

Article 14

**Mindfulness Matters: Practices for Counselors
and Counselor Education**

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Introduction

Effective counselors employ an array of skills. Carl Rogers (1975) believed that the counselor's ability to be congruent, accepting, and empathic is necessary for clients to be able to change, and these skills are routinely taught in counselor education. Later in his life, Rogers also articulated the need for a quality of presence that is an essential aspect of client-centered therapy. In an interview published by Baldwin (2000), Rogers referred to the essential nature of presence, of the counselor's "being":

I am inclined to think that in my writing I have stressed too much the three basic conditions (congruence, unconditional positive regard, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is very clearly, obviously present. (p. 30)

This therapeutic presence is more a quality of relationship than a set of skills, and it is more difficult to introduce into counselor education programs than basic skills training.

There is abundant research evidence that empathic responding and related skills can be taught by combining instruction, modeling, and feedback. While easily taught, these skills are not necessarily internalized by students (Lambert & Ogles, 1997; Lambert & Simon, 2008). Greason and Cashwell (2009) concluded from their review of literature that counselor education training has focused on external and observable behaviors such as mirroring and reflection of feeling rather than cultivating the internal habits of mind needed to control attention and respond with both cognitive and affective empathy. In addition, other counselor educators have noted that students' development of cognitive complexity has been a haphazard process and piecemeal (Choate & Granello, 2006; Fong, Borders, Ethington, & Pitts, 1997). Mindfulness practices have been used to train

other health care practitioners in attention and empathic response and may be useful in counselor education programs. The purpose of this paper is to describe the characteristics of mindfulness, review the literature on mindfulness practices used in the education of health care practitioners, offer several exercises that can be used in counselor education as means of developing mindfulness, and encourage research into this promising educational practice.

What Is Mindfulness?

Kabat-Zinn (1994) described mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (p. 4). This is a human capacity that was described by the American psychologist William James (1890) as essential for excellence in education:

The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgment, character, and will. No one is *compos sui* if he have it not. An education which should improve this faculty would be the education par excellence. But it is easier to define this ideal than to give practical directions for bringing it about. (p. 424)

While it may have been true in James’ time that there were few practical directions for training attention so that one could be “master of one’s self,” mindfulness practices developed in a number of religious and contemplative traditions are now widely available and the subject of numerous research studies.

Mindfulness includes concepts such as awareness, attention, and consciousness, all of which defy decades of Western scientific efforts to refine and achieve consensus definitions. For example, contemporary researchers in Western psychology have defined mindfulness as a self-regulatory capacity (Brown & Ryan, 2003), a skill involving acceptance of one’s internal experiences (Linehan, 1994), and a skill of meta-cognition (Bishop et al., 2004). Brown, Ryan, and Creswell (2007) described mindfulness as a “receptive attention to and awareness of present events and experience” (p. 212). Mindful processing involves a state of mind wherein attention is kept to a bare registering of the facts observed. This is contrasted with a conceptual mode of processing in which cognitive schemas, beliefs, and opinions are imposed, often automatically, on everything encountered.

Even with the lack of definitional clarity, the practice of mindfulness skills has been found to lead to increases in self-focused attention as well as changes in characteristics of attention so that it becomes less biased, more flexible, and nonreactive. Mindfulness is an important building block that facilitates change in the emotional realm (Davidson, 2010). Dispositional mindfulness as well as mindfulness interventions consistently have been found to be associated with a number of measures of emotional well-being (Greeson, 2009). Mechanisms of action in this inverse relationship between mindfulness and psychological distress also have been investigated and include a mediating role for rumination and non-attachment (Coffey & Hartman, 2008; Jain et al., 2007; Ramel, Goldin, Carmona, & McQuaid, 2004), experiential avoidance (Lavender, Jardin, & Anderson, 2009), and cognitive reactivity (Raes, Dewulf, Van Heeringen, & Williams, 2009). Self-regulation of emotions through greater emotional awareness, acceptance, and the ability to correct or improve unpleasant mood states are additional

pathways suggested by other researchers (Baer et al., 2008; Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007).

Over the past 20 years, the practice of mindfulness has been increasingly used to treat a range of mental health disorders including depression, anxiety, substance abuse, eating disorders, attention deficit disorders, and personality disorders (reviewed by Baer, 2003). Aspects of mindfulness practice have been incorporated into Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Mindfulness-based Cognitive Therapy (Segal, Williams & Teasdale, 2002), Addiction Treatment and Relapse Prevention (Marlatt & Gordon, 1985), Dialectical Behavior Therapy (Linehan, 1993), and Mindfulness-based intervention for Eating Disorders (M-BEAT; Kristeller & Hallett, 1999; Wolever, 2009).

In addition to the practice of mindfulness in mental health treatment, there is tantalizing evidence from a recent randomized controlled trial that clinicians who develop mindfulness through the practice of meditation have clients with better outcomes compared to clinicians who don't have a meditation practice (Grepmaier et al., 2007). This study examined the course and treatment results of 124 mental health inpatients treated for 9 weeks by 18 psychotherapists-in-training. Half of the therapists were randomly assigned to be part of a meditation group, and the other half did not practice meditation. The patients also were randomly assigned to the meditating or non-meditating therapists. Patients assigned to the therapists who meditated showed significantly better results than patients assigned to therapists who did not meditate on measures of somatization, insecurity in social contact, obsessiveness, anxiety, anger/hostility, phobic anxiety, paranoid thinking and psychoticism. No significant differences in outcome were found between the two groups on measures of their perception of distrust and the feeling of being used (paranoid thinking). In addition to the health benefits that come with meditation for clinicians themselves (e.g., Greeson, 2009; Hoffman, Sawyer, Witt, & Oh, 2010), promoting mindfulness in mental health counselors shows promise as a useful tool for improving the treatment results of their clients.

Mindfulness in Health Care Education

There is growing interest in mindfulness to develop relational skills of health care providers. Several authors have advocated the importance of mindfulness in the cultivation of healing presence in physicians (Epstein, 1999; McDonough-Means, Kreitzer, & Bell, 2004). The research base for the effectiveness of mindfulness in the training of health care providers in the United States began in the 1970s. Lesh (1970) found that counseling psychology students who engaged in a meditation intervention were able to demonstrate increased empathy in comparison to students who were on the wait-list. Shapiro and Brown (2007, as cited in Shapiro & Izette, 2008) reported that counseling psychology students who went through the eight-week Mindfulness Based Stress Reduction course (MBSR; Kabat-Zinn, 1990) significantly increased in empathy. These results were similar to those of a randomized controlled study of medical students (Shapiro, Schwartz, & Bonner, 1998) and a study of nursing students (Bruce, Young, Turner, Vander Wal, & Linden, 2002). Mindfulness facilitates empathy through (a) reducing stress, (b) increasing self-compassion, and (c) loosening identification with personal subjective experience. Although not specifically about mindfulness as a training

practice, Greason and Cashwell (2009) surveyed 179 master's level counseling interns and doctoral counseling students to determine their levels of mindfulness, attention, empathy and self-efficacy. In this study, mindfulness was a significant predictor of counseling self-efficacy and attention was a mediator of that relationship.

Several different approaches to incorporating mindfulness training into the curriculum of mental health practitioners have been reported including integrating mindfulness into existing courses (Gehart & McCollum, 2008; McCollum & Gehart, 2010), a 6-week curriculum (Kramer, Meleo-Meyer & Turner, 2008), and a complete 3-unit course (Schure, Christopher, & Christopher, 2008).

Integrating Mindfulness Into the Curriculum

Gehart and McCollum (2008) introduced mindfulness into both of their marriage and family therapy education programs, one accredited by the Council for the Accreditation of Counseling and Related Programs (CACREP), and one accredited by the Commission for Accreditation of Marriage and Family Therapy Education (COAMFTE). The mindfulness practices fit within two-semester practicum courses which are their students' first clinical experiences. Instruction began with a rationale for integrating mindfulness into the curriculum. Students were required to engage in 5 minutes of a mindfulness practice for 5 days a week and journal about their experiences. In-class discussion and in-class guided and unguided meditations were also included in the course. Themes from a qualitative study of students' experiences in these courses included students' increasing ability to be present in sessions (McCollum & Gehart, 2010). Students' also reported being better able to balance being and doing modes in therapy as well as developing acceptance and compassion for clients and themselves.

A Six Week Training Module

Kramer et al. (2008) described a six week Interpersonal Mindfulness Program (IMP) based on Insight Dialogue (ID), a formal practice of interpersonal meditation. Their meditation instructions/guidelines are to Pause, Relax, Open, Trust Emergence, Listen Deeply, and Speak the Truth. In a practice session, after some individual meditation, participants pair up and a contemplation topic is introduced. An example could be the topic of aging or dealing with disappointment. Partners trade roles talking about the topic and mindfully listening, bringing awareness to thoughts, emotions, and body sensations as they arise in the moment. During the dialogue a bell is rung occasionally to bring the meditators back to silent mindfulness and help further establish the meditative quality of their interactions. A loving kindness meditation is used at the close of each IMP class period and ID sessions.

A Complete Course

Schure et al. (2008) described a 4-year qualitative study on the influence of teaching hatha yoga, meditation, and qigong to counseling graduate students. Participants in the 15-week, 3-credit mindfulness-based stress reduction course reported positive physical, emotional, mental, spiritual, and interpersonal changes and substantial effects on their counseling skills and therapeutic relationships.

Experiential Exercises

Experiential exercises demystify the concept of mindfulness and create opportunities for practicing mindfulness in the counselor education curriculum as well as daily life. Initial practice in group settings is beneficial in normalizing the discovery of how active and distracted our minds typically are as well as normalizing the difficult emotions and thoughts that can be noticed by participants. The first two exercises can be practiced alone. If practiced alone, decide on a brief period of time, 5 to 10 minutes, to devote to this practice. Find a place where you will not be disturbed by others, and set a timer with a gentle alarm so that you can devote your attention to the object of mindfulness.

Mindfulness of Breathing

Attending to the sensations of breathing is a time-honored way to bring your attention back to the present moment, because the breath is a constant part of living. Assume a sitting posture that will encourage alertness with eyes either closed or opened. Set an intention to be kind towards yourself and draw your attention to the sensations of breathing. What are the qualities of your breath: shallow or deep, fast or slow, ragged or smooth? Where in the body do you notice the sensations of breathing: coolness or warmth in the nostrils or back of the throat, the rib cage rising and falling, the diaphragm sinking and rising? Your attention will inevitably wander, and when you notice this, congratulate yourself on noticing that your mind has wandered. This is how you train mindfulness. Gently bring your attention back to the sensations of breathing.

Mindfulness of Eating

Bringing mindful awareness to the food we eat is another practice that is fairly easily incorporated into daily life since we must eat to live. As you begin this practice, set an intention to be accepting towards yourself and your experience. Devote your attention to each moment of the process of eating. Place a few raisins in your hand. If you don't have raisins, any food will do. Imagine that you have just arrived from planet Mars and you have never eaten this food before. Explore the food with your senses before you put it in your mouth. What do you smell? What do you see? What do you feel? What do you hear? Before you place the food in your mouth, become aware of the impulse to move the food towards your mouth. Refraining from biting into the food, place the food in your mouth and notice how the food enters your mouth. How does it come to contact your tongue or palate? What is the texture, the smell, the taste of the food? Is there a point in time that more saliva collects in your mouth? When you're ready, intentionally bite down on the food and continue to notice the textures, smell, and taste of the food. Chew slowly enough so that you can be aware of how the food changes in consistency and taste as you chew. Before you swallow, become aware of the intention to swallow. See if you can notice the sensations of swallowing the food, sensing the movement down your throat towards your stomach. If at any point your attention wanders from the sensations of eating, gently bring your awareness back to the present moment and the sensations of eating. It is the practice of bringing the attention back to the present moment, over and over again, that strengthens our human capacity for mindfulness.

Mindfulness of Communication

This two-person exercise is useful in basic skills classes to teach the importance of being fully present and mindful while listening to another person. The first part of this exercise involves one partner being purposefully mindless, and the second part involves being purposefully mindful. At first, partner A will share something significant about his or her day, and partner B will try to be mindless, doing whatever he or she normally does to disconnect during communication. This can be accomplished in a very short period of time (30 seconds). Partners can then switch roles. Debriefing questions for this part of the exercise can be focused on what the partners noticed, what they did in order to be mindless, and how easy or difficult it was. The second part of the exercise involves mindful listening. Partner A again shares something significant about his or her day, and partner B will listen mindfully, as fully present to the communication as possible. Partners then again switch roles. Debriefing questions can again be focused on what the partners noticed, what they did in order to be mindful, and how easy or difficult it was. How were the conversations similar and how were they different?

Final Considerations

While mindfulness meditation practices were initially part of a religious or spiritual context, these practices can be taught without reference to their religious roots. In secular educational settings, this distinction is important to avoid placing students in the position that they are being forced into a religious practice. Before incorporating mindfulness practices into the counselor education curriculum, students need a rationale for engaging in practices that don't initially appear to be relevant to the practice of counseling. This rationale can include the importance of self-care for clinicians as well as the impact of the practices on development of empathy. In addition, an ongoing practice of mindfulness is important for developing an experiential understanding of the mindfulness based interventions used in mental health clinical practice.

The field of research into the effectiveness of mindfulness in counselor education is wide open. We need to know which forms of practice may be most effective in the counselor education curriculum as well as how much practice is needed and the timing of practice. Further research can help counselor educators deliver mindfulness training components more effectively.

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