# Risks

In addition to the many positive effects of mindfulness and meditation exercises, as described in the research section (see p. 41 ff.), there are also some potential risks involved if the exercises are not done correctly or if participants have serious mental health issues – although experience indicates this is not a frequent concern in a university context, it's important to address these issues responsibly. Before the program begins, it's essential to discuss key concerns with the participants. Several important points are highlighted below.

The most significant risks are:[1]

- A prior diagnosis of psychiatric, psychosomatic or somatic illnesses/predisposition
- Mental and/or emotional instability
- Overly ambitious goals / the undertaking of meditation techniques that are too demanding
- Practicing meditation without a teacher or group guidance
- Practicing meditation with guidance by inexperienced teachers

## Pre-existing psychiatric illnesses

"Psychiatric illnesses" are understood to mean clinical disorders with a clear disease value such as schizophrenia, psychoses, bipolar disorders, anxiety disorders and depression as well as trauma-related disorders, but also personality disorders such as borderline personality disorder or narcissistic personality disorder. In addition, it makes sense in this context to also consider potentially existing "preconditions" in the sense of physical, psychosomatic or psychosocial vulnerabilities such as epileptic symptoms, ADHD, migraines or addiction/dependency problems. To what extent the use of mindfulness and meditation exercises is even possible with this type of pre-existing condition or predisposition depends on the severity of the impairment and the potential danger from practicing meditation. It has proven a good idea to follow a "traffic light" model, which divides people interested in meditation into categories: "harmless", "potentially endangered" and "most likely endangered and therefore participation in the program not recommended". Although, when in doubt, such concerns can only be confirmed by a course leader with medical or psychological training. Course instructors without this background should therefore not be afraid to openly express their reservations to participants if they themselves are unsure, and recommend that they consult medically/psychologically trained experts who are also sufficiently familiar with meditative practices.

Niko Kohls, medical psychologist and Professor of Health Sciences and Health Promotion and board member of the Society for Consciousness Science and Consciousness Culture, points out that an important criterion for the application of mindfulness-based interventions to psychiatric diseases is the extent to which a sufficiently stable ego structure or ego stability is still present in the person concerned. If this is not the case, interventions cannot work and should not be carried out. In individual cases, the symptoms may even be intensified, such as dissociative processes, depression or anxiety, or in the case of trauma sequelae, the occurrence of stressful memories, known as intrusions.[2]

Kohls – who in addition to conducting and evaluating numerous mindfulness programs in school, university, and work contexts, has also worked with soldiers in the field of mission-related stress management – reports that in highly stressed groups/patients, it's often only basic trust exercises that can initially be applied sensibly. It's only after such an exercise as being carried in water, that low-threshold mindfulness-based interventions, related to everyday life and preferably physical can be useful. This ensures that the duration, depth and quality of meditation correspond to the psycho-emotional competencies and resources of the person concerned. This prevents the development of too early an inner orientation and unintentional confrontation with stressful thoughts and feelings, which in extreme cases could lead to re-traumatization.

In this context, Ortwin Lüers, Ph.D., a specialist in the field of mindfulness-based treatment of trauma, emphasizes that in the case of trauma, the conscious or unconscious steering towards stressful issues can unintentionally enable injuries to resurface, triggering sudden flashbacks. Due to the trauma, a reassessment of the traumatic situation in the present is usually not successful and the result can be dissociation[3] and re-traumatization.[4] Another point that Lüers says must be considered is that people who suffer from chronic psychiatric illnesses, particularly those with long-lasting depression, often also experience profound physical exhaustion. Such chronic psychiatric diseases are emotionally, mentally and above all biologically determined. For this reason, when applying mindfulness exercises, it is crucial not to exceed the participant's available energy level, otherwise the exercise is likely to fail. This failure can quickly lead to negative self-attribution, which places an additional burden on the person concerned.[5] Starting with too much intensity can also lead to the consequence of total demotivation.

According to Lüers, the most important factor for the successful implementation of mindfulness exercises is a pleasant atmosphere that reflects warm-heartedness, acceptance and compassion, so that participants feel no pressure to succeed. Thus, it's not about placing emphasis on a particular goal of the exercise, such as improving attention or stress reduction – these should be promoted only indirectly.

Like Kohls, Lüers also addresses the importance of focusing on the body. In addition, he recommends that the exercise practice for people with pre-existing psychiatric conditions should be designed in such a way that the exercises are suited to a short concentration span and kept short, with no great effort involved. If the therapeutic work involves several people at the same time, it should be done in small groups. The environment should be comfortable and warm, and the eyes should preferably not be closed. Breathing exercises should be kept very simple and should only be briefly performed.[6]

In order to avoid an aggravation of symptoms by the mindfulness-based interventions and the reoccurance of trauma, Lüers believes that professional care by therapists with their own mindfulness and meditation experience is essential for people with trauma.[7]

In his book, *Trauma-Senstive Mindfulness. Practices for Safe and Transformative Healing* David Treleaven, Ph.D., a psychologist, trauma therapist and mindfulness specialist, emphasizes that practicing simple meditation exercises automatically awakens traumatic stimuli. In his opinion, it's important for people to "learn they can shift their focus away from traumatic stimuli during mindfulness practice."[8], therefore it's important that "anchors of attention" such as objects in the room or focusing on the feeling of having one's feet on the floor be used.[9] Treleaven therefore recommends that only short exercises be offered. Body scans, for example, which often take 30 to 45 minutes in the regular MBSR programs[10], are too long for trauma survivors and may trigger anxiety and a feeling of alienation rather than promote relaxation.[11]

Brigitte Fuchs, Ph.D., meditation teacher and private lecturer at the Julius-Maximilians-Universität of Würzburg, warns against too rapid an introduction to meditation techniques when working with those with mental illness. She has developed the concept of "Therapeutic Meditation" for this target group, which consists of eight successive stages and introduces the participants step by step to mindfulness and meditation techniques.[12] Fuchs also advocates for intensive and individually tailored mindfulness and meditation support for those affected.

The Professor of Psychological Sciences and Internal Medicine at Texas University (USA), Yi-Yuan Tang, also points out the potential negative consequences of mindfulness exercises in the case of various conditions: "Regarding patient populations with PTSD, schizophrenia, and epilepsy[13] or individuals who are at risk for psychosis or seizures, some concerns have been raised that mindfulness practice might put these individuals at elevated risk for exacerbation of these symptoms, or trigger adverse events or experiences such as a trauma or depressive episodes."[14] Tang sees a need for further research to better explore the potential applications in this area and the associated risks, due to the limited amount of empirical studies.[15]

Peter Sedlmeier, Professor of Research Methodology and Evaluation, writes in his book *Die Kraft der Meditation. Was die Wissenschaft darüber weiß [The power of meditation. What science knows about it]*: "While there is now widespread agreement that meditation can be helpful in the treatment of depression and anxiety as well as other emotional and psychological problems, there is still controversy over whether it is suitable for therapy in the case of psychoses such as schizophrenia."[16]

In his book *Meditationstiefe. Grundlagen, Forschung, Training, Psychotherapie [Meditation Depth. Basics, Research, Training, Psychotherapy],* Harald Piron, Ph.D., psychotherapist and co-founder of the Society for Meditation and Meditation Research (SMMR) and the Quality Circle for Meditation-Based Psychotherapy, presents a series of exercises that can be applied in a psychotherapeutic context; including the areas of anxiety disorders and depression.[17] However, Piron also sees the possibility of side effects and contraindications for the practice of meditation in a therapeutic context and warns that under no circumstances should the affected person be left alone when incriminating elements emerge from the unconscious.[18]

In his detailed descriptions of suitable meditative exercises for depression, Piron distinguishes between motor, physiological, emotional and cognitive effects.[19] In particular, by promoting an awareness of self-responsibility, meditation can help the affected person to find a way out of depression.[20]

Niko Kohls points out that mindfulness-based interventions are definitely powerful programs that have the potential to achieve highly relevant health-promoting effects. As an example, standardized mindfulness programs for depression, with the exception of severe depression, can even surpass the effect of psychotropic drugs.[21] Among other things, they help the respective person to be more present in the here and now and to be more aware of the current moment and to focus less on negative thoughts. By reducing the wandering of thoughts, so-called mind wandering, through the practice of mindfulness, brooding and worrying usually also decrease.

Another important factor is that mindfulness practice has a positive influence on self-regulation and self-efficacy and that those affected are better able to take countermeasures on their own instead of being dependent on medication.[22] Mindfulness practice can also improve overall mental hygiene.[23]

As for the treatment of depression, loving kindness meditations or metta meditations can also help. These meditation techniques strengthen the connection with the social environment and counteract the subjective feeling of being isolated. According to neuroscientist Richard Davidson, one of the pioneers of mindfulness and meditation research, the experience of social connectedness is an important parameter for a healthy psyche.[24] In contrast, people with depression often experience melancholy and frequently suffer from a feeling of loneliness and exclusion.[25] "Opening the heart invigorates the ability to relate. The experience of being able to give (and as a sick person not only having to take) conveys a feeling of inner richness."[26]

When applying mindfulness and meditation techniques with persons with acute and non-acute psychiatric disorders, it is important that these techniques are not used to replace psychotherapy. If applied without professional psychological and psychotherapeutic experience on the part of the facilitator, there is a great danger that the approaches may have harmful consequences, especially in the case of severe disorders such as schizophrenia and borderline disorders.[27] Piron emphasizes: "Psychotherapy and meditation are not mutually exclusive, but can run side by side on an equal footing. They can even be coordinated to complement each other."[28]

According to Ulrike Anderssen-Reuster, Ph.D., Head of Department for Psychosomatic Medicine in Dresden-Neustadt, this includes that mindfulness and meditation teachers should recognize when participants with mental disorders need to be referred to psychotherapists and vice versa – that psychotherapists enable patients to use such approaches if this is feasible from a standpoint of health, and if these patients show interest in such approaches and/or express the desire to take up such options.[29]

## Health problems without previous psychiatric illnesses/preload

Even if there is no previous psychiatric illness, the practice of mindfulness and meditation techniques can still cause problems. Since these exercises have an effect on the personal development of the respective person, enrtirely new experiences can sometimes arise, which are not always positive. This can include experiencing a certain emptiness and loneliness or the relativization of previous habits and views. Likewise, it can increase sensitivity in sensory perception, which can create more stress.[30]

Piron sees the potential for abuse and the risks that can arise on the part of the meditator during the practice of mindfulness and meditation, such as when the practice reinforces one's own ego-centeredness; when it is used too much as self-optimization; when it is used to repress one's own deficits; or when the practitioner devotes himself too submissively to a spiritual teacher.[31]

Sedlmeier, too, cautions against engaging in the evasion of one's own deficits:"However, one should under no circumstances try to ignore one's emotional difficulties and psychological problems, attempting to solve them in the meditation fast lane: spiritual bypassing won't work."[32]

To enable more insight into the practice of meditation and the possible occurrence of spiritual crises, Michael Tremmel and Ulrich Ott, Ph.D., psychologists and mindfulness and meditation researchers at the Bender Institute of Neuroimaging at the Justus Liebig University Giessen, argue for professional systematization and categorization: "In the long run, new diagnostic categories are needed to deal properly with the variety of meditative development processes and possibly crisis-prone transitional phenomena."[33]

## Munich model: dealing with psychiatric pre-illness/preload

The first priority when applying mindfulness and meditation exercises in a university context is to reduce any potential risks so that participants do not come to harm. It must be clarified in advance whether acute or non-acute psychiatric pre-existing conditions are present.

The instructor bears a great deal of responsibility here. In the event that the instructor is not trained in medicine, psychology or psychotherapy, they should contact the psychosocial counseling service at the university if they detect any signs of previous psychiatric illnesses/conditions.

In the case of the Munich Model, participants for the respective mindfulness and meditation programs are selected through an online application process. All course descriptions state as a prerequisite that participants must be in stable mental health.

For the advanced courses, participants must also prove that they already have previous experience in meditation. This can include having attended an introductory course on "Mindfulness and Meditation" or another offering within the framework of the Munich Model, or one's own practice at a recognized meditation school.

Since the summer semester of 2020, a fact sheet is handed out to the participants in the first lesson which asks them to verify the state of their emotional and mental health. This fact sheet explains the practice of mindfulness and meditation in summary form. The participants are then required to sign an agreement that states they are not currently undergoing psychiatric or psychological treatment and are not taking psychotropic drugs. In the case of a previous psychiatric illness or condition, they must first consult with the treating therapist and present a certificate in order to be able to participate in the respective course.[34]

There are basically several ways of confirming the participants' mental health in every program offered under the Munich Model: firstly, in the question and answer session of the introductory lesson and secondly, in the group discussions that follow the exercises. There's also a third opportunity in the regular courses: in reviewing the students' meditation journals.

In the first teaching unit there is a question and answer session which asks students to answer: why did they sign up for the course? What do they expect to get out of the course? Do they already have experience with mindfulness and meditation techniques? There is also a discussion of what mindfulness and meditation involves, and specifically what meditation is not as well as defining some of the prevalent misconceptions about it.[35] In particular, emphasis is placed on the fact that meditation is not about ambition or ambitious intentions and achievement. The importance of health and a stable mental condition is also explained. Anyone who is uncertain about this and has personal questions can talk to me about it in detail after class.

Secondly, after the exercises in the framework of the program, regular feedback sessions are held in small groups and then in the entire group. In this way it is possible to observe how the participants cope with the respective exercises. Moreover, they can also learn from each other how to practice the exercises correctly and how to deal with any difficulties.

As part of the regular courses, the meditation journals are handed in for a week in the middle of the semester. I then read them and thus have an additional opportunity to check how the participants are coping with the respective exercises. Possible corrections to the exercises are then discussed as feedback during the courses. This happens anonymously; by sharing the individual difficulties in the whole group, the other participants can also learn from them. In the case of serious problems, a personal one-on-one conversation takes place with the respective participants, for example, directly after class or during office hours.

A private, personal conversation with the instructor is always available to the participants. Therefore, in addition to professional competence, the factor of trust between teachers and participants is very important (see p. 81).

To date, among the 2000 participants that have taken part in the courses through the Munich Model, there has only been one student who had to leave the course a result of acute trauma.

Even in the additional open courses, which are freely accessible to all students, only a few have thus far been denied participation. These were not properly "grounded". After a personal conversation, they were advised to meditate less or not at all for a certain time. They were given instructions for everyday mindfulness exercises in order to become more firmly established in normal (everyday) life. They were always given the opportunity to re-register for the program after a certain period of time.

In recent years, more and more participants with physical limitations, including wheelchair users, have applied for the courses. As each of them had a stable mental and emotional condition, they were welcome to participate. This has enormously enriched the courses. Some exercises had to be adapted for them, for example, a walking meditation became a "roll meditation", which was a heartfelt experience for the other participants. The group discussions about how to deal with problems and stressful thoughts also became more profound. Once a blind student also took part in a course. All the participants were impressed by the way she described her experiences during meditation.

## Too ambitious goals/ Too demanding meditation techniques

Another risk is that participants want to achieve too much at once and engage in the exercises too rashly and excessively. This problem can be exacerbated in the regular courses, where credits including grades and ECTS are also awarded. I try to defuse the risk of being overly motivated by making it clear to the participants that it is about quality and not quantity. It's about getting to know oneself better through the practice of mindfulness and meditation and to listen well to one's own inner voice. Above all it's about gaining more insight into one's own mental, emotional and physical processes and their interactions. For example, at what time of day do I like to meditate, or when not? Why does meditation sometimes go better and sometimes less well?

Ulrich Ott points out that people with overly ambitious goals run the risk of becoming too far removed from reality, of becoming unmoored and "hovering two centimeters

above the ground"[36]. In extreme cases, this could lead to depersonalization and derealization syndrome, whereby the person in question loses touch with himself and his environment. According to Ott, in this case it is advisable to reduce or suspend meditation for a certain period of time. In the first instance, it is then a matter of becoming more down-to-earth again, for example through physical activity such as gardening. A balanced, healthy diet is also important. Even a "hearty meal" can be helpful in some cases.[37]

In addition to the risk of intensity of effort being far too high, there is also the risk of choosing techniques that are too demanding and overtaxing. This is often the case when meditation beginners sign up for longer silent retreats. The risk of overstraining is particularly high when there is also too little sleep and too little food. Ott compares the path of meditation exercise with mountain climbing: "If you want to reach the top happily, you have to plan the path well."[38]

Within the framework of the Munich Model, the practiced mindfulness exercises can be performed well and safely without the risk of overexertion. As far as the more intensive sitting meditations are concerned, the meditation times are increased gradually and according to the level of experience of the participants. If at the beginning the sitting meditation is done for only a few minutes, from the middle of the series of classes it lasts 15 to 20 minutes. For home practice it is also recommended that the meditations not exceed 20 minutes. If participants wish to delve deeper into a particular meditation form, it is recommended they attend recognized, certified meditation schools where they can familiarize themselves with more advanced meditation techniques under the guidance of professional teachers.

Some 50 students from the Munich Model courses, for example, have now studied the "Vipassana" form of meditation and have participated in 10-day retreats at external meditation centers. Other participants have received further training through MBSR courses or have studied Christian meditation forms and Zen techniques during monastic stays. Some have also visited centers such as the Inter-Sein of Thich Nhat Hanh or the Munich Sri Chinmoy Center.

## Practicing meditation without guidance by teacher or group

A further risk when dealing with meditation can also arise if one tries to learn certain meditation exercises by oneself and thus receives no feedback to ensure one is doing the exercises correctly. In this case, the important dialogue about this is also lacking. It becomes particularly problematic if, in addition, there are also risks such as pre-existing psychiatric illnesses, overly ambitious goals and other personal characteristics that are non-conducive to meditation. As explained above, in such cases the guidance of a teacher is necessary.

In general, professional guidance is preferable, especially if one wants to intensify and deepen the practice of mindfulness and meditation.[39] If one also practices regularly in a group or community (sangha[40]), one has the opportunity to exchange experiences.[41]

In the context of the courses offered by the Munich Model, considerable emphasis is placed on group exchange. This is especially the case in the courses where participants meet weekly. In conversation with an established group, the participants can learn more about the successes and difficulties of the others.

## Practicing meditation with guidance by inexperienced teachers

Harald Piron describes in his already mentioned handbook a number of qualitative criteria which can be helpful in the search for a suitable meditation program; he lists among others: the qualification of the teacher, the authenticity of the school and transmission, the organizational structure and they way they present themselves, their openness to science and research, as well as entrance fees and participation fees.[42]

These criteria are important because meditation techniques have a strong impact on the overall mental health of the individual. "For obvious reasons, extreme caution is therefore required when attempting to influence instinctive physical processes such as breathing or heartbeat. An abuse of the physical process can ruin a person's health and considerably disturb his mental balance, hence the great importance of a reliable guide."[43]

As explained in the sections "Research" (p. 41 ff.) and and "Conclusion" (p. 169 f.), an essential point for a successful implementation of mindfulness and meditation programs is the way they are taught. A distinction must be made between the teaching of basic mindfulness exercises and the teaching of meditation techniques.

For teachers and lecturers, there are various training and continuing education opportunities, for example, the MBSR training courses or the certificate training courses on the topic of "Mindfulness in Teaching" as offered by the universities in Jena and Osnabrück (see p. 65 and p. 170). If, however, more inwardly directed sitting meditations are taught, the meditation teacher must also have many years of experience. Piron writes: "Only after he has thoroughly studied and examined the meditative path by himself and with other companions, and then comes to the conclusion that it does not seriously harm anyone, but helps in many ways, if it is followed in the right way, can he teach this kind of practice with a clear conscience."[44]

Within the framework of the Munich Model, instructors need several years of meditation experience as well as proven participation in silence retreats to teach the sitting meditations. Several times during the semester, exchange meetings take place among the lecturers at which teaching experiences and related topics are discussed.

A good teacher should above all be authentic. "What matters is that something of the path he himself has taken for the greater part of his life so far shines through him or is expressed in him in an authentic way."[45]

## Conclusion

Despite the risks highlighted in this section, which can lead to harmful consequences if mindfulness and meditation approaches are not applied correctly or if participants have serious mental health issues, the numerous positive effects speak for themselves. In the last two decades in particular, mindfulness and meditation research has scientifically proven that mindfulness and meditation promote, for example, mental hygiene, concentration and attention, emotion regulation and a constructive approach to stress (see p. 46 ff.).

The ten years of the Munich Model have also confirmed the scientific research findings to date. I have observed numerous positive effects of mindfulness and meditation, which became evident through observations in class, in discourses with participants and in the reading of meditation journals. If the above-mentioned points regarding risks are taken into account, there is, in my opinion, no reason not to start practicing mindfulness and meditation techniques. It would be unfortunate if students who show a sincere interest in them were denied this opportunity.[46]

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[1] Cf. Piron 2020, p. 214 ff.; Hofmann / Heise 2017; Tremmel / Ott 2017; Ott 2018, p. 64 ff.; Fuchs 2011, p. 223 ff.; Sedlmeier 2016, p. 174 ff.; In terms of risk research, Brown University (USA) has created a Meditation Safety Toolbox with a series of documents, protocols and best practice guidelines from the UMass Memorial Center for Mindfulness, the Mindfulness Centers in Bangor and Oxford, as well as other mindfulness researchers. It is available at: **https://www.brown.edu/research/labs/britton/meditation-safety-toolbox** (accessed September 13, 2020). On the subject of "Spirituelle Krisen und Krisenbegleitung" see also Tremmel / Ott 2017, p. 242.

[2] Telephone interview with Professor Niko Kohls on April 5, 2020. See also Piron 2020, p. 217.

[3] For possible signs of dissociation and cushioning measures see Treleaven 2018, p. 140 ff.

[4] Skype interview with Ortwin Lüers, Ph.D., on April 5, 2020.

[5] Cf. Treleaven 2018, p. 143 f.

[6] Skype interview with Ortwin Lüers, Ph.D., on April 5, 2020. For criteria of mindfulness-based methods as therapy for people with psychotic disorders, see also Sedlmeier 2016, p. 187 f.

[7] Lecture "Meditation bei Traumafolgestörungen. Grenzen und Möglichkeiten" on the 16th SMMR-day "Meditation und Mitgefühl", October 7-9, 2016. Also Skype interview with Ortwin Lüers, Ph.D., on April 5, 2020.

[8] Treleaven 2018, p. 113.

[9] Cf. Treleaven 2018, p. 113.

[10] For an introduction to Mindfulness-Based Stress Reduction (MBSR) see Kabat-Zinn 2013.

[11] Cf. Treleaven 2018, p. 143.

[12] Cf. Fuchs 2011, p. 226 ff.

[13] In the case of epilepsy, a reduction in the number of seizures has also been reported in some cases, but there are not yet sufficient research results available (cf. Tremmel / Ott 2017, p. 235).

[14] Tang 2017, p. 89.

[15] Cf. Tang 2017, p. 89. A short study conducted by the University of Wiscon-Madison and the Center for Healthy Minds under the direction of Richard Davidson showed, for example, that special breathing exercises in the case of war veterans with PTSD reduced sleep disorders and dependence on psychotropic drugs for a number of study participants (see Ambo 2013).

[16] Sedlmeier 2016, p. 186 f. [Author's translation].

[17] See Piron 2020, p. 177 ff. 23; For a cognitive therapy for bipolar disorder based on mindfulness interventions see Deckersbach, Tilo / Hölzel, Britta / Eisner, Lori / Lazar, Sara W. / Nierenberg, Andrew A. (2014).

[18] Cf. Piron 2020, p. 214 ff.

[19] Cf. Piron 2020 p. 188 ff.

[20] Cf. Piron 2020, p. 194 f.

[21] Lecture "Achtsamkeit – Konzept, Forschungsstand und Messung" at LMU Munich, November 2013.

[22] For the effect of self-control on depression see Tang 2017, p. 69 f.

[23] For a cognitive therapy for depression based on mindfulness interventions see Segal / Williams / Teasdale 2018.

[24] See lecture and panel discussion "We can change the brain, by changing the mind" on March 19, 2019a, Professor Richard Davidson in Munich at the Forum für den Wandel of the Edith-Haberland-Wagner Foundation, www.ehw-stiftung.de (acessed September 13, 2020); see also Davidson 2018.

[25] Cf. Anderssen-Reuster 2015, p. 111; see also Panel Discussion "We can change the brain, by changing the mind" March 19, 2019a, Erick Rinner MBA, in Munich at the Forum für den Wandel of the Edith-Haberland-Wagner Foundation, www.ehw-stiftung.de (accessed September 13, 2020).

[26] Fuchs 2011, p. 228 [Author's translation].

[27] Cf. Sedlmeier 2016, p. 102 f.

[28] Piron 2020, p. 221 f. [Author's translation]; see also Hölzel / Brähler 2015, p. 12 f.

[29] Cf. Anderssen-Reuster 2015, p. 112; see also Treleaven 2018, p. xxv.

[30] Cf. Tremmel / Ott 2017, p. 235 f.; see also Kohls 2017, p. 10 ff.

[31] Cf. Piron 2020, p. 220 ff.; see also Hofmann / Heise 2017, p. 146 ff.

[32] Sedlmeier 2016, p. 193 [Author's translation].

[33] Tremmel / Ott 2017, p. 242 f. [Author's translation].

[34] This approach has been successfully practiced by Professor Niko Kohls for many years in his mindfulness and meditation courses at the Coburg University of Applied Sciences and Arts. For MBSR courses, prospective students initially receive a questionnaire when they register, which is used to check, among other things, whether they have ever had suicidal thoughts and/or depression.

[35] Cf. Gunaratana 2019, p. 11 ff; see also Ricard 2015c, p. 31 f.; for misunderstandings regarding mindfulness meditation see Tang 2017, p. 75 ff.

[36] Ott 2018, p. 67 [Author's translation].

[37] Cf. Ott 2018, p. 67.

[38] Ott 2018, p. 66 [Author's translation]; see also Tremmel / Ott 2017, p. 241.

[39] Cf. Sedlmeier 2016, p. 193.

[40] Cf. Thich Nhat Hanh 2013, p. 7 ff.

[41] Cf. Ott 2018, p. 66 f.

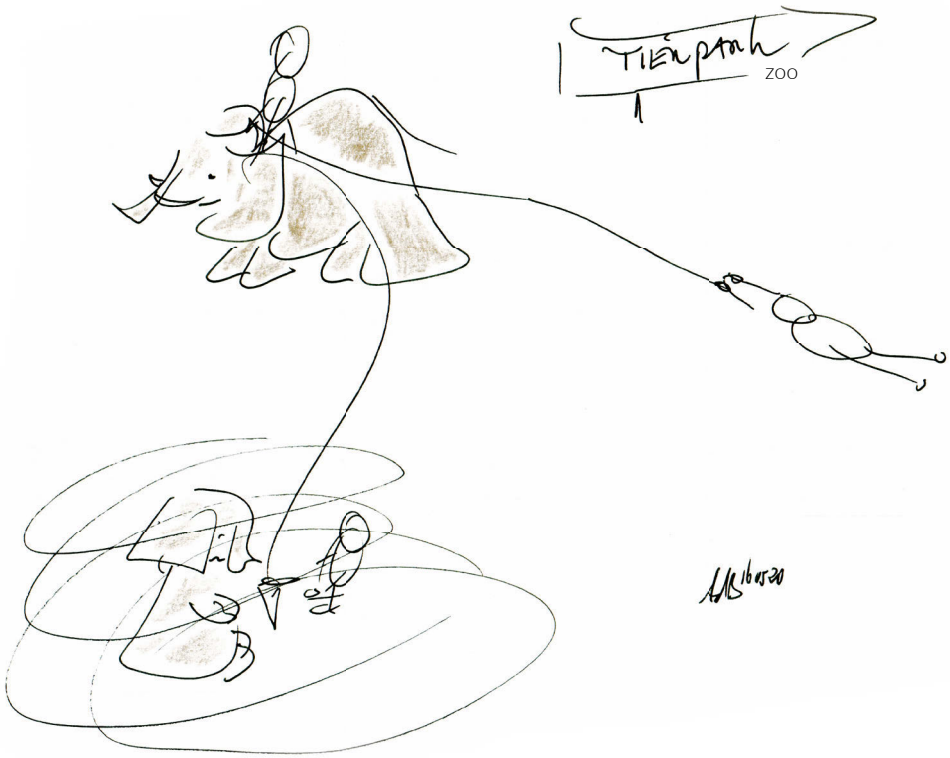
[42] Cf. Piron 2020, p. 226 ff.

[43] Ware / Jungclaussen 2002, p. 60 f. [Author's translation]; cf. Hofmann / Heise 2017, p. 151.

[44] Piron 2020, p. 227 [Author's translation].

[45] Piron 2020, p. 226 [Author's translation].

[46] Cf. Sedlmeier 2016, p. 194; see also Ott 2018, p. 67 und Piron 2020, p. 217.




How do you catch
an elephant?