EXPLORING THE MEANING OF A RURAL MIND-BODY MEDICINE GROUP CURRICULUM FROM THE PERSPECTIVES OF COMMUNITY-BASED PARTICIPANTS

A Dissertation
Submitted to the Graduate Faculty
of the
North Dakota State University
of Agriculture and Applied Science

By

JoAnne Marie Riegert

In Partial Fulfillment of the Requirements
for the Degree of
DOCTOR OF PHILOSOPHY

Major Program:
Counselor Education & Supervision

April 2020

Fargo, North Dakota

North Dakota State University
Graduate School

Title

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JoAnne Marie Riegert

The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota State University's regulations and meets the accepted standards for the degree of

DOCTOR OF PHILOSOPHY

SUPERVISORY COMMITTEE:

Brenda Hall, Ed.D.
Chair

Jodi Tangen, Ph.D.

Jill R. Nelson, Ph.D.

Donna Grandbois, Ph.D.

Approved:

April 13th, 2020
Date

Chris Ray, Ph.D.
Department Chair

ABSTRACT

The challenges and stress that are present in our daily lives can be consuming and are often associated with chronic illnesses and mental health concerns. In rural communities, residents may experience greater exposure to a range of potentially traumatic events at both a personal and community level (Handley et al., 2015). Additionally, in many rural areas, the availability of health services is a significant issue. One emerging approach utilized to treat the increasing numbers of chronic illnesses and trauma-related mental health problems in a rural population is the integration of meditation skills presented in a group setting, to counterbalance the effects. This phenomenological study explores seven individuals' perspectives on the impact of participation in a Mind-Body Medicine Group Curriculum, in a rural community. The findings illuminate etic clusters of the impact of worry, the importance of forgiveness, growth of self-love and self-compassion, the benefits of the therapeutic bond in the group experience, and micro and macro healing. Emic themes of self-actualization and the importance of relational connection were discovered. These outcomes suggest that healing in rural communities is obtained in group settings, as an additional alternative to individual therapy. Implications for integrating mindfulness into psychotherapy practice, the impact of group work in rural areas, as well as applications for counselor educators and graduate training programs, are additionally explored.
Keywords: qualitative, group, mindfulness, meditation, rural, trauma, healing

ACKNOWLEDGEMENTS

I want to acknowledge the Creator and ancestors, family, colleagues, spiritual community, and my research dissertation committee for all of the support that has been given to me on this journey. To the Creator and ancestors who are always around me, in the air I breathe and the beautiful images I witness every day, I am honored. I know that your guidance and assurance is walking next to me, daily. To my husband, John, who has picked up all of the pieces so that I could accomplish this dream, I am eternally grateful for your love, commitment, and cheerleading for the past eight years; you are now married to a doctor! To my mom, Germaine, who always told me, and has shown me that education is one of the most important gifts, and it is something that no one can take from you. Thank you for your love and the supportive words that you give to me every day. To my sister and brothers (along with their families) who cheered me along the way, I appreciate you. All of the work we do is very different, but we all have the drive that mom and dad instilled in us to work hard and love our families, no matter what. Thank you to my children, Leah, Jacob, Jacob, and Maria, whom I hold in such deep love and respect. You are wonderful young people who contribute positively to the world we live in; I am eternally proud and grateful the Creator has given me such gifts in each of you. To all of my classmates who have supported me throughout the coursework, I appreciate your wisdom. To my spiritual community, including my ceremony brothers and sisters, thank you for the encouragement and love you provided each time we encountered another. Thank you, Dr. Hall, for your guidance through this project, and your encouragement along the way. Not only have you imparted your knowledge, but you have become a trusted friend. Thank you also, Dr. Nelson, Dr. Tangen, and Dr. Grandbois, my dissertation committee, for your feedback and support in this process.

Gratitude, also, to my research team and participants, who provided insight, guidance, and assistance.

DEDICATION

I dedicate this dissertation to my dad, Leo and my grandson, Wiiba Masaabens Giizis, you have both taught me how to love, and “say a little prayer”. Also, to my past and my future ancestors, I am blessed. -Girls

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CHAPTER ONE: INTRODUCTION

We live in a world where there are overwhelming demands for productivity, inclusion, and perceived desires to be everything to everyone, with little awareness of what these expectations and stress are creating, and the damage that is resulting in our mind and bodies. As a result, there is a trend of increasing numbers of people diagnosed with anxiety, depression, Post Traumatic Stress Disorder, heart disease, high blood pressure, and various other chronic illnesses (Cohen et al., 2015). As these illnesses continue to increase, alternative treatment for them is being explored. The adage of only taking medication for such ailments is being re-evaluated while incorporating mindfulness and meditation into treatment is on the rise. In rural communities, trauma is often present, and the disparity of limited access to mental health providers is of concern (Stamm et al., 2007). Providing alternatives to healing, through a group context, in these communities, is one way for counselors to access multiple individuals and promote community health and wellness. The purpose of the current research is to explore the experiences of participation in a ten-week Mind-Body Medicine (MBM) group curriculum, in a rural community, to gain a deeper understanding of the impact individually and relationally with others.

Background and Context

Living in a rural area has benefits but also challenges. The benefits include serenity and an openness to explore the natural world around us. Nevertheless, one of the most significant challenges is access to health care, and the availability of mental health professionals who can and are willing to serve rural areas (Henderson et al., 2014). Also, there are often long wait times to be seen by a psychotherapist. Based on these health disparities, it is necessary to consider options that make it easier for clients to afford and take advantage of the services and

support around them. Providing differing or alternative ways of healing seems essential in rural communities' overall health. For instance, offering services and support in a group setting is a cost-effective way (McCrone et al., 2005) to create a ripple effect of healing. As suggested by Yalom (1995), the imitation process of social learning is a benefit of group work. As such, group members modeled aspects of other group members, tried new behaviors, and then carried them into their lives in the broader community.

Mindfulness and meditation practices are specific modalities that can be presented to groups of participants in rural settings and have the ability to impact multiple individuals succinctly. Several studies indicate that self- reported mindfulness is associated with adaptive psychological functioning and decreased symptom distress (Visted et al., 2014). Epidemiological data suggested that among U.S. adults, utilization of meditation has more than tripled between 2012 and 2017 (4.1 to 14.2%) in the past year (Clark et al., 2018). The utilization of mindfulness techniques can have a significant effect on overall health and wellness. Mindfulness is defined as an awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to things as they are (Williams et al., 2007). Therefore, a key element of mindfulness meditation is that it focuses on the unfolding of the present moment experience (Williams et al., 2007). Mindfulness trains one in the systematic practice of attending to moment by moment experiences, thoughts, and emotions from a non-judge mental perspective (Lopez et al., 2019). The utilization of mindfulness is shown to decrease overall stress and improve mood (MacDonald, 2016).

Kabat- Zinn (2013) suggests the use of a whole range of holistic Eastern and Western interventions to promote health and restore well-being; symptoms can be diminished as

individuals learn to be mindful and maintain an awareness of the breath often referred to as meditation:

> One of the most healing things you can do for your body
> during the day is to use your breath periodically to penetrate
> the pain and help it to soften in the same way that we use
> it in the body scan. You can do this by consciously directing
> your breath into the painful region, feeling it as it moves into
> your back and then visualizing the pain softening and dissolving
> as you relax and let go into each out-breath (pg. 303).

Bringing this specific healing meditation modality to rural communities has an innate ability to impact not only the individual participating in the group experience but for the skill to reach each individual's family and support system through discussion and dialogue about it. The use of this intervention involves an important assumption relating to holistic health: the improved health of one member of a family can be an immediate improvement for the entire family (Vest et al., 1997). Thomas Delbanco (1993) recognized that families can interfere with medicine, or they can be the medicine (pg. 53). Respecting and facilitating family and community bonds may be more crucial to a patient's survival than the latest diagnostic procedure or therapeutic innovation (Delbanco, 1993). The research suggested that the involvement of individuals in a group process can influence each other's health and can improve the quality of overall community wellness.

Problem

As a mental health professional practicing in a rural community where health disparity is evident, mental health concerns and chronic illness are prevalent, and access to mental health is limited, the researcher was enthusiastic and excited to explore how to integrate mind and body

for healing and wellness. A mind-body medicine group is an added asset to the existing structure of available healing modalities. When presented in a group format, the researcher was hopeful to gain significant impact on her work within a community where access to mental health support is limited. The purpose of the qualitative study was to understand the impact of a Mind-Body Medicine group curriculum on rural community-based participants both individually and relationally with others.

The Rationale for Qualitative Methods

The purpose of qualitative inquiry is to understand and explore participant meaning. To understand a phenomenon, the individuals who are affected by the phenomenon must be observed or talked to in order to understand it most comprehensively and engagingly possible (Hays & Singh, 2012). Exploration in qualitative research invites the possibility of observing phenomena from different angles. Because topics are exploratory, qualitative designs tend to include research questions that address how or what, versus why. This process allowed the researcher to gain a deeper understanding of the phenomenon studied. More specifically, Creswell (1998) defines qualitative research as an inquiry process of understanding based on distinct methodological traditions of inquiry to explore a social construct. Through this process, the scholar is allowed to discover and expand upon existing research more thoroughly.

The research is based on the experiences of participants who have completed a Mind-Body Medicine Group Curriculum in a rural community. It explored the experience both individually and relationally with others, from the participants' perspectives.

Theoretical Perspective

The theoretical foundation of this study is phenomenology. Phenomenology, as a practice, involves researchers approaching a phenomenon with a fresh perspective, as if viewing

it for the first time, through the eyes of participants who have direct, immediate experience with it (Hays and Singh, 2012). Phenomenologists gather other people's experiences because it allows them, vicariously, to become more experienced themselves (Van Manen, 2014). Edmund Husserl is credited as the father of phenomenology. The basic premise of this discipline is that various structures are experienced from the first-person point of view. According to Husserlian phenomenology, our experiences are directed towards, represents, or intends, things only through particular concepts, thoughts, or ideas, and these make up the meaning of a given experience (Creswell, 1998).

For this research, phenomenological interviewing is used as a semi-formal interactive process. This interview practice was applied to elicit a comprehensive personal description of a lived experience of a phenomenon, for a small number of individuals who have experienced it (Cypress, 2018). The focus of the interview is the direct description of a particular situation or event as it is lived through, without offering causal explanations or interpretive generalizations (Patton, 2015). Phenomenological interviewing is less concerned with factual accuracy, but rather the account of our living sense of it. Through the interview questions, individuals express their experience of the group, and the impact individually and relationally with others.

Purpose Statement and Research Question

As indicated, the purpose of the current research was to explore the experiences of participation in a Mind-Body Medicine (MBM) group curriculum in a rural community. The goal of the study was to explore the impact of the curriculum on rural, community participants individually and relationally. The overarching research question was: what is the impact of a 10-week Mind-Body Medicine group curriculum on rural community-based participants exploring the experience both individually and relationally with others? The results of this study provided

an understanding of the benefits of a group MBM curriculum, and its impact in a rural community where physical and mental health disparities are prevalent.

The various community stakeholders acknowledge that this is the first structured opportunity to present this knowledge to this rural community. With the knowledge that emerges from the research, it is hopeful to determine the effect that the MBM curriculum has on individuals and the community as a whole, particularly one where trauma is present. People residing in rural areas may experience greater exposure to a range of potentially traumatic events at both a personal and community level (Handley et al., 2015). This individual and community trauma has a ripple effect on the well-being of the entire rural community. Rural residents often rely on tight-knit community relationships supported by kinship ties extending back generations, and this social support provided by the family is essential to the community (Cohn & Hastings, 2013). When there is disruption or trauma within a family or in the community, the entire community experiences discord. As a result, there is a direct impact on each individual within the community. In rural communities, it is not uncommon for many families to be related to one another. As a result of these kinship ties, when trauma occurs, each member of the community often feels it. The healing process from these experiences often, however, occur through individuation and at times in isolation.

The findings solidify the importance of the healing connection between mind and body in rural communities where there is limited knowledge of this methodology, and health disparities exist. Based on the outcomes and perceptions of the participants, it is hopeful that the opportunity to increase the number of groups offered occurs, and the prospect of training more facilitators to present this wisdom to the broader rural community transpires.

CHAPTER TWO: LITERATURE REVIEW

There is a considerable popular dialogue around the practice of mindfulness and a growing awareness of the clinical application of this approach to the burgeoning mental health problems we encounter today (MacDonald, 2016). Mindfulness, which is a way of paying attention and cultivating awareness in everyday life, is being promoted as a way of reducing cognitive susceptibility to emotional disturbance, keeping us open to what is happening in the here and now of our life (Kabat-Zinn, 2013). The premise of mindfulness therapy focuses on maintaining a moment-by-moment awareness of our thoughts, feelings, body sensations, and surrounding environment without judging them and being open to experiencing life as it unfolds (Hosseinzadeh & Barahmand, 2014). With roots in Buddhist meditation, mindfulness is considered to be an inherent quality of human consciousness, that is, a capacity of attention and awareness oriented to the present moment that varies in degree within and between individuals and can be assessed empirically and independent of religious, spiritual, or cultural beliefs (Peltz & Black, 2014). As such, mindfulness involves intentionally bringing one's attention to the internal and external experiences occurring in the present moment and is often taught through a variety of meditation exercises (Hosseinzadeh & Barahmand, 2014). Mindfulness research has found that people with higher natural levels of mindfulness report feeling less stressed, anxious and depressed, and more joyful, inspired, grateful, hopeful, content, vital, and satisfied with life (Chiesa & Serretti, 2014). In summary, the widespread growth of mindfulness and meditation in the treatment of many emotional and physical ailments is promoted as an essential prescription for healing.

Mind-Body Medicine Curriculum

The Mind-Body Medicine curriculum originates from The Center for Mind-Body Medicine (CMBM) which was founded in 1991 by James S. Gordon, M.D., a professor of psychiatry and family medicine at Georgetown University Medical School and former chairman of the White House Commission on Complementary and Alternative Medicine Policy, under Presidents Clinton and G.W. Bush. In the 25 years since then, CMBM has become a worldwide leader in making self-care, group support, and community-building central to all healthcare, the training of health professionals, and the education of children. CMBM has focused on providing innovative solutions to some of the world's most intractable and complex psychological and physical problems. CMBM's international faculty of 160 experts have trained over 5,000 health professionals, educators, and community leaders in our pioneering mind-body medicine model of self-care, self-awareness, and group support; they, in turn, integrate our model into their communities and use it with the populations they serve, allowing us to benefit millions of people (The Center for Mind-body Medicine, 2019).

The researcher has been given the opportunity, through a professional development grant, to learn and practice a model that builds the essential skills of mindfulness and meditation. Proponents of the mind-body medicine (MBM) group curriculum teach a variety of mindfulness and meditation skills that include breathing techniques, journaling, imagery, biofeedback and autogenics, movement (shaking, dancing and fast, deep breathing), mindful eating, forgiveness and a closing ritual. The research for this study is constructed from this curriculum (Gordon, 2000), and the researcher is a nationally trained Mind-Body Medicine facilitator.

Mind-Body Medicine Curriculum Effectiveness

The curriculum has been presented to global trauma relief programs throughout the world. These include post-hurricane Puerto Rico, post-conflict treatment of PTSD in Kosovo, treatment of children and adolescents with depression and PTSD in Palestine and Gaza, and work with Syrian refugees in Jordon. In the United States, the curriculum was presented in Houston, TX, in the aftermath of Hurricane Harvey and in the Broward County Marjory Stoneman Douglas High School, where 17 students and staff were killed, and community-wide stress and trauma relief response was necessary. The curriculum's foundation is a series of mindfulness and meditative practices that are introduced as experiments to promote healing. There are various techniques, such as breathwork, guided imagery, movement, drawings, and mindful eating.

Published research provides justifications for the successful implementation and effects of the MBM curriculum. In post-war Kosovar, 82 adolescents diagnosed with PTSD were randomly assigned to a 12 session MBM group, and changes were measured using the Harvard Trauma Questionnaire. Students in the intervention group had significantly lower PTSD symptom scores following the intervention than those in the wait-list control group (F= 29.8, df= 1,76; p,.001) (Gordon et al., 2008). The research indicates that Mind-body skills groups can reduce PTSD symptoms in war traumatized high school students and are effectively led by trained and supervised schoolteachers. The decreased PTSD symptom scores were maintained in the initial intervention group at the three months follow up.

Research conducted by Staples et al. (2011) found similar results. Five hundred children participated in mind-body skills groups taught by 31 Center for Mind-Body Medicine (CMBM) trained health professionals in Gaza in 2007-2008. Before participation in the program, 26% of

the children had symptoms that qualified them as having PTSD. In those having qualifying PTSD symptoms, the PTSD symptom scores were significantly decreased (56%) following the program. This improvement was partially maintained at 7-month follow-up with a 39% decrease in scores compared to baseline. In this study, fifty-six percent of those qualifying as having PTSD also qualified as having depression, using cutoff values on the Children's Depression Inventory. The depression scores were significantly decreased (29%) following the program. This improvement was partially maintained at 7-month follow-up with a 20% decrease in scores compared to baseline. The children felt more hopeful about their future and their lives, as indicated by a statistically significant decrease in hopelessness scores (28% decrease) following participation in the mind-body skills groups. This improvement was fully maintained at follow-up. In summary, this research suggests that a significant change in mental health outcomes are evident when the MBM curriculum was presented in communities where trauma has and is occurring.

Structure of a Mind-Body Medicine Curriculum

The curriculum is designed to be presented in a group setting. The MBM groups are generally composed of six to eight members and are approximately two hours in length. The curriculum is offered once per week for eight to ten weeks. In the first group, ground rules are established, and expectations for participation are suggested. The emphasis in each group is that members are asked to be present and become aware of their thoughts and feelings through the process. During the sharing opportunities, group members are allowed the opportunity to 'pass' if they feel that they are unable to share their experiences openly at the time. Since each group operates circularly, there may be an opportunity at a later time in the group process, for that individual to share what they experienced.

Each group has a similar structure or template. A meditation technique is used for centering, and each member is asked to check-in and share their experiences or events from the past week. Staying in the present moment is encouraged throughout the process. The facilitator presents didactic information that provides primary material about the skill and the impact on physiology. Each skill is presented as an experiment, and it is acknowledged that the impact of the skill varies based on the participants' experience. Next, an experiential exercise is conducted, where participants share what they have learned and discuss the effect of the skill. Brief homework is then suggested for the participants to practice until the following week. The group concludes with a brief meditation and allows participants closure and the ability to move into the rest of their day. The groups allow participants the opportunity to learn the basics of the interaction between mind and body. Each group develops a sense of safety where participants can share openly and feel supported by mutual members. Learning from other members' experiences is also an essential component of the process.

Skills of the Mind-Body Medicine Curriculum

Each skill presented in the following section is introduced through a review of the literature. Next, didactic information about the skill will be presented. Third, a brief explanation of the experiential exercises will occur. Furthermore, lastly, evocative questions are suggested along with homework. The didactic information and scripts are based on the curriculum written by Dr. James Gordon (2014), founder of The Center of Mind-Body Medicine. Though the didactic information and experiential skills are outlined, it is suggested that each facilitator use them as a guide, and adaptation, to specific audiences is encouraged. The skills that are presented include breath work, drawings, shaking and dancing, guided imagery, dialogue with a symptom,

biofeedback and autogenics, mindful eating, spirituality/forgiveness meditation, and a closing ritual to end the group experience.

Breath

Deep relaxing breath is a foundation of all the mindfulness skills that are part of the curriculum. The autonomic nervous system (ANS) and respiratory activity have been shown to be closely associated with the experience of emotions (Kreibig, 2010). Kop et al. (2011) suggest there are specific characteristics of sympathetic/parasympathetic activity and respiration that are correlated with particular emotional states such as anxiety or happiness. Jerath et al. (2015) state that negative mood states such as stress, anxiety, and depression cause sympathetic activation that is due to widespread depolarization throughout the brain and body, and that slow, deep breathing and meditation lead to parasympathetic activation. One of the oldest and arguably, most efficient treatments of excessive stress is controlled breathing (Everly & Lating 2013). Breathing and meditation techniques are readily available and do not pose the risk of side effects (Jerath et al., 2015). After only ten or twelve minutes, tight shoulders relax, heart rates slow, and the torrent of disturbing thoughts abates (Gordon, 2019). Afterward, people say they feel calmer, happier, more stable, more present, and more hopeful (Gordon, 2019). This research suggests that mindful breathing has a significant impact on the autonomic nervous system and can reduce stress and improve mood.

Application in the MBM Curriculum

The soft belly meditation is introduced as an essential breathing exercise. It is useful because it combines body awareness with guided imagery and is accessible to everyone, regardless of his or her familiarity with meditative techniques. The soft belly meditation invites group members to relax, let go of thoughts and activities preoccupying them, and to help them to

enter into a group. This meditation is used each week to bring participants into the group space in a meditative, relaxed, and open way. The soft belly skill can be summarized as:

> The soft belly is just one of many forms of meditation aimed at inviting a relaxed state. This relaxation is the basis for the other mind-body skills and is the first and foundational exercise that we use each session. The more you practice relaxing using soft belly, the more likely you are to notice the powerful healing and helping affect it can have on you. The soft belly is a meditation you can practice at any time and in any place. Participants are asked to get comfortable and relax and become aware of their breath; they are guided to breathe in 'soft' and breathe out 'belly.' They are encouraged just to let their intrusive thoughts come and go and come back to the breath. If any tension is felt in their body, they are encouraged to breathe into that space and release any tension felt. The facilitator and the participants breathe quietly together for approximately three minutes, and their attention is then brought back to the room.

Evocative questions and homework: Do you feel any different than before, if so in what way? Do you notice anything different in your body? For a homework suggestion: begin to practice soft belly three times per day and become aware of any changes that you experience.

Drawings

Creative Art Therapies help individuals to use an expression in order to access emotions and change behavior (Prinz, 2003). Through relating to one's own artwork, possibilities of expression are created. Previous experiences can be symbolized and expressed in a safe way. Through the fostering of symbolization and (nonverbal) communication, new perspectives and insights can be gained; specifically, the revival and fostering of creative resources increase self-efficacy and coping abilities in stressful situations (Martin et al., 2018). Artistic activity is a vital

self-object function of turning at times painful mental states into creative activity, a transformation that—at least temporarily—relieved their mental suffering and made successful communication of their experiences possible (Ornstein, 2006). The drawings that are utilized in the MBM skills curriculum directs the participants to draw three different images. In the first drawing, participants are asked to illustrate an image of how they see themselves at the current moment. In the second image, they are asked to draw the most prominent problem or challenge they are experiencing. In the third image, they are to draw what it may take to have their most significant problem solved. Drawings are easy for all of us to do and are safe, playful ways to express and share what is going on inside of us (Gordon, 2019). Drawing can be used when dealing with difficulty during times when there is considerable uncertainty, and the next steps are unclear. They are also able to bring clarity to difficulties.

Application in the MBM Curriculum

Using a simple drawing exercise allows group members to work with a basic form of imagery, pictures, to explore a particular challenge in their lives. Through drawings, group members have the opportunity to use their imagination and intuition to become aware of issues and to explore possible answers or new possibilities. In preparation for the exercise, three sheets of paper and various colored crayons are available for each participant. The drawing exercises are introduced this way:

> Drawings are a form of imagery that allows us to access our unconscious mind and the knowledge we hold within ourselves. Drawings have the ability to help us find answers for stressful situations. Participants are encouraged not to be critical of their drawing skills but instead participate in the experience. They are encouraged to draw quickly, using information that comes first to their mind. In the first image, they are asked to draw

themselves how they see themselves today. In the second image, they are asked to draw the most significant problem or issue, and in the third image, draw how they see their most significant problem or issue solved. Participants then share their drawings with the group members.

Evocative questions and homework: What do you see on the page? What is the most important thing you notice about your drawing? What is the story in your drawings? Is there anything in your most significant problem drawing that gives a hint to the solution? For homework, encourage the use of simple drawings to cultivate awareness as they move through problems or challenges of the group member's experience.

Shaking and Dancing

Expressive meditation is probably the oldest kind of meditation. It is one that indigenous healers use around the world for thousands of years; this includes chanting, dancing, shaking, rapid breathwork, and whirling (Gordon, 2014). Bodywork helps ground individuals when they are anxious or have ongoing nervous system agitation; it can lift someone when they are depressed, and it can relieve the pain that is a primary cause in some forms of depression (Mcneill & Gee, 2013). Shaking and dancing is a way to move your body and let go of the tensions and express feelings (Gordon, 2019). During trauma or times of high stress, our bodies are tight, our minds are fixed, and our breathing is shallow. Expressive meditation can break up these fixed patterns and allow tension to be released. Haas et al. (2017) found that when young adults engaged in more daily moderate to vigorous movement-based behaviors than their usual level, they reported lower levels of negative affect in the same evening. Yang (2018), also endorsed that daily movement-based behaviors (standing and moving relative to sitting) also yielded an inverse association with negative affect; when people moved or stood (relative to

sitting), they experienced lower levels of negative affect. As such, it can be determined that body movement has a direct impact on mood and can reduce levels of stress.

Application in the MBM Curriculum

Shaking and dancing, as referred to in the MBM curriculum, it is a form of expressive meditation. Expressive meditation can be chanting, dancing, shaking, and whirling. In expressive meditation, we move our bodies through extreme activity to come somewhat later to stillness and awareness. In preparation for this exercise, the facilitator brings in recorded rapid, drumming music and dancing music to help facilitate the experience. The script to introduce shaking and dancing can be presented similar to this:

> This exercise can be useful for releasing any stuck-ness that we might feel. This can occur in our thinking patterns or in our body postures. The shaking component of the exercise helps to break up fixed patterns in our thoughts and bodies. The new space that is created allows us the opportunity to see and feel differently about situations. There are three components to this skill; the first includes shaking, next being still and noticing the breath, and third dancing. Participants are encouraged to face the wall to avoid looking at what another member might be doing and to remain focused on self. They are encouraged to recognize that there is no right way to do this medication. Lastly, participants share the experience.

Evocative questions and homework: What was it like to shake, dance? What kinds of thoughts or feelings did you have? Do you notice any physical, mental, or emotional changes after this exercise? Homework: shake and dance at the beginning of the day or before you have to engage in something stressful. Or, use it when you feel depressed or stuck in anxiety or fear.

Guided Imagery

Guided imagery is a quasi-perceptual, multi-sensory, and a conscious experience that closely resembles the actual perception of some scene, event, or object, but occurs in the absence of an external stimulus (Thomas, 2016). This definition is what makes guided imagery so powerful. When we imagine ourselves in various situations, our bodies respond to the stimuli as if it were actually occurring. Research has shown that under some circumstances, guided imagery events are experienced as actual events (Kealy & Arbuthnott, 2003). Guided imagery can be auditory, kinesthetic (feeling), gustatory (taste), and olfactory (smell) as well as visual (Gordon, 2019). When used as part of mindfulness and meditation skills, guided imagery has the potential for creating opportunities for a type of mental and emotional time out. This allows our body and mind to rest and restore. Experiencing the 'imagined' environment as if it were real might facilitate similar reactions to being in the real environment (Nguyen et al., 2018).

Historically, guided imagery has been used for stress management. A two-group non-randomized trial tested a cognitive-behavioral program with 117 participants who completed different doses of imagery exposure across several weeks. Results showed that participants who completed the study (77.8%) had significant improvements in mental well-being scores from pre- to post-test that were sustained during a follow-up period (Bhutani, 2015). Over forty years of published research has demonstrated that consciously use guided imagery to create mental images: people of all ages have used imagery to decrease anxiety and pain, enhance digestive functioning and immunity, promote mental concentration, and alleviate depression (Gordon, 2019). In summary, as individuals are able to activate their intuition and imagination through imagery, the ability to transform the way that you think and feel about a range of situations becomes easier to achieve.

Application in the MBM Curriculum

Guided imagery is a type of deliberate and directed daydreaming. Imagery accesses all of the senses; vision, smell, sound, touch, and taste. Through imagery, thoughts are made vivid. Through this process, a connection to the emotional part of the brain is possible. Guided imagery has the ability to help us feel better and deal with a multitude of chronic illnesses. Imagery has the ability to affect physical functions and mental attitudes. Through imagery, there is the possibility to bring about physiological changes as it activates the part of the brain that is virtually identical to those experienced in a real situation. A guided imagery script in the MBM curriculum can be summarized as:

> Just as negative images in our mind can provoke fear in distress, positive images can create warmth, relaxation, peace, love, and connectedness. This imagery exercise allows participants to balance the sympathetic and parasympathetic nervous systems. Participants are encouraged to find a comfortable or safe place in their mind using their imagination to create the space. They are encouraged to reflect on sites, smells, and sounds in a comfortable space. They are requested to breathe deeply and enjoy the comfort and relaxation that occurs in this space. It is acknowledged that they can return to this space at any time, and then they are asked to come back into the room and be aware of their bodies in the chair.

Evocative questions and homework: Where were you, and how were you dressed? What did it feel like to be in this comfortable space? Did you have any trouble getting there? Homework: the work of guided imagery is about accepting the wisdom of your own unconscious. You can use this experience when you feel upset, or at a specific time during each day. Be open to

whatever comes to you. Allow 15 to 20 minutes for this exercise when you begin to use it. If this exercise is challenging at times, try again later. The more you practice it, the easier it becomes.

Dialogue with a Symptom

This particular skill in the MBM curriculum is an exercise where participants have a dialogue with a particular issue, problem, or symptom as if it were sitting in a chair across from you. Symptom dialogue is explained as a way to access the unconscious knowledge that we all have. And often, if we are able to sit and engage for a period of time, the answer to the problem is contained in the symptom. Currently, there is no universally agreed-upon definition of a narrative, but generally speaking, a narrative is a story about a sequence of events that occurs in time and is organized in a script (Rodriguez et al., 2014). Through narratives, human beings give meaning to what happens to them (Clandinin & Connelly, 2000). Pennebaker (2018) asserts that clarity occurs when people reveal parts of their personalities, social behaviors, thinking styles, and social connections through their word use. This narrative metaphor implies that human psychology has an essentially narrative structure, such that human life can be seen as storied, and narratives can be seen as the organizing principle for human action (Sarbin, 1986). Dialogue with symptoms as part of narrative therapy can be constructed as a process of story repair in which problematic self-narratives are reconstructed to become more coherent, complex, and inclusive (Avdi & Georgaca, 2007). Furthermore, through this process, individuals are often able to discover meaning and clarification to the problem or challenge they are experiencing.

Application in the MBM Curriculum

Initially, the facilitator presents didactic information regarding the benefits of journaling and expression of emotions. Emotions are healthy, and something that we all experience. They only become problems when we get stuck in them and can't move through them. If you're upset

continuously with rage or resentment, consumed by anxiety, or burdened by sadness and grief, this affects not only your emotional life but also your physical body, which in turn puts you at risk for developing a chronic illness. One of the keys to stress management is experiencing your emotions fully and moving through them, rather than being stuck in them. Meditation practices such as journaling can help you develop an awareness of your emotions and provide an opportunity for self-expression. The work of mind-body medicine depends on the continual interplay between becoming aware of our emotions and expressing them. A script for describing the experiential exercise of dialogue with an issue symptom or problem can be summarized as:

> Participants are encouraged to become aware of a problem or challenge they are experiencing and imagine that challenge sitting in a chair across from them. They are then asked to have a written dialogue with the challenge for approximately five minutes. The written dialogue should be very similar to a conversation that goes back-and-forth between two individuals. They are encouraged to write quickly without analyzing what they have written, but just let it flow freely. They are encouraged to ask specific questions and receive answers from the problem. Once finished, they are asked to re-read what they have written and share it with the group.

Evocative questions and homework: as you look over your dialogue, what did you learn? What are some of the most important lessons? What new directions does this dialogue suggest to you? For homework, encourage group participants to continue the dialogue process at home. Think of this exercise as an ongoing process. Set aside 10 minutes this week to dialogue with a problem or concern, and then review what you've written for any new insights.

Biofeedback and Autogenics

At one point in history, it was believed that we had little or no control over our heart rate and the ability to self-regulate our breath. In the past 30 years, numerous studies have pointed to the significant relationship between autonomic imbalance and physiological, specifically cardiovascular health (Stanton & Meston, 2017). Heart rate variability (HRV), an index of the beat to beat changes in heart rate, is one mechanism that impacts depression and anxiety levels. Heart rate variability is mediated by the parasympathetic and sympathetic nervous systems and reflects the capacity for the parasympathetic nervous system to self-regulate (Kemp et al., 2012). Increased HRV reflects a healthy autonomic nervous system that is able to respond to changing environmental circumstances (Porges, 2011). By contrast, a compromised HRV is a marker of autonomic inflexibility and ill health (Dekker et al., 2000) and can impact depressive symptoms. Research suggests that anxiety is also impacted by HRV. Anxiety is characterized by anxious apprehension and worries, involving pre-attention biases to threat information, and rigid and inflexible response patterns (Mogg & Bradley, 2005). Kemp et al. (2012) found that individuals who were diagnosed with depression and anxiety were able to decrease their symptoms through adaptations in heart rate variability by engaging in autogenic training. Given these established relationships between HRV and mental health symptoms, researchers have attempted to manipulate HRV through biofeedback, in order to decrease symptoms (Kudo et al., 2014; Nolan et al., 2005). This manipulation, known as autogenic training, has been shown to significantly increase HRV and reduce symptoms associated with a wide variety of physiological conditions, including depression and anxiety (Stetter & Kupper, 2002). The biological consequences of stress can be reversed through the use of imagery. Through autogenics (meaning self-generating) phrases created by the participate create images that are designed to

give gentle but firm instructions to his or her autonomic nervous system; which tells the parasympathetic nervous system to activate and to do the job of quieting and calming the sympathetic system (Gordon, 2019).

Application in the MBM Curriculum

The facilitator presents a small didactic presentation on the sympathetic and parasympathetic nervous system. The goal of this teaching is to provide participants the foundation of a basic understanding of how our autonomic nervous system functions. Then, participants were led through a series of phrases and given a bio dot to use to determine if alterations in body temperature through biofeedback are occurring. The script may be summarized as:

> Our bodies strive to maintain homeostasis in the midst of a continually changing external world. The fight, flight, or freeze response allows us to address danger around us. Basically, blood is being moved to the large organs and muscles of our body, which allows us to respond to the threats presented. Once the emergency or experience is over, our body is able to return to homeostasis and rest again. The parasympathetic and sympathetic nervous systems work much like the gas and brake on a car. The sympathetic nervous system engages our large muscles to accelerate when necessary to escape dangerous or stressful situations- essentially the gas pedal. Our parasympathetic nervous system is the brake. Activation of this allows our body to rest and relax. When these two systems work back and forth in a complementary fashion, we are able to obtain optimal physical and mental health. Learning to use biofeedback is one scientific way to prove that mindfulness and meditation have a physiological impact on our bodies. In our

exercise, we used a bio- dot, or a thermistor to measure the temperature in our hands as we relaxed.

Each participant is then given a bio dot or thermistor to place on their non-dominant hand in the web between their index finger and thumb. These dots measure the temperature in the hand and register the temperature. When each participant in the group has their bio dot or thermistor placed, the following can be introduced:

I want you to notice the temperature or the color of your bio dot before we begin. Please make a mental note of this. In a moment, I will begin repeating to you a series of six phrases and will repeat them six times. After each phrase, I will ask you to repeat that phrase in your head. Imagine that the sensation in each phrase is happening in the body as completely as possible.

My arms are heavy and warm (pause) I am at peace (pause)

My legs are heavy and warm (pause) I am at peace (pause)

My heartbeat is calm and strong(pause) I am at peace (pause)

My abdomen radiates warmth (pause) I am at peace (pause)

My forehead is pleasantly cool (pause) I am at peace (pause)

My breath is calm and relaxed (pause) I am at peace (pause)

Participants are encouraged to visualize themselves being strong and healthy.

Evocative questions and homework: Did your biodot change color, if so, in what way? If it didn't, do you feel more relaxed, and in what parts of your body? It's important to note that for some individuals, it takes time for this experiment. It may take a while before the body reacts to the verbal exchange. For homework, I encourage you to wear the biodot throughout the day to see if it changes color based on the exercise you encounter. At what times does it go up or

down? The more that you pay attention to the connections, the more you begin to understand what is causing you to stress and what creates a relaxation effect.

Mindful Eating

Mindful eating is broadly defined as a practice in which participants, in the space of non-judgment, become aware of the physical and emotional sensations associated with eating (Pannowitz, 2015). It also extends to noticing the self-talk that accompanies eating or food choices. The aim of the practice is to reacquaint one's self with the natural physiological processes that govern eating regulation (Pannowitz, 2015). Psychological and cognitive processes have a strong influence on dietary intake; for example, reduced mealtime attention to what one eats, due to distraction or lack of visual information on the amount of food consumed, has been shown to increase immediate intake and possibly later intake as well (Robinson et al., 2013). The two most common approaches to mindful eating practice in much of the published literature are: to focus on the sight, smell and texture of the food presented to enjoy it thoroughly, and the use of relaxation effect of mindfulness to focus on hunger, taste, satiety and eating triggers (Stroebe et al., 2008). It is believed that by creating the space for a pause for exercising mindfulness, this practice may be useful in weight loss, binge eating, improved responses to satiety, improved healthy eating, and alertness to external eating cues (Pannowitz 2015). Camilleri et al. (2015) found that in women, greater overall mindfulness was associated with a lower risk of overweight and obesity. The findings support the interest of a shift in perspective, taking into account positive psychological and cognitive factors, such as dispositional mindfulness, which can impact overall weight (Camilleri et al., 2015). In summary, mindful eating can help individuals explore the meaning behind their food choices, begin to eat foods that best meet the needs of our bodies, and can have an overall impact on weight.

Application in the MBM Curriculum

What we eat has a profound impact on our health. Every time you put food into your mouth, you have an opportunity to either enhance or diminish your life. Making good food choices is one of the most important ways you can care for your body. Chronic health problems such as obesity, heart disease, diabetes, anxiety, and depression are often influenced by the foods we eat. Whole foods that are minimally processed are the best. Examples might include fresh fruits and vegetables, whole grains, beans, nuts, seeds, unprocessed fish, chicken, and other meats. Even small changes can create significant effects. Recent research suggests that we should eat foods from our ethnic backgrounds, as our body physiology is specifically designed to use the nutrients from these foods to improve our overall health. An experiential exercise is presented to illustrate mindful eating. The script for the presentation of mindful eating may resemble this:

> Sit comfortably and breathe slowly for just a moment or two. Allow images to come to your mind about the role of food in your life or your relationship with food. When you are ready, take a moment to draw and create meaning from the images. Write a description of what you see in your drawing and what it means to you.

Evocative questions and homework: What role do foods play in your life? Have you drawn yourself alone or with family and friends? What kinds of foods are essential to you? What life events or emotions contribute to your relationship with food? Homework suggestions might include drawing a quick image when you begin to crave certain foods, or after a meal that brought satisfaction or vitality to your life.

Mindful, meditative eating means giving full attention to your experience with food. We all eat for different reasons. Many of us eat to fill emotional needs and don't stop eating when our

physical hunger is satisfied. Practicing meditating eating may change what and how you eat. You may find yourself feeling satisfied sooner because you noticed when your body is full. A mindful eating script may be summarized as:

> Typically, most of us eat automatically and mechanically. We are now going to participate in an exercise where we pay full attention in a nonjudgmental way of staying open and in the present moment as much as possible. Participants are encouraged to look at the piece of food as if they've seen it for the first time acknowledging the new elements of it. They are asked to place it in their mouth and hold it there without chewing and focus just on the experience.

Evocative questions and homework: What were your experiences eating the grape or piece of chocolate, mindfully? Did you have any memories that came up? Did these memories relate to your family or childhood experiences? For homework, encourage participants to eat more real food, more fish and chicken and less red meat. Encourage a wide variety of fruits and vegetables of different colors. Notice when you are full and become aware of how food makes you feel physically and emotionally.

Spirituality/Forgiveness Meditation

Spirituality itself refers to the innate capacity and the demand for a given individual to transcend him or herself (Chandler et al., 1992), and this transcendent aspect of a human being can be found both inside and outside of the self and may extend beyond the religious domain (Koenig, 2010). Most theoretical approaches are in favor of the relationship between mental health and spirituality (Da Silva & Periera, 2017). Pargament (2007) asserts that spirituality can be a part of the solution to psychological problems, can be a source of the problem in and of itself, people want spiritually sensitive help, and spirituality cannot be separated from

psychotherapy. A study by Sodhi and Manju (2013) concluded that spirituality is significantly correlated with better mental health. The spiritual outlook is related to improved quality of life levels, and to a certain extent, to the ability to cope with disease through mindfulness (Da Silva & Pereira, 2017). Greeson et al. (2011) found where there is an increase in spirituality, characterized by a state of alertness and connection, there is an essential indicator of mindfulness and is one of the primary mechanisms in optimal mental health index. Research supports the recurring use of religious coping in maintaining psychological balance, namely in the face of stress (Ano & Vasconcelles, 2005) and depression (Loewenthal et al., 2001) and should not be discarded. Spirituality, as a state of transcendence, inherently contains the capacity for a positive outlook on the world (Da Silva & Pereira, 2017). As such, it appears that mindfulness is a good indicator of spiritual outlook, and mental health professionals should recognize the spiritual needs of their patients and prepare appropriate interventions in order to attend to them (Da Silva & Pereira, 2017).

Forgiveness is an element of spirituality. Many aboriginal tribes have regular or periodic rituals of confession and apology, restoration and justice, that free their people and their community from the disruptive and distractive forces of hatred and resentment, as well as the individual and social dangers posed by revenge (Gordon, 2019). As such, many of the world's major religions and spiritual traditions celebrate forgiveness and treasure it as a blessing to the one who forgives. Forgiveness is therapeutic. Forgiveness through mindfulness has the ability to balance the sympathetic nervous system and enhances our capacity for perspective and compassion (Gordon, 2019). Oman et al. (2008) assert that increased forgiveness and reduced rumination are encouraging and suggest that meditation training fosters positive relationships among individuals. Meditation is perceived as beneficial for spiritual growth and personal

effectiveness (Astin et al., 2005). Forgiveness as defined by Robert Enright and colleagues (Enright et al., 1998) is an " a willingness to abandon one's right to resentment, negative judgment, and indifferent behavior toward one who has unjustly injured us, while fostering the undeserved qualities of compassion, generosity, and even love towards him or her" (pg.13). In summary, spirituality and openness to forgiveness through the use of meditation can help to improve overall mental health and well-being.

Application in the MBM Curriculum

Spirituality is your connection with a power greater than yourself. Though spirituality is the living heart of every religion, you can be spiritual without being religious. It is essential to recognize that there is a difference between spirituality and religion. Religion is the name that we give the ways we organize our spiritual practices, yet someone can be spiritual without belonging to a particular religion. Spirituality is connected with healing in most religious traditions. How we are with ourselves and others and nature can be described as spiritual. The forgiveness script can be presented similar to this:

> In this experiential exercise, we will integrate forgiveness into our interactions with others. There are three parts to this exercise. I will lead you through this, as a type of guided imagery. First, allow an image of someone to come to you where are you have had or held anger or resentment. Let yourself see that person now as if they were sitting in a chair across from you. Choose whomever you like. Look at that person and say to them, 'I forgive you for whatever you have done to harm me intentional or unintentional I forgive you.’ Feel yourself soften towards that person. Now let them go saying 'I forgive you.’

Become aware of yourself again in your chair. Now, imagine someone whom you have harmed in some way. Imagine them as if they were sitting in a chair across from you. Choose whomever you like. Look at that person and say to them, 'forgive me for what I have done to harm you intentionally or unintentionally forgive me.' Hold them there, now, let them go, thanking them for the forgiveness that they're offering to you, and allowing yourself to feel the forgiveness flowing from them to you connecting you. Become aware again of yourself in your chair. Now, allow the image of yourself to come to you. Imagine that you're sitting across from yourself in a chair. Look at yourself and say to yourself, 'I forgive you for whatever you feel you've done to hurt yourself, for, howevern you've let yourself down, I forgive you.'

Now allow the feeling of forgiveness to spread from you, from your heart to all those on the planet who are in need of forgiveness—saying to yourself and to everyone on the planet who needs forgiveness, 'I forgive you.' Feel yourself now sitting in your chair with your feet on the floor, breathing deeply and relaxing. If you like, you can now write your experiences down in a journal.

Evocative questions and homework: whom did you select to heal, and why? How did you feel during the practice? Did any fear or vulnerability come up for you? For homework, you might practice this exercise with someone you know or care for seems to be in pain or in distress. Pick someone in your life who is struggling and try to practice forgiveness for them for about 10 minutes a day. How might this practice work if we did it daily? What are the outcomes we might find?

Closing Ritual

Rituals are enacted in community and invite contemplation, witnessing, acknowledgment, and feasting; they may also include spiritual practices such as singing, praying, offering blessings, and extending love (Richardson, 2012). Rituals consist of a number of stages. These include (1) deciding who will participate, (2) inviting people in and creating a sacred space often with candles, appropriate music, the setting up of chairs, and attention to comfort, (3) entering into a purposeful ritualistic task such as creating a gift or acknowledging a gesture, (4) entering a deeper space, experiencing collective deepening, personal insights, or "aha" moments in response to the process, (5) moving back into the daily reality, sharing or debriefing with structured conversations and reflections, (6) closing the circle, and (7) sharing food together (Richardson, 2012). Rituals strengthen the bonds between us and enhance the tend and befriend response (Gordon, 2019). Rituals are also particularly important at times of change and uncertainty. In summary, rituals are a necessary part of our daily experiences and have the ability to bring order, connection, and ongoing trust and support.

Application in the MBM Curriculum

During the last session of the group experience, the Mind-Body Medicine curriculum suggests a closing ritual to allow group members to share openly with each other about their experiences as part of the group, and to share their gratitude for the group experience. The ritual acknowledges and celebrates the connections that have been made and is a way to savor the experience. This ritual is a way of saying goodbye and can become the container for the emotions involved in letting go and moving forward. The script for the closing ritual can be presented as:

The ritual we are going to participate in marks the end of the time that we have spent together. It is an appreciation of what the group has offered you and what you've accepted and embraced. It recognizes and celebrates what you've learned and how you've changed. On the sheet of paper given to you, write down everything you want to take with you from this group experience. As you write down each experience and realization, make it a part of you, claiming it as your own. Take time to savor this.

Evocative questions and homework: what has surprised you most by this experience? Do you have a new understanding of yourself as a result? What meanings or experiences transfer into your family or community? For your ongoing homework, I encourage you to revisit this drawing on a regular basis and recall the love and support found through this experience.

Rural Trauma and Impact

Recognizing the significance of trauma in rural communities and understanding the impact of traumatic events on rural residents is particularly important. The compounding effect of multiple trauma exposure at both personal and community levels, along with lower availability of services and rural attitudes of self- reliance, suggest that rural residents may, in turn, have an increased likelihood of poorer health outcomes in the event of adversity, such as Post-Traumatic Stress Disorder (PTSD), depression and anxiety (Bisson et al., 2007). Evidence suggests that some traumatic events may occur more frequently in rural regions, and knowledge of the long- term impacts of trauma, including factors that promote psychological recovery or mediate risk to the development of psychiatric sequelae such as PTSD, and anxiety, is critical (Handley et al., 2015). Promoting existing support networks, and establishing new modalities, such as a Mind-Body Medicine group, within rural communities may be an essential strategy to enhance recovery among those exposed to potentially traumatic events. Social support has

consistently been observed as a particularly important construct in rural areas, contributing significantly to better mental health and overall wellbeing, as well as protecting against psychological distress (Ziersch et al., 2009). Through engagement in a Mind-Body Medicine group, the promotion of social support occurs, and individuals, as well as the community, can heal.

Mindfulness and Trauma

A field-wide effort has focused on illuminating mechanisms underlying the development of and resilience to psychopathology following trauma exposure (Nitzan-Assayag et al., 2015). The use of mindfulness has been implicated as a promising, malleable process relevant to posttraumatic stress, trauma, resilience, and recovery (Bernstein et al., 2011). Cross-sectional studies have documented that higher levels of mindfulness are related to lower levels of posttraumatic stress disorder (PTSD) symptoms (Bernstein et al., 2011), greater psychological adjustment following exposure to trauma, and fewer anxiety and depressive symptoms (Garland & Roberts-Lewis, 2013). Furthermore, preliminary intervention research demonstrates the potential therapeutic promise of mindfulness training in facilitating recovery post-trauma (Nitzan-Assayag et al., 2015). Mindfulness can be used as a mediator to allow the mind to process trauma in a healthy way to promote healing. Mindfulness may provide a novel means of cognitive and affective exposure, facilitate an alternative set of behaviors to avoidant strategies such as suppression of intrusive thoughts, avoidance of situations that may elicit negative experiences, or other means of avoidance detrimental to recovery post-trauma (Bernstein et al., 2011). The defused, self-distanced perspective driven by mindfulness, may contribute to less intense and dysregulated emotional responding to trauma cues, less automatic maladaptive responding to trauma cues, and may promote a less avoidant attitude towards such trauma-related

internal states (Nitzan-Assayag et al., 2015). In summary, trauma, when considered and processed through mindfulness interventions, can be attended to without causing further distress to the individual.

Summary

In summary, mindfulness and meditation skills presented through the Mind-Body Medicine curriculum can change, alter, and transform individuals and the community in which they live and work. This can be significantly important, especially in rural communities, where access to healthcare can be limited. Presenting the curriculum in group format allows for individuals to be affected singularly, but also creates a ripple effect within the group and in families and communities. Through the use of breathing techniques, journaling, imagery, biofeedback and autogenics, movement, mindful eating, spirituality/forgiveness, and a closing ritual, participants are able to understand themselves and those around them better. Didactic information, along with experiential exercises, allow connection to self and others in a supportive, respectful, trusting way.

CHAPTER THREE: METHODS

The purpose of this research study was to explore the experiences of participation in a Mind-Body Medicine (MBM) group curriculum in a rural community. The goal of the study was to explore the impact of the curriculum on community participants individually and relationally. Research data was gathered from seven participants who completed a ten-week MBM curriculum. Chapter three defines the methodological procedures used to develop a deep understanding of the participant's lived experience. The qualitative research tradition, procedures, description of participants, methods of qualitative data analysis, reflexivity, and trustworthiness are outlined. Through these comprehensive strategies, the researcher developed an understanding of the impact of an MBM group in a rural community, where health disparities are prevalent.

Ontology/ Epistemology

There are several core philosophies of science that are embedded within research paradigms and traditions that help construct scientific inquiry in qualitative research (Hays & Singh, 2012). Ontology and epistemology are factors that help us to understand relationships in qualitative inquiry.

Ontology refers to the nature of reality; in qualitative research, this term is defined as the degree to which a universal truth is sought regarding a particular construct or process (Guba & Lincoln, 1981). The ontological perspective is characterized by the degree to which you believe that reality is limited or predetermined. This understanding implies that there may be multiple experiences, beliefs, and behaviors that surround a specific construct.

Epistemology is the process through which knowledge is acquired. It is how we know what we know (Guba & Lincoln, 1981). The spectrum ranges from limited knowledge to

unlimited knowledge. The researcher's worldview and experiences of the concept studied was an essential component of understanding qualitative research. An epistemological perspective in qualitative inquiry typically involves the notion that knowledge about a research topic is limited only by the quality of the interactions of those involved in the research process (Hays & Singh, 2012). The researcher used an epistemological foundation to explore the reactions of participants to gain a deeper understanding of the impact on their lives.

The researcher had a working relationship with each of the participants for ten weeks; this prolonged contact and evolution of relationship allowed her the ability to begin to understand each member fully. Acknowledging this close relationship, the researcher utilized multiple elements of reflexivity throughout the entire data collection and evaluation process. Strategies of credibility and trustworthiness are discussed in detail. The roles of an insider/outsider or emic/etic researcher are discussed.

Research Tradition

This study was a qualitative, phenomenological design. The focus was to discover and describe the meaning or essence of participants' lived experiences or knowledge as it appears to consciousness (Hays & Singh, 2012). This structure has roots in the works of Edmund Husserl, who set the stage for modern phenomenology in writings that explored experiences through perception and thoughts. The model is grounded in constructivism, which postulates that reality and knowledge are constructed in and out of our interactions between individuals and their world (Hays & Singh, 2012). The research tradition for this qualitative research is based on phenomenology. The purpose of phenomenology is to discover and describe the meaning or essence of participants' lived experiences, or knowledge as it appears to consciousness. It is the understanding of individual and collective human experiences and how we actively think about

experiences (Patton, 2002). A common thread in phenomenology is the value of subjective experiences and the connection between the self in the world we live in. Phenomenological researchers gather other people's experiences because it allows them, in a vicarious sort of way, to become more experienced themselves (Van Manen, 2014).

Research Design

Phenomenology is based on the understanding of individuals, and that we can enter into these practices through an intimate dialogue of their experiences (Edward, 2011). For the purpose of this study, I utilized a data analysis design by Thorpe (2013), which is similar to my work as a counseling therapist. In addition, Colaizzi's (1978) seven-step data analysis for phenomenological studies were intentionally interwoven throughout the process.

Strategies of Inquiry

The strategy of phenomenology is to discover and describe the meaning or essence of participants' lived experiences or knowledge as it appears to consciousness. It is the understanding of individual and collective human experiences and how we actively think about experiences (Patton, 2002). This practice involves observing a phenomenon from a fresh perspective through the eyes of the participants who have direct experience with it. It is important that the researcher was able to bracket off her values and assumptions regarding the phenomena. This process is known as epoche, a Greek word for refraining from judgment (Moustakas, 1994). As researchers encountered the experience of a phenomenon, they moved back and forth to assess the essence of experiences as well as variations of that experience; the final product was a written representation of the structure of experience through several participant's viewpoints (Hays & Singh, 2012).

Procedures

The researcher first gained support for the study with an introduction of the project through her peers in a qualitative course, and the professor, Dr. Jill Nelson. Further, the project was expanded on, with the support of the researcher's advisor, Dr. Brenda Hall, and became this dissertation endeavor. Academic peers were utilized to give feedback and answer clarifying questions related to the research that was explored. Academic peers also helped the researcher design the research questions for the study. An application to conduct the research was submitted to North Dakota State University (NDSU) Institutional Review Board (IRB) for approval. Once approved, the study began.

Collection of Data

The researcher contacted participants via phone, through a prewritten script that was approved by the IRB (see Appendix A), and up to eight individuals were contacted who have participated in an MBM curriculum. The intention of the researcher was to select the number of respondents necessary to obtain saturation in the interview process. Once the respondents agreed, the time and a confidential place were designated for the interview. The researcher met in person with each interviewee. Before conducting the interview, an informed consent document was thoroughly reviewed and discussed with the interviewee, details explained, and all questions answered. Once agreeable to the informed consent (see Appendix B), participants were asked to engage in an audio-recorded interview. Participants were informed that they could stop the interview at any time during the process, without consequence. Each interviewee was given a $5 gift card to the local coffee shop for participation in the interview, regardless of their decision. The password-protected recording device was stored in a secure area until the data was downloaded and transcribed with multiple steps of security (including a password-protected

computer, password-protected documents, and pseudonyms) to help ensure the confidentiality of the participants. Then the data was transcribed.

Research Protocol/Interview Questions

The researcher developed the interview questions through peer consultation as part of a research team. This consultation occurred to ensure that the questions were succinct and addressed the issues that the researcher wanted to explore (see Appendix C).

Within the interview, individuals were asked a series of questions in a semi-structured interview format to determine the impact of a 10-week mind-body medicine curriculum on community-based participants exploring the experience both individually and relationally with others. The interviews lasted between 20 to 50 to minutes.

Each of the seven interviews were recorded on a password-protected audio recording device. Once recorded, the interviews were downloaded from the audio recording device and transcribed to a password protected computer. Deidentification occurred to ensure confidentiality. Throughout all of the transcribed documents, each participant was given a pseudonym. This pseudonym practice was utilized to enhance confidentiality further.

Participants

Throughout the past year, the researcher conducted several MBM groups in the rural community. Group members have varied in age from young adults (18) to elders (80); approximately 30 individuals have completed a 10-week MBM group curriculum.

Sampling Procedures

Purposive sampling was used to require that the researcher develop a specific criterion for the sample of the study prior to entering the field (Hays & Singh, 2012). In purposive sampling, researchers carefully select subjects based on the studies' purpose with the expectation

that each participant provides unique and rich information of value to the study (Lee-Jen et al., 2104). This method of sampling can be useful, but caution was taken as there is a lack of random sampling and can be open to selection, bias, and error. Comprehensive sampling strategies (Hays & Singh, 2012) were used as the researcher selected an entire group of people based on an established set of criteria. This method is often used when the population is typically small. The established set of criteria is based on the completion of a 10-week mind-body medicine group curriculum. The participant sample was chosen in this way because it felt that the information they provided was rich with detail as a result of participation in the MBM group.

The participants in the study are seven individuals who completed a 10-week MBM group community-based curriculum, that was facilitated by the researcher. The participants were asked to share their lived experiences in the MBM group. Criteria for inclusion included (a) individuals who met a minimum of 18 years old, (b) have participated in a group community-based MBM curriculum experience, and (c) agreed to engage in an audio-recorded interview of their experience. Participants are viewed as co-researchers because of their extensive firsthand knowledge of the experience (Hays & Singh, 2012). Each participant was interviewed individually, approximately 45 days after their completion of the group experience. This time-lapse provided the participants with the opportunity to reflect on the group experience and begin to integrate the skills into their personal lives. During the interview, each participant was provided with a list of the various skills that were introduced in the group curriculum. Participants were encouraged to discuss their experiences of the group curriculum freely. Numerous interviews were conducted with the goal of saturation. A member of the research team validated saturation. A brief psychobiography of each participant follows.

Participant psychosocial summaries

Geri

Geri is an elderly woman who was introduced to mindfulness through a close friend. She stated that she found benefit from participation in a few meditation practice sessions that they shared and did some research on the internet about it as well. When Geri became aware that there was going to be a Mind-Body Medicine group offered in her rural community, she was interested and decided to participate. She stated that she has lost her husband of 48 years recently and is now helping to raise her 16-year-old grandchild. Geri is also a lifelong student and is taking classes at the community college to keep her mind sharp, though she indicated that as she ages, she has declining physical health concerns.

Rabia

Rabia is a middle-aged woman who developed an interest in the Mind-Body Medicine group when it was discussed in her church community. She stated that the name of the group interested her, and she thought it might be an experience where she would find support. Rabia stated that she knew that the facilitator was a mental health professional in the community and thought she might gain some insight from participation in the experience. She states that she is a single person who has never been married and is comfortable engaging in events in her community alone. As a leader in her community, she is often self-aware of how she is perceived by the people she comes in contact with.

Mary

Mary is an elder who lives in a rural community. She stated she was invited to the MBM group through a friend who encouraged her to attend. Mary is a supportive helper at the local school district and is married to her husband of 25 years. She is helping to raise a grandchild

with special needs. Mary states that she suffers from chronic illness and is always in search of ways to better care for herself and her family.

Jeannie

Jeanne is a woman in her 50s, who was intrigued by a flyer that was published for the Mind-Body Medicine group. She indicated that she loves mind-body medicine work and enjoys learning about spirituality and mindfulness, and this group sparked her interest. She is married to her husband of five years and has five grandchildren. She indicates a desire to teach her children and grandchildren mindfulness to improve their overall health and well-being. Jeannie stated she practices mindfulness often and wanted to participate in continuing to build her skills.

Mary Ann

Mary Ann indicated that she was invited by a friend to participate in the group but shares that she did not know much about mind-body medicine. She indicated that she has dealt with high levels of anxiety and depression for many years and was looking for something to help. She is a wife and a mother of one child. She lives in an urban community in the local area. She states that her main goal of participation in the group was to get tools to help with anxiety, relaxation, and learning how to enjoy life rather than worrying about it all the time.

Joan

Joan is a single woman who states that she wanted to learn about mindfulness as she was feeling very stressed out about her work, not eating well, and self-medicating to ease her distress. She indicated that she suffers from social anxiety. Joan hoped to be able to relax and slow her mind down, indicating that she was constantly worrying, feeling anxious, and feeling burnt out. She was hopeful to learn how to meditate, slow herself down, and learn about healthy eating.

Sue

Sue is an elder in the community and indicates her reason for being part of the group was to look into a self-discovery kind of learning; indicating that she wanted to find natural ways to heal herself because human-made prescription drugs have detrimental effects to her health and if a natural way to heal is out there she wanted to learn and begin to use it. She is a mother and a grandmother. She is employed by a local nonprofit agency whose goal is to provide support and structure to community members. She indicates her interest in the group is both personal and professional.

Data Analysis

In this research study, two methods of phenomenological data analysis were interwoven to develop a deep understanding of the participants lived experience in an MBM group, in a rural community. First, the data was explored through Thorpe's (2013) five sequential phases of qualitative analysis. This process is similar to a counseling psychologist conducting therapy and includes the development of the therapeutic experience. Thorpe's evaluative process is the primary evaluative measure of the current research, as the researcher is a practicing psychotherapy clinician. Thorpe describes five phases that include reflexivity and the choice of topic, the research interview and data gathering, thematic analysis, meta-analysis, and presentation of the research. Second, to add rigor to the data analysis method, Colaizzi's (1978), seven steps of data analysis is utilized. Colaizzi's analysis includes transcription and translation of the interviews, extracting significant statements from the research questions, formulation of meanings from significant statements, organizing aggregate meanings into clusters, writing an exhaustive description, identification of the fundamental structure, and finally validation of the exhaustive description by the participant. This dual qualitative evaluative process was used to

create a deep understanding and an accurate reflection of the participant's lived experience in an MBM group held in a rural community.

Thorpe's Phenomenological Analysis Method

The transcriptions were read and re-read by the researcher, continually aware of researcher bias, several times before analysis begins. Thorpe (2013) outlines the following five sequential phases in data analysis; application to the researcher's analysis is discussed in each phase:

Reflexivity and Choice of Topic

Bracketing is an awareness of the researcher's shaping and contribution to the construction and meanings in the research. Ideally, qualitative researchers engage in an ongoing process of reflexivity before, during, and after the completion of the research. It is suggested that counseling researchers should extend their personal reflexivity to include what may be termed psychological reflexivity. Psychological reflexivity is a mindful, psychologically sophisticated manner in which good clinicians understand their moment and manifest motives, drives, and processes (Avdi & Georgaca, 2007). This task was to provide a safe space in which researchers make curious, open, and honest reflections on their topic of investigation. This included a continual reflection upon the historical and dynamic reasons why they entered into the helping profession and what their strengths, trigger points, biases, and blind spots are (Avdi & Georgaca, 2007). As a professional counselor working in a rural community, I am continually striving to find therapeutic interventions that are evidence based and best meet the needs of the individuals I serve. When I was presented with the opportunity to learn the skills of mind-body medicine and integrate them into my own practice of health and wellness, I quickly realized the effectiveness of this modality. It then became essential that I begin to incorporate these skills into the

community that I live and practice in. After facilitating several groups and training many people in this modality, it only seemed a natural fit for this researcher to explore participant's experiences and to try and understand the impact in their personal lives. Because I am the facilitator of the MBM group and the researcher for this study, and I conducted my research through an insider and outsider perspective. As a result of the dual roles, it was essential that I used bracketing, reflexivity, and a research team throughout the entire process. My curiosity and patience with data analysis were crucial in developing a deep understanding of the participant's lived experience.

The Research Interview and Data Gathering

The research interview is the phase of qualitative research, which was most overtly congruent with the process of engaging in psychological therapy. This included the universal quest to be able to hear, feel, understand, and value the stories of others and convey that sense of empathy and understanding back to the participant. The quality of the research was fundamentally dependent on the depth and richness of the information gathered from the participants during the research interviews. This, in turn, was dependent on the scale of the researcher, the narrative and reflective capacities of the participant, and the relationship that had developed between them. An open and trusting relationship facilitates the gathering of data that is authentically grounded in participant's experiences and gives rise to a greater depth, complexity and richness of the data gathered. In this qualitative research, the amount of time and effort spent interviewing the participants was characteristically less than the time spent on the analysis of the data. In order to optimize the depth, quality, and openness of the material shared by the participant, I needed to engage in certain qualities, including active listening, warmth, accurate understanding, acceptance, respect, and genuineness. These attributes are similar to

those employed as a psychotherapist. For the participant to feel heard, accepted, and understood, I needed to demonstrate empathy. This process was taken with extreme awareness as not to blur the lines between therapy and research. To ensure credibility throughout the research process, I utilized verbatim responses, research team reviews of the analyzed data, and provided the participants the opportunity to review the transcribed interview to ensure correct understanding of the responses given.

Thematic Analysis

This phase marked the initial identification of recurrent meanings or themes. In order to obtain a felt sense of the participant's lived experience, the researcher repeatedly listens to the audio recordings and reads the transcripts. The researcher developed a sensitivity to the emerging findings. This is not a process of only doing whatever the researcher likes, but rather an extremely attentive attunement to thinking and listening to how the text speaks. Reviews of the transcribed data occurred frequently. I stepped away from the data for several days and came back to it to ensure that the themes were adequately formulated. Once thematized, a peer review, consisting of the research team, again occurred to broaden the lens of the researcher and ensure meanings are interpreted correctly and thoroughly.

Meta-analysis

This vital phase marks the transition to symbolic sophisticated, and meta-analysis thinking. This higher-order process can be the most complex, time-consuming, unclear, frustrating, and anxiety-producing. The meta-analysis and abstract processes share much in common with some of the abilities employed by seasoned counseling psychotherapist while conducting therapy. This phase has been described as exciting, engaging, and overwhelming. To tolerate these experiences and remain open, curious, and resistant to the temptation of premature

closure, the researcher needs to be sufficiently supported and grounded. Remaining open to multiple perspectives and unexpected responses may conflict with the researcher's need for control and structure. The researcher, similar to the counselor, must be amenable to unexpected incidents, be flexible, open, and willing to change, yet still expectant. The qualitative researcher needs to tolerate and sit with uncertainty. I continually remained open to the process of meta-analysis and was committed to finding the meanings as the participants described them. I was incessantly aware of my bias as a facilitator of the group and the impact the group had on the individual participants.

Presentation of the Research

Writing about qualitative research aims to capture the respondents' lived experience by producing emotionally engaging, authentic, and empathetic stories. Congruent with the focus of counseling psychology, it also attempts to make a direct social difference by empowering people to improve their lives. Good qualitative writing appeals to the reader to connect in a personal way. It aims to stimulate curiosity, reflexivity, and creativity in the reader and invites them to make their journey. A similar experience occurs when counseling psychotherapist communicates with other professionals about their clients in a style that elicits the engagement, empathy, curiosity, and reflexivity that is firmly grounded in the client and therapist lived experience. The goal was to stimulate the reader into further thinking in order to develop understanding and stimulate curiosity. As the primary researcher, I aimed to present accurate results of the research to the participants and stakeholders of the broader community to aid in further understanding the lived experience of participation an MBM group. As part of this process, thematic summarization was used to ensure that the data I presented was accurate to the participant's lived experience in the group. Participants were given a second opportunity to

examine the clusters and thematic outcomes to ensure that an appropriate understanding of meanings was accurately depicted. This process was utilized to increase trustworthiness in qualitative analysis.

In addition, the outcomes will illustrate to potential funders, the impact that this experience has, on rural community members. Also, it can serve as a goal to find additional financial resources to train other MBM facilitators will be explored.

In summary, through the use of Thorpe's inquiry, qualitative research collection and data analysis are similar to psychotherapy practice in aims, values, and agendas. Since I am a practicing clinician in a rural community, where access to mental health support is limited, this model of research analysis aligns with my values and goals for psychotherapy. This includes adhering to practicing counseling in a sensitive, relational, and responsive way in rural areas where strong kinship ties are valued.

Colaizzi Phenomenological Analysis Method

Colaizzi's (1978) phenomenological analysis also contributed to advancing a rigorous approach to phenomenological inquiry. Colaizzi outlines seven steps to this process. They include transcribing all of the subject descriptions, extracting significant statements, creating formulated meanings, aggregating meanings into theme clusters, interpretive analysis of symbolic representations, identifying the fundamental structure of the phenomenon and lastly validation of the findings is requested from the participants to match the researcher's results with the participant's experience. Each step is defined, elements of Thorpe's (2013) model is interwoven as appropriate, and application is discussed.

Transcribing the Subject's Descriptions

In this step of the analysis process, participant narratives are transcribed from the audiotaped interviews held with each individual. The narratives do not need to be transcribed verbatim, as long as the essence of what the participant was communicating is caught in the transcription. The respective participant then validates individual transcriptions of interviews. This step is similar to Thorpe's research interview and data gathering phase. Participants were sent a transcribed copy, through encrypted email, to validate that I accurately depicted the information that was presented to me through the interview. Participants commented, and agreed, that their thoughts and statements were accurately presented through the transcription. My own thoughts and feelings about each interview were recorded in a personal diary to build the trustworthiness of the experience.

Extracting Significant Statements Related to the Phenomenon Under Investigation

Any statements in the participant's narratives that relate directly to the phenomenon under investigation are considered significant. The statements are numerically entered into a list (i.e., 1, 2, 3, 4), which assembles all of the significant statements. In this step, I pulled verbatim statements from the transcribed data and began to sort and formulate like statements with similar meanings. This is similar to Thorpe's (2013) phase of thematic analysis, where listening to the text with attentive attunement occurs. Similarly, I stepped away from the data for periods of time. I was careful here to intentionally not create meanings, but just to begin organizing statements. This was a lengthy process that took significant time and organizational structure.

Creation of Formulated Meanings

In this step of the analysis, Colaizzi recommends that the researcher attempt to formulate more general re-statements or meanings for each significant statement extracted from the

participants' narratives. In this step, I began to organize significant statements into formulated meanings. The goal is to create exhaustive meanings from the data to reflect the intention of the participant accurately. Again, as in Thorpe's (2013) thematic analysis phase, I stepped away from the data for several days to ensure that accurate meaning was depicted. The research team was also utilized in this step to ensure that statements were organized correctly.

Aggregating Formulated Meanings from Significant Statements

During this step, I assigned or organized formulated meanings into groups of similar types. At this point, the formulated meanings were grouped into like categories. Each category included all of the formulated meanings related to the particular statements.

Organizing the Aggregate Formulated Meanings into Clusters

In this step, an exhaustive description was developed through a synthesis of all categories and associated formulated meanings that are explicated by the researcher. Each meaning was coded to include similarities that formulate related group meanings. Through activation of the research team, the definitive agreement was solidified, and I was able to formulate clusters. During this step of the analysis, the clusters were extracted, and an exhaustive description was obtained.

Writing an Exhaustive Description of the Phenomenon

Through this step, the essence of the experiential phenomenon is revealed through a rigorous analysis to exhaust the description of the phenomenon. The reduction of the findings included removing redundant descriptions to present a clear understanding of the phenomenon. This step is similar to Thorpe's (2013) meta-analysis process, where I was tolerant, open, curious, flexible, and patient. The application of this data analysis method was necessary for the development of clusters and finally, themes.

Validate the Exhaustive Description with Each Participant

In the seventh step, a follow-up appointment is made between the researcher and each participant for the purpose of validating the essence of the phenomenon with the participants. Participants were contacted a second time to review the clusters and themes with them. Colaizzi notes that during this step, alterations are made according to participant feedback to ensure that their intended meaning is conveyed in the fundamental structure of the phenomenon. Validation of cluster and theme meaning was provided to the participants and deduced into the final description of the phenomenon. This step is similar to Thorpe's presentation of the research and is essential in the data collection, analysis and evaluation process. This final step was significant as I wanted to accurately reflect the experiences of participation in a mind-body medicine group, in a rural community.

In summary, I utilized and intertwined elements from Thorpe's (2013) and Colaizii's (1978) models to create a comprehensive inquiry. I felt that these two models provided all-inclusive clarity in the data collection and evaluation process as a qualitative researcher while honoring my role as a psychotherapist in the rural community in which I live and work.

In the above outlined processes, the researcher did not move mechanically from one clear developmental phase to another but instead moved between the phases reflexively reworking, re-contextualizing and synthesizing the data (Thorne et al., 2004).

Bracketing /Trustworthiness

A critical step of bracketing, acknowledging this researcher's bias of her experiences of MBM, was initially evaluated, and then continually explored through the research experience. Bracketing is a methodological device of phenomenological inquiry that requires deliberately putting aside one's own beliefs about the phenomenon under investigation or what

one already knows about the subject prior to and throughout the phenomenological investigation (Carpenter, 2007). Bracketing is a means of demonstrating the validity of the data collection and analysis process (Ahern, 1999). The researcher intentionally utilized bracketing to remain as open as possible to ensure that the interviewee's own realities were illuminated. The presumptions of the researcher can limit the understanding of perspectives and can potentially introduce bias into the data collection and analysis process. In the data analysis process, individual quotes from participants were used to help safeguard their individualized experiences. By becoming curious, the researcher was able to bracket prior understanding. Through the concepts of being self-aware and self-critical, the researcher attempted to limit partiality. The researcher's reflective statement, expanded on in the following paragraphs, brings to consciousness presuppositions of her own participation in a Mind-Body Medicine group curriculum. With the implementation of these ongoing active procedures, the researcher is hopeful of limiting assumptions in the data collection and analysis process.

Strategies for trustworthiness were also utilized throughout the collection of data. To establish credibility, several tactics were used. This included submersion with the data, reflexivity, field journals, a research team, and member checking. Credibility requires adequate submersion in the research setting to enable recurrent patterns to be identified and verified (Krefting & Krefting, 1991). Thus, it is an important strategy to spend an extended period of time with the informants (Guba, 1981). Since the researcher spent ten weeks with the participants, she was able to develop relationships and understand their perspectives. As a result, prolonged engagement (Guba, 1981) enhanced the research findings through intimate familiarity. The extended time that the researcher spent with the participants increased rapport and, as a result, often disclosed sensitive information. Although close researcher informant relationships

are critical to the research enterprise, it is possible to lose the ability to interpret the findings; to help ensure that this extreme overinvolvement does not recur, a strategy called reflective analysis or reflexivity is useful (Good et al., 1985). Again, the researcher discusses her reflexivity statement in the following paragraphs. One of the ways that researchers can describe and interpret their behavior and experiences within the research context is to make use of a field journal (Krefting & Krefting, 1991). The researcher used a personal diary to reflect her thoughts, feelings, ideas that were generated after interviewing the participants. She also noted any questions, problems, or frustrations that occurred, always being aware of her own biases and perceived assumptions. To continue to build trustworthiness, the triangulation of investigators, also known as a research team, was utilized. Triangulation of investigators occurs in a study in which a research team rather than a single researcher is used; team members often have a diversity of approaches (Krefting & Krefting, 1991). The research team included the primary researcher, her advisor, Dr. Brenda Hall, a Ph.D. counseling education faculty; Dr. Julie Smith, a school counseling faculty; and Sara Erie, a clinical mental health professional, and colleague of the researcher. Each member of the research team reviewed the data and was able to agree on the consensus regarding overall meanings, themes, and clusters. Lastly, member checking was completed to ensure meanings were identified correctly. To test the overall interpretation, near the conclusion of the study, the researcher must do a terminal or final member check with the key informants to ensure that the final presentation of the data reflects the experience accurately (Lincoln & Guba, 1985). This last step was essential to ensure that the participant's experiences were truthfully depicted. Also, throughout the entire process, the researcher incorporated the values of honesty and transparency to warrant trustworthiness.

Researcher's Reflexive Statement

The research was conducted by a 51-year-old female mental health professional who lives and works in a rural community where access to mental health support is limited, and health care disparities exist. Since she was six years old, the researcher knew that she wanted to be a helper. The researcher's grandmothers and mother were grooming her for a role this long before she understood what her position in life would be. The examples and expectations her grandmother's and mother set for her were clear: she was to accept and love others unconditionally and be an example of this every day. First, the researcher was expected to pray about any situation and next trust that her inner guide would help her solve the concerns of the day; and she should never ignore what she felt in her heart and spirit.

Throughout her life, the researcher has experienced challenges. In her marriage, she was a victim of domestic violence verbally, emotionally, mentally, spiritually, physically, and financially. The researcher shares this brief history of her life as it has a direct impact on who she is today, and how she has learned to be her best self, despite difficulties and challenges. The researcher, from a very young age, was taught to acknowledge problems and listen to her heart for answers, and to learn from them, as it was essential for her continued growth.

Several years ago, the researcher attended a workshop of interest. The training was titled Mind-Body Medicine (MBM), through the Center of Mind-Body Medicine and thought it seemed to be a good fit for her in her role as a mental health professional. About three months later, the researcher was allowed to participate in advanced training for MBM. As a result of the positive impact it was having in her life both personally and professionally, she agreed to attend. Next, the researcher requested to be considered a candidate for the international certification in MBM. This certification process has taken her two years to complete. In February

2019, the researcher was granted international certification as a Mind-Body Medicine trainer through the Center for Mind-Body Medicine. All of this training, including supervision, travel, and per diem, was gifted to the researcher as a result of a grant that was procured by a local organization. The researcher is genuinely grateful for this contribution as it relates to her personal and professional growth; and has decided that the gift is too generous to not share with others. The MBM curriculum aligned with the teachings that she was given as a young child; the answers to your problems lie within your inner spirit; what you have to do is be mindful and self-aware, and you can answer many of your questions, which ultimately will reduce the level of stress experienced.

Insider/Outsider and Emic/Etic Perspectives

The researcher comes from an insider and outsider perspective. From the inside perspective, she presented the curriculum, shared didactic information, and led the experiential exercises with the participants. From the outside perspective, the researcher collected and critically analyzed the data of her participants, paying particular attention to the teacher-researcher bias that is occurring. This insider-outsider research (IOR) is defined in the following two ways: (1) research is conducted on the participants in the context of the researcher's participant group and (2) there is basically no control group with which to compare (Nakata, 2014).

The insider and outsider perspectives can further be delineated in qualitative research through examining the described viewpoints. Insiders are often first order observers whose way of observing and acting and is not an order of perspective, but simply a way of relating to the world (Niblo & Jackson, 2004). For the purpose of this research study, the participants were defined as the experts to their experiences from the insider perspective. The researcher can be

defined through this qualitative analysis study as an outsider as she considers, evaluates, and attempts to make meaning of participants (insiders) lived experiences. The terms emic can be replaced with the word insider and etic with outsider (Hibbs, 2018) and, in this sense, represent two perspectives on communicative behavior and interpretation of participant's experiences. Kenneth Pike coined the terms emic and etic several decades ago, and the terms have been widely used in the fields of linguistics and anthropology (Hibbs, 2018). Pike (1967) indicates that the emic and etic perspectives should not be conceptualized as opposite ends of a continuum; instead, that emic and etic concepts are like two perspectives in a stereographic image; separately, they give a flat but different perspective of reality. Together, they provide a rich three-dimensional understanding of occurrences. Mostowlansky and Rota (2016) suggest that researchers rely on larger etic patterns to focus and create particular areas of emic behavior or experiences. This lens of analyzing insider/outsider or emic/etic data in the current study was further utilized to develop deep meaning from the lived experiences of participants who completed an MBM curriculum in a rural community and the impact it created.

Summary

This qualitative study was essential as it reflects the experiences of participants who participated in a rural, 10-week Mind-Body Medicine group. To this research's knowledge, this is the first time that this type of a mindfulness curriculum is presented in this community. The methodological strategies used in this research study included the importance of ontology and epistemology, the research tradition and design of qualitative analysis, strategies of inquiry, data procedures, collection of data, research protocol, interview questions, sampling procedures, and brief psychosocial descriptions of the participants. Procedures of data analysis are discussed, which include Thorpe's (2013) and Colaizii's (1987) frameworks for analysis of qualitative data.

These methods explored and extracted meanings, clusters, and themes from the data that developed a deep understanding of participants' lived experience in a 10-week mind-body medicine group. Also, my role as a researcher is defined through a discussion of bracketing, trustworthiness, a comprehensive reflexive statement. Through these comprehensive strategies, the researcher is hopeful of developing an understanding of the impact of an MBM group in a rural community, where health disparities are prevalent.

CHAPTER FOUR: FINDINGS

The purpose of chapter four is to examine collected interview data and explore participants' personal lived experiences as a result of completing a 10-week Mind-Body Medicine (MBM) group that was being held in a rural community. The researcher designed the research questions to gain deep understanding about the impact of the group individually and in relation to others. Through the interview responses, the researcher was able to identify emic clusters (the participant/ insider views). By synthesizing the clusters, two etic themes (the researchers/outsider view) emerged to create multifaceted meanings of participants' lived experiences.

Clusters and Themes

The researcher systematically gathered and analyzed the data to find complex relationships among the participants. Thorpe's (2013) and Colaizii's (1978) data analysis methods are intentionally interwoven to develop an expansive, exhaustive description to ensure that participant's narratives were correctly constructed. The researcher identified recurrent meanings and clusters through the use of Thorpe's phases of thematic process. Through the use of Thorpe's phases of the thematic analysis process, recurrent meanings or clusters became identifiable to the researcher. Colaizii's step three of creating formulated meanings is similar to this and is directly applied during data exploration. During this data analysis and exploration, six emic clusters were generated and defined by the participants which include (a) the effect of stress, worry, and anxiety on participants lives and desire to change, (b) the impact of forgiveness in healing, (c) the importance of self-love in change, (d) how being self-compassionate is essential in caring for self, (e) the benefits of the therapeutic connection or bond that is created as a result of being in the group, and (f) ongoing micro and macro

healing. As a result of these six emic clusters, two overarching etic themes emerge. These themes were created through the lens of Thorpe's meta-analysis process. During this phase, the transition to symbolic and sophisticated evaluative processes occur which allowed the researcher to understand the deeper impact of the Mind-Body medicine curriculum. Thorpe (2013) states in this phase the researcher must be willing to tolerate experiences and remain open, curious and resistant to the temptation of premature closure. In addition, the researcher needs to be sufficiently supported and grounded. This ability to tolerate uncertainty is vital for the qualitative researcher. This resonates with Carl Rogers' (1961) view that increased insight is dependent on the development of sufficient psychological strength to endure new perspectives. As researchers adapt to increased stress, frustration and uncertainty unfolds in personally, specific ways. Passing successfully through this chaos leads to an illumination of the phenomenon under investigation in a new and meaningful manner (Thorne et al., 2004). This meta-analysis phase is integrated with Colaizii's step of developing an exhaustive description, in which a synthesis of the clusters was explicated to give meaning to the participant's lived experience. Subsequently, the two etic themes that the researcher saw emerging include; (1) participants' movement toward self-actualization and (2) the significant impact of relational connection.

Clusters

Cluster 1- Anxiety, Stress, and Worry

The researcher asked the participants to identify what sparked their interest for engaging in a Mind-Body Medicine group, and what they were hoping to gain from the experience (research questions: What sparked your interest in a Mind-Body Medicine/ Mindfulness group? What, if anything, did you hope to gain from this experience?). After listening and reviewing the recorded transcripts multiple times, all seven of the participants were able to recognize and

provide emic statements that support how anxiety, stress, and worry had a significant impact on their functioning. Each participant was able to describe a desire to engage in activities that would teach them how to reduce these symptoms. The first emic cluster is supported by the participants' statements. Sue shared how confusion and stress impact the way she performs:

> I was like, I can't take it anymore because I had no skills to do it. I didn't know what to do. I was scared to death and wondered why this stuff was happening to me. I had no other way of thinking. I needed to find something to help me grow and change.

Mary shared how anxiety was impacting her functioning:

> For several years now, I've been dealing with high levels of anxiety and depression and was looking for something to help with that, and in the past, I had this weight, and I was just like I'm too tired to even think about getting better, you know? My main goal was to get tools and things to do to help with anxiety, relieving anxiety, relaxing, and learning how to basically enjoy life rather than worrying about it all of the time.

Joan described how anxiety was impacting nearly every area of her life:

> Everything, in the beginning, was just stress, anxiety, and the things that I wanted in my life were completely unrealistic. I was feeling very stressed out about work, I wasn't eating very well, I wasn't sleeping very well, I was always anxious and on edge, and it was hard for me to move forward with a project. The group helped me to realize that my job was not bringing me joy. I wasn't happy with it anymore, and it was really a huge cause of stress in my life, I was ready for change.

Jeannie explained how stress had a physiological impact on her health and wellbeing:

> The stress of life will definitely affect your body. When stressed out, I can get pretty cranky. I would say that little things could upset me, and just you know, go into a little

rant. Stress also affected my physical health; the level of stress that I carried had a direct effect on my blood pressure.

Additionally, Mary Ann stated, "I would have anxiety attacks so bad that I would be shaking because of the stress and everything that my job put me under was practically killing me.' Geri discussed how anxiety impacted her ability to learn and how participation in the group helped her, "I'm an anxious person, and I wanted to feel better so I can use the skills that I learned when I go to take an exam, it helps a lot to calm me down, so my mind isn't fluttering all over."

By listening to the individuals above, it became evident to the researcher that the participants were seeking support and wisdom from the group experience. They were looking for information about how to manage stress, worry, and anxiety, as these symptoms were significantly impacting their lives. Research conducted by Garland et al. (2015) suggest that mindfulness exercises increase positive affect and decrease anxiety and negative affect. The participants summarize their experiences of anxiety, stress, and worry hoping to attain a positive affect by engaging in the mindfulness exercise.

Cluster 2- The Importance of Forgiveness

Next, the researcher asked participants if there were specific skills that impacted or resonated with them, as a result of participation in the MBM group (research question: Were there particular skills that resonated or impacted you, and if so, which ones?). Though participants were able to identify some of the skills used, they did not expound on the impact, except for the spirituality/ forgiveness meditation. In reviewing the data, a second emic cluster of forgiveness evolved. The data presented allows the researcher to gain significant meaning from various participant quotes, which stated the importance of forgiveness as an essential aspect of healing and movement toward becoming their best self. As illustrated through the group

experience, members learned to forgive themselves for past issues and mistakes to bring new hope to their lives. Forgiveness of self is defined as a willingness to abandon self-resentment in the face of one's own acknowledged objective wrong while fostering compassion, generosity, and love toward oneself (Enright, 2004). According to Chang et al. (2004), the process of forgiving oneself and others is the same as individuals begin to see their problems as challenges rather than grievances, they develop new stories about themselves and others. To help people create these new stories, Chang et al. (2004) encourages broadening perspectives through a series of reflective exercises. The group session in the MBM curriculum, which focused on forgiveness, provided the opportunity for participants to engage in the forgiveness of self. As a result, participants illustrate what this group experience meant for them. Joan shared her journey and the pride she feels as a result:

> I'm working on my forgiveness. I've actually gotten really good at forgiving myself because I was, I'm still hard on myself, but I've gotten so much better at forgiving myself for not doing things perfectly, you know. And being proud of myself for being able to do this.

Rabia described the importance of the forgiveness mindfulness experience, "the forgiveness mediation was helpful, and I have used different techniques to work on forgiveness, you know, in my prayer practice". Sue discussed the way she was able to find her power through forgiveness:

> It's all the fears, the self-doubts; in the past, it felt like I had no power. I'm finding I'm getting powerful inside. I'm able to communicate more with others to help them because hey, you know, I've been there; it is through my forgiveness this occurs.

Jeannie stated how she has been able to grow as a result of engaging in forgiveness:

> The most growth out of all the classes that I experienced; it would have been the one on forgiveness. That would be my most growth because I think I did the other ones pretty well already, but that one I really had to work at; it took me a while, that was my most growth experience, but it was also the hardest one. I would say that if you're going to grow, it's not always easy. In growth, sometimes you have to face something that you don't always want to face and forgive, so that was my most significant moment of the whole class.

Mary Ann shared how she has had to engage in forgiveness to be her best self:

> I always say, 'you have to have those feelings', you have to, even painful moments you have to face them, feel them, and let them go. Then I had to forgive myself for not facing the issue because I'm very hard on myself. You practice what you preach, and I wasn't doing that even though it was a long time ago, I still buried that and it was affecting me. I would have to say that learning how to forgive myself was my most significant part; it was the most hurtful yet also the best.

Geri shared her meaning of forgiveness:

> Being able to let go, being able to let a higher power take over the hurts and just give it up and forgive; and not stress out over it because it's not something that you can control anyway. It's hard, but it's also cleansing and healing for me, and I am thankful for forgiveness.

As the participants illustrate, being able to engage in forgiveness is key to overall health and wellness. Foulk et al. (2017) state that individuals who practice mindfulness, concerning forgiveness, can gain a greater understanding and shift the focus from past offenses to the present, which helps individuals decrease blame and enhances their ability to experience

forgiveness. Through reviewing the participants' statements, it became clear to the researcher that forgiveness of self was occurring through the process of the group.

Cluster 3- Self-Love

The researcher asked participants if partaking in the group influenced their ability to better relate to themselves, and if so, in what way (research question: Did participation in the group influence your ability to relate to yourself, and if so, in what way?).

The concept of self-love was a third cluster identified. Morrell (2007) describes that the process of self-love transpires when individuals become informed and empowered consumers of larger social collectives; this occurs when they are self-actualized and when they have begun the process of healing and loving themselves. Mary described her experiences of self-love and connection in the group through this description:

> It has centered me, it's focused me, and it's helped me be a better me, to love myself, so I can help others; because if I'm not good to me, then I'm no good to my community, so it's really helped me that way. I have to do this because it has become so powerful in my daily care, you know this love, just like brushing my teeth and taking a shower.

Whereas, Joan simply stated, "I actually love myself more now". Mary Ann discussed the impact of the group in developing her self-love as:

> I don't know where I'd be right now without the group experience. I mean, to me, it was one of the most important things that I have done for myself. I believe it changed my life. I feel I have hope now that I'm not always going to be like I was. I look back to a year ago, and there were times when I was close to suicide. I mean, I just was at a loss, and I just didn't know what else to do, and after the group, I feel like it totally changed me, I know that I am worthy of loving myself.

Sue expressed her development of self-love in this way:

> I now have a new understanding of why I see and do things the way I do, and where it comes from. I have a different way of thinking about things that might help me solve more problems that I run into. I needed a new outlook on how to function, to love myself.

Rabia shared how she has developed self-love and an ability to accept living alone:

> I live alone, and after coming home I don't feel like 'oh, I'm alone', I feel like I'm still part of the community around me and that I have their support even when I am by myself. I'm now comfortable being by myself, like going to a movie or going to a restaurant. I don't give it a second thought. I am loving me; more; in the past, I needed to be with someone to feel this.

These participant quotes point to the importance of self-love. Rockwell (2019) asserts that loving the self is the first step in a one love philosophy that is not self-indulgent but instead gives permission to dance to our dance, be true to our nature and embrace our particularized self-actualizing path. Also, Rockwell (2019) states that self-love is self-knowing, pointing to the part we play in the larger production, a capacity to connect to the community, to touch and be touched emotionally, to be part of both local and global healing and to be co-creators of a more expensive and inclusive 'we'. In summary, the quotes from participants regarding self-love point to the healing properties of self, and self with others.

Cluster 4- Self-Compassion

A fourth cluster, self-compassion, unfolds through reflection of the data. Self-compassion can be defined as simply compassion directed inward. People who have developed self-compassion are kind to themselves; they recognize and accept failure as a shared human

experience, and they take a balanced approach to emotional setbacks (Neff et al., 2007). Self-compassion is relevant when considering personal inadequacies, mistakes, and failures, as well as when confronting painful life situations that are outside of our control (Germer & Neff, 2013) Self-compassion, is a relatively new structure in psychological literature and has a negative relationship with General Anxiety Disorder syndrome (Neff et al., 2007). Mary described this by saying:

> I know I'm supposed to take care of myself, but do I? I don't as much as I probably should, and this curriculum is kind of like right here in front of me saying 'you need to do this'. When I start feeling unraveled and not knowing what to do, I just take a second and center myself, so I can do what I need to do, being patient and kind to myself is important.

Geri discussed her participation in the group and the benefit it has on her self-compassion:

> I just really think being in the group has been a great tool for me, and it's taught me a lot about myself and what I need to do to be a better self because at times I was hurting myself by the choices I made.

Rabia shared an understanding of compassion. She stated, "we are all wounded healers,' and we are all growing in some way. Being kind and compassionate to ourselves and others, matters". Mary Ann described how she has learned to be kind to herself:

> That is a big thing right now in my life, I understand my issues, and I'm working on them, getting better at controlling them, and the importance of accepting myself. I always used to look for external things to change, like if I do this, then it'll get better, or if I do this, then I'll have less stress. Whereas I never looked inward, so I would say my relationship

with myself has gotten a little bit better. I don't dislike myself as much, so learning to be okay with my stress and how I am because that's just how I am.

Jeannie expressed her self-compassion in this way:

> I always say you have to have those feelings, you have to, even painful moments you have to face them, feel them, and let them go, that is where the real healing begins. I'm a better person for this class, and even though it was really super hard for me, I worked my way through it.

As illustrated by the participants' statements understanding the importance of self-compassion was essential to their ongoing growth.

Cluster 5- Therapeutic Connection

Participants were asked to describe how the group influenced their ability to relate with others, (research question: Did participation in the group impact your ability to relate to others? If so, in what way). From the data, a fifth emic cluster emerged. Participants illuminated the therapeutic bond that was created with each other through the process. Joan described her relationship with the members of the group:

> I just felt so much love and acceptance from everyone around me. I really looked forward to seeing the group each week, and to just to be with you all because we were all there for the same reason. It felt really good knowing that I had new friends that weren't all going through the same thing as me but would be learning the same thing as me. It was a place where I felt safe; I could spill my guts, and nobody judged me. The ladies that were in the group, I just feel so dang close and bonded to all of them, and you, it was a really good experience. I feel safe with them knowing who I am, and I feel like I've gained lifetime friends.

Geri reflected on the therapeutic connection by describing her experience in this way:

> The group has taught me that every one of us has a story and we don't know the other person's story. It's when we listen with our ears and hear with our hearts; we find the depth of that person and how that person relates to their problems and to their world, and to us. It's been really an eye-opener for me. I feel so connected to each and every one of them. These groups help me to make connections and see those connections in each other. It's cleansing to know that people in the group are standing with you through all things, and they understand some of the hurts because they've suffered them themselves; so, they know why you hurt and what you need. They're just there, they are just there to be part of it, and I thank the Creator for them.

Mary Ann shared her experience with connection:

> We're all gathered together with similar experiences, I mean obviously not the same, but knowing that there are other people out there that feel the same way, that struggle, that need help like I do, helped me to feel like I'm not alone, and we feel bonded.

Rabia discussed how the group helped her connect to others:

> It's important for me to connect with people. I just felt like I could share in the group, and I feel like I'm part of the community around me because I had support from them. Also, the format of being in a circle, that I would grow with the group, along with them over time and develop some trust, even friendships. I think that was something I hoped for, a sense of community. So, for me, it just felt like a safe place, a place where I could connect. I felt like we supported both strength and compassion to each other through the process, and there's a gift in that.

She goes on to share how the group allowed her to open up and share honestly:

> What it stands out is that it's been a small and intimate group and how open people are with each other and sharing, whatever's going on. I think that's really special; it's a place where we have permission to really be honest, it's not small talk. It feels safe, and honestly, I don't think that that can't be underestimated because not every community space is like that, it really isn't.

Jeannie described her connection to members in the group through this quote:

> I made really good friends in the group, and I love to see the different perspectives. I think it made us bond because we are all interested in the same thing, mind/body, and spirit and healing, but I think we bonded more because of differences, the way we see things, and the way we respect each other's views.

In summary, it became clear that the experience of the group impacted each participant in a connected way. Participants felt and created intimacy with each other through the process, and, in several cases, created deep friendships. The group members formed trusting, caring relationships and developed empathy for each other.

Cluster 6- Micro and Macro Change and Healing

Through a research question, participants were asked what was most significant for them as a result of engagement in the MBM group process. From the transcribed data, the researcher discovered a sixth emic theme emerge, as participants expressed the desire to continue to engage in opportunities that will bring change and healing to the communities in which they live and work. Mending was described on a micro-level, through their families and friends, and also at a macro-level to the larger community.

Micro Change and Healing

On a micro level, Jeannie described how the group impacted an interaction with her granddaughter:

> I was sitting with my granddaughter, it was early morning just a few weeks ago, and she was sitting on the chair where my husband usually sits, and I said 'look at that' at a beautiful sunrise, she'd never even noticed a sunrise before, and she just sat there and stared at it. For me to watch her because I know how beautiful the world can be and she just sat there for probably 20 minutes and just watched that sunrise come up. My granddaughter said, 'I don't remember seeing anything so pretty in my whole life'. So, just being in that present moment and to be able to share that with my granddaughter was just so wonderful. I think without these, if I wouldn't have attended the classes, I think I probably wouldn't have experienced change and healing. I would have continued to stay so busy that I wouldn't have noticed, and I wouldn't have been able to show this to my granddaughter.

Mary Ann shared how being part of the group brought healing change for her and was then able to interact with her son, husband, and mom differently, which impacted change on a micro level:

> I've become more open with my son. I feel before I was just kind of stuck in my bubble, and I had a hard time playing with him or doing activities with him because I was just, I was nervous that I would do it wrong or he wouldn't like it. I don't know. It created anxiety to do stuff like that, so I think with him, it's allowed me to open myself up and be a better mom. Because of this group, I'm a happier person, and even my husband has said that since I've been going, I've been different. So, he's noticed it, and I know my mom has

> noticed it, too. I'm more talkative and just more willing to get out and do things with them, whereas before, I was more comfortable staying at home.

Sue shared how she discussed the group with her family members and close friends:

> I'm sharing about the group; I'm telling them, 'you guys need to come here, just let it out, wipe out all your crap inside you, just get it out, let somebody hear it like a sounding board' you will feel better. It's just like a giant sounding board, the group members are there for you, you feel safe, you can just let it out, and sometimes you will get some really good encouragement and everything back. I told them how much I loved it. It was just such a relief for me to let go of all that stuff I was holding, and that if they came, they could feel healing, too.

Macro Change and Healing

On a macro level and in the broader community, participants shared how the group impacted their work, and the desire to continue this type of community healing. Mary expressed how the group helped her and how this impacted her work in the community by saying:

> It's centered me, it's focused me, and it's helped me be a better me so I can help others; because if I'm not good to me, then I'm no good to my community, so it's really helped me that way.

Jeannie shared how the experience of being in the group relates to her work in the community:

> I would like to see us do more of it because it is a group for building, and it makes us all better people when we share and learn to know each other. It's beautiful, and especially now, I think it's important that we do this because we need to build peace.

Mary volunteered in a school setting and is part of the school board, she shared this experience of the group:

> I work in healing circles and help people when they're in trauma and things like that. I was working with a young girl, and I sat down next to her, and I just started doing the soft belly, I just started breathing like that and then she just kind of looked at me, and she started breathing, and then pretty soon she was able to talk. You don't even need to speak those things with some people; you just need to start doing it. I'm on the school board at the school, and I've talked to them about maybe trying to bring this into the school because there's a lot of trauma going on in the community, and it can help. I'm very grateful that this is happening now in our community, and I hope that it continues.

Geri also discussed her hopes for broader community involvement, as she is a student:

> The first thing that comes to mind was mind/body medicine and how what I was learning was helping me, and maybe it would help these young people who are so shy and are afraid to speak out to become more vocal and let the world know what beautiful people they are inside and what gorgeous thoughts they have to share. Through sharing it more, we get more people involved. We need to invite more people because five of us can't change the world, but if there were a dozen of us, we could make a difference, so that's what I would like to see.

Joan expressed her desire to expand this to more people "I think that we need more of this. I think we need this in our community; I know that we need this". Sue shared this about the engagement of others for greater healing "I hope the groups just keep going and growing because I feel this is what we need now in our lifetime because everything is so depressing, the people have lost hope; I think this is the mending tool for it".

In summary, thorough reflection and reviewing of the data led the researcher to understand and acknowledge the expressed desire of the participants to continue engaging in

opportunities that will bring change and healing to their communities by both micro and macro experiences. In rural communities, accessing mental health supports can be challenging. Engaging in a Mind-Body Medicine group is one way to experience community healing. Through this engagement, space can be created where individuals start to trust the group process and begin the progression of healing.

Etic Themes

In the researcher's review of the six emic clusters that were formulated from the data analysis, two major etic themes emerged. This development is further delineated through the lens of Thorpe's meta-analysis stage, where symbolic, sophisticated, higher-order processing occurs with the data. Thorpe (2013) states that this higher order process stage is the most complex, time consuming, unclear, frustrating and anxiety producing. In addition, the process of engagement in this phase has been described as exciting, interesting, exhausting, overwhelming and frustrating. As cited earlier, this resonates with Carl Roger's (1961) view that increased insight is dependent on the development of sufficient psychological strength to endure new perspectives. In this phase of data analysis, the researcher has to take a risk and commit to making interpretations (Sandelsowski, 1986). In conjunction with Colaizii's (1978) phenomenological analysis step, this is marked by formulating an exhaustive description of the phenomenon under study. From this, the goal was to form an unequivocal statement of meta identification. As a result, the emic clusters were integrated to form etic summative descriptions (from the researcher's outsider perspective). As noted, the six emic clusters were unified, and two etic cohesive themes evolved from the data (1) participant's movement toward self-actualization and (2) the significant impact of relational connection.

Theme 1-Movement Towards Self-Actualization

The interviewer asked participants to describe how the group impacted them, and which skills, if any resonated with them. As a result of the in-depth analysis of the interviews, participants provided four descriptive clusters that point toward individual goals of self-actualization. The four clusters include (a) the effect of stress, worry and anxiety on participants lives and the desire to find change, (b) the impact of forgiveness in healing and movement toward their best selves, (c) the importance of self-love, and (d) how being self-compassionate is essential in caring for self. The researcher utilizes sophisticated symbolic meanings to describe the participant's lived experiences to define the etic theme of self-actualization. Rogers (1961) identified self-actualization as a path toward, and a manifestation of psychological health. Rogers expands on this definition:

> Whether one calls it a growth tendency, a drive toward self-actualization, or a forward-moving directional tendency, it is the mainspring of life, and is, in the last analysis, the tendency upon which all psychotherapy depends. It is the urge which is evident in all organic and human life – to expand, extend, become autonomous, develop, mature – the tendency to express and activate all the capacities of the organism, to the extent that such activation enhances the organism or the self (Rogers, 1961, p. 35).

The high self-actualizing person engages in an ongoing process of channeling maximum effort toward the development of their potential (Bietel et al., 2014).

Reflective data processes enabled the researcher to develop a deeper understanding of the participants' desire to grow, change, and put significant effort towards becoming their best selves. Each week, participants engaged in thoughtful reflection and applications of the prior week's skills and how self-discovery and change were occurring. Several individuals discussed

how they were able to meet challenges head-on and make movements towards goals that they previously set for themselves. The researcher witnessed participants engage in personal growth and how these changes impacted themselves and their families. Several times, group members would disclose intimate concerns, sharing that this is one of the few safe spaces, a place where self-healing can begin. Absences were at a minimum, and disappointment was expressed if the group was not able to be held. Participants were open to the process of learning, allowing vulnerability to occur and openly sharing how each of them were changing individually. Also, members were able to notice change in one another through the group process.

Participants were observed in the community sharing about the group and the impact it was having on their individual lives. Due to participants sharing this experience with others, the researcher was often approached by potential new members asking when the next group session would be held, and their desire to begin when this occurs. The researcher connected with these inquiries through face to face conversation and email responses. Several community members approached the researcher and expressed disappointment that they were unable to participate in the group currently offered but were hopeful to be able to join in the next group series. Through this interest, it became clear to the researcher that the participants were talking in the community about the individual benefits that were occurring as a result of the experience. It is through these witnessed practices, and again through the data analysis where emic clusters were identified, the researcher found etic meaning, which is defined as a desire for participants to become self-actualized. The self-growth that occurred in the group allowed participants to increase self-confidence and self-love. The outcomes indicate a positive perception of the group, and the positive impact the group was having on participants. In summary, the group members were able

to improve individual autonomy, becoming open to self, others, and the rural community in which they lived.

Theme 2- The Significant Impact of Relational Connection

Participants described two clusters that were significant to connection as a result of participating in the group. The clusters include the benefits of the therapeutic connection/bond that was created as a result of being in the group, and an ongoing desire for micro and macro healing. These clusters were interwoven, and the researcher discovered an expansive etic theme of relational connection. This broad concept of relational connection was evident in specific quotes that pointed to this overarching view. Geri spoke about the relational connection in this way "these groups help me to make connections and see those connections in each other". Research suggests that the relational facet of mindfulness seems to be gathering momentum (Baker, 2003). Surrey (2005) proposes that the fruits of meditation include a growing experience of deep into connection with others, and with the larger world. In this, a co-meditation practice is established in which mindfulness and attuned relationship support and build upon each other. Joan exemplified this relational connection and stated, "through this group, I began to feel safe with them knowing about my deepest self, that is why I feel like I've gained friends, like lifetime friends".

As the researcher observed the relationships being built in the group each week, and as evidenced by the data analysis, it became increasingly clear that participants looked forward to the group each week. Through listening to the participants weekly, the researcher learned that some of them were meeting for coffee on Saturday mornings to discuss the group. Additionally, the researcher also learned that several of them designed a cooking class as a result of the meaningful relationships that were established. Also, members of the group created a group chat

to share differing mindfulness practices that built on the skills they were learning. In summary, shared interests began to bloom outside of the sessions. New supportive friendships were being built through this process, and a ripple effect was occurring, spreading health and wellness further into the community. The relational connection became a core outcome of participation in the MBM group.

Summary

In conclusion, this chapter utilized qualitative research with a phenomenological design to help the researcher gain deep understanding of the experiences of participants who completed a Mind-Body Medicine group in a rural community. The data is systematically gathered and analyzed, finding complex relationships among the participants. Significant statements were pulled from the interviews and organized into six emic meaning clusters. Finally, the clusters were interwoven, and two primary etic thematic constructs emerged from the data. Strategies of reflexivity and trustworthiness were continually engaged throughout the data collection and inquiry. The researcher used member checking to ensure that the interview data was transcribed correctly and again presented the summarized data to the participants to ensure that meanings were organized as the interviewee intended. The research team was consulted to help formulate clusters and themes from the lived experiences, while etic and emic codes were used to deepen meanings. Thorpe's (2012) and Colaizii's (1978) data analysis methods were intentionally interwoven to develop an expansive, exhaustive description to ensure that participant's narratives were correctly constructed.

CHAPTER FIVE: SUMMARY OF STUDY

As suggested earlier, living in a rural community has benefits. Serenity and access to natural wonders are everywhere. These small communities have strong kinship ties, and the sense of connectedness is something that many people long for and appreciate considerably. However, because of the considerable distance between small towns and community hubs, rural living can also be lonely and isolated. Accessing support for physical health care, and even more significantly, mental health support can be a substantial challenge. Often, there are only a few mental health professionals available for individual therapy and wait times to engage in this healing modality can be lengthy. Additionally, the stigma surrounding these modalities of treatment are significant.

Having access to a mindfulness and meditation group in the local community is one way to counterbalance these challenges and bring alternative healing modalities to these remote areas. Providing this alternative for health and wellness is a way that rural counselors can impact substantial numbers of persons and help stimulate individual and collective community healing. The current body of mindfulness literature suggests that integrating this seemingly simple approach yields consistently positive outcomes (Brown et al., 2013).

Due to rural communities having such close kinship ties, when trauma or loss occurs, it is felt by nearly everyone in the community, in some manner. In essence, the community is 'hurt together'. Often though, healing from these experiences is done in somewhat separate and isolated ways. Frequently, the individual or family journeys through healing, alone.

Through participation in an MBM group curriculum, alternatives to individual and community healing can occur. Through this opportunity, it has allowed the participants the prospect to 'heal together' in a setting that is safe and trusting. This collective healing practice benefits not only

the individual participating, but also evokes a ripple effect of holistic healing for much of the community. As indicated by research cited earlier, the use of this intervention involved an important assumption relating to holistic health. In essence, the improved health of one member of a family can be an immediate improvement for the entire family (Vest et al., 1997). This reciprocal concept can be extended to individual and community healing.

The Mind-Body Medicine curriculum is presented in a group format and can provide skills for individual and shared healing. The group becomes the container for healing, and the members benefit from this cooperative effort. The wisdom that is carried by the facilitator and various community members is shared, and ultimately all benefit.

The purpose of this qualitative study was to explore the experiences of participation in a Mind-Body Medicine (MBM) curriculum in a rural community. The goal of the study was to (a) explore the perceived impact of the Mind-Body Medicine (MBM) curriculum on participants individually and (b) the influence the curriculum has on participants' relationships with others. Seven individuals who completed an MBM curriculum were interviewed to explore how the group impacted them and gain a deep understanding of their experiences. Through analysis of the data, it became evident that the participants grew in several ways, and the results add to the importance of partaking in a mindfulness and meditation curriculum, in a rural area. Six clusters were formulated from meaningful statements given by participants and were further condensed into two overarching themes of self-actualization and relational connection. These findings were determined as a result of the support and safety found in the group process. Participants described the desire to have this healing channeled back into their community at micro and macro levels for overall health and wellness.

Participants shared an overwhelmingly positive response from participation in the MBM group. It was interesting to note that participants did not elaborate on specific skills, but spent more time reflecting on the group experience itself, the connections made in the process, and a desire for continued growth. Additionally, they shared how being together each week impacted them significantly. The interview data points to the desire for participants to become their best selves and then being able to transfer this knowledge to their family and close friends, and ultimately the rural community in which they live. A most exciting component for the researcher, personally, was the desire for this type of group to continue to occur and build within the community. The request for this to continue was remarkable.

Participants discussed how important it is for them to be healthy and well so that they can engage in healthy activities for themselves, with their family, friends, and community. It became clear through the interviews that the stress, worries, and anxieties of life were significant challenges before the beginning of the group, and all participants were seeking ways to diminish this effect. Through the safety of the group process, individuals were able to share openly and discuss their challenges while feeling supported by the other members of the group, which provided a reciprocal learning process. Mutual learning means that all members of the group, both students and teachers, learn from each other; and that reciprocal learning in groups can improve the quality of learning for all participants (van Swet & Ponte, 2007). Through this process, group members worked together and realized that all contributed to others' learning and growth.

Though it is essential to acknowledge their individuality of the experience, the six clusters that developed indicated that all seven participants were impacted in similar ways. Engagement with others, through this group curriculum, created a sense of safety and

connectedness that is not found in other places or public spaces, even though the participants and the researcher live in a small rural community. Through the MBM experience, participants were able to develop trust with others and a deep connection with others in a sacred space. This space allowed them to grow individually and bring their realization of influence into their personal lives and the broader community.

Because of the significant positive impact of the group, and discussion of the affirmative effects in the rural community, the researcher continues to be asked to facilitate the MBM group curriculum in numerous settings in the community where she lives. The researcher believes these findings solidify the need for ongoing mind-body medicine groups in rural communities where members experience significant amounts of stress, encounter traumatic experiences, and access to support is limited.

Researchers Role as a Psychotherapist and Facilitator of the MBM Group

The researcher is a mental health professional in the community, where she offers the MBM group curriculum. Initially, the researcher participated in training for the curriculum through the Center of Mind-Body Medicine to build skills to aid in her personal and professional life. Because the curriculum impacted her in such positive ways, she began to integrate these skills into her psychotherapy practice, with the ultimate goal of becoming a certified facilitator in MBM. Research suggests that the counselor's practice of mindfulness benefits their clients, even when they are unaware that their counselor is practicing this (Grepmair et al., 2007). This statement proved to be especially true in the researchers work as a facilitator of the Mind-Body Medicine group. The researcher's ability to use the curriculum in her life has impacted how others perceive her. Rabia described the researcher in these words, " it's hearing other people talk about their lives and how they deal with things and then it… like, just hearing you talk about

what it's like to juggle and just being aware of all that you have going on and yet like you seem balanced and centered". The researcher acknowledges that living by the principals of the curriculum, she has created a profound sense of inner peace and can engage in her personal life and professional work more fully. The relationships that the facilitator has built with community members, as a result of the facilitation of the MBM group, has been enriching. The facilitator has been able to develop deep connections with participants, and new friendships have been established. Also, through this research, the facilitator has learned to understand the experiences of others in a meaningful way.

Implications for Counselors and Counselor Educators

There is an extensive amount of research published on the benefits of mindfulness and meditation. This research discusses the various ways that this modality has had a positive impact on individuals and groups. Through this study, the researcher has developed a deeper understanding of how an MBM group presented in a rural community, impacts participants. As a result, this research has several implications for counselors and counseling educators. Suggestions include the importance of integrating mindfulness care into counseling practice, how mindfulness groups can efficiently provide healing and are a benefit to the individual and community in which they are presented, and how the integration of this curriculum in graduate programs can impact counselors in training.

Integration of Mind-Body and Self-Care Practices in Counseling Practice

Practicing clinicians who are familiar with mindfulness and meditation can integrate mind-body and self-care practices into individual sessions with clients for optimum health and wellness. Skills that are learned in the therapy session can be practiced outside of the session as clients move about their day to day experiences. This transfer of knowledge and skills to life

experiences as they occur provides an opportunity for healing to continue outside of the session and self-care to be practiced.

Psychotherapists who offer psychoeducation and practice mindfulness and meditation with clients, can provide skills to individuals that can be used throughout a lifetime, and accessed when self-regulation is necessary. These skills, when learned, have a significant impact on decreasing mental health symptoms and increasing overall health and wellness, which ultimately allows for the emergence of more excellent self-care knowledge (Young & Hayes, 2002). Brief mindfulness training helps individuals learn how to regulate negative responses to stimuli, and even infrequently practiced mindfulness meditation increases well-being and reduces worry, general anxiety symptoms, and psychological distress for people with anxiety symptoms (Vesa et al., 2016). From the perspective of clinicians working with clients, we recognize that the purpose of psychological therapy is often to enable clients to develop a robust sense of themselves to interact with the world around them in a way that is effective and genuine and enhances their well-being (Cole, 2015). Achievement of this goal is through our ability to have clients attain this, and often starts with a genuine relationship in the client-counselor connection. As we work towards our goal of being completely present with our clients and working to attain a nonjudgmental stance to problems presented, we were able to practice mindfulness.

Through modeling mindfulness and meditation, psychotherapists have the means to allow clients to achieve a more relaxed state and be open to the possibility of not engaging in stress responses as they occur. Teaching clients how to engage mindfulness skills allowed them to step back from stressful situations, live in the here and now, and thoughtfully respond to them, which created an overall decreased stress response (Christopher & Maris, 2010). Ultimately, a therapist's hope for clients is that they are comfortable with the person they know themselves to

be and feel confident acting in ways that are in harmony with that person and their needs (Cole, 2015). Brene Brown (2013) discusses this essence of balance and defines this concept as the attainment of wholehearted living. She describes this as engaging in life from a place of worthiness, cultivating the courage to acknowledge imperfection while feeling a sense of being worthy of love, belonging, and joy. She further notes that a critical component of wholeheartedness is self-compassion. Through self-compassion, we begin to talk to ourselves like we speak to someone we love, that means giving up criticism and acknowledging that it is OK to make mistakes, and to begin to develop self-love and understanding (Brown, 2013). The development of self-compassion was an essential component of self-care. Kristin Neff (2003) operationalized self-compassion as consisting of three main elements: kindness, a sense of common humanity, and mindfulness. These components combine and mutually interact to create a self-compassionate frame of mind, which was relevant when considering personal inadequacies, mistakes, and failures, as well as when confronting painful life situations that were outside of our control (Germer & Neff, 2013). Counselors can teach clients how to use warm, understanding language with themselves to build self-compassion and improve self-care practices. Also, the possibility exists of turning toward our painful thoughts and emotions and seeing them as they are without suppression or avoidance (Neff, 2003). The mental space provided by taking a mindful approach to our complicated feelings allows for greater clarity, perspective, and equanimity (Baer, 2010).

Participants of the MBM group shared how stress, anxiety, and worry impact their everyday experiences. Through skill acquisition and in the group process, each of them were able to recognize the importance of forgiveness, self-love, self-compassion, and ultimately self-actualization as elements of self-care and aid in the development of their best selves.

Group Work as a Format for Healing and Developing Connections

As a practicing clinician in a rural community, I have witnessed first-hand the difficulty in finding mental health support. In the community-based program that I work in, it is not uncommon for clients seeking help to wait nearly six weeks for an individual session. Typically, when an individual reaches out for support, they need the appointment in the immediate future. This long wait time impacts and often discourages engagement in mental health support. Having the opportunity to engage in community-based groups, such as the MBM group, would be one way for prompt support to occur. Group work has the potential to promote healing efficiently and fosters growth-producing connections (Jordon, 2017).

Since groups are often already occurring within communities, participation in them can be almost immediate. Engagement in the group experience itself can contribute to individual and collective healing (McCrone et al., 2005).

Group work has many of the benefits of the individual therapy session, yet it also allows for community members to share and learn from one another's wisdom. Irvin Yalom (1995) a foundational theorist of group therapy, states that the group therapy experience facilitates inspiration to participants by their peers, results in substantial improvements in medical outcomes, reduces health care costs, promotes the individual's sense of self-efficacy, and often makes group interventions superior to individual therapies. Yalom (2005), insists that group members interact in the here and now, and encourages that trust be established within the group; this allows group members to be able to give open, honest feedback and receive such feedback in return. This here-and-now concept is similar to the idea of living in the present moment, as suggested by mindfulness and meditative practice. The group has the potential to create what Yalom (2008) describes as rippling. Rippling refers to the fact that each of us creates, often

without our conscious intent or knowledge, concentric circles of influence that may affect others for years, even generations. Essentially, the effect we have on other people, in turn, is, in turn, passed on to others, much as the ripples in a pond go on and on until they are no longer visible but continuing at a nano-level (Yalom, 2008). Judith Jordon (2017) states that we grow through and toward connection throughout our lives and suggests that relationship with others is a survival need. The group process is a container for this growth to occur. As one person changes, so do others. Jordon (2017) states that this relational connection to others is a powerful healing practice. As this research suggests, when practicing counselors engage in group therapy work, both individual and collective growth occur reciprocally.

In the current research, the MBM group became the container for a safe, trusting environment where the vulnerability was allowed to be acknowledged, new skills were learned, and participants were permitted opportunities of collective growth and self-actualization. This transformation occurred individually and co-jointly within the MBM group, then gave rise to extending this experience to the broader rural community in which the participants lived. In essence, the participants were healing personally and collectively. They then expressed an interest in extending this to micro and macro levels where their families, friends, and community could also benefit. In summary, a ripple effect of healing occurs in the process. This ripple effect supports the concept of how collective healing can influence mutual hurt in small rural communities where kinship ties are important and valued.

Introduction of Mind-Body Practices Professional Graduate Training

As a counselor educator, teaching this curriculum in a graduate program would be of benefit. Attainment and utilization of the skills can help to regulate some of the discord and demands that are placed on graduate students who are often working and attending classes at the

same time. Additionally, the curriculum and skills can be used in the counseling practicum domain.

The professional development of counselors and psychotherapists is fraught with many risks (Christoper & Maris, 2010). Burnout, compassion fatigue, and vicarious trauma can have significant impacts for practicing counselors and counseling educators (Baker, 2003). For instance, Shapiro et al. (2007) suggests that stress may have harmful effects on counseling student's effectiveness and success by reducing their capacity for attention, concentration, and decision making. Before using or adapting meditative practices in clinic work, counselors in training have an opportunity to engage in reflexivity, or to explore the elements of personal and professional relevance of such a method to develop a strong understanding of the practice itself (Surmitis et al., 2016). Essentially, counselors in training need to develop a thorough knowledge of self before they practice this in the field of professional counseling, through formal training in a graduate program. Integration of the mind-body medicine curriculum, through coursework, may help facilitate counseling student's growth and minimize the impact of fatigue and post-secondary stress in masters and doctoral level counseling programs. Research by Greason and Cashwell (2009) suggests that mindfulness practices can enhance therapist empathetic ability towards clients. As a result, integrating this curriculum into the plan of study for master and doctoral level students could decrease stress levels, fatigue, and possibly burn out. This researcher feels that offering this type of course in masters and doctoral level training programs would have a significant positive effect and increase the self-efficacy of students and faculty members. Larson and Daniels (1998) found that higher counseling self-efficacy is related to perseverance in the face of challenging counseling tasks, had an increased ability to receive and incorporate evaluated feedback and also note that counselors with strong counseling self-efficacy

report less anxiety and interpret the anxiety they do have as challenging rather than overwhelming or hindering. Also, Christopher and Maris (2010) note that students who practice mindfulness have an increased ability to remain relaxed and focused, even in the presence of their own or their clients' distress. In summary, offering this curriculum to counselors in training can be beneficial. This knowledge can be transferred into the practicum counseling session, which enables growth in the client and counselor, respectively.

Limitations

This study had several limitations. As previously mentioned in the methods section, the researcher had several roles. She was the facilitator for the group along with researching this study. Part of the challenge in presenting the curriculum is that the researcher moves between a participant of the group, as well as a facilitator of the group. There is an expectation that movement occurs between the roles interchangeably as facilitator/participant when the curriculum was offered each week. The researcher completed the interviews for the research being conducted, which may have created a positive bias of the group experience, as the participants may not have wanted to disappoint me. On the other hand, had an independent researcher asked the research questions, there may have been other themes that could have evolved.

A second limitation was the number of opportunities the mind-body medicine curriculum had presented in the rural community. The facilitator has been able to complete three different curriculums in the rural community. The participants who agreed to engage in the research study were pulled from two of the groups. However, had the individuals from all three groups been interviewed, the outcomes may also have been different. Also, if the group had been presented in several rural villages, by several different facilitators, the findings might be different. As a result,

it may have added to the validity of the research. A small sample size of seven individuals were interviewed. Though the researcher attempted to attain saturation of the data, a more significant sample size may have produced differing thematic constructs. The researcher is hopeful that in the future other studies can be completed that will allow various facilitators and various other rural communities to be part of the participant pool to be interviewed. It is hopeful that ongoing research can be conducted in the future and could expand upon the impact of a rural mind-body medicine group. A larger study design could also impact future research. Expanding the interviews with as many as 15 people may affect outcomes.

A third limitation was that the researcher was a single facilitator in the group. Had a co-facilitator been present, it may have changed some of the group dynamics, and ultimately, the experience of participants. Quite often, the mind-body medicine group is presented by two facilitators. Because of the rural community, and the lack of other trained facilitators, this was not possible. The researcher hopes that soon there will become more trained facilitators, and the option for co-facilitation will occur. Also, it is hopeful that through the presentation of the positive impact of the group on the community, funders and stakeholders will appreciate the essential need to continue to find funding to train additional facilitators.

A fourth limitation was that all seven of the participants were women who live and engage in the local community. If male participants would have been interviewed, there may have been different outcomes. Though the women interviewed were of varying ages from young adults to elders, the influence of males may also change the results.

The fifth limitation is that the group curriculum was presented once per week. If the facilitator was available to meet with participants twice per week and spend more time on each experiential activity, the participants might have gained a deeper understanding and then been

able to internalize the skills presented at a deeper level. The researcher is aware of the importance of using mindfulness and meditation skills as outlined in the curriculum daily and checking with participants bi-weekly may have allowed the particular skills to create a more significant impact on participants.

A sixth limitation is that my professional role in the community may influence the perception of the participants as they may see me as an individual who has power because of the advanced degree I hold; as a result, the interviewees may not want to disappoint me.

Future Research

In addition to exploring how to implement this throughout the rural community better, it would be interesting to see how this might impact a younger group of participants, for instance, school-aged children. Within the mind-body medicine curriculum training, there is a specific tract for youth and children. Also, it would be fascinating to observe the impact of the curriculum on a group of family members who have experienced trauma. Both of these experiences could add to the existing literature on the effectiveness of the MBM group curriculum.

Future research could also be conducted on participants who have been impacted by a significant event in their community. The mind-body medicine curriculum has been presented throughout the United States, and throughout the world, in various communities where there have been mass shootings, war-torn countries, and areas of natural disasters. The researcher could offer a mind-body medicine curriculum when a traumatic event happens within her local community as part of a first response to the tragedy. The researcher can identify one particular community tragedy where three members of the same family were lost in an accident. If the researcher could have presented the Mind-Body Medicine curriculum immediately after this tragedy, the opportunity for community healing could occur.

In the future, a separate study could also be done on each of the clusters and themes that were extricated from the data. Expounding on each of these research areas may provide greater insight into the impact of the curriculum in a rural community.

Further research could also be conducted if the mind-body medicine curriculum was presented to different departments in the agency that the researcher is employed. The researcher would be interested in knowing how the mind-body medicine curriculum impacts employees who work in the substance abuse field, or the home health nursing program. A study of nursing students found a significant drop in psychological symptoms and higher levels of quality of life after participating in a mindfulness-based stress reduction program (Young & Hays, 2002). If staff in these departments are trained in this curriculum, it may benefit and create a positive impact on the individuals and the people they are serving. The MBM group may also strengthen leadership qualities in these programs and aid in the development of resiliency strategies to post-secondary trauma experienced by support staff.

Conclusion

Growing evidence indicates that a significant rural-urban disparity exists in the United States, driven largely by urban longevity gains that have not been shared among those living in rural places (Ziller & Coburn, 2018). While there is substantial variation across the country, rural residents are more likely on average, to live in poverty and lack formal education; these interrelated social determinants are known contributors to sickness through a complicated pathway of inadequate health care access, health behaviors, and exposure to toxic levels of stress (Ziller & Coburn, 2018). In addition to these challenges, rural residents face challenges because many communities lack a sufficient number of healthcare professionals, specifically mental

health professionals. Furthermore, often in rural communities, there is a stigma that is associated with accessing mental health support.

Ziller and Coburn (2018), suggests that rural community leaders can work to engage and train members of their communities to support each other through initiatives like mental health first aid and community healthcare worker programs. These initiatives enable lay professionals from affected communities to obtain skills and knowledge to meet some of the supportive health needs of their families and neighbors. Historically, these rural communities thrive through innovation and creativity and can make significant impacts with limited resources (Coleman, 2018). Becoming trained in mindfulness and meditation practices, through the Center of Mind-Body Medicine, is one opportunity to expand the reach of services to rural populations. The MBM curriculum has the potential to build on one of the greatest strengths of these tight-knit communities, the sense, and importance of social connectedness and healing that occurs between families and neighbors. Providing access to supportive, safe spaces for healing, that acknowledges the shared wisdom and restorative practices, is essential to rural area's ongoing success. Understanding, recognizing, and supporting the needs of rural communities will allow them to continue to be thriving, desirable places to live.

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APPENDIX A. TELEPHONE INVITATION

Hi, this is JoAnne Riegert calling. I am a graduate student at NDSU in the counseling education and supervision program. I am doing a study that will explore your experiences as a participant in the Mind Body Medicine curriculum. You are invited to participate in my study. If you agree to participate, I will come you, or meet with you in a confidential space to complete an interview. During the interview I will be asking you about your experience about the MBM curriculum. For example, I will be asking you how or which elements impacted you the most, and also which elements impacted you in your relationships with others. The interview will take approximately 50 to 60 minutes of your time, and be audio recorded. I will use the audio recording to analyze the information you share with me. Please know if you decide to participate all of your responses will be confidential and your participation is voluntary. If you are interested, can we set up a time to meet? A $ 5.00 gift card from a local coffee shop will be given to you as a small token of appreciation for participation in the recorded interview. This "thank you" will be given whether or not you complete the interview.

APPENDIX B. INFORMED CONSENT

NDSU **North Dakota State University**

Department -School of Education

NDSU Dept. 2625

PO Box 6050

Fargo, ND 58108-6050

701.231.7202

Title of Research Study: Exploring the experience of a community-based Mind Body Medicine curriculum for participants, both individually and in relation to others.

Dear ______________:

My name is JoAnne Riegert. I am a graduate student in the Department of Education in the Counseling Education and Supervision Program at North Dakota State University (NDSU), and I am conducting a qualitative research project to explore the experiences of participants who have engaged in a Mind Body Medicine (MBM) curriculum. The curriculum consists of various meditation and mindfulness techniques to improve mood and ease distress. The research will examine the impact of the curriculum on participants both individually and relationally to others. It is our hope, that through this research, we will learn more about how a MBM curriculum impacts participants, and the influence the curriculum has on participants relationships with others. This information will be utilized only for a class project to enhance my knowledge of qualitative research.

Because you have engaged in a MBM curriculum, you are invited to participate in this research project. You will be one of approximately eight people being interviewed for this study.

You may find it interesting and thought provoking to participate in the interview. If, however, you feel uncomfortable in any way during the interview session, you have the right to decline to answer any question(s), or to end the interview.

It should take about 50 to 60 minutes to complete the interview. We will ask you about which components of the curriculum have impacted you, and which components you identify as most

important. You will also be asked to identify how the curriculum has impacted your relationships with others. The interview will be audio recorded. We will keep private all research records that identify you. When the interview is transcribed, you will be given a pseudonym of your choice, and other potentially identifying information will be left out of the transcripts. In any written documents (including publications) regarding the study, only the pseudonym will be used.

A $ 5.00 gift card from a local coffee shop will be given to you as a small token of appreciation for participation in the recorded interview. This "thank you" will be given whether or not you complete the interview.

Audio files will be stored in a password protected file on a computer that is only accessible to the principal investigator and co-investigators. Electronic copies of the interview transcripts will be saved and protected in the same fashion. After the data has been analyzed, the audio recordings and the interview transcripts will be deleted.

If you have any questions about the study, please contact me at 218-401-0016 or email address: joanne.hickey@ndsu.edu or contact my advisor, Dr. Brenda Hall, NDSU; 701-231-7415 email address: brenda.hall@ndsu.edu.

You have rights as a research participant. If you have questions about your rights or complaints about this research, you may talk to the researcher or contact the NDSU Human Research Protection Program at 701.231.8995, toll-free at 1-855-800-6717, by email at ndsu.irb@ndsu.edu, or by mail at: NDSU HRPP Office, NDSU Dept. 4000, P.O. Box 6050, Fargo, ND 58108-6050.

Thank you for your taking part in this research. If you wish to receive a copy of the results, please contact myself at the above listed phone or address.

APPENDIX C. INTERVIEW GUIDE

Research Question:

What is the impact of a 10-week Mind Body Medicine curriculum on community-based participants exploring the experience both individually and relationally with others?

Interview Questions:

1. What sparked your interest in a Mind Body Medicine/ Mindfulness group?
2. What if anything did you hope to gain from the experience?
3. Were there particular skills that resonated or impacted you, and if so, which ones?
4. Do you practice any of the skills on a regular basis, and how does this effect you?
5. Did participation in the group influence your ability to relate to others? If so, in what way?
    a) Personally- relationship with self
    b) Friends and family
    c) Professionally or in your work
6. What impact if any, did this experience have on your spiritual and/or physical health?
    a) Spiritual
    b) Physical
7. What about this experience was most significant for you?
8. What parts of this experience was least significant for you?

APPENDIX D. COPYRIGHT AND USE ACKNOWLEDGEMENT

May 04, 2020

This letter is to acknowledge that JoAnne Riegert, a graduate of The Center for Mind-Body Medicine's (CMBM's) Professional Training Program and Advanced Training Program, has received comprehensive training in the use of CMBM'S Mind-Body Skills Group model and is authorized to facilitate these groups for other individuals. It is, additionally, permissible for JoAnne Riegert to have utilized the didactic and experiential resources included in CMBM's Advanced Training Manual, and to integrate these resources into the Mind-Body Skills Group she led, as well as into her research for her doctoral dissertation.

JoAnne has obtained permission from CMBM to utilize copyrighted material and has acknowledged CMBM as the source from which utilized materials were garnered.

Gordon, J. S., Fisher, T., Lord, S., Buckley, R., Kimmel, J., & Shinal, A. (2000). The advanced training manual. Washington, DC: The Center for Mind-Body Medicine.

James S. Gordon, MD
Founder and Executive Director of The Center for Mind-Body Medicine
5225 Connecticut Avenue, NW, Suite 414,
Washington, DC 20015
tel. 202.966.7338 fax 202.966.2589
www.cmbm.org