number of educators.

Although MBSR teachers do not have to be certified, there is a recognized certification process through the CFM. As the field of mindfulness grows,

medical insurance companies are beginning to insist that MBSR practitioners be trained through the CFM.

For the first half of this 7-day retreat, health care providers were invited to participate in an intensive MBSR exploration, similar to what participants of an 8-week MBSR course experience. Each day started at 6am and ended at 9:30 pm. The days were an immersion into the MBSR program, daily walking, sitting, lying and eating meditations. Meals were served at the center's dining hall and participants would gather and dine together and then continue on with the MBSR curriculum. The program instructors initiated one day of silence just before the second half of the retreat. Silence included no use of cell phones, computers, reading, writing or drawing materials, as well as avoidance of "intimacy of the eyes" (Santorelli, personal communication, 2011). The second half of the retreat was more focused on the pragmatic, consisting of an extensive review of the requirements for training and resources for those seeking to become MBSR providers.

Consultation with Mindfulness Programs and Practitioners

In addition to participating in mindfulness retreats, professional conferences, and presentations, consultations with and observations of MBSR instructors and mindfulness program directors were made. Questions were answered about their experiences with the barriers to teaching mindfulness to underserved communities in Massachusetts. Their input is discussed earlier throughout this dissertation and cited as personal communications. The mindfulness professionals consulted were; Jon Kabat-Zinn, former Director of

the Stress Reduction Clinic at the University of Massachusetts Medical School; Saki Santorelli, Director of the Center for Mindfulness at the University of Massachusetts Medical School; Fernando de Torrijos MBSR instructor and former director of the innercity clinic in Worcester; and Zayda Vallejo an MBSR instructors at the Center for Mindfulness.

Qualified Practitioners for Teaching MAT-C

Mental health professionals have an ethical obligation not to practice therapeutic methods that are outside the scope of their competence. Because this curriculum combines mindfulness interventions with art therapy methods in a novel way, it is of critical importance that practitioners who wish to use this curriculum have received proper training. The qualifications that a practitioner must have before undertaking this curriculum with participants are reviewed in this chapter.

The proposed curriculum integrates two seemingly different but complementary interventions for stress reduction – mindfulness practice and studio art therapy – for use in a setting that presents unique challenges. It is crucial that mental health practitioners who wish to use this curriculum with clients are fully competent in their understanding and use of mindfulness practices and art therapy. Practitioners should cultivate their own mindful awareness practice/training and be familiar with delivering art therapy interventions before attempting to implement MAT-C. For that reason, to properly employ this integrated curriculum, a practitioner must first have a foundation of knowledge and experience with art therapy. According to Good

(as cited in Moon, 2002), “being an art therapist is the development of a way of living in this world that sees things from an image and aesthetic point of view...” (p. 256). To that end, the MAT-C includes an addendum of resources for practitioners and a guideline for determining whether a practitioner is qualified to utilize the curriculum with participants.

Training for mindfulness practice. MBSR is an effective mindfulness intervention, sensitive to the cultural aspects of the client and empirically supported by the research. The MAT-C is designed to be facilitated by mental health practitioners with training at master’s level or higher. These practitioners, in addition, must experience and understand the importance of mindfulness meditation practice in their own life before teaching it to others (Santorelli and Kabat-Zinn, personal communication, 2011). The University of Massachusetts Medical School, which originated MBSR, provides useful guidelines for MBSR instructor qualifications (Baer et al., 2006). Many other programs throughout the United States offer training in mindfulness meditation and psychotherapy as well. Practitioners should cultivate their own mindful awareness practice and training before attempting to implement MAT-C.

Implementing art therapy methods for the MAT-C. The researcher, a registered, board-certified art therapist, uses art therapy in treatment with families and troubled children in school settings. In particular, during the APA pre-doctoral internship, the researcher discovered the utility of art therapy interventions in a mindfulness context of treatment for children and families in

therapy; this discovery formed the basis for MAT-C. The curriculum integrates art therapy methods of healing with MAPs.

The art therapy portion of MAT-C utilizes 2 existing paradigms within the art therapy discipline: studio art therapy, which involves the process, materials, and therapeutic space of art making; and focusing-oriented art therapy (FOAT) that describes the intention and attitude in which the art process unfolds (Rappaport, 2009). FOAT training is available for practitioners who may be unfamiliar with certain art therapy techniques. The MAT-C has clear guidelines for practitioners unfamiliar with art therapy.

Organization of the MAT-C Curriculum

The proposed curriculum's goals are to provide community mental health practitioners with a resource for training in mindfulness meditation and art therapy, and to create a mindfulness course for parents in underserved inner-city communities. The curriculum provides interventions for parents based on empirically supported interventions in mindfulness.

MAT-C was modeled on the 8-week program given at the Center for Mindfulness in Massachusetts. With that framework, art therapy methods were synthesized within MAT-C curriculum thereby creating an interdisciplinary course useful for outpatient mental health clinics. It was further adapted to address cultural considerations for families in diverse communities, particularly African American, Latino, and immigrant, as well as issues related to reimbursement for mental health clinics. This curriculum is directed toward

parents, though in future it may be worth exploring a modified curriculum that includes children as well as their parents.

Evaluating the Mindfulness Curriculum

Once the investigator received approval from the institutional review board of Pepperdine University, a recruitment process was initiated for evaluators of the MAT-C. For the purpose of assessing the cultural relevance, quality and effectiveness of the MAT-C, five mental health practitioners, each with a Master's degree or higher and 3 years or more of experience providing direct clinical services in Mattapan, Roxbury, Dorchester, Codman Square, and some areas of Waltham were chosen. The inclusion criteria was as follows: (a) Mental health practitioners must possess a master's or doctoral degree in one or more of the following disciplines; art therapy, psychology, social work, human services, counseling or psychiatry; (b) they must have familiarity with mindfulness and/or art therapy interventions; and (c) and at least 3 years of experience providing direct services to clients in the communities specified.

Recruitment of evaluators. Evaluators were contacted by email with an introductory letter that described the project and researcher affiliation. The email clearly stated the eligibility criteria for participating in this study and gave an overview of the procedures. Out of the 15 evaluators contacted, 8 evaluators responded. Of those 8 evaluators that responded, 6 met the criteria for participating in this study. One evaluator did not complete the evaluation or respond to follow-up calls once asked to participate in the study.

Five evaluators confirmed that would participate in the study (n=5). Each evaluator was made aware throughout the recruitment process that participation in the study is completely voluntary and that they may withdraw from the study at any time without consequence or question. The evaluators received a structured questionnaire utilizing 15 Likert scale items and 8 open-ended questions. The Likert scale items measured the opinions, beliefs, and attitudes of the professionals regarding their perception of potential parents' participation in MAT-C. The questionnaire allowed for measurement in five areas of focus: (a) the use of mindfulness interventions (b) cultural competence of the curriculum; (c) the use of mindfulness art therapy with clients; and (d) the use of yoga and mindfulness meditation with clients and (e) the need for a stress reduction program at their agency.

The questionnaire presented 15 declarative statements asking for levels of agreement. The evaluators indicated their level of agreement with 6 possible responses: strongly disagree, moderately disagree, mildly disagree, mildly agree, moderately agree, and strongly agree. The 8 opened- ended questions included items such as "how would you improve the curriculum for use with your clients?" and " Would you recommend the MAT-C to other community mental health centers?" (see Appendix A through F).

Chapter III: Results

This chapter will provide an overview of the development and structure of the MAT-C and a summary of the evaluation process. First, the literature review and participatory methods will be presented. Next the structure of the MAT-C will be summarized. Finally, responses obtained on the questionnaire of the evaluators' critique of the MAT-C will be presented.

Overview MAT-C Development

Literature review. The initial phase for development of this curriculum included an extensive literature review as discussed in Chapters I and II of this dissertation. The literature review focused on empirically supported mindfulness interventions and, more specifically, the use of mindfulness intervention in underserved communities. Art therapy methods were also reviewed for their cultural significance and compatibility with mindfulness practice. Existing mindfulness resources were examined in order to avoid creating a similar curriculum or overlap in the field.

Participatory research. In addition to extensively reviewing the literature, participatory methods were employed for additional data gathering. Participatory research for this project included: (a) giving presentations on mindfulness and conducting information sessions in urban community health care centers with question and answer sessions for clinicians; (b) participating in conferences and events that focus on meditation, mindfulness, and art therapy workshops and seminars; and (c) consulting with mindfulness practitioners on

the success of various methods, and with mental health agencies to discuss their needs and viewpoints on mindfulness.

The information that was obtained presented strong evidence that a mindfulness resource would be relevant for underserved communities. To state it more concretely, parents in underserved communities would benefit from a curriculum designed around their needs. Research indicates that MAPs significantly reduce stress and increase good health and wellbeing. Yet despite the high levels of stress that prevail in underserved communities, stress reduction resources are minimal.

Description of the Structure and Content of the MAT-C

The goal of this study was to develop a mindfulness curriculum designed specifically for parents in underserved communities that would be both responsive to their needs and culturally congruent. *The Mindfulness Based Art Therapy Curriculum* aims to provide community mental health practitioners with a resource for teaching mindfulness practices in the communities they serve. The activities comprising MAT-C are intended: (a) to enhance personal development; (b) to increase awareness of self and others; (c) to cultivate the capacity for attention; and (d) to assist in self-regulation of emotional states. The full curriculum is presented in Appendix D.

Orientation. A group orientation precedes the course. The orientation is intended to provide information about the course and to address any religious or cultural concerns. Evidence has shown that participants in underserved communities are more likely to attend a mindfulness-based stress reduction

course if they attend orientation along with others in their community (Santorelli, personal communication, 2011). During orientation for MBSR, the instructor will ask participants to write down 3 goals (Santorelli and Kabat-Zinn, personal communication, 2011). Pre-program assessments will include consents to photograph artwork (but community members are not required to sign consents in order to participate in the course. The Mindful Attention Awareness Scale (MAAS) will be used for pre- and post-test course evaluation among participants.

During the session, the instructor will utilize a psychoeducational model. MBSR practitioners have highlighted the importance of a psychoeducational component while working with communities (Vallejo & Amaro, 2009; Santorelli, personal communication, July 2011). The instructor will outline the purpose of the 8-week course and discuss the effects that mindfulness, meditation, and art-making have on body and mind. He or she will also discuss the utility of mindful art activities and how the activities will support their MAPs.

Addressing religious concerns. Participants will be asked to establish how they personally relate to religion/spirituality (Adapted from Au, 1989, pp. 136-137). This is not a part of the orientation process in MBSR, but it is utilized here in order to address religious and spiritual barriers that may be of concern for the community. The purpose is to raise awareness of ideas about a Higher Power and belief systems that may influence one's life and behaviors.

More specifically, this exercise is meant to help the participants carry those images through the 8-week course if they choose. MBSR practitioners have

noted that Catholic and Christian participants often raise questions about mindfulness's religious intentions (de Torrijos, personal communication, 2011; Vallejo, personal communication, 2011).

By acknowledging personal beliefs prior to the course, it is hypothesized that participants will not experience a challenge to their beliefs, and so will be able to participate in the curriculum more freely. The directive may be reintroduced again for contemplation during the first week of the course. This procedure (Au, 1989) will be guided by verbal instruction and has been adapted to accommodate a variety of beliefs or no belief. Participants will also receive information about contemplative practices in general and Christian contemplative practice in specific.

Windows procedure. As part of orientation, participants will take part in an art therapy exercise called the "windows procedure." The instructions for the exercise are as follows:

1. Divide a sheet of paper in half with a straight horizontal line, and then in quarters with a straight vertical line down the middle. The sheet should now resemble an old-fashioned window with four panes.
2. In the first pane, express your spiritual/religious beliefs with a drawing, symbols, or words as has been presented or taught to you by parents, teachers, and friends.
3. In the second pane, express through a drawing, symbols, or words the Image you have formed from your own experiences or personal search.

Here you might describe moments you experienced in prayer or contemplation, whether in happy or difficult times.

4. In the third pane, express the image of the beliefs that you live by.
5. After finishing the three panes, study your page and note what the juxtaposition of the three images gives rise in you in terms of insights, questions, and feelings.
6. In the fourth pane, write down how your images affect your life and decisions.

The orientation session is also a time when participants can ask questions, discuss concerns, and create goals for the 8-week course.

The MAT-C

Eight-week course. MAT-C is modeled after the 8-week MBSR program given at the Center for Mindfulness in Massachusetts. Within that framework, art therapy methods are synthesized with mindfulness, creating an interdisciplinary course that teaches skills relevant to coping with stress.

The first section of the MAT-C's 27-page manual provides an overview of the professional guidelines for clinicians and mental health centers to follow before implementing the MAT-C (Appendix D). It then describes the curriculum week-by-week, each description beginning with a list of supplies needed for that session. The manual also provides general instructions to coincide with the mindfulness skills to be introduced. "Mindfulness" evokes religious and cultural concerns in the predominantly African American, Latino, and immigrant

communities. MAT-C is adapted to address such cultural considerations.

Reimbursement for community mental health clinics is also considered.

Mindfulness meditation practices begin each session except for weeks 6 and 7 (see chart below). After the formal meditation, to support the mindful meditation practice, each session then incorporates art therapy.

Suggestions to guide the facilitator appear in the curriculum in blue italic font, but it is recommended that each facilitator allow for their own language and style. The curriculum ends with an addendum that includes explanations of exercises such as the body scan, sitting meditation, and loving-kindness meditation. Resources are also provided for mindfulness research and sources, art therapy methods and training, and educational resources for literature on stress (Appendix D, pp. 23-24).

Table 2.

A Week-by-Week Overview of the MAT-C for Parents

| Week | Mindfulness Skills | Art Therapy Skills |
|------|---|--|
| 1. | Results of MAAS from the orientation session reviewed. An Introduction to Meditation: The body scan. Discussion: Intention, attention & attitude in meditation practice. | The Window Pane Assignment reintroduced for silent contemplation. Descriptively your name art therapy directive: Participant introductions using the descriptive name drawing. |
| 2. | Using the Breath: Body Scan meditation. Guided sitting meditation. | Introduction to Art-Making: Draw a Person directive. |
| 3. | Compassion for Self and Others: Guided sitting meditation Yoga (mindful stretching) | Exploring Mind Body Relationship: Draw yourself as animal, fruit or vegetable Directive. Discussion. |

(Continued)

| Week | Mindfulness Skills | Art Therapy Skills |
|------|---|---|
| 4 | The Nature of Mind Meditation: Retrospective & Prospective Scripts. Yoga, sitting & walking meditation. | Scribble Drawing: Creativity in the chaos. |
| 5 | Sitting with Whatever Arises; Sitting meditation. Walking meditation. | Collage using images to construct thought. |
| 6 | Psycho-Education on Stress: Reacting vs. Responding (Kabat- Zinn, 1994). | Group Clay Project: Each person creates a clay object. Objects are then placed in a co-created environment. |
| 7 | Day-Long Silent Retreat. Guided Meditation. | Open Studio. |
| 8 | Culminating Ceremony: The Impermanence of all things: Guided Meditation. | Art Work returned to participants; Open forum for discussion of art process. MAAS completed by participants. |

Week-by-Week Overview

Week 1. Participants will be introduced to meditation with a discussion about intention, attention, and attitude for MAPs. The windowpane assignment from orientation will be reintroduced for silent contemplation. The purpose of silent contemplation is to allow participants psychic space to attach their own spiritual or cultural significance before beginning the course. The mindful art therapy directive will be utilized to further discuss the intention, attention, and attitude for practice. Each participant will descriptively draw their name your name in a way to introduce something about themselves. Following this directive, participants share what brings them to the course. The instructor will introduce the guided body scan method (sitting or lying down) will be

introduced during this session for a short duration and participants will be asked to share their experience.

Week 2. The instructor will use a psychoeducational model to draw a connection between focusing on the breath and MAPs. Participants will practice the body scan during this session, adding to the instruction from the previous week. Once the body scan is complete, the instructor will lead the “draw a person” art therapy directive allow participants a non-verbal opportunity to explore their experience.

The instructor will then introduce guided sitting meditation. Participants will learn to pay attention to the inhalation and exhalation. This technique helps participants increase concentration and lessen distractibility (Kabat-Zinn & Santorelli, personal communication, June 2011).

Week 3. “Compassion for Self and Others,” or empathy as it is described in psychological terms, is essential to MAPs. The participants will again engage in guided sitting meditation this week, followed by an introduction to Loving Kindness Meditation. This meditation guides the participants to practice connecting to feelings of love and kindness toward self, loved ones, strangers, enemies, and all beings successively.

Yoga (mindful stretching) will follow. This will help participants explore their body sensations through movement.

The instructor will transition to an art therapy directive by asking participants to draw portraits of themselves and loved ones as fruits or vegetables. This activity assists participants heighten their awareness of others.

After the art activity, participants will be asked to identify the chosen fruit, vegetable or animal and connect the qualities with the individual it represents. This directive invites participants to look at themselves and others in a new way or ways they had not realized before.

Week 4. The instructor will lead a discussion about “The Nature of Mind.” This will be followed by sitting meditation on the same topic. After meditation, the instructor will guide participants in a discussion about their thought process during meditation. Participants will be encouraged to discuss any physical or mental discomforts that they may experience while sitting. Special attention will be given to the mental activity that happens for participants and how they relate to their thoughts during the sitting meditation. The participants will then learn about walking meditation.

Next, the instructor will give an art therapy “scribble drawing” directive, inviting participants to cultivate creativity in chaos. In the scribble drawing exercise, the participants try to see something in their own scribble drawing (Detre et al., 1983; Naumberg, 1966). This directive is designed to help participants recognize how easily they can contain their thoughts with effort.

Week 5. “Sitting with Whatever Arises” will be the discussion topic for this week. The instructor will help participants accept what is, without assigning a value or mental label (judgment). This is an essential practice in mindfulness.

The participants will again practice sitting and walking meditation. Adding to the content of the previous week, participants will gradually walk and sit for longer periods of time.

Collage will be the week's art therapy directive. Collage uses combinations of found images to construct new thoughts. Collage in art therapy means "glued to assemble or create a new whole" (Malcholdi, 2007). This art directive is designed to help participants accept what arises.

Week 6. The instructor will begin this week's session with a psychoeducational component. The instructor will focus on teaching participants how MAPs can cultivate the ability to respond as oppose to reacting in stressful situations. This way of responding to stress has been proven to increase good health and longevity. The participants will then engage in a discussion of the mental and physical effects of stress.

The week's art therapy directive will be a group clay project. Each person will create a clay object to later be placed in a co-created environment. Art therapy theorists value clay as a medium for the release of stress and tension.

Week 7. A day-long silent retreat (5 to 6 hours) will start the session. Participants will be asked to refrain from eye contact, cell phone use, and reading. The instructor will lead a guided meditation session.

Open studio art will be available for participants during the silent retreat. This differs form the MBSR version of silent retreat, which requires participants to remain silent in every way – no eye contact, no reading, no writing, and no drawing. The silent studio art is a method to induce internal reflection and calmness.

Week 8: the culminating ceremony. "The impermanence of all things" will be the focus of the guided meditation. Any remaining art products will be

returned to participants. The instructor will offer the participants an open forum for discussion of the art-making process.

Evaluation of the MAT-C

The investigator analyzed the questionnaire responses by using a mixed methods approach to analyzing the data. For the qualitative data (i.e. open ended questions, participant recommendations), the analysis consisted of finding themes within the evaluators' responses and summarizing the results.

The nominal data collected from the Likert scale questionnaire was converted into numbers representing the frequency of responses within the five areas of measurement described above. The questionnaire data was then converted into a bar graph for a visual representation of the Likert scale responses.

Description of the evaluators. Five (n=5) clinicians with experience in working with diverse communities were chosen to evaluate the MAT-C after the curriculum was completed. The evaluators included 1 licensed clinical psychologist, 1 board certified art therapist who is also a licensed mental health counselor, 1 psychiatrist and 2 licensed clinical social workers. All evaluators related their level of familiarity with mindfulness and years of experience in working with in community mental health (table 3).

Evaluator 1 is a clinical psychologist providing services outpatient mental health services with 15 years community mental health experience. Evaluator 2, an art therapist and mental health counselor, has 15 years community experience and provides services in an outpatient and residential mental health setting.

Evaluator 3, a clinical social worker with over 15 years of community experience, provides services in an outpatient the outpatient clinic of a community agency.

Evaluator 4 is a psychiatrist with over 15 years experience in community mental health. Evaluator 5 is a licensed clinical social worker with over 15 years experience providing services for families in the community.

Summary of the Results

First, the evaluators’ demographics gleaned from Part 1 of the evaluation form are presented. Next, the Likert scale questionnaire (Part 2 of the evaluation form) is analyzed. The questionnaire measured the following four areas: cultural responsiveness, utility of mindfulness practices, utility of art therapy methods, feasibility of yoga practices and overall need for stress reduction in the community. Finally, the evaluators’ responses to the open-ended questions in Part 3 of the evaluation form are reviewed for thematic content across evaluators.

Part One: Evaluator Questionnaire

Table 3.

Evaluators’ Demographics

| Evaluator | Ethnicity | Profession | Years of Experience | Familiar with Mindfulness |
|-----------|--------------------|---|---------------------|---------------------------|
| 1. | European/Caucasian | Licensed Clinical Psychologist | 15+ | Very |
| 2. | European/Caucasian | Art Therapist & Licensed Mental Health Counselor (LMHC) | 15 | Moderately |
| 3. | African-American | Licensed Clinical Social Worker | 15+ | Mildly |
| 4. | African-American | Psychiatrist | 15+ | Moderately |
| 5. | Haitian-American | Licensed Clinical Social Worker | 11 | Mildly |

Evaluators were provided a copy of the curriculum, an evaluation form, and an informed consent form. Each evaluator reviewed the MAT-C and completed the written evaluation form in approximately two weeks. At the completion of the evaluation, materials were returned to the researcher.

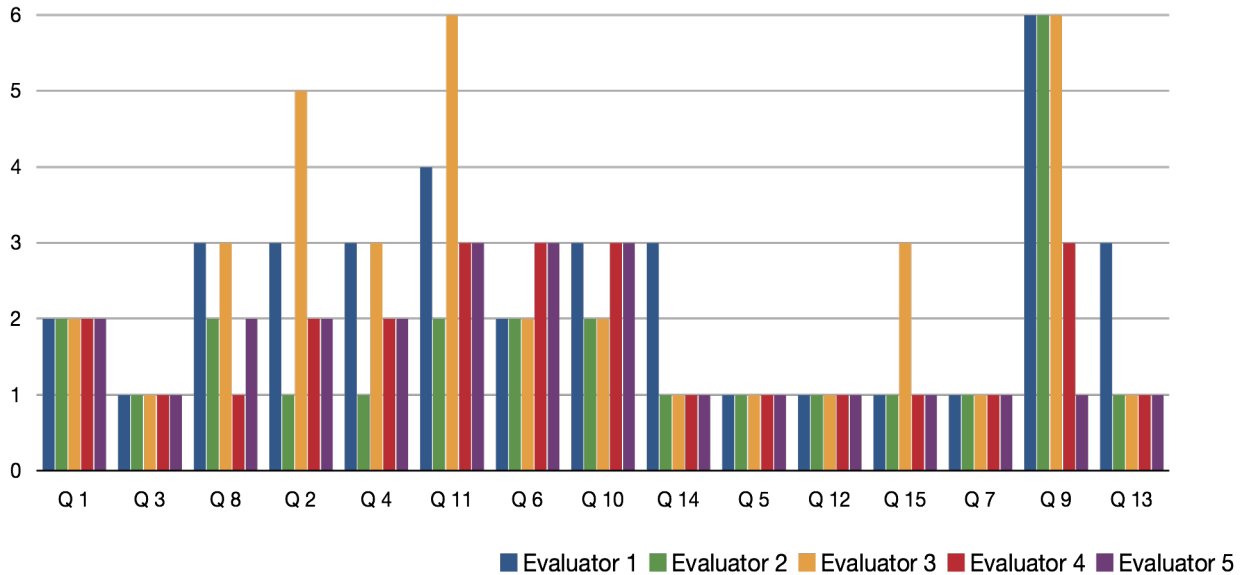
Part Two: Likert Scale Questionnaire

The questionnaire presented declarative statements asking for levels of agreement. The evaluators indicated their level of agreement with six possible responses: (a) strongly disagree, (b) moderately disagree, (c) mildly disagree, (d) mildly agree, (e) moderately agree, and (f) strongly agree. These values are represented on the x-axis in figure 1.

The questionnaire measured the evaluators' attitudes in the following 5 content areas; *cultural responsiveness*, *utility of mindfulness practices*, *art therapy methods*, *attitudes about yoga practices* and overall *need for stress reduction* in the community. The y-axis of figure 1 represents the responses of the evaluators in the five content areas:

1. Mindfulness Practice Questions; Q 2, Q 4, Q 11
2. Cultural responsiveness Questions; Q1, Q 3, Q 8
3. Art therapy methods Questions; Q 6, Q 10, Q 14
4. Yoga practice Questions; Q 5, Q 12, Q 15
5. Need for stress reduction Question; Q 7, Q 9, Q 13

Figure 1. Evaluator responses in the five content



Mindfulness practices. Evaluators indicated that parents would be open to learning mindfulness practices, and that meditation is a compatible approach with their clients. Evaluators varied between strongly agree and mildly agree on whether or not mindfulness practices would benefit parents in reducing stress.

Cultural responsiveness. On the item for cultural responsiveness, evaluators varied in the degree in which they found MAT-C congruent with cultural practices of parents they serve. Three evaluators indicated an agreeable attitude regarding cultural responsiveness and 2 evaluators mildly agreed about the cultural congruence MAT-C. On question 11, *I see cultural barriers in MAT-C that may be of concern to parents served at my agency*, 4 evaluators indicated that the

MAT-C did not contain cultural barriers, and 1 found that cultural barriers existed in the MAT-C.

Art therapy methods. Evaluators varied between strongly agree and mildly agree on whether or not art therapy methods were compatible for use with their clients. Evaluators mildly agreed that studio art therapy methods might be compatible with their clients. Four evaluators responded that art therapy would benefit their clients though parents may not want to participate with art therapy directives.

Yoga practices. There was a high level of agreement among evaluators on the compatibility of yoga practice with the parents they serve. Evaluators responded that yoga would benefit their clients and that the yoga practices in the MAT-C in particular would benefit their clients.

Need for stress reduction interventions. Evaluators varied slightly in responses on the need for stress reduction interventions at their agencies. On question 9, *My agency offers a stress reduction course for parents*, 3 evaluators indicated a strong disagreement with this statement, while 2 others indicated that their agencies offered stress reduction interventions. Most evaluators agreed strongly that MAT-C addressed the stress reduction needs of their clients.

Overall, evaluators' responses in the five areas measured reflected that they found MAT-C useful for parents served in their communities.

Part Three: Open-Ended Responses

Tables 3 through 9 present the evaluators' responses on part 3, the open-ended questions, as listed on the evaluation form.

Table 4.

Evaluators' Response to Question #1

1. What do you see as the barriers for your clients participating in an 8-week mindfulness intervention course for parents? Please explain.

| Evaluator | Comments |
|------------------------------------|---|
| 1. Licensed Clinical Psychologist | 1. Time/ Transportations 2. Childcare 3. Educational level 4. Trauma response |
| 2. Art Therapist/LMHC | Barriers would be schedule conflicts, transportation issues, childcare issues financial issues related to these barriers (work, no money for the MBTA [transit system], single parents with young children, parents would feel shame that they can't handle their stress. Many of the parents are constantly in crisis and can't be consistent. Some parents would be initially resistant using the art materials. Plus process oriented art directives due to the anxiety related to not being "good art," Some parents may find mindfulness in conflict with their religious practices, even though this is addressed. Parents may not feel comfortable in a room together. |
| 3. Licensed Clinical Social Worker | The primary barrier would be to get support for childcare. Many of our parents' children suffer from serious emotional issues that may preclude them from being consistent and full present. For these types of activities. Many parents may not have the level of education to participate (may not know how to read or write). |
| 4. Psychiatrist | ...Each individual brings their individualized patterns of managing and coping with stress and anxiety. Many are a) insightful and b) have a strong, stable sense of self-esteem and c) fully recognize the role of anxiety and stress influencing medical and psychological symptoms. These individuals are likely to benefit from this curriculum. But for those who are not as adept at managing their internal life and correlating it with medical and psychological symptom formation. |

(Continued)

| Evaluator | Comments |
|------------------------------------|--|
| 5. Licensed Clinical Social Worker | I have encouraged several of my clients to come into the office and participate in our weekly yoga sessions for children and adults. They have all expressed an interest but have never attended. Clients may be hesitant to try something they are unfamiliar with. Transportation is an issue, many clients rely on public transit. They may see self-care as a waste of time, especially if they are very busy parents. They may be reluctant due to disapproval of family and friends. |

The evaluators' responses to this question varied, however childcare and transportation issues was viewed as a potential barriers by evaluator 1, 2 and 5. Evaluator 3 responded that a low educational level might preclude so clients form participation. Evaluator 4 commented on the resiliency and insightfulness of some clients who could utilize these interventions without much effort but pointed out that other clients would need more of an educational component in order to participate. Evaluator 5 suggested that clients are often hesitant to try something new or different and that the approval of others may affect their participation.

Table 5.

Evaluators' Response to Question #2

How would you improve this curriculum? Please explain.

| Evaluator | Comments |
|-----------------------------------|--|
| 1. Licensed Clinical Psychologist | -Didactic information would be shared in multi-sensory / modal manner to address different styles of learning. -More attention given to self care for participants plus acknowledgment of potential triggering response to exercises. |

(Continued)

| Evaluator | Comments |
|------------------------------------|--|
| 2. Art Therapist/LMHC | A MAT-C for children to run concurrently would alleviate some of the barriers. I might add some mindful drawing activities such as blind contour drawing or drawing a mystery object (feeling an object and drawing from a tactile sense rather than visual). Also eating meditation (raisin meditation) is a nice intro to mindfulness. |
| 3. Licensed Clinical Social Worker | I feel this is a well thought out curriculum. The barriers mentioned above can easily be addressed by insuring that the right candidates are selected for the program. To increase access to people who can't read or write, some activities can be performed by the facilitator (i.e. provide verbal instructions). |
| 4. Psychiatrist | I would more overtly designate anxiety and stress as factors that stimulate, precipitate and sustain medical and psychological dysfunction. The possibilities exist in session 1 and 2. An extension of the curriculum could accommodate this. |
| 5. Licensed Clinical Social Worker | I do not have suggestions for improvements. It appears to be well thought out and I do believe the psychoeducational component will be important in order to educate participants about the benefits of mindfulness. |

Evaluators varied in their responses on question 2. Evaluators 1 and 2 suggested that the MAT-C address different learning styles in a multi-modal way.

Evaluator 2 gives an example of an art therapy exercise, feeling an object and drawing from a tactile rather than visual representation. Evaluator 1 suggested more of a consideration for participants' self-care for and the potential of exercises to raise a triggered response. Evaluator 3 suggested more focus on

anxiety and stress related education. Both evaluators 3 and 5 found the curriculum well thought out

Table 6.

Evaluators' Response to Question #3

What do you see as a weakness in this curriculum? Please explain.

| Evaluator | Comments |
|------------------------------------|---|
| 1. Licensed Clinical Psychologist | Limited consideration of trauma and the reaction of clients for whom sitting quietly can be very distressing as can body based focused. Not clear on screening process of participants. –Also language such as juxtaposition too complicated for many participants. |
| 2. Art Therapist/LMHC | I wasn't clear about the length of each session (what the recommendation for this is). Parents may need more of a rationale for why art therapy is used to augment the mindfulness practices to feel safe in engaging in the art process. |
| 3. Licensed Clinical Social Worker | The assumption that everyone can read/write and be able to understand written instructions. |
| 4. Psychiatrist | The curriculum covers a wide swath of topics and issues that influence mindfulness and the mind body relationship. I would recommend expansion by 2 or 3 additional sessions. This may not be as practical due to the time and commitment required from busy parents. |
| 5. Licensed Clinical Social Worker | I don't see any weakness in the curriculum. It looks fun and potentially effective and I believe it can be beneficial to the families we serve. |

Evaluators called for more clarity in regards to the screening process, recommended time of the MAT-C sessions and the rationale for art therapy tasks to enhance mindfulness practice. One evaluator commented that the meditation

practices in MAT-C do not account for the reactions that may be experienced with participants experiencing trauma.

Table 7.

Evaluators' Response to Question #4

What are some cultural concerns parents may have that could be addressed in this curriculum? Please explain.

| Evaluator | Comments |
|------------------------------------|--|
| 1. Licensed Clinical Psychologist | Permission to opt out of anything that felt uncomfortable or inconsistent with religious practices. |
| 2. Art Therapist/LMHC | Some Christian and Catholic parents worldview mindfulness as Buddhist plus against their spiritual beliefs despite orientation directive. This holds true for yoga as well even if it is labeled as gentle stretching. The facilitator would need to acknowledge personal and cultural beliefs with careful attention plus address individual concerns (pp. 2-3) thoroughly during the initial screening/ referral process. Many clinicians working with parents and families also have difficulty accepting mindfulness due to cultural and spiritual concerns. |
| 3. Licensed Clinical Social Worker | The religious aspect is huge. I feel that Jennifer did a great job in acknowledging the cultural barriers and planning to address them at the orientation session. |
| 4. Psychiatrist | –An overt discussion about the distinction between spirituality (a personal awareness of determining factors bigger than frail human beings can solve) and organized religion (a community of believers supporting each other in their individual walk through life; decidedly influenced by human concerns, likes and opinions). Continued reassurance and support that issues of mind/body are applicable to individuals who may not have an extensive formal education or high income, etc. |
| 5. Licensed Clinical Social Worker | The possibility of blending mindfulness and religious practices should be discussed over the course of the curriculum in order to reassure clients who may be hesitant due to their religious beliefs. |

Religious and cultural practices of parents raised concerns across all evaluators. Two evaluators suggested a continued acknowledgement and an open dialogue of religious and cultural concerns throughout the initial screening process, while another suggested that this process should occur throughout the course. One evaluator suggested giving participants permission to opt out of any activity inconsistent with their beliefs and 1 evaluator commented that the researcher covered religious and cultural concerns were addressed more than adequately in the initial orientation.

Table 8.

Evaluators' Response to Question #5

What factors would you consider in a decision to have this curriculum taught at your center.

| Evaluator | Comments |
|------------------------------------|---|
| 1. Licensed Clinical Psychologist | <ul style="list-style-type: none"> -Space for group -Funding -Screening of potential clients |
| 2. Art Therapist/LMHC | The barriers described in #1 would need to be addressed. Childcare would need to be provided. A day and evening session would need to be offered. Space considerations a space for meditation and for art making may be difficult in some agencies. |
| 3. Licensed Clinical Social Worker | My agency already embraces mindfulness as an evidenced based treatment. The curriculum would be a great fit. However the participants for the group would need to be enrolled in individual therapy for a period of time to prepare them for the group. |
| 4. Psychiatrist | I would want to be assured that those individuals taking this curriculum are properly primed regarding stress and anxiety. |

(Continued)

| Evaluator | Comments |
|------------------------------------|--|
| 5. Licensed Clinical Social Worker | I would love to have the curriculum taught at my location since stress and destructive behaviors of coping with stress are common themes with families we serve. |

Two evaluators cited space as a concern for mindfulness practices as well as art-making. Screening of potential clients was a concern for 3 of the evaluators, 1 suggesting that clients undergo individual therapy to prepare for the course and another suggesting clients be prepared with stress and anxiety education before participation.

Table 9.

Evaluators' Response to Question # 6

Would you recommend it to other community health centers?

| Evaluator | Comments |
|------------------------------------|--|
| 1. Licensed Clinical Psychologist | If their population wasn't heavily weighted on trauma. |
| 2. Art Therapist/LMHC | Yes. |
| 3. Licensed Clinical Social Worker | Yes! |
| 4. Psychiatrist | Yes, I would recommend it. |
| 5. Licensed Clinical Social Worker | Yes I would. |

The evaluators would recommend the MAT-C to other community agencies, although one evaluator warns that MAT-C would not be appropriate for a population heavily weighted on trauma. This evaluator expressed concerns the curriculum's limited ability to address trauma throughout the evaluation.

Table 10.

Evaluators' Response to Question #7

What strengths do you see in this curriculum?

| Evaluator | Comments |
|------------------------------------|--|
| 1. Licensed Clinical Psychologist | [The] skills are very important and I love the art activities. |
| 2. Art Therapist/LMHC | The use of the art process to deepen the experience of MAPS. |
| 3. Licensed Clinical Social Worker | Mindfulness activities have been proven to be very effective with trauma victims. This curriculum would address many underlying trauma issues in our community. Also the subsequent sessions would build on skills taught in previous sessions. |
| Evaluator | Comments |
| 4. Psychiatrist | I think that the art therapy component is inventive and potentially very helpful for many individuals who can benefit from 'manipulating' a concrete item. Using activities that challenge individuals who often 'need' to have something concrete upon which to focus to expand intangible sensibilities and imagine instead. |
| 5. Licensed Clinical Social Worker | I often encourage my clients to keep an open mind and try new things that may not necessarily be familiar to their community. I believe a curriculum like this would be a wonderful opportunity for them to learn healthy and different ways of coping with and managing stress. |

Evaluators found MAT-C to be a useful and inventive way to teach coping skills. The evaluators expressed that the art therapy activities could potentially, deepen the mindfulness practices, offer tangible mechanisms for focusing and

different ways of managing stress. One evaluator expressed the potential use of MAT-C with victims experiencing underlying trauma issues.

Table 11.

Evaluators' Response to Question #8

Do you find the Mindful Attention Awareness Scale appropriate for use with the parents you serve? Please explain.

| Evaluator | Comments |
|------------------------------------|---|
| 1) Licensed Clinical Psychologist | Yes– so long as it is provided with the option to have it read out loud in case literacy is an issue. |
| 2) Art Therapist/LMHC | Yes, I think it's appropriate, although some parents can't read. |
| 3) Licensed Clinical Social Worker | Yes, the questions are culturally sensitive. I can even say neutral – almost anyone can relate. |
| 4) Psychiatrist | The MAAS is appropriate for use with the parents that I serve. The continued focus on inattention, distraction and support for naming, identifying, tolerating and then utilizing feelings is very appropriate with the patients I serve. |
| 5) Licensed Clinical Social Worker | I think the questions are culturally considerate. |

Overall, the evaluators found the MAAS appropriate and culturally sensitive for use with clients. One evaluator found that MAAS added support for clients, enabling them identify aspects of inattention and distraction. Two evaluators expressed a concern for the literacy and educational level with 1 suggesting the option of having the MAAS read out loud.

Summary

Evaluators' feedback provided critical information on the feasibility, cultural responsiveness and relevance of MAT-C for the community. Strengths

and limitations of MAT-C are presented in the discussion chapter of this dissertation based on the information received by the evaluators.

Chapter IV: Discussion

The purpose of this study was to develop a mindfulness-based art therapy curriculum to be facilitated by mental health clinicians serving parents in underserved communities. The MAT-C curriculum was developed through use of participatory methods, an extensive review of the literature, and an evaluation of the curriculum by community clinicians in varied disciplines.

The literature review consisted of a search of empirically validated research studies, online resources, popular books, and manuals on both mindfulness and art therapy methods. Broad areas of mindfulness were first explored, followed by a narrower focus on literature about mindfulness and art therapy interventions in underserved communities.

As emphasized throughout this dissertation, the researcher employed participatory methods in order to investigate the utility of mindfulness for diverse peoples. The participatory methods included participation in scholarly mindfulness conferences, retreats, community presentations, and consultations with and observations of mindfulness practitioners.

After completion of the curriculum and approval from the institutional review board of Pepperdine University, five experienced community clinicians were recruited to evaluate the MAT-C. Evaluators reviewed MAT-C for its relevance and effectiveness, focusing on five content areas reviewed in the results chapter of this dissertation.

Summary of Results

In an effort to address the emotional health and wellbeing of peoples in underserved communities and to provide clinicians with an empirically reported resource to assist parents in the community, this study focused on the development of a mindfulness based art therapy curriculum (a) to enhance personal development; (b) to increase awareness of self and others; (c) to cultivate the capacity for attention; and (d) to assist in self-regulation of emotional states. The *Mindfulness Based Art Therapy Curriculum* (MAT-C) was designed for clinicians to teach these four stress-alleviating skills to parents in underserved communities

In order to determine the cultural responsiveness, the need for stress reduction resources, an openness to art therapy, and an acceptance of mindfulness in the community, five clinicians critiqued the MAT-C in the content areas previously described. Overall, evaluators found MAT-C to be a culturally congruent, useful resource for reducing stress in underserved communities.

Evaluators described the program as a unique and inventive synthesis of art therapy methods with mindfulness interventions. Even though evaluators favored the use of art therapy methods, Likert scale responses indicated that they believed clients might be hesitant to try art therapy. It is not surprising that adults would be hesitant or fearful in producing art. In fact this is often a part of the art therapy process (Bayles & Orland, 1993; Malchiodi, 2003, 2007). It is therefore a necessity that facilitators are familiar and adept in art therapy

methods to assist clients through fear and anxiety and educate them on the art therapy process.

The evaluators overall agreed that their clients would be open to mindfulness meditation and yoga practices. Further, evaluators expressed a need for stress reduction interventions at their agencies and a willingness to recommend MAT-C as an option.

Some areas of the MAT-C evaluators found a need for improvement were limited attention to religious concerns and cultural practices, a lack of support for clients who may be lacking in education and literacy, a consideration of time commitment for busy parents, and childcare and transportation issues. Evaluator 1 expressed concern overall about the potential for MAT-C to trigger trauma responses in some clients although, in contrast, Evaluator 3 felt that using MAT-C as an intervention for survivors of trauma would be beneficial.

Religious and cultural concerns. Although the evaluators support the acknowledgement and activities pertaining to religious and cultural beliefs in the initial orientation (Appendix D), 4 of the evaluators suggested further attention through continued acknowledgement and open dialogue about religious concerns. On the other hand, 1 evaluator found the exercises in the initial orientation and first session of the course more than adequate in addressing these concerns. Overall, religious and cultural concerns were recurrent themes in many areas and evaluators gave suggestions on how this could be further addressed.

Education and Literacy. A few activities of the MAT-C involve reading and writing (e.g., completion of the MAAS form during orientation and the final session). Four evaluators raised education and literacy issues as a concern for some parents who may not be able to read, write, or understand written instructions. Two evaluators suggested that the facilitator verbally give instructions, and 1 evaluator suggested other modes of learning and another suggested more psychoeducational sessions and an extension of the course by 2 to 3 weeks. Evaluators concurred that literacy obstacles could be circumvented with careful attention.

Time Commitment/Childcare/Transportation. Evaluators pointed out that some chronic issues for parents are lack of childcare, schedule conflicts for working parents, unreliable transportation, and inability to pay for public transportation. Evaluator 2 suggested that the MAT-C run on day and evening sessions with coordinated childcare – one such option being to concurrently teach a mindfulness course for children.

Strengths of MAT-C

A significant strength of the MAT-C is its contribution to clinicians serving underserved clients with prevalent stress issues. As discussed throughout this study, there are limited mindfulness interventions in community mental health despite the positive outcomes shown in a few community-based studies (Kabat-Zinn, personal communication, June 2011; Roth, 1997; Roth & Creaser, 1997; Roth & Stanley, 2002; Roth & Stanley, 2004). The literature shows that psychological and physical health can be damaged due to effects of chronic

stress associated with low SES and other prevalent environmental problems in urban communities (Baum et al., 1999).

MAT-C fills a need: it is based on an empirically supported intervention (MBSR) and created specifically to assist diverse, underserved clients, and directly addresses cultural concerns that other mindfulness programs ignore. The emphasis on self-care, good health, and emotional wellbeing is a new direction for many practitioners who often employ interventions with a pathological view of clients (Seligman & Csikszentmihalyi, 2000). The viewpoint of MAT-C is that “there is more right with you than wrong with you” (Kabat-Zinn, personal communication, June 2011) and MAT-C aims to assist clients in accessing their innate coping mechanisms.

Another strength is the collaborative method with community clinicians and agencies throughout the inception of MAT-C. Studies show that a collaborative model to community healthcare increases positive outcomes for clients served (Barr & Threlkeld, 2000). The researcher gathered feedback from community practitioners and clinical supervisors about the stress reduction needs of their communities and relevance MAPs. Through this collaboration, certain adaptations were made in order to support the needs of clients in the community. Vallejo and Amaro (2009) found that adjusting MBSR to the needs of their clients, mothers in recovery in a Mattapan treatment center, was a necessity for their continued participation. MAT-C is adapted to fit the needs parents involved in community mental health with while maintaining empirically valid interventions throughout the course.

Limitations and Future Directions

Although the MAT-C offers a significant, culturally responsive stress-reduction resource for community mental health, there are limitations. One such limitation is the inability to address barriers that hinder parents from accessing services (i.e. childcare, transportation, financial). With the assistance of an NIH grant were able to cover childcare and transportation costs for participants for 7 years their inner-city clinic in Worcester, Massachusetts, a satellite location to the stress reduction clinic at the University of Massachusetts Medical Center (Kabat-Zinn, personal communication, June 2011). Without that type of funding and affiliations in community mental health, a curriculum such as MAT-C may face obstacles being to being implemented. A small number of medical insurance companies reimburse for preventive care, including empirically based mindfulness interventions facilitated by trained practitioners. Even though this is a great leap in healthcare practices, parents trying to access clinic-based services face a range of challenges.

The importance of ‘languaging’ community work. One area of cultural competence that should be added to the MAT-C curriculum is attention to language and its ability to foster connection with participants. Languaging, as explained by Jon Kabat-Zinn and colleagues (personal communication, 2011), is a way for MBSR practitioners to avoid alienating their audience with terms related to stress and meditation that may be unfamiliar to participants. This is especially true in community outreach, where understanding the nomenclature is an essential component of joining (Minuchin, 1974) with community clients.

Facilitators may have their own approach but it is necessary to consider the audience, parents of the community, and what will resonate with them. Some examples of particular biblical versus that would support skills taught in the course are identified below.

“Be still and know that I am...” (Psalms 46:10 King James Version).

“Neither shall they say, Lo here! or, lo there! for, behold, the kingdom of God is within you.” (Luke 17:21 King James Version). These versus could be placed in the curriculum manual under objectives assisting the facilitator with rapport.

Quotes from writers familiar to and respected by the community can also be included in order to make the program more culturally syntonic. In addition, there exist a variety of writers and culturally familiar people with whom participants may feel a sense of kinship. African American poet Maya Angelou and writer Saundra Cisneros are two examples. These writers and others may have significance to multiethnic communities and their stresses.

Language of art therapy. The art expression and the art process are also involve non-verbal language between practitioners and clients. One consideration that should be explicitly added is a guide for choosing art supplies. When working with multicultural populations it is a necessity to have supplies that reflect their identity. Recently, art supplies come in a variety of skin tones from light brown to dark-brown, this includes markers, crayons, clay and papers. These are necessary supplies when working with diverse populations and should be considered by clinicians and added to the manual under “supplies.” Two specific examples follow.

Week 5 – a collage-making activity. It is necessary to have a range of magazine images that reflect the interest and identity of the group the facilitator is guiding. This could be parenting magazines, culturally specific media that feature Latino, African American and peoples, international media that immigrant communities may relate. One responsibility of the facilitator would be to pre-select images and divide them into categories (i.e. nature, food, people, clothing, colors, cars). Pre-selected images helps to avoid the temptation to read media, thereby diminishing focus on the art process (AATA).

Week 6 – an art activity using clay. Modeling clay and other forms of clay comes multicultural and ethnic shades in recent years, allowing clinicians the freedom to offer clients choices that reflect a variety of skin tones and shades. This is especially important if a client chooses to create a representation of themselves. The supplies that a clinician offers a client can communicate the clinicians' appreciation and understanding of the person (Malchiodi, 2007).

An evaluator suggested a mindfulness MAT-C for children to run concurrently with MAT-C for parents. This would address some childcare concerns. It could also significantly improve the health and wellbeing of whole families. As discussed previously in this dissertation, mindfulness programs that include parents and their children show better outcomes for both (Burke, 2010; Dumas, 2005; Hastings & Singh, N., 2010). Creating a program for children was considered during the initial phase of this study, but it was necessary to limit the scope and focus of this dissertation to MAT-C for parents. A MAT-C for children could strengthen the effectiveness and increase the accessibility of this course.

Educational barriers are another limitation of MAT-C. In low-SES communities, according to the American Psychological Association, low academic achievement caused by deficient education increases school dropout rates (APA fact sheet), increasing illiteracy rates as well. This increased rate of illiteracy in underserved communities makes it essential to implement and facilitate strategies in MAT-C that incorporate all levels of education. Evaluators concurred that education and literacy issues were important factors to address before implementing of this curriculum. Possible ways to address the limitations of MAT-C include an increased focus on the educational component about stress and related issues, more time allotted to explaining the rationale for using art therapy methods, more explanation on the use of the FOAT method in alleviating fear and anxiety of the art process and greater focus on discussions of the mind-body connection and its effect on health.

An additional limitation is that MAT-C is a theoretical curriculum that has yet to be piloted. Evaluators' critiques and suggestions were invaluable for further development, restructuring, and future design considerations for the curriculum – but until MAT-C is put into practice, vital parent input will be lacking.

For example, all evaluators saw religious and cultural concerns as a major obstacle to participant involvement in the course. To adequately address these concerns, input from parents is crucial. A collaborative approach to healthcare establishes better outcomes for clients; in fact, collaborative exploration of religious, spiritual, and cultural concerns could assist in deepening the

participants' experience of the course. A pilot of MAT-C with parents will be an important consideration for future development.

Qualifications to Facilitate this Curriculum

The MAT-Cs intended facilitators are those practitioners with at least a master's degree in a mental health related discipline including licensed professionals in social work, mental health counseling, psychotherapy, marriage and family therapy, and expressive arts therapy. In addition to those qualifications, facilitators must also have their own mindfulness practice and a familiarity with art therapy practice. Those unfamiliar with art therapy can consult with a certified art therapist. This curriculum is also intended for those community agencies open to mindfulness practice. It is necessary for agencies to have an openness to mindfulness in order to suggest these practices to their clients.

Future Studies

In addition to the many healthy aspects mindfulness studies have shown, one core mechanism, attention regulation, is crucial in supporting increased wellbeing. There may be other ways sustained attention and present moment experiences can be cultivated. Other contemplative practices or other disciplines such as focusing art therapy may support this core mechanism. These areas would need to be further studied for the possibility that they may also positively change brain structure and increase wellbeing.

Conclusions and Implications of this Study

Parents and children in underserved urban communities are at risk for a range of environmental, psychological and physical health concerns, including social-emotional difficulties, behavior problems, and poor academic performance (Waite & Ramsay, 2010). Low socioeconomic status brings with it a level of stress involving environmental, institutional, and mental health concerns (Baer, 2006). This includes stress due to economic issues, housing problems, lack of resources, and other systemic issues that are chronic in inner-city communities.

Traditional psychological interventions often view clients as pathological (Seligman & Csikszentmihalyi, 2000), ignoring the various ecological, sociological and economic issues that clients in underserved communities experience daily. Traditional methods also ignore the resiliency in communities, thereby missing an opportunity to build on a person's internal resources. There exists a need for alternate healing approaches – such as mindfulness-based therapeutic practices – that nurture the whole person and support the internal attributes that exist in all.

Yet despite an increased focus on mindfulness in the last 4 decades, only a limited number of studies have researched the use of mindfulness practices in mental health for underserved urban communities. Its use and effectiveness in the community remains relatively unexplored, and the need remains unsatisfied.

MAT-C seeks to address the need for mindfulness practices in the community. By synthesizing art therapy with mindfulness, MAT-C represents a novel, alternative, strengths-based approach that utilizes innate coping abilities,

and allows individuals to control their health and psychological and physical health. As it evolves through implementation and further evaluation, there is a strong possibility that MAT-C can make a positive contribution to urban community wellbeing.

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APPENDIX A
Introductory Email Script

Hello (Clinicians Name)

My name is Jennifer Brown and I am a doctoral student in psychology at Pepperdine University Graduate School of Education and Psychology. I am writing to inquire if you would be willing to assist me with my dissertation research by evaluating a culturally competent mindful awareness curriculum.

I am presently conducting my research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The goal of this study will include the development of a culturally sensitive mindful awareness curriculum for parents in underserved communities.

The initial stage of this project includes a comprehensive review of the literature in search of studies that support the utility of mindfulness based interventions in the community and in community art therapy interventions. The information has been used to develop a culturally aware mindfulness-based curriculum synthesized with art therapy interventions (MAT-C).

If you agree to participate in this study and meet the criteria for serving as an evaluator, you will be asked to evaluate MAT-C for its usefulness in community mental health, cultural responsiveness and relevance. The evaluation can be completed in approximately one hour in a single sitting at a comfortable, leisurely pace. However, you may choose to complete the evaluation program at a time that is convenient for you taking breaks to alleviate disinterest or boredom at your own pace.

As the evaluator you may choose to end participation in this study at anytime without prejudice, consequence or penalty. A recorded phone interview lasting approximately twenty minutes will conclude the study. I (the investigator) will schedule a time to speak with you for a follow up interview for part three, the open-ended questions, once you have returned the completed evaluation. The phone interview will allow you to ask any questions concerning the study and/or evaluation.

Your participation in this study is completely voluntary. If you would like to participate, you must have at least 3 years of clinical experience in working in community mental health in at least one of the communities in the greater Boston area listed below:

- Mattapan
- Roxbury
- Dorchester
- Codman Square
- Underserved areas of Waltham

You must possess a master's or doctoral degree in art therapy, psychology, social work, human services, counseling or have a medical degree and specialization in

psychiatry, and be familiar with mindfulness interventions and/or art therapy interventions. If you meet these criteria and would like to participate in this study please email your mailing address so that I may send you the proposed curriculum and evaluation materials.

Thank you for taking the time to consider this request. If you have any additional questions about this research project please contact me, the research investigator, Jennifer Brown, M.A., ATR-BC at this phone number xxx-xxx-xxxx or email address jennnifer.d.brown@myuniversity.edu. You may also contact Shelly Harrell, Ph.D. at the phone number or address listed below.

Sincerely,
Jennifer Brown, M.A., ATR-BC (art therapist board certified)
Pepperdine University
Graduate School of Education and Psychology

Shelly Harrell, Ph.D.
Dissertation Chairperson at Pepperdine University
Graduate School of Education and Psychology
6100 Center Drive, Los Angeles, CA 90045
(310) xxx-xxxx

APPENDIX B

Evaluation Packet Cover Letter

Dear (Name of Evaluator)

Thank you for volunteering to evaluate the proposed mindfulness curriculum for my dissertation titled *A Mindfulness Based Art therapy Curriculum for Parents in Underserved Communities* (MAT-C). Enclosed are an outline of the proposed mindfulness curriculum, two informed consent forms (one is yours to keep), and a curriculum evaluation form.

Please note that within the curriculum there is a copy of the Mindfulness Attention Awareness Scale (MAAS) and MAT-C consent forms that are both intended for use with future participants of the course. This scale and consent forms are clearly marked within the curriculum and are there for you to review for their relevance to the curriculum, not for you to complete as a part of the evaluation.

You may complete the enclosed evaluation in as many sessions that are comfortable for you. Once your evaluation of the program is complete, please return the signed consent form and the curriculum in the postage paid, pre-addressed envelope provided.

Your input is valued and appreciated in this project, however, please be aware that you may discontinue your participation at any point. If you decide not to participate in this study for any reason, please return all materials in the postage paid, pre-addressed envelope provided.

The time you are investing in this project is valued and much appreciated.

With Gratitude,

Jennifer D. Brown, M.A., ATR-BC
Pepperdine University
Graduate School of Education and Psychology

APPENDIX C

Evaluator Informed Consent

I authorize Jennifer Brown, M.A. ATR-BC, a doctoral student in the clinical psychology program at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include me in the research project titled *A Mindfulness Based Art therapy Curriculum for Parents in Underserved Communities* (MAT-C). I understand that participation in this study is completely voluntary.

I have been asked to participate in a study that intends to develop a mindfulness-based curriculum to be utilized with parents in underserved communities. I have been chosen because I meet the criteria to evaluate this study. I possess a master's or doctoral degree in one or more of the following areas; art therapy, psychology, social work, human services, counseling or have a medical degree and specialization in psychiatry. I am familiar with mindfulness and/or art therapy interventions. I have at least 3 years of clinical experience in at least one of these designated underserved communities in the greater Boston area:

- Mattapan
- Roxbury
- Dorchester
- Codman Square
- Underserved areas of Waltham

I understand that participation in this study will consist of reading over a mindfulness based curriculum and evaluating it. This evaluation task will take no longer than one hour.

I understand that the investigator will contact me by email, to ensure receipt of the evaluation packet and to schedule a follow phone interview. The follow-up phone interview will be offered to me and conducted once the investigator has received and reviewed the materials. This phone interview is estimated to be 20 minutes at least, however I may choose to continue after 20 minutes have passed or end the call whenever I would like without penalty.

The intent of the interview is to discuss and clarify responses on part three of the evaluation and to answer any questions I might have about the study. The interview will be audio recorded using a digital recorder and later transcribed by the investigator to insure that my responses are accurately analyzed. If I decline to be interviewed and/or recorded, I may still be included in the study if I choose to do so. The research investigator without phone interview input may evaluate my responses.

I understand that all information obtained from me in this study will be kept confidentially. The informed consent will be separated from all other project materials and stored. I will not be asked to put my name or any personally identifying information on the evaluation form. All research materials will be kept in a locked cabinet for 5 years and destroyed after that time. I understand that the principal investigator (Jennifer Brown) may publish in professional journals or present to professional audiences all or part of this study and that no identifying information will be released.

I understand that possible risks for participation in this study are no more than minimal but may include mild fatigue from reading the curriculum and responding to the open

ended and scale questions on the evaluation form. I have been advised to complete the evaluation in as many sessions necessary for my own comfort. I understand that I have the right to decline answering any question listed on the evaluation form and may withdraw from the study at any point in time without consequence.

I understand that there are no direct benefits for individual participants in this study. However, I may feel empowered from the evaluation process due to involvement in increasing knowledge and practice of culturally competent community mental health care.

If I have any questions regarding the study procedures I may contact Jennifer Brown, M.A., ATR-BC (art therapist board certified) at this phone number: xxx.xxx.xxxx or may email her at Jennifer.d.brown@pepperdine.edu. I also understand I am free to contact the researcher's supervisor, Shelly Harrell, Ph.D., and/or the Graduate and Professional Schools Institutional Review Board at Pepperdine University at the addresses/ numbers below.

Shelly Harrell, Ph.D.
Graduate School of Education and Psychology
Pepperdine University
6100 Center Drive
Los Angeles, CA 90045
(310) xxx-xxxx

Graduate and Professional School IRB
Jean Kang, CIP, GPS IRB Manager
Graduate School of Education & Psychology
Pepperdine University
6100 Center Drive 5th Floor
Los Angeles, CA 90045
(310) xxx-xxxx

Signature

Date

Print Name

If you agree to participate in the study, please return the signed consent document along with the completed research materials in the enclosed envelope

APPENDIX D

MAT-C

Overview

Mindfulness based stress reduction (MBSR) as described in the literature, is an effective mindfulness intervention, sensitive to cultural aspects of the client as well as empirically supported by the research. This proposed MAT-C¹ will be modeled on the 8-week program as given at the Center For Mindfulness and integrated with art therapy tasks. Adaptations are made in order to further address: cultural considerations for families in diverse underserved, urban communities. Empirically supported mindful awareness interventions, programs and literature were researched for developing this curriculum. Research of available medical insurance reimbursement for mindful awareness practices (MAPs)², found that empirically supported programs with clinicians certified in MBSR receive reimbursement.

A synthesis of a mindfulness practice with art therapy is created for this course in consideration for use in-outpatient groups for mental health clinics. MAT-C is 8-weeks long plus an orientation (nine sessions total). This curriculum is developed for implementing with parents; research for the development of MAT-C for children is intended in the future.

Orientation. Participants will first be asked to establish how they personally relate to Religion/Spirituality (Adapted from Au, 1989, pp. 136-137). This is not a part of the orientation process in MBSR, but it is utilized in MAT-C in order to address religious or spiritual barriers that may be of concern for participants. Although this curriculum is not

¹ MAT-C- the proposed curriculum for this study; *A Mindfulness Art Therapy Curriculum for Parents in Underserved Communities.*

² MAPs- will refer to mindful awareness practices in general.

a religious one, the purpose of this exercise is to raise awareness of ideas about a Higher Power and belief systems that may influence one's life and behaviors. More specifically, this exercise is meant for the participant to carry those images through the 8-week course if they choose. By acknowledging personal beliefs prior to the course, it is hypothesized that participants will not experience a challenge to their beliefs. The directive may be reintroduced again for contemplation at the first week of the course. The procedure itself (Au's Window on God) has been adapted to accommodate a variety of beliefs or no belief. Participants will also be given information on contemplative practices in general and specifically Christian contemplative practice; Christianity is the dominant religious belief within the communities this researcher has clinical experience with.

MBSR practitioners acknowledge that Catholic and Christian participants have raised questions about mindfulness and its religious intentions (Vallejo & de Torrijos, personal communication, 2011). In consideration of these concerns, this curriculum establishes a connection between some contemplative practices in religious traditions.

Orientation will be done in a group format because evidence has shown that participants in underserved communities are more likely to attend a mindfulness-based stress reduction course if they attend orientation along with others in their community (Santorelli, personal communication, 2011). During the session, the instructor utilizes a psychoeducational model, outlines the purpose of the 8-week course and discusses the effects that mindfulness and meditation have on body and mind. The instructor discusses the utility of mindful art activities and how the activities will support their mindful awareness practices (MAPs). The instructor explains that the course is

psychoeducational not psychotherapeutic and persons with major mental illness can consult with the agency for appropriate treatment.

MBSR practitioners have noted the importance of a psychoeducational component while working with communities (Vallejo & Amaro, 2009; Santorelli, personal communication, 2011). In the MBSR curriculum homework is included, providing participants with recorded guided meditation instruction. According to Vallejo (personal communication, 2011) attempting to assign homework to participants in an underserved neighborhood in the Boston area, Mattapan, created a barrier between the instructor and participants; heightened anxiety and distress for participants; and caused some to avoid the course all together. Vallejo eliminated the homework requirement and noticed increased attendance (personal communication, 2011). In MAT-C, participants will not be required to do homework but will be encouraged to practice what they have learned in the course outside of class. Further, it is acknowledged that parents who participate in MAT-C may not have time in their schedule for required homework.

Mindfulness Based Art Therapy Curriculum for Parents (MAT-C)

- This program is intended for facilitation by a graduate level clinician with at least Master's degree in psychology or related field training (e.g., social work, counseling).
- It is recommended that a clinician trained in mindfulness and art therapy facilitate the curriculum. However, a skilled clinician with knowledge of art therapy and a personal mindfulness practice may deliver this curriculum. Consulting a board certified art therapist or MBSR instructor is also recommended in this case.

- Training in yoga or other physiological exercise is recommended or the facilitator may have a trained yoga consultant for this aspect of the curriculum.
- This curriculum is intended for use with parents in underserved communities.
- An addendum is included in this manual with supplemental information on the meditation activities (walking, sitting and body scan) and resources on stress education for the facilitator.

The italic, blue font in intended to assist the facilitator in guiding the groups but the language and wording is dependent upon each facilitator.

Orientation

Supplies Needed For this Week

- 8.5 x 11 inch drawing paper
- Pencils
- Notepads (to be placed on the table for each participant)
- Brochures or handouts with date and time of the course

Good (morning, evening, afternoon) the clinician states their name and discipline for the participants and introduces orientation agenda.

Before we get started with our orientation for this 8-week course, Mindfulness Based Art Therapy or MAT-C, for all of you parents here today. Lets take a moment to recognize why you are here today, and discuss what you would like to see happen for you at the end of this course. Think of three goals for yourself in this course and write them down on the notepad in front of you.

The clinician answers any question from participants during this time.

Who would like to share what brought them here today and your three goals for this course? Please tell me your name and what you would like to share with us today, right now.

The facilitator makes a mental note of each participant's familiarity with mindfulness, i.e., the level of awareness of mindfulness that participants have brought into the course. This is established during orientation during the evaluation process. However, the instructor needs to have an awareness of the mindfulness baseline of each participant in that moment.

I'd like to share with you some information about the health benefits of mindful awareness practices. These practices include, sitting meditation, yoga or stretching, walking meditation and art activities. The studies show that mindful awareness practices reduce stress, anxiety and depression. Some studies have found that mindful awareness practice help decrease high blood pressure, alleviate anxiety and reduce chronic pain for some people (it is important at this point that facilitators are knowledgeable about the current literature in mindfulness practices before giving information to participants). In this course you will learn some basic mindful awareness techniques, to assist you in having a good attention span, help you relieve stress and control anxious feelings. We will do stretching and breathing exercises, sitting and walking meditation and some art activities. Participants are encouraged to ask questions at this time. After questions the facilitator introduces the Windows to Religion/Spirituality directive.

Now we are going to use the drawing paper in front of you to express thoughts or feelings that may arise when you think about meditating. In particular, religious or

spiritual thoughts; although this course is not a religious or spiritual course, meditation is a practice in many spiritual and religious disciplines and traditions.

At this point, the facilitator addresses any concerns participants may have culturally or religiously.

The facilitator introduces this exercise by demonstrating how to fold the paper and by giving a verbal description of each step.

First, divide a sheet of paper in half with a straight horizontal line, and then in quarters with a straight vertical line down the middle. The sheet should now resemble an old-fashioned window with four panes.

In the first pane, express your spiritual/religious beliefs with a drawing, symbols, or words as has been presented or taught to you by parents, teachers, and friends.

In the second pane, express through a drawing, symbols, or words the image or words the spiritual/ religious or belief-related image you have formed from your own experiences or personal search. Here you might describe moments you experienced in prayer or contemplation, whether in happy or difficult times.

In the third pane, express the image of the beliefs that you live by.

After finishing the three panes, study your page and note what the juxtaposition of the three images gives rise to in you in terms of insights, questions, and feelings.

In the fourth pane, write down how your images affect your life and decisions.

After the windows directive participants will be asked to hold onto their windows for later contemplation during the course. *Before we end our orientation today, there is a small amount of paper work to be completed for those of you who would like to continue*

with this course. For those participants that leave the facilitator can thank them for their time and welcome them back if they should like to try the course another time. For the participants that stay, they will be asked to sign consent forms for their permission for the facilitator to photograph the artwork or other products they may produce in the course and to complete the Mindful Attention Awareness Scale (MAAS). *We can look at the MAAS to compare your level of mindfulness before and after this course. I am excited that you have chosen to continue the course, we will begin* (facilitator gives the date and time for the first week of the start of the 8 week course).

Week One

Supplies Needed For this Week

- 11x14 inch drawing paper
- Markers
- Colored pencils
- Pencils

Objective 1: Discussion of intention, attention and attitude for practice.

Objective 2: The body scan is introduced.

Objective 3: Introductions through the art therapy directive.

Let's think about the goals that you've written down and put them aside for a moment as you prepare for this course. I will ask you to start this course without expectation and see what happens when the 8 weeks are over. We will call this our 'intention.' This is a new experience for most of you, so let us try our best to be open to the activities and be patient with ourselves and other people. In this way we exhibit an

attitude of non-judgment. With each activity that is introduced, try your best to focus on that activity, notice when your mind wanders and but bring the focus back to that activity.

The windowpane assignment from orientation will be reintroduced for silent contemplation. The purpose of silent contemplation is to allow participants psychic space to attach their own spiritual or cultural significance before beginning the course.

The mindful art therapy directive will further the intention, attention and attitude for practice for this week. Each participant will be asked to *descriptively draw their name your name in a way to introduce something about themselves.* The facilitator will also introduce himself or herself through this directive once all participants have had a chance to be introduced. Following this directive, participants will be asked to share what brings them to the course. *Now we are going to end our course today with what is called a body scan. This is a mindful practice that helps us to notice areas in our bodies that maybe tense or in pain. I will ask you to focus on areas of your body starting with the feet and slowly I will guide you to the head. Mats are provided for those of you who would like to try this lying down. This may also be practice sitting in your chair.* Once participants are in position the facilitators vocally guides them through areas of the body, while participating in the practice as well. The facilitator will gently direct participants out of the body scan, giving appropriate time for relaxation and end this weeks course.

Week Two

Supplies Needed For this Week

- 8.5x11 inch Drawing paper
- Pencils, erasers

Objective 1: Educational Presentation on stress.

Objective 2: Sitting meditation introduced.

Objective 3: Art therapy directive connecting mind body experience.

When participants enter they will be directed to sit, with notepads for each participant. The facilitator will give a PowerPoint (or other) presentation on the physical and mental origins of stress and its damages (It is important that the facilitator be knowledgeable about stress and it's effects through their own training, experience and research of the current literature (see resources on stress theories in the addendum section of this manual). The benefits of mindful awareness practices and a brief history of mindfulness based stress reduction will be presented. *Last week we practiced the body scan, lets open with the body scan this week.* Facilitator will guide participants in the body scan, adding about 10 minutes more than the previous week, while participating as well. Once the body scan is over the facilitator will gently direct participants to a sitting position. *Now we are going to learn a practice that is considered to be the core of stress reduction courses, sitting meditation. Sit in a position that is comfortable for you, in a chair or with pillows. As you sit, pay attention to your breathing, don't manipulate your breathing in anyway, just pay attention the inhalation and the exhalation of your breath. Even when we are sitting in a comfortable position, after a while the body starts tends to ache, itch, want to move, the mind wanders and our thoughts may be many. Notice this when it happens ad then take your attention back to the inhalation and exhalation of your breath.* After about 15 minutes of guided sitting meditation, participants will be asked to come together in the art activity area of the room where supplies are already placed. The

Draw-a-Person art therapy directive will be given allowing participants a non-verbal opportunity to explore their experience. *I'd like you to think about your experience today and place your attention to the art supplies in front of you, using what is there, I would like you to draw a person.* Facilitator will wait for participants to reach a conclusion on their drawing and ask if anyone wants to relate the person they've drawn to the experience they had during the body scan and sitting meditation. After participants have spoken, the instructor will end the session. *Thank you for your focus and attention during today's practice, we will continue next week.*

Week Three

Supplies Needed For this Week

- 11x14 inch Drawing paper
- Colored pencils
- Markers and pastels (oil and chalk)
- Pencils (ebony pencils and a range of 2h through HB pencils)
- Erasers (mars plastic and pink pearl)
- Charcoal sticks

Objective 1: Discussion of intention, attention and attitude for practice.

Objective 2: Loving Kindness meditation introduced.

Objective 3: Introductions through the art therapy directive.

Compassion for Self and Others or empathy as it is described in psychological terms is essential to MAPs. Guided sitting meditation will be utilized this week with an introduction to Loving Kindness Meditation.

This meditation guides the participants to practice connecting to feelings of love and kindness toward self, loved ones, strangers, enemies and all beings successively (see addendum). There are a variety of ways to deliver this guided meditation and the facilitator should choose their own style. Speaking is very limited in this guided meditation as the facilitator asks each participant to reflect. Yoga (mindful stretching) will be introduced allowing participants to explore their body sensations through movement. [A yoga instructor or a facilitator capable of teaching light stretching exercises to others should teach Yoga.]

Now lets transition into the art space with the same intention, attention and attitude as we did in our guided meditation. For our art practice today I would like you to think of those people close to you, family members or good friends, whoever it is that makes up your community. Now I want you to draw two or more of those people as fruit or vegetables, don't forget to include yourself as a fruit or vegetable as well. Whatever comes to mind when you think of the people in your life. After the art activity, participants will be asked to identify the chosen fruit or vegetable and connect the qualities with the individual it represents. This directive invites participants to look at themselves and others in a new way or in a way that had not been realized. Attention will also be placed on the positioning of the fruits and vegetables on the page and in relationship to each other. *Thank you for your focus and attention during today's practice, we will continue next week.*

Week Four

Supplies Needed For this Week

- Large poster size paper
- A variety of pencils charcoal

Objective 1: Meditation on the nature of mind.

Objective 2: Walking meditation introduced.

Objective 3: Art therapy directive; creativity out of chaos.

We are now into our fourth week of this course and we've been sitting together, breathing together and stretching together. We've really started to bring our focus and awareness into this moment. During this time the participants will be asked to position themselves for sitting meditation. *I'm sure you all have noticed at this point that as you are sitting, stretching or breathing and focused in the present moment, the mind likes to go somewhere else. This of course is the nature of mind it tries to put you somewhere else. Either somewhere in the past to an event that has already happened or somewhere into the future, a place that doesn't exist.*

The instructor will introduce a new term for MAT-C, *retrospective and prospective scripts* that we tend to run in our heads. *I'm sure we have all experienced the tendency to over think conversations that have already happened... or conversations we plan to have in the future...Even emails we plan to write or the ones we've already sent. When we do this...it is our mind taking us away from the present moment. The past has already happened and the future does not exist. This moment is all we have.* The instructor may elaborate on this idea and then move into the next activity. *Pay attention*

to this during your practice and simply bring yourself back here, to this moment, the only moment there is.

The instructor will demonstrate walking meditation and invite participants to join. *Now lets transition into the art space with the same intention, attention and attitude as we had in our guided meditation.*

The art therapy scribble drawing directive will be given inviting participants to cultivate creativity in the chaos. *It is the nature of mind to organize, place things into categories, it is always working at work. The mind is intent on doing and having you do. Like right now the mind is saying “why are you just sitting here, I’m bored just sitting here breathing,” or “this is stupid, I should be doing something else.” This is the nature of mind, however, for this 8-week course I would like to give yourself permission for non-doing. In the spirit of ‘non doing’ I’d like you to take a pencil or charcoal stick scribble over the entire page with scribble, moving your body around as your work.* The instructor demonstrates this by drawing all over the page in a scribbling motion with an emphasis on using the arm, not just the hand to mark the page. Scribbling on the page is intended to initiate movement and connection to the art process. The scribble itself helps participants to understand that the process of doing art is central to MAT-C, not the product. Once participants have finished they will be asked to create something from their scribble drawing (The scribble technique; Detre et al., 1983; Naumberg, 1966;). This directive is designed to show participants the importance of process over product and how the mind can makes sense out of abstraction. *Thank you for your focus and attention during today’s practice, we will continue next week.*

Week Five

Supplies Needed For this Week

- Magazine clippings organized into files
- Decoupage
- Glue
- Scissors
- Large heavy weight paper

Objective 1: Meditation on sitting whatever arises internally or externally.

Objective 2: Meditation time will be extended for sitting, walking and body scan.

Objective 3: Art therapy directive using collage (preprinted images) to accept and utilize what is.

Sitting with Whatever Arises will be the discussion topic for this week, helping participants to accept what is without assigning a value or mental label (judgment), an essential practice in mindfulness. Participants will be asked to position themselves to sit for guided meditation. *We've talked about the nature of mind and the tendency for our thoughts to take us out of the present moment. How the mind is always active and would like us to keep doing, striving thinking about past events that are no longer or future events that do not exist.* The facilitator will close the seated meditation and ask participants to rise for walking meditation. Adding to the content of the previous week, participants will gradually walk and sit for longer periods of time. The facilitator must use their judgment to decide what length of time to add to each meditation each week.

Now lets transition into the art space with the same intention, attention and attitude as we did in our guided meditation.

Using these existing images let's see what we can create, what kinds of thoughts develop from what is already there. Collage using images to construct thought out of what arises through the images will be the art therapy directive. Collage in art therapy means “glued to assemble or create a new whole” (Malchiodi, 2007). This art directive, constructed of pre-printed images, is designed to assist participants in acceptance of what arises. Although collage is a creative process, the participant is limited by the images that already exist, to accept the preprinted imagery while creating a new whole. *Thank you for your focus and attention during today's practice, we will continue next week.*

Week Six

Supplies Needed For this Week

- Self hardening clay
- Clay tools
- Heavy project board or poster board
- Markers
- Handouts on stress and with information on resources (recommended)

Objective 1: Educational question and answer period on alleviating stress.

Objective 2: Guided sitting meditation on “responding versus reacting” (Kabat Zinn, 1994) in stressful situations.

Objective 3: Art therapy directive; the use of clay to reduce stress.

A discussion on the mental and physical affects of stress will follow a psychoeducational component. Participants will be given time to ask facilitators questions about stressors, it's effects and effective methods of alleviating stressors in their lives. Other concerns related to the course may also be introduced at this time. This will also allow the facilitator an awareness of the participant's progress in the course. The facilitator should lead this discussion with knowledge and insight (prior research before this session is recommended). The level of discussion is dependent upon the facilitator's knowledge and expertise; however, the focus should be on how MAPs assist in responding as oppose to reacting in stressful situations (Kabat-Zinn, personal communication, 2011). The facilitator should end the question and answer period with a brief stretching or yoga session, leaving enough time for the art directive. *Now let's transition into the art space with the knowledge that we are alleviating stress in our lives through these moment-to-moment activities.*

A group clay project will be the art therapy directive. *I'd like for each of you to create a clay object.* Once everyone has made an object the facilitator explains the next step. *Using the poster board and markers placed between you, let's create a community for these objects.* A discussion can follow this directive, asking participants about the co-created community and the interaction between objects. *Thank you for your focus and attention during today's practice, we will continue next week with a day of silence. For this silent retreat, I will ask each of you to refrain from eye contact, cell phone use and reading. Avoid wearing any clothing with letters or words. When you walk into the room next week the silent retreat begins. Art supplies will be available for you in the art space*

to create as you like. The following week after our silent retreat week, will be our culminating ceremony. Let's take a few moments right now to plan how you would like to end our time together. Facilitator allows participants to plan their ceremony, for example, participants may decide to bring food or want to make cards for each other.

Week Seven

Supplies Needed For this Week

- Markers
- Colored pencils
- A variety of pencils and erasers
- Charcoal
- Different sizes of drawing paper
- Clay and clay tools
- Collage materials
- Glue

Objective 1: Silent Retreat

A guided meditation session will be opened by the facilitator but only to introduce the session, meditation will be in silence for about 30 minutes, then instructor will guide participants into a walking meditation. *In silence, lets take a seated position for meditation. You may use this space to continue meditation, walking, body scan or sitting or you may use the open art studio space.*

The silent studio art day is a method to induce internal reflection and calmness therefore the facilitator should be aware and alert if any participants are having difficulty.

If this should happen, the facilitator then uses their mental health skills to assist participants. *Thank you for your focus and attention during today's practice, we will end our time together next week, with our planned culminating ceremony.*

Week Eight

Supplies Needed For this Week

- Markers
- Colored pencils
- A variety of pencils and erasers
- Charcoal
- Different sizes of drawing paper
- Clay and clay tools
- Collage materials
- Glue

Objective 1: Culmination of MAT-C for Participants

Objective 2: Guided sitting meditation on the impermanence of all things.

Objective 3: Art therapy directive; open studio

Culminating Ceremony: "The Impermanence of all things" will be the focus of the guided meditation. *Today we end our practice together, we may never be in this room the same way again or we may never see one another after this time. Change is a natural part of life.* Any remaining art products will be returned to participants and an open forum for discussion of the art process will be offered. For this final session, the

facilitator will use their knowledge of the class participants and psychological knowledge about adjusting to life changes and acceptance of moving forward at the end of course.

Addendum

The Body Scan

Traditionally, the body scan in MBSR is practiced lying down but it can also be practice sitting in a chair, with feet flat on the ground. For the MAT-C, the facilitator should offer each option, sitting in a chair or lying down a mat equally. The facilitator guides participants in evaluating different areas of the body for tension or discomfort, in succession starting with the feet and ending with the top of the head. The facilitator is also participating with the body scan as he/she guides the participants. For MAT-C, it is recommended that upon first introduction of the body scan, the facilitator sit in order to be aware of participants who may be struggling. The facilitator should ask participants to recognize signals in their body like tense muscles, pain or other sensations that signal stress, tension or the need for relaxation. This prepares participants for mindfulness meditation by assisting in relaxation to relieve tension and discomfort.

Sitting Mindfulness Meditation

Facilitator instructs participants to sit comfortably on the floor with cushions or chairs, with an upright, non-rigid posture. If sitting in a chair, participants are instructed to place feet flat on the floor. Participants are instructed to notice their breathing, not to focus on the breath or change their breathing, but simply to notice their breath. The facilitator instructs participants to notice if their breathing is shallow, if it comes for the

chest or the belly. Participants are instructed to breath into their bellies and out, so that the chest and belly expands. The facilitator may word these instructions in their on voice.

Walking Meditation

The walking meditation works the same way as the sitting meditation but is only demonstrated by the facilitator, not guided with instructions throughout. Facilitator participates during the walking meditation. The focus is on lifting the foot, moving it, shifting the weight and again lifting the other foot, moving and shifting the wait. This should be done at a slow pace when introduced but increase into a regular walking pace as the course progress. Depending on the space of the room, participants can find a space to walk back and forth or they can be instructed to circle around the room single filed.

Mindful Stretching

Hatha Yoga is traditionally practiced in MBSR but may be referred to as mindful stretching for MAT-C. The stretching uses gentle movements and breathing to assist in body regulation. The focus is on thoughtful breathing and listening to the body's signals. The literature is overwhelmingly in support of many forms of yoga for treating mental illnesses, health issues, and cultivating a healthy lifestyle. The facilitator should emphasize for participants to have an awareness of their breathing, movement, posture and limits. No facilitator should teach mindful stretching if they are not an active participant in their own yoga practice or certified to teach physical activities.

Loving Kindness Meditation

This is a specific form of meditation where one wishes well to oneself and also wishes others well. It can be adapted to suit facilitator's style.

May I/you be safe
May I/you be happy
May I/you be at peace
May I/you be filled with joy and love

Stress and Coping Resources

The Transactional Model of Stress and Coping

Lazarus, R.S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Lazarus, R.S. & Cohen, J.B. (1977). Environmental stress. In I. Altman and J.F. Wohlwill (eds.), *Human Behavior and Environment*. (Vol 2) New York: Plenum.

Acute Stress Response

Walter Bradford Cannon (1915). *Bodily Changes in Pain, Hunger, Fear and Rage: An Account of Recent Researches into the Function of Emotional Excitement*. Appleton-Century-Crofts.

Walter Bradford Cannon (1929). *Bodily changes in pain, hunger, fear, and rage*. New York: Appleton-Century-Crofts.

The tend-and-befriend model of stress and coping

Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A. R., & Updegraff, J. A. (2000). Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review*, 107, 411-429.

Chronic Stress

Charlesworth, E. A., & Nathan, R. G. (1984). *Stress management: A comprehensive guide to wellness*. New York: Atheneum.

Miller, L. H., Smith, A. D., & Rothstein, L. (1993). *The stress solution: An action plan to manage the stress in your life*. New York: Pocket Books.

Seaward, B. L. (2008). *The art of peace and relaxation workbook*. Boston: Jones & Bartlett Pub.

Seaward, B. L. (2009). *Managing stress: Principles and strategies for health and well being*. Sudbury, MA: Jones and Bartlett.

Mindfulness Research Guide.

<http://www.mindfulexperience.org>

David S. Black, M.P.H., Ph.D.
Founder, Mindfulness Research Guide
dblack@mednet.ucla.edu
University of California at Los Angeles
Semel Institute for Neuroscience & Human Behavior
Cousins Center for Psychoneuroimmunology
Mail Code 707624
300 Medical Plaza, room 3156
Los Angeles, California 90095-7076

The Center For Mindfulness

<http://www.umassmed.edu/cfm/home/index.aspx>

Center for Mindfulness in Medicine, Health Care, and Society
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

Phone: 508-856-2656

Fax: 508-856-1977

Focusing Oriented Art Therapy training (FOAT)

<http://www.focusingarts.com/index.html>

Contact Laury Rappaport at: laury@focusingarts.com.

Overview Table of the MAT-C for Parents

| Week | Mindfulness Skills | Art Therapy Skills |
|------|---|--|
| 1 | Results of MAAS from the orientation session reviewed. An Introduction to Meditation: The body scan Discussion about intention, attention and attitude in meditation practice. | The Window Pane Assignment reintroduced for silent contemplation. Descriptively your name art therapy directive: Participant introductions using the descriptive name drawing. |
| 2 | Using the Breath: Body Scan meditation Guided sitting meditation | Introduction to Art making: Draw a Person directive |
| 3 | Compassion for Self and Others: Guided sitting meditation Yoga (mindful stretching) | Exploring Mind Body Relationship: Draw yourself as animal, fruit or vegetable Directive Discussion |
| 4 | The Nature of Mind meditation: Retrospective and Prospective Scripts Yoga and sitting meditation Walking Meditation | Scribble Drawing Creativity in the chaos |
| 5 | Sitting with Whatever Arises; Sitting Meditation Walking meditation | Collage Using Images to construct thought. |
| 6 | Psycho-education on stress: Reacting vs. Responding (kabat-zinn, 1994) | Group Clay Project: Each person creates a clay object. Objects are then placed in a co-created environment. |
| 7 | Day long Silent Retreat Guided Meditation | Open Studio |
| 8 | Culminating Ceremony The Impermanence of all things Guided Meditation | Art Work returned to participants; Open forum for discussion of art process. MAAS completed by participants. |

APPENDIX E
Curriculum Evaluation Form

PART I

Please answer the questions below about yourself, your professional experience and the community that you provide services to. All of the information on this form will be kept completely confidential.

1) What is your gender? Male Female

2) How many years have you provided services within the community? 3-6 7-10
 11-14 15+

3) What is your ethnicity? African-American Asian/Pacific Islander European American /Caucasian

Native-American Latino(a) Multiethnic Other _____

4) What is your title? (e.g.. art therapist, social worker, psychologist)

5) Do you have licensure or credentialing in the state of Massachusetts? If so, what type?

6) Briefly describe the community and population you provide clinical services to (e.g., diversity, socioeconomics, cultural/religious practices):

7) Please rate your familiarity with mindfulness on the scale below:

| 1 | 2 | 3 | 4 | 5 | 6 |
|---------------|---------------------|-----------------|-------------------|-----------------------|---------------------|
| very familiar | moderately familiar | mildly familiar | mildly unfamiliar | moderately unfamiliar | Not at all familiar |

PART II

Instructions: Using the 1-6 scale below, please indicate how strongly you agree with each statement regarding the Art Therapy Mindfulness Curriculum for Urban Communities.

| 1 | 2 | 3 | 4 | 5 | 6 |
|--|------------------|--------------|-----------------|---------------------|-------------------|
| strongly agree | moderately agree | mildly agree | mildly disagree | moderately disagree | strongly disagree |
| 1.) My clients would participate in guided meditation. | | | | 1 | 2 3 4 5 6 |
| 2.) This curriculum supports the cultural practices of my clients. | | | | 1 | 2 3 4 5 6 |
| 3.) My clients would benefit from mindfulness exercises to reduce stress. | | | | 1 | 2 3 4 5 6 |
| 4.) The activities in this curriculum support the diversity that my clients represent. | | | | 1 | 2 3 4 5 6 |
| 5.) My clients would benefit from learning yoga techniques to reduce stress. | | | | 1 | 2 3 4 5 6 |
| 6.) My clients would participate in art therapy directives to reduce stress. | | | | 1 | 2 3 4 5 6 |
| 7.) There is a need for stress reduction interventions for my clients. | | | | 1 | 2 3 4 5 6 |
| 8.) Meditation is a compatible approach with my clients. | | | | 1 | 2 3 4 5 6 |
| 9.) My agency offers stress reduction course for clients. | | | | 1 | 2 3 4 5 6 |
| 10.) Studio art therapy practice seems compatible with my clients. | | | | 1 | 2 3 4 5 6 |
| 11.) I see cultural barriers in this curriculum that may be of concern to my clients. | | | | 1 | 2 3 4 5 6 |
| 12.) Yoga as described in this curriculum would help my clients | | | | 1 | 2 3 4 5 6 |
| 13.) My client's stress can be addressed through this curriculum. | | | | 1 | 2 3 4 5 6 |
| 14.) Art therapy is something my clients may benefit from trying. | | | | 1 | 2 3 4 5 6 |
| 15.) Yoga seems a compatible intervention for my clients. | | | | 1 | 2 3 4 5 6 |

PART III

Please answer the following questions numbered 1 through 8.

1. What do you see as the barriers for your clients participating in an 8-week mindfulness intervention course for parents? Please explain. (Use additional paper if necessary)

2. How would you improve this curriculum? Please explain.

3. What do you see as a weakness in this curriculum? Please explain.

4. What are some cultural concerns parents may have that could be addressed in this curriculum? Please explain

5. What factors would you consider in a decision to have this curriculum taught at your center?

6. Would you recommend it to other community mental health centers?

7. What strengths do you see in this curriculum?

8. Do you find the Mindful Attention Awareness Scale appropriate for use with the parents you serve? Please explain.

APPENDIX F

Mindful Attention Awareness Scale

Mindfulness Attention Awareness Scale (MAAS)

Please indicate the degree to which you agree with each of the following items using the scale below. Simply circle your response to each item.

| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|------------------|--------------------|------------------------|--------------------------|----------------------|-----------------|
| | almost always | very frequently | somewhat frequently | somewhat infrequently | very infrequently | almost never |
| 1. I could be experiencing some emotion and not be conscious of it until some time later. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. I break or spill things because of carelessness, not paying attention, or thinking of something else. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. I find it difficult to stay focused on what's happening in the present. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. I tend to walk quickly to get where I'm going without paying attention to what I experience along the way. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. I tend not to notice feelings of physical tension or discomfort until they really grab my attention. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I forget a person's name almost as soon as I've been told it for the first time. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. It seems I am "running on automatic" without much awareness of what I'm doing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. I rush through activities without being really attentive to them. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. I get so focused on the goal I want to achieve that I lose touch with what I am doing right now to get there. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. I do jobs or tasks automatically, without being aware of what I'm doing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. I find myself listening to someone with one ear, doing something else at the same time. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. I drive places on "automatic pilot" and then wonder why I went there. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. I find myself preoccupied with the future or the past. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. I find myself doing things without paying attention. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. I snack without being aware that I'm eating. | 1 | 2 | 3 | 4 | 5 | 6 |

APPENDIX G

Telephone Script for follow-up interview

Hello, (name evaluator) this is Jennifer Brown, the doctoral student from Pepperdine University's Graduate School. I am calling to conduct our scheduled follow up interview to discuss any part of the evaluation form of the MAT-C, that you may want to discuss or clarify?

If no, I will thank the evaluator for their time and attention then end the call.

If yes, I will continue discuss questions with the evaluator.

This will also be a time when I am able to clarify questions that may have arisen from reviewing the evaluator's responses, but only if I need a response to be further explained.

I would like to record this interview to make sure I understand your responses accurately.

If the participant agrees, I will continue.

If the participant does not agree, I will ask if he or she would like to continue without the recording, but I will take notes on paper.

If the participant agrees I will continue the follow up interview, taking notes on paper. If the participant says no, I will ask if we can continue the interview without taking notes.

At the conclusion of the study I will thank the participants for their time, and say goodbye.