

AN ABSTRACT OF THE DISSERTATION OF

Mark D. Stauffer for the degree of Doctor of Philosophy in Counseling presented on December 17, 2007.

Title: Mindfulness in Counseling and Psychotherapy: A Literature Review and Quantitative Investigation of Mindfulness Competencies

Abstract approved:

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There is substantial interest in the application of mindfulness in counseling and psychotherapy. The appeal of mindfulness training and mindfulness-based interventions has increased as research continues to demonstrate benefits. Mindfulness practice has not only been effective in clinical applications with clients, but has also been conceptualized as beneficial for counselors and psychotherapists. Counselors are required to adhere to the ethical codes and standards of counseling related professional associations by practicing in a new specialty area only after appropriate education and training experience. With the desire to apply this new specialty area of counseling, educational opportunities are being offered by academic institutions, training programs and literature geared to counseling and psychotherapy professionals. Recommendations and qualifications can be found in the literature for specific mindfulness training programs and therapies, however, no set of competencies for mindfulness training have been proposed for the general or integrative practices of counseling and psychotherapy.

The purpose of this dissertation study is to produce two manuscripts related to mindfulness in counseling and psychotherapy, and importantly, explore what it means to be competent to provide mindfulness training to clients. The dissertation investigated to what extent experts (N=52) agreed with a proposed set of 16 mindfulness competency statements. The mindfulness competency survey was investigated for reliability and validity. In conjunction with recommendations in the professional literature on mindfulness trainer qualifications, this research suggests that experts on mindfulness in counseling and psychotherapy, in general, agree with the 16 proposed competency statements.

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Mindfulness in Counseling and Psychotherapy: A Literature Review and Quantitative
Investigation of Mindfulness Competencies

by
Mark D. Stauffer

A DISSERTATION

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Mark D. Stauffer, Author

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CONTRIBUTION OF AUTHORS

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CHAPTER I: GENERAL INTRODUCTION

Dissertation Overview

The purpose of this dissertation study is to demonstrate scholarly work by using the *manuscript document dissertation format* as outlined by the Oregon State University Graduate School. In following this format, chapter 1 provides explanation as to how two journal-formatted manuscripts found in chapters 2 and 3 are thematically tied and build toward research conclusions pertinent to counseling. Chapter 2 is a literature review titled, *A Review of the Literature on Mindfulness in Counseling and Psychotherapy*, and chapter 3 presents quantitative research in a manuscript entitled, *Mindfulness Competencies for Counselors and Psychotherapists*. Both of these manuscripts focus on the construct of mindfulness. In short, manuscripts thematically converge on the application and competent use of mindfulness in counseling and psychotherapy. Mindfulness is a process of intentionally placing attention on present moment experience with an orientation that is characterized by non-evaluative observation and curiosity (Allen et al., 2006; Bishop et al., 2004; Shapiro, Carlson, Astin, & Freedman, 2006). Empirical evidence suggests that mindfulness-based interventions are efficacious for numerous physical and mental health concerns (Baer, 2003; Bonadonna, 2003; Grossman, Niemann, Schmidt, & Walach, 2004; Shigaki, Glass & Schopp, 2006). The first scholarly manuscript of this dissertation is a literature review that provides background, definition and theoretical underpinnings of mindfulness and also reviews research implicating the benefits of counselor and therapist mindfulness practice. The second manuscript presents descriptive research on a survey of mindfulness experts about their perceptions of mindfulness competencies for counselors and psychotherapists

training clients in mindfulness. Chapter 4 provides a general conclusion to this dissertation study, which suggests that the research literature and experts, in general, agree that sufficient education and personal practice of mindfulness are necessary for providing mindfulness training to clients. Suggestions for future research are also included.

Thematic Introduction

The purpose of this dissertation study is to explore the construct of mindfulness and *mindfulness training* (MT) of clients in counseling and psychotherapy. MT is a loosely defined term referring to a program of study in mindfulness and usually includes the practice of multiple mindfulness methods. These manuscripts converge on the construct of mindfulness and the use of mindfulness in counseling and psychotherapy. Two important components of this theme are, first, the education of counselors and psychotherapists to train clients in mindfulness, and second, mindfulness training competencies for the general and integrative practitioner.

Mindfulness was chosen as the focal point of research because of its relevance as an emerging technique in counseling and psychotherapy. The survey on mindfulness competencies was conducted because there is a perceived need for such guidance and standards. This perception was formed by the author as a result of experiences as an instructor and in review of the professional literature on mindfulness (e.g., Dimidjian & Linehan, 2003). Importantly, the topic has much personal relevance to the author, who has practiced these methods for over a decade, trains counselors in these methods and is vitally interested in the responsible and replicable application of these ancient methods in the realm of counseling and psychotherapy.

The theoretical and empirical literature suggests substantial interest in mindfulness (Allen et al., 2006; Baer, 2003; Grossman et al., 2004; Kabat-Zinn, 2003; Shigaki et al., 2006). Mindfulness practice is being adapted from the Buddhist tradition and is finding wide acceptance as a technique for clients to improve well-being, mental and physical health and in dealing with symptoms of disorder. Naturally, as mindfulness training produces compelling results as noted by empirical research, its promise for the field of counseling and psychotherapy grows as does the demand and opportunities for counselors and psychotherapists to receive the necessary instruction to train clients (Capuzzi & Stauffer, 2006; Christopher, Christopher, Dunnagan, & Schure, 2006; Germer, Siegel, & Fulton, 2005; Stanley et al., 2006).

The implications of this research extend beyond the realm of counselor education. The research described in these manuscripts are relevant for counseling and psychotherapy, and so have a broad use for those whose professional degrees relate to counselor education, psychology, general medicine, social work, psychiatry, and nursing among others.

The first manuscript, a literature review, examines the potential value of mindfulness methods for clients, counselors and the field of counseling. Review of the relevant literature in this first document contains information regarding the history of mindfulness, the construct of and important definitions related to mindfulness, a brief introduction to its use in health and mental health settings, an examination of its potential as a method to improve counselors' therapeutic qualities and attributes, educational opportunities for counselors and psychotherapists wishing to train clients in mindfulness

methods, and finally, a brief introduction to the need for competencies related to training clients to use mindfulness methods.

The second manuscript highlights the need for expert recommendations on how to be competent to provide clients with mindfulness training. Professional literature, university courses, professional sessions at conventions and textbooks devoted to educating counselors and psychotherapists in mindfulness-based techniques attest to a growing demand by the field for mindfulness training and mindfulness-based interventions. As with many arenas in the counseling field, if specific expertise is required for an intervention or for working with a specific population, then there is an ethical mandate to be competent in that specific expertise (American Counseling Association [ACA], 2005, A.9.b, C.2.a; American Psychological Association [APA], 2002, 2.01). Furthermore, whenever new specialty areas are adopted appropriate education, training and supervision experiences are needed before working with clients in that specialty area (ACA, 2005, C.2.b.; APA, 2002, 2.01c). Recommendations on how to be competent or qualified exist in the literature though many are geared for specific mindfulness-based treatment programs and therapies (Baer, 2006; Dimidjian & Linehan, 2003; Germer et al., 2005; Kabat-Zinn, 2003, Kabat-Zinn & Santorelli, 2001). Outside of a credentialing process for the Mindfulness-Based Stress Reduction (MBSR) program, no known national credentialing mechanism exists for mindfulness training in general (Kabat-Zinn). As of yet, empirical research on a set of competencies for counseling and psychotherapy has not been conducted.

Brief introduction to mindfulness

Defining and exploring the construct of mindfulness is important to the central theme of this dissertation. Mindfulness originated from the 2,500 year old Buddhist tradition and has been referred to as a psychological process, a technique or method and also a skill (Bishop et al., 2004; Germer, 2005a; Hayes & Shenk, 2004). In brief, mindfulness is intentionally paying attention to present moment reality with an orientation of acceptance and curiosity marked by non-evaluative observation. In theory, when practitioners notice that attention has wandered from this orientation, they gently reorient the mind back to a more flexible or open state of awareness (Germer; Kabat-Zinn, 1990). Rejecting unwanted thoughts is not part of the practice protocol; on the contrary, one observes such thoughts without getting carried away by them. There has been a shift from the popularized use of the word mindfulness to attempts to operationalize mindfulness for research (Bishop et al., 2004). Bishop and colleagues formed a panel that advanced the process of defining mindfulness for research purposes. The definition has two components, the first

involves the self-regulation of attention so that it is maintained on immediate experience thereby allowing for increased recognition of mental events occurring in the moment. The second involves adopting a particular orientation toward one's experiences in the present moment, an orientation that is characterized by curiosity, openness and acceptance. (p. 232)

Defining mindfulness for research purposes has not been easy and is still in its initial phase (Hayes & Shenk; Kabat-Zinn, 2003; Shapiro et al., 2006).

Rationale

For decades, introductory texts and key players in forming the counseling profession have advocated for counselors to be in the here-and-now, attentive and aware of the client in session (e.g., Rogers, 1951). Yalom (1980) pointed to the importance of a here-and-now orientation,

an existential perspective does not mean that one explore the past; rather it means that one brushes away everyday concerns and thinks deeply about one's existential situation. It means to think outside of time, to think about the relationship between one's feet and the ground beneath one, between one's consciousness and the space around one; it means to think not about the way one came to be the way one is, but that one is....The future-becoming-present is the primary tense of existential therapy. (p. 11)

Mindfulness practice provides counselors and psychotherapists with a tangible set of tools to brush away the distractions of everyday concerns and refocus on the ground beneath one's feet, and furthermore, be able to attend to clients more fully. Mindfulness is a skill that can be developed and applied (Takahashi et al., 2005; Germer, 2005a). In the past, few techniques were available or offered to counselors in training to increase here-and-now awareness. Lewis (2006) commented on the promise of mindfulness as a construct,

For decades, we have been interested in discovering the common curative ingredients uniting the various forms of psychotherapy. Mindfulness appears to be one of those factors....it may be one of the factors that contributes to a strengthened alliance and enhanced mentalizing capacity. (p. 83)

Counselors and psychotherapists must be competent when delivering specialized techniques with clients and must take necessary educational and training steps when adopting a new specialty (ACA, 2005, C.2.b). The ACA *Code of Ethics* (2005) states, “Counselors must practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience” (C.2.a.). Similarly, the APA *Ethical Principles* (2002) states that, “Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience” (Principle 2.01a). Professional competency as defined by the author is requirements of professionals to properly and diligently perform their job role. Requirements include a combination of knowledge, skills, behaviors, beliefs and attitudes. This dissertation entails research that explores competencies to train clients to use mindfulness methods. The Likert-type survey specifically addresses the research question to what degree do experts on mindfulness agree with a proposed set of mindfulness competencies.

Mindfulness based techniques have been around and used for mental health, health and spiritual/existential concerns for thousands of years (Dryden & Still, 2006; Kabat-Zinn, 2003). It is only recently that it has emerged in the West as a viable method for addressing health and spirituality. Though there are hundreds of journal articles and treatment texts currently available on mindfulness-based programs and therapies (Bonadonna, 2003; Kabat-Zinn, 2003; Ryback, 2006; Shigaki et al., 2006), to the author’s knowledge there are none published that sufficiently address what kind of training is

needed for the generalist and integrative practice of counseling and psychotherapy. To the author's knowledge, empirical research on mindfulness competencies has not been conducted nor has a set of competencies been proposed. It is hoped that the second manuscript adds to current recommendations and helps in the process of creating a profession wide acceptable competency set. Results of this study add empirical research to the investigation of competencies that are needed for this set of techniques.

Competencies are not created by individuals, but by groups of professionals. The author wanted to inquire of experts on the topic of mindfulness in counseling and psychotherapy in order to advance discussion, research and collaboration.

Glossary of Terms

Awareness: Part of consciousness that registers stimuli by searching the internal and external environment (Brown & Ryan, 2003).

Attention: The part of consciousness that has the capacity to narrow the focus of awareness to specific stimuli registered by awareness (Brown & Ryan, 2003).

Dukkha: A complex term often described as unsatisfactoriness or suffering (Schumacker & Woerner, 1994).

Psychotherapy: “In the most inclusive sense, the use of absolutely any technique or procedure that has palliative or curative effects upon any mental, emotional or behavioral disorder” (Reber & Reber, 2001, p. 586).

Psychotherapist: Professional health care provider with an advanced degree who provides psychotherapy.

Meditation: In this dissertation, a non-contemplative practice involving attention regulation and awareness.

Mindfulness: The “self-regulation of attention so that it is maintained on immediate experience thereby allowing for increased recognition of mental events occurring in the

moment” that “involves adopting a particular orientation toward one’s experiences in the present moment, an orientation that is characterized by curiosity, openness and acceptance” (Bishop et al., 2004, p. 232).

Mindfulness methods: Techniques used to practice mindfulness; traditional Buddhist mindfulness practices.

Mindfulness training (MT): A program of study in mindfulness, usually involving the practice of multiple mindfulness methods.

Mindfulness experts: Those with high levels of personal mindfulness practice and who have professional contributions on mindfulness.

Mindlessness: Attention to a subset of contextual cues which “trigger various scripts, labels and expectations, which in turn focus attention on certain information while diverting attention away from other information” (Nass & Moon, 2000, p. 83).

Practice (of meditation and mindfulness): The engagement in the discipline of mindfulness, “the inward gesture that invites and embodies” mindfulness and meditation (Kabat-Zinn, 2003, p. 147).

Professional competency: Requirements of professionals to properly and diligently perform their job role.

**A REVIEW OF THE LITERATURE ON
MINDFULNESS IN COUNSELING AND PSYCHOTHERAPY**

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Abstract

This article reviews the counseling and psychotherapy related literature on mindfulness and mindfulness methods. Mindfulness has become popular among clients and helpers alike as a practical tool to improve physical and mental health. In the last several years, researchers on mindfulness have begun to provide an operational definition for this pre-scientific concept and practice. This article explores the question, what is mindfulness? It also examines what counselors and psychotherapists might gain as professionals by practicing mindfulness. Research suggests mindfulness might improve important qualities of mind and performance variables relevant to counseling and psychotherapy. Finally, the authors examine the training of counselors and psychotherapists in mindfulness methods.

Introduction

Mindfulness has gained considerable attention in health related literature over the last two decades with the influx and increasing acceptance of Eastern practices.

Mindfulness has become popular, but, why is this so? Lewis (2006) captured the promise mindfulness holds for counseling professions, “For decades, we have been interested in discovering the common curative ingredients uniting the various forms of psychotherapy. Mindfulness appears to be one of those factors, much like the therapeutic alliance or mentalization” (p. 83).

What is mindfulness?

The first broad use of the term mindfulness originates from the English language and relates to having implicit awareness of context and informational content (Langer, 1989), such that a counselor might be mindful of culture, client developmental needs or standards of practice. Mindfulness by this definition means to take heed of or to take care (Dryden & Still, 2006). This is not the type of mindfulness addressed within this article.

Mindfulness will refer to our second usage which is an English transliteration of the Pali word *Sati* (Germer, Siegel, & Fulton, 2005). Mindfulness can be simply described as purposely placing one’s attention in the present in a non-judgmental way while limiting evaluative thought processes. This second usage of the word mindfulness is contingent upon the regulation of attention (Kabat-Zinn, 1990). According to Brown and Ryan (2003), *attention* and *awareness* are basic components of consciousness that have distinctive functions. There is awareness which registers stimuli by “searching the inner and outer environment” like radar would register flying objects in a certain field of airspace, and attention, the capacity to narrow the focus to specific stimuli within

awareness, much like a spotlight can pick out an object in space (Brown & Ryan, p. 243). For example, a counselor may sit in session and have a floating awareness of the many of internal and external stimuli such as the content of conversation, internal emotions, nonverbal communication, sound of the heater, or sun coming in through the window. From the field of awareness, the counselor's attention might focus primarily on stimuli most important to counseling: a client non-verbal reaction, the counselors own internal response, the memory of what was just said, and the client's facial expressions.

In an interview with Sykes Wylie and Simon (2004), Jon Kabat-Zinn commented, "Mindfulness is really about bringing attention to virtually any situation or any circumstance or any mental state. It's not about staying in any one particular state" (p. 64). It allows for a state of mind that is alert, relaxed, and "aware of our thoughts without identifying with them or allowing them to take over" (Ladner, 2005, p. 19). Germer et al. (2005) suggested, "Mindfulness is simply about being aware of where your mind is from one moment to the next, with gentle acceptance" (p. xiii). The practice is usually as simple as resting attention on the immediate task at hand-i.e., smelling coffee, listening to the sound of a passing car, feeling wool or a pine cone, noticing the bodily sensation of gravity while swaying, or perhaps, observing the sensations of breathing during consecutive exhalations. The important aspect of mindfulness practice is to "remember to reorient" and to gently do so whenever elaborative patterns of thinking arise have clouded direct experience (Germer, 2005, p. 6).

The professional literature has also examined *mindlessness* which points to what mindfulness is not. In the literature, mindlessness is defined as focused attention on a subset of contextual cues that "trigger various scripts, labels and expectations, which in

turn focus attention on certain information while diverting attention away from other information” (Nass & Moon, 2000, p. 83). Hayes and Shenk (2004) noted that verbal events are important and essential to psychological flexibility and creativity, however sometimes the functions of language dominate one’s sense of reality thus creating inflexibility. As an example, a counselor ruminates on a therapeutic rupture with a client and is thereby unavailable to the client in the present moment. Mindlessness may also be acting automatically or *rushing around with a scattered mind*. One might say mindfulness techniques help a person be more open to the many facets of experience because they are not caught up in mindlessness (Kabat-Zinn, 2005; Langer, 1992).

In contrast to mindlessness, mindfulness is resting attention with an attitudinal disposition of non-striving, non-judgment, acceptance and non-conceptual curiosity. Mindfulness is not a trance, hypnotic state or dissociation. So it is neither a method to escape or avoid life, nor is it thought blocking, or even, surprisingly, a solution to the fact of decay, disease and death. It is a technique used to live in the present moment as fully as possible despite aspects of pain or pleasure.

“Mindfulness is a deceptively simple concept that is difficult to characterize accurately” (Brown & Ryan, 2003, p. 242). In the literature, mindfulness has been referred to in several ways: as a psychological process, as a method or practice, and also as a skill that can be developed (Germer, 2005; Hayes & Wilson, 2003; Kabat-Zinn, 2003). Multiple meanings attributed to the word mindfulness have led to some confusion and difficulty when defining this construct (Hayes & Shenk, 2004). Bishop and colleagues (2004) formed a professional panel on mindfulness to propose by consensus an operational definition of mindfulness for empirical research. They proposed a two

component model of mindfulness that emphasized the cognitive processes of mindfulness practice. The first component of this model involves the “self-regulation of attention” so that it is centered on immediate experience of internal and external stimuli and involves metacognition, or in other words “the recognition of mental events occurring in the moment. The second component involves adopting a particular orientation toward one’s experiences in the present moment, an orientation that is characterized by curiosity, openness and acceptance” (p. 232). Hayes and Shenk noted that this is a good start in advancing the definition of mindfulness for research, but “seems to give less emphasis to a nonevaluative perspective, to context, to observing and describing, or to a basic perspective on language and cognition” (p. 253). Shapiro, Carlson, Astin, and Freedman (2006) also noted that Bishop’s definition overlooks the importance of intention to mindfulness practice.

Mindfulness has been referred to as a technique or method. For example, practicing mindfulness is often taught as a structured step-by-step process which involves: (a) resting attention on current experience with an accepting and open attitude, (b) catching/noticing when attention is narrowed to consuming thoughts (e.g., noticing rumination about personal financial problems), (c) remembering to reorient, (d) reorienting or “switching” attention to current experience without judgment of the previous distraction (Bishop et al., 2004, p. 231), and then, (e) when the practice period is over, cease to practice. Sometimes another step is added, which is labeling, noting or naming the mental state (e.g., fantasy) prior to reorienting the mind.

Mindfulness is also associated with the practices that were traditionally taught in Buddhism. Some of the more central practices are body scanning, mindfulness of

breathing, walking meditation and sitting meditation (Gunaratana, 2002; Kabat-Zinn, 2005). Body scanning is taught as a formal practice or technique where it is important to maintain “awareness in every moment, a detached witnessing of your breath and your body, region by region, as you scan from your feet to the top of your head” (Kabat-Zinn, 1990, p. 89). During the practice of body scanning one systematically observes the body, one area after another, primarily recognizing any and all sensations (painful, pleasant or neutral), and secondarily external events, emotions, and cognitions that may arise while observing the body (Hamilton, Kitzman, & Guyotte, 2006). When attention is consumed by mindlessness (e.g., excessive worry about the body), the practitioner notices this mental activity (possibly labeling it “worry”), and then gently reorients attention back to the body and breath. As another example of a traditional mindfulness exercise, walking meditation is taught as a technique in various forms (e.g., fast or slow, unstructured or deliberate path of movement), but essentially in walking meditation one observes the present-moment experience of walking (Kabat-Zinn, 1990).

Mindfulness is also referred to as a skill (Germer, 2005), because mindfulness methods and their related qualities of mind and body can be developed with practice. For example, Valentine and Sweet (1999) found that as the practice of mindfulness and meditation increases so too does the ability to sustain attention. Brown and Ryan (2003) commented that although attention and awareness are basic and natural capacities of most people, they observed, “(a) that individuals differ in their capacity and willingness to be aware and to sustain attention to what is occurring in the present and (b) that this mindfulness capacity varies within persons because it can be sharpened or dulled by a variety of factors” (p. 822). Bishop and colleagues (2004) made the observation that

mindfulness requires ability, the ability to switch back or return one's attention to a given stimuli. However, Hayes and Shenk (2004) added that many other methods for sustaining attention may exist without the ability or skill of switching one's attention. In theory, mindfulness is also a skill that may transfer across learning and behavioral domains, such that those who learn to focus on the present experience of breathing are better able to transfer the ability to be present for other experiences such as eating, communicating, observing difficult emotions or pain, and riding a bike. Finally, to the degree that one automatically engages in mindfulness, mindfulness can be defined as a habit. Ideally, mindfulness is a habituated way of being, a way of being flexible and open.

The philosophy informing mindfulness training places emphases on the actual practice rather than on goal attainment. Many western therapies and mindfulness meditation ease suffering; however, in its traditional sense, mindfulness is not practiced to get rid of disease and disorder. Furthermore, the theoretical underpinnings do not assume pathology (Hamilton et al., 2006). For example, at first glance, mindfulness practice appears to be a relaxation technique. However, unlike relaxation techniques which are expressly used to reduce undesirable conditions of body and mind, mindfulness methods create conditions for acceptance and put the practitioner in touch with the multiple experiences and layers of self. Efforts to make progress are not central while engaging in mindfulness practice, though paradoxically, clients and even the helper must have a reason for practicing mindfulness methods in the first place.

Mindfulness also entails an orientation toward certain attitudes. Kabat-Zinn (1990) suggested that a non-judging stance, patience, adopting a beginner's mind, trusting yourself and experience, non-striving, acceptance, and an ability to let go or

release attachment to conditions. It is not that one maintains all of these attitudes while practicing, but that the overall practice is marked by these attitudes. Furthermore, these listed attitudes simply point at the felt experience, orientation or space that is occupied when practicing mindfulness. Gunaratana (2002) provided a series of rules or slogans to remember about the right attitudinal orientation: “don’t strain,” “don’t rush,” “don’t expect anything,” “don’t cling to anything or reject anything,” “let go,” “accept everything that arises,” “be gentle with yourself,” “investigate yourself,” “view all problems as challenges,” “don’t ponder,” and “don’t dwell upon contrasts” (pp. 39-42).

Mindfulness and meditation

The terms mindfulness, meditation and mindfulness meditation are often used interchangeably. As noted above, discussing mindfulness may be confusing because different “psychological processes and methods are described with the same term” (Hayes & Wilson, 2003, p. 166). Conversely problematic, multiple terms refer to the same mindfulness practice adding to confusion. So for example, placing attention on the experience of walking might be referred to as mindful walking, walking meditation, or kinhin. After all, mindfulness is a pre-scientific activity and concept that has not yet fully matured in a coherent manner conducive to scientific research (Hayes & Wilson). For this reason, mindfulness meditation often refers to the traditional exercises of Buddhism.

In English, the term meditation describes many different activities (e.g., guided meditation, contemplative meditation, mindfulness meditation, devotional meditation) and seems to have been the best word to capture the essence of the practices that had come from the East. Regardless of whether the term mindfulness or meditation is applied, mindfulness methods have various attentional foci, but essentially they support non-

evaluative observation (Hamilton et al., 2006). So for the current research, meditation refers to those types of meditation that do not intentionally focus on cognitive content or contextual factors (e.g., devotion or contemplation). The exception to this is that at times one might label or name the mental content before returning focus in mindfulness meditation.

A distinction can also be made between mindfulness meditation and other types of meditation based on the rigor of attention regulation. One way to conceptualize the difference is by viewing meditation as either concentrative or receptive in how attention is regulated (Valentine & Sweet, 1999). In concentrative meditation (e.g., Transcendental Meditation), a specific focus is vigorously maintained, or even manipulated, to the exclusion of all other stimuli (Brown, 1977; Takahashi et al., 2005). In this style, one returns to the narrow focus of concentrative attention. In receptive meditation (e.g., mindfulness) one has a ‘wide-angle lens’ approach and broadly orients to a range of stimuli (Shapiro, 1982). Mindfulness meditation requires self-regulation of attention and monitoring of mental activity but has a quality of pure observation of phenomena. Research comparing these two types of meditation has demonstrated differences in how each type cultivates attention (Valentine & Sweet) and effects psychophysiology (Takahashi et al.).

History of Mindfulness

So is mindfulness a fad or here to stay? Mindfulness has been practiced in the East for at least 2,500 years. It is part of the repertoire of Eastern physical, mental and spiritual health. In the West, long standing meditation traditions emphasized devotion and contemplation making the introduction of mindfulness with its present moment

orientation a new addition. Mindfulness emerged out of the tradition of Buddhism. It's in its early stages of Western clinical use and empirical study. Buddhism' historical founder, Gautama, taught techniques such as meditation and mindfulness as part of a spiritual path that addresses *Dukkha*, a complex term often described as suffering, but includes a more basic human sense of unsatisfactoriness that arises in response to unavoidable painful and pleasurable life circumstances (Carlson, 1989; Schumacker & Woener, 1994; Styrk, 1968). Though mindfulness has its origins in Buddhism, it is a basic technique that has widespread cross-cultural applications. This undoubtedly is due to its emphasis on experiential reality rather than on particular cultural constructs or informational content. Baer (2003) remarked that mindfulness techniques can be taught in the context of western mental health without reliance on Buddhist spiritual teachings. The field has taken steps in order to separate the religious context from the clinical training of clients (Dimidjian & Linehan, 2003). Seemingly, this has not been a difficult process.

Mindfulness use was popularized in health settings by the work of Jon Kabat-Zinn at the Massachusetts' Medical School and by the publication of his highly useful and practical book on mindfulness, *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face, Stress, Pain and Illness*, now in its 15th anniversary revised edition (Kabat-Zinn, 1990, 2005). This book introduced the American lay person to mindfulness, but also to a novel wellness idea that is latent in the method: mindfulness is not primarily an allopathic or naturopathic cure, but a way to face and embrace symptoms, illness, ourselves and life. One can face and embrace difficulty with attention and acceptance, and the subsequent result is reduced symptoms, better health and improved quality of life. Kabat-Zinn's introduction of Mindfulness Based Stress Reduction (MBSR), a

mindfulness-based treatment program, gained wide acceptance and continues to receive support from emerging research.

As its popularity grew as a practical tool, researchers began to make efforts to define mindfulness and to understand its effects on physical and mental health (Bishop et al., 2004, Shapiro et al., 2006). Research into mindfulness has examined benefits that apply to both the counselor and client when they practice mindfulness (Christopher, Christopher, Dunnagan, & Schure, 2006; Newsome, Christopher, Dahlen, & Christopher, 2006). Furthermore, research has investigated the effects of mindfulness use in clinical settings noted by the following categories: (1) the effects of mindfulness training on clients or the training of clients to use mindfulness methods on their own, (2) the effects of counselor mindfulness as a result of personally practicing mindfulness outside of counseling sessions, and (3) the effects of counselor in-session mindfulness. The majority of research in health related fields has examined clinical outcomes when clients are trained to use mindfulness practices.

Mindfulness training is in the process of being adopted into healthcare systems (Bonadonna, 2003; Shigaki, Glass, & Schopp, 2006). Within healthcare, mindfulness-based techniques have been integrated as an adjunct to conventional treatment modalities. Research has suggested that mindfulness-based interventions are effective for treatment of physical symptoms. It has been applied as a primary, secondary and tertiary intervention strategy (Bonadonna) for clinical work with disease, disorders and symptoms that range from the acute (e.g., headaches) to the chronic (e.g., HIV, cancer). Mindfulness has been applied to a number of physical health problems such as high blood pressure and cholesterol levels (Ryback, 2006), cancer (Ott, 2006), Psoriasis (Kabat-

Zinn, 2003, Kabat-Zinn et al., 1998), traumatic brain injury (Bédard et al., 2003; McMillan, Robertson, Brock, & Chorlton, 2002), insomnia (Lundh, 2005; Thomas, Inka, Burkhard, Matthias, & Johannes, 2006). Mindfulness methods have been used in symptom management, but also with assisting client acceptance of health concerns, resulting in decreased levels of perceived pain (Dahl & Lundgren, 2006; Plews-Ogan, Owens, Goodman, Wolfe, & Schorling, 2005). It has been used successfully in palliative care as well (Bruce & Davies, 2005; Plews-Ogan et al.).

In western mental health, mindfulness has been “adopted as an approach to increasing awareness and responding skillfully to mental processes that contribute to emotional distress and maladaptive behavior” (Bishop et al., 2004). Research has shown mindfulness to be effective in the treatment of anxiety disorders (Semple, Reid, & Miller, 2005), depression (Rokke & Robinson, 2006; Telner, 2005), borderline personality disorder (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; Shaw Welch, Rizvi, & Dimidjian, 2006), addiction (Bowen et al., 2006), and eating disorders (Baer, Fischer, & Huss, 2005; Kristeller, Baer, & Quillian-Wolever, 2006). Thus far, research has been positive, however, research on mindfulness has been mostly done without control groups and has drawn results from research on treatment packages, such as MBSR, making it tough to note the variables related solely to mindfulness (Allen et al., 2006, Grossman, Niemann, Schmidt, & Wallach, 2004; Hamilton et al., 2006; Shigaki et al., 2006). The desire to explore effects of mindfulness-based methods appears to be increasing.

Another important step has been the advent of mindfulness-based treatment programs and therapies, also referred to as treatment packages. Mindfulness-based treatment packages bundle together a set of different mindfulness exercises to be learned

or applied over several sessions. They may entail traditional mindfulness exercises or methods that encourage mindfulness (Hayes & Shenk, 2004). For example, Kabat-Zinn's (2003, 2005) Mindfulness Based Stress Reduction (MBSR) program teaches clients how to use and integrate traditional mindfulness skills such as bodyscanning, mindfulness of breath, walking meditation, and eating mindfully. Other treatment programs combine or integrate mindfulness methods with other treatment modalities and interventions. For example, Mindfulness Based Cognitive Therapy (MBCT) uses mindfulness methods in conjunction with Cognitive Therapy (CT) (Segal, Teasdale, Williams, & Gemar, 2002; Teasdale & Williams, 2000). Treatment packages have allowed for a more standardized and even manualized approach to imparting these methods and carrying out research. The most commonly used packages outside of MBSR and MBCT are Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT).

Mindfulness Use by Counselors and Psychotherapists

Mindfulness is being conceptualized as a strategy for changing the way counselors and psychotherapists are in session. Mindfulness may change the behaviors, attitudes, and qualities of consciousness important to the therapeutic relationship (Crane & Elias, 2006; Epstein, 1999; Stanley et. al, 2006). Students in Newsome and colleagues' (2006) 15 week course based in mindfulness methods reported "substantial effects on their counseling skills and therapeutic relationships" (p. 1881). Preliminary research suggests personal practice of mindfulness by counselors will better position them in their work with clients. In theory, clients will benefit because counselor practice of mindfulness will foster increased attention, acceptance, non-avoidance of experience, empathy, therapeutic alliance, and meta-cognitive awareness on the part of counselors.

Attention regulation

Practicing mindfulness may allow counselors and psychotherapists to be more attentive because mindfulness increases the ability to sustain attention (Takahashi et al., 2005; Valentine & Sweet, 1999). As a result of mindfulness practice a counselor learns through persistent practice the ability to reorient the mind. In the context of counseling and psychotherapy, reorientation means returning attention to more important stimuli such as the therapeutic relationship and client concerns. Students of Newsome and colleagues' (2006) study indicated they had more ability to focus on the needs of their clients as a result of the mindfulness-based training. For some time, theories of counseling and psychotherapy have held that attending skills are essential, yet it is often assumed neophytes would either be naturally attentive because of personal traits or find a way to acquire this ability (Morgan & Morgan, 2005). Ongoing practice of mindfulness may be a critical tool for counselors to sharpen their ability to be attentive.

Acceptance and non-judgment

Accepting clients with a non-judgmental attitude is a central aspect of counseling, if not a core condition (Rogers, 1951). Mindfulness training cultivates this attitude in the present moment, which is assumed to extend into an ability to suspend judgment and negative perceptions towards clients (Crane & Elias, 2006; Kabat-Zinn, 1990). Strupp (1993) conducted a series of empirical studies that produced results regarding the effects of psychotherapists' judgments on therapeutic outcomes. Over several decades, this research demonstrated that immediate negative attitudes toward the client were associated with unfavorable clinical judgments and loss of empathy. Strupp commented, "On the

basis of these data, I hypothesized that the therapist's initial attitude toward the patient might give rise to a self fulfilling prophecy" (p. 431).

Facing rather than avoiding difficult experiences

Mindfulness may help counselors face issues rather than avoid them. Counselors work in environments that expose them to vicarious traumatization, stress and burnout, which can impact attention to and acceptance of clients and clinical experience. McKenzie Deighton, Gurriss, and Traue (2007) studied a group of 100 trauma therapists and found those therapists who worked through rather than avoided traumatic events had less compassion fatigue, burnout and distress. Mindfulness has shown promise in reducing experiential avoidance with client populations. Dalrymple (2006) in studying a client population found that by applying mindfulness based techniques, by way of ACT, over a third of participants had less experiential avoidance. Mindfulness has also been viewed as a way to decrease emotional reactivity and increase recovery time after emotional reaction. Hayes and Wilson (2003) highlighted that this is the opposite of what occurs with either avoidance or over-engagement. The rationale is this: counselors may be more available and able to witness, delve into and explore uncomfortable and distressing experiences with clients as a result of practicing a method that cultivates equanimity towards experiences that might normally be viewed as undesirable and quickly avoided. Often "contexts of literality, reason giving, and emotional control narrow the relevant stimulus functions in a situation largely to those that emerge from within language itself" (Hayes & Shenk, 2004, p. 252). In practicing mindfulness one is taught to make friends with what is uncomfortable by allowing it to be observed. One of

the core mindfulness practices is to simply bring attention to the qualities of mind and body during intense emotional states.

Empathy

Mindfulness has been studied as a catalyst for empathy in psychotherapy (Aiken, 2006; Andersen, 2000; Fredenberg, 2002). Empathy has been recognized as an important component of counseling and psychotherapy (Bohart & Greenberg, 1997; Borzarth, 1997). “Therapeutic empathy can be defined as the ability to accurately experience and understand the felt sense of a client's inner experience and perspective, and to communicate that awareness in such a way that the client perceives himself or herself as being recognized and understood” (Aiken, p. ii). In theory, mindfulness allows counselors to better connect with empathic modes of being and responses because it (a) decreases self-focused and self-related behaviors and cognitions and (b) allows for a more present engagement of clients. Morgan and Morgan (2005) added another viable reason why mindfulness is likely to promote empathy, “As we grow in mindful awareness of our own struggles in life, and in awareness of our psychological landscape and mental processes, we can more readily identify with and understand the same in our patients” (p. 81). Mindfulness may allow counselors and psychotherapists to have greater familiarity with the internal sensations involved in empathy. Ryback (2006) depicted the importance of sensation in describing deep empathy as an advanced stage where “the conceptual (frontal cortex) and emotional (amygdala and other elements of the limbic system) work in concert to create bodily sensations enriching the feeling aimed at affecting nonverbal body language (including facial expression) through neuronal, neurotransmitter and muscular systems” (p. 85). The literature suggests that the practice

of mindfulness may be a useful practice to cultivate empathy, yet more research is necessary to connect empathy developed by a therapist's mindfulness practice to empathy in clinical practice (Morgan & Morgan, 2005). Aiken summarized a qualitative research project that demonstrated a link:

Lengthy qualitative interviews were conducted with 6 mindfulness mediators who had attended at least 10 mindfulness retreats of 10 days or more, had maintained a daily mindfulness meditation practice for at least 10 years, and had been licensed psychotherapy practitioners for at least 10 years. Among the resulting themes were suggestions by the research participants that mindfulness contributes to a therapist's ability to: achieve a felt sense of the client's inner experience; communicate their awareness of that felt sense; be more present to the pain and suffering of the client; and help clients become better able to be present to and give language to their bodily feelings and sensations. (p. iii)

Therapeutic alliance

The quality of the therapeutic alliance may also be affected positively when counselors practice mindfulness. Horvath and Symonds (1991) in a meta-analysis of 15 years of therapeutic alliance research concluded that the quality of the therapeutic alliance was a robust predictor of positive therapeutic outcomes. The working alliance effected outcomes irrespective of technique or style, and importantly, attention placed on the relationship in session is more effective than attention placed on extra therapeutic issues (Horvath, 2000). Horvath concluded, "Empirical data indicate that attention to the here-and-how aspect of the relationship is more likely to produce results than interpretations linking the current relational crises to past experiences" (p. 171).

Mindfulness may improve the quality of the therapeutic alliance because it is a skill that cultivates the ability to be present. In one study, Wexler (2006) found significant positive correlations between both therapist and client perceptions of therapeutic alliance and mindfulness.

Metacognitive awareness

One of the suggested benefits of mindfulness training is an increase in metacognitive awareness. Teasdale et al. (2002) clarified a distinction between metacognitive awareness and metacognitive belief. *Metacognitive belief* refers to how much one holds beliefs about cognitions to be true, so it relates simply to thoughts about mental events, where *metacognitive awareness* refers to, “how much thoughts, for example, are experienced as thoughts (mental events) rather than as aspects of self or direct reflections of truth” (p. 277). So by practicing mindfulness, thoughts begin to be seen as mental events rather than reality or an accurate view of reality (Williams, Duggan, Crane, & Fennell, 2006). Mindfulness encourages metacognitive awareness which allows the counselor to see thoughts as mental events rather than taking the content of thoughts for reality, known as cognitive fusion. In theory, this encourages flexibility of perception and suspension of judgment which are vital aspects of counseling.

Hamilton et al. (2006) suggested that one of the main benefits of mindfulness is that heightened attention to internal processes increases one’s ability to get to know and understand the internal landscape (e.g., thoughts, emotions, behaviors). Teasdale and colleagues (2002) in studying the effects of mindfulness on depressive relapse noted that mindfulness allows access to metacognitive sets, access that creates the possibility to work with thoughts. Likewise, counselors may be able to better understand client mental

states due to greater access to their own thoughts and subsequent self-knowledge (Morgan & Morgan, 2005).

The construct of *psychological mindedness* (PM) is closely related to metacognitive awareness. It is “in its broadest sense, awareness of psychological processes, such as feelings, thoughts and behaviors” (Beitel, Ferrer, & Cecero, 2005, p. 740). PM is an ability to connect relationships between psychological processes. High PM persons are said to be better able to cultivate awareness of the psychological processes in themselves and others. Beitel and colleagues found in a study of 103 liberal arts undergraduates PM was related to mindfulness, as well as affective and cognitive indices of empathy. It makes sense that counselors would want to cultivate the ability to connect relationships between psychological processes and also have heightened awareness of psychological processes as they help clients navigate and explore thoughts, behavior and affect.

Mindfulness Training of Counselors and Psychotherapists

Mindfulness training may be popular because it holds both personal and professional benefits for counselors and psychotherapists. Newsome and colleagues (2006) created a 15 week 3-credit course using MBSR to promote well being for counselors-in-training. Research based on four years of offering this course indicated students learned skills to manage burnout and stress. Students of this mixed methodological study also “reported physical, emotional, mental, spiritual and interpersonal changes” (p. 1881). With the increased interest many counselors are actively pursuing educational opportunities to learn how to practice mindfulness for their own health, but also so they can use these sets of techniques with their clients.

Efforts to train counselors are noted by the increase of the topic at national conferences (Capuzzi & Stauffer, 2006, 2007), in empirical literature (Newsome et al., 2006; Stanley et al., 2006), course offerings (Christopher et al., 2006) and in texts devoted to mindfulness-based treatment modalities for the clinician (Baer, 2006; Hayes, Follette, & Linehan, 2004; Germer et al., 2005; Segal, Williams, & Teasdale, 2002; Orsillo & Roemer, 2005). An important question exists for counselors who wish to initiate mindfulness training. How does one go about being trained in these methods for personal benefit as well as to use mindfulness as a new specialty area? Closely related to this question is another question researchers are beginning to ask, “How should therapists be trained in order to deliver mindfulness interventions competently?” (Dimidjian & Linehan, 2003, p. 168)

Educational resources on mindfulness

There are several ways counselors can undertake training in mindfulness methods above and beyond delving into the theoretical and practical literature, attending educational sessions at conventions and enrolling in coursework offered at a local university or college. One common method is to seek out non-profit and spiritually based groups who regularly provide free or donation-based trainings.

Another excellent mode to obtain training is to enroll in a course designed for counselors to learn one of the standardized treatment programs or therapies. For example, the Mindful-Based Stress Reduction (MBSR) treatment package is taught nationally and internationally on a regular basis. Counselors can find information about ongoing programs and resources from the Center for Mindfulness in Medicine, Healthcare, and Society at the University of Massachusetts website: www.umassmed.edu/cfm/education/.

The University of Massachusetts also offers a host of professional education courses including: intensive teacher training, practicum and weeklong retreats. Supervisor and consultation is often part of these educational programs so that someone with substantial experience can advise while integrating mindfulness as a new specialty area in counseling.

Others turn to audio and video resources that teach the methods and techniques common to mindfulness practice. A typical instruction CD can be acquired for personal use or for use with clients. Many of these resources can be found at minimal cost online. Many of them provide introductions to body scanning, walking meditation as well as mindfulness of breath, sound, and sight.

Home practice and ongoing practice of mindfulness with a group are both recommended to truly integrate these methods for clinical applications. Home practice is simply applying methods in ones daily life. Practicing with a group provides a desirable supporting effect for many trying to integrate a practice into daily life. One of the advantages of practicing with a group is long term practitioners who are members or leaders of such groups may be able to aid with questions about technique, posture and mental phenomena that arise.

At first, it may also be beneficial to learn about and experientially explore different mindfulness practices for personal use. Mindfulness-based techniques are varied and some may be better suited for different persons. For example, some find following the breath more effective than mindfulness of sound. In an investigation of MBSR, Kabatt-Zinn, Chapman, and Salmon (1997) found students who complain of more

somatic related anxiety do well with mindfulness meditation and those whose anxiety takes the form of cognitive anxiety may do better with mindfulness-based yoga.

Competency to train clients in mindfulness methods

Competencies or standards are often created as a way to prevent harm to clients but also to ensure the beneficial effects of a practice. Some suggest a substantial time period of practice before training clients in mindfulness methods (Kabat-Zinn, 2003). As of yet, no set of competencies exist for the general application of mindfulness in counseling and psychotherapy. Moreover, recommendations exist in the literature but are not uniform. For example, Mindfulness Based Stress Reduction (MBSR) guidelines recommend regular daily mindfulness practice, whereas Dialectical Behavior Therapy (DBT) and also Acceptance and Commitment Therapy (ACT) do not require but may encourage such regular practice (Dimidjian & Linehan, 2003; Roemer, Salters-Pedneault, & Orsillo, 2006). Some other issues related to being qualified to use mindfulness in a clinical setting include, but are not limited to: having an advanced helping degree, knowledge of the empirical and popular literature, skill development in mindfulness methods, knowledge of mindfulness techniques, attendance at mindfulness retreats, yoga training when teaching mindfulness-based yoga, having an experiential understanding of mindfulness, having appropriate attitudes (e.g., acceptance rather than a change agenda), and cultural sensitivity with mindfulness-based interventions. Lastly, those that practice eclectic or integrative modes of counseling and psychotherapy (Hollanders, 1999; McClure, Livingston, Livingston, & Gage, 2005) may need additional training and experience to integrate mindfulness training.

Conclusion

Mindfulness continues to be applied to clinical settings and empirically studied for its benefits. This pre-scientific concept and practice holds much promise for the profession of counseling and psychotherapy. Evidence is emerging that mindfulness methods and mindfulness-based treatment programs may prove to be effective in treating disorders and symptoms of disorders. Mindfulness may also provide clients and counselors with a tool to be more present in the moment resulting in a better quality of life, well-being and improved health. Mindfulness has become a strategy for counselors and psychotherapists to improve attitudes, behaviors and qualities of mind, essential factors in counseling. However, existent recommendations need further development. Professional education and training resources in mindfulness are available and are encouraged as a path to competency when integrating mindfulness as a new specialty area.

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MINDFULNESS COMPETENCIES FOR COUNSELORS AND
PSYCHOTHERAPISTS

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Abstract

This manuscript examines results of a survey on mindfulness competencies in the area of counseling and psychotherapy, specifically competencies needed for training clients in mindfulness methods. This study investigated whether experts on the topic (N=52) agreed with a proposed set of 16 competency statements. In addition, the survey included questions on recommended levels of personal mindfulness practice for those new to the specialty area. Results suggest, in general, that participants agreed on the proposed 16 competencies.

Introduction

The use of mindfulness is a new specialty area currently in the process of being integrated into counseling and psychotherapy. As a response to professionals who have advocated for educational and experiential standards for counselors and psychotherapists related to mindfulness training of clients and in review of the literature, the authors pursued two objectives. The first objective was to investigate the extent to which experts agree upon a set of proposed mindfulness competencies for generalist counselors and psychotherapists. The second research objective was to gather information regarding recommended daily practice levels for those counselors and psychotherapists who are new to practicing mindfulness methods. To the author's knowledge, there is not an empirical study on a proposed set of competencies for counselors and psychotherapist who train clients in mindfulness methods.

Mindfulness has been described as being intentionally present to internal and external events (i.e., stimuli) occurring in momentary experience (Baer, 2003; Bishop et al., 2004; Kabat-Zinn, 1990). In addition, mindfulness is resting one's attention with a non-judgmental orientation that minimizes distraction caused by absorbing thought processes. While practicing, one allows goals and agendas for outcomes to subside. Mindfulness necessitates that one is able to "monitor the focus of attention," or in other words, self-regulate attention, which requires metacognition -i.e., knowledge or observing of thoughts (Allen et al., 2006, p. 286). Often one of the first practices given to those new to mindfulness is an exercise in minutely exploring the eating of a raisin. In this exercise, participants purposefully direct attention with the above mentioned

orientation to one raisin. He or she is asked to visually observe it, touch it, bring the raisin to the nose and proceed to smell it. Eventually, the participant is guided to place the raisin in the mouth and prior to swallowing it, taste it, roll it around, and chew it, observing ever-arising qualities of minute experience at each step.

In the literature, mindfulness has been referred to in several ways: as a psychological process (the quality of mind that is attentive and accepting, as in touching or tasting a raisin), as a method or technique (step-by-step practice of regulating attention with acceptance, such as bringing the mind back to the taste or feel of the raisin when the mind drifts off) and finally as an skill that can be developed (Allen et al., 2006; Hayes & Shenk, 2004; Hayes & Wilson, 2003). There is also a philosophy guiding mindfulness practice, which asserts that one can embrace life by acquainting with “the way things are” (Kabat-Zinn, 2003, p. 145). The philosophy behind the practice encourages mental functioning that does not

try to freeze time, does not grasp onto our experience as it flows by, and does not try to block things out or ignore them. It is a level of experience beyond good and bad, beyond pleasure and pain. It is a lovely way to perceive the world.

(Gunaratana, 2002, p.11)

Generally speaking, training clients in mindfulness methods means training clients to practice a technique grounded in a philosophy, which is oriented toward certain psychological processes that can be developed with practice.

There is a distinction between formal and informal mindfulness practice (Germer, 2005a; Kabat-Zinn, 2005). Formal mindfulness practice refers to mindfulness meditation, and often, involves one of the more of the traditional mindfulness techniques such as

body-scanning or meditation on the breath for a structured period of time and is associated with deeper states of meditation and “sustained, disciplined introspection” (Germer, p. 14). Informal practice of mindfulness is about bringing mindfulness to ordinary daily life. It is applied in a more fluid and spontaneous manner. For example, one listens to ambient sounds at a bus stop, notices taste while drinking a glass of water or observes the feeling of warm water while washing the dishes after breakfast.

What does eating a raisin as a mindfulness practice have to do with counseling and psychotherapy? Just as with the raisin, if counselors or their clients practice mindfulness, the belief is they will observe and attend to life more fully resulting in insight, relaxation, acceptance, compassion and appreciation. This is the simplified understanding of what occurs with the general application of mindfulness.

The research literature offers promise that mindfulness-based methods are professionally and personally beneficial for counselors and are at least modestly efficacious for helping clients deal with symptoms of mental and physical disorders (Bear, 2003; Christopher, Christopher, Dunnagan, & Schure, 2006; Grossman, Niemann, Schmidt, and Walach, 2004; Newsome, Christopher, Dahlen, & Christopher, 2006; Shigaki, Glass, & Schopp, 2006). The quality and volume of research projects devoted to mindfulness suggest this construct has a perceived importance for professional training for counseling and psychotherapy. Furthermore, texts and manuals for the mental health professional on the use of mindfulness in clinical settings attest to its popularity as an intervention (see Baer, 2006; Hayes, Follette, & Linehan, 2004; Germer, Siegel, & Fulton, 2005; Orsillo & Roemer, 2005; Segal, Williams, & Teasdale, 2002).

Research can be divided by three types of exploration into how mindfulness is being used in the context of counseling and psychotherapy. The first is the impact on client outcomes when counselors and psychotherapists are personally practicing mindfulness outside of sessions (Aiken, 2006; Christopher et al., 2006; Germer et al., 2005; Wexler, 2006). In this way, mindfulness practice is being conceptualized as a strategy to change the essence of who a counselor is by affecting qualities of consciousness and attitudes as well as behavior and performance (Epstein, 1999; Stanley et al., 2006). Recently, researchers have examined whether helpers are more empathic (Aiken, 2006; Andersen, 2000; Fredenberg, 2002), attentive and aware (Morgan & Morgan, 2005) and psychologically minded (Beitel, Ferrer, & Cecero, 2005) as a result of practicing mindfulness outside of therapeutic sessions. Furthermore, researchers are investigating how changes, as a result of mindfulness practice affect key therapeutic variables such as the therapeutic relationship (Newsome et al., 2006) and the therapeutic alliance (Wexler, 2006). Germer (2005a) introduced the term “mindfulness-informed psychotherapy” alluding to those psychotherapists that “identify with a frame of reference based on mindfulness, but they do not explicitly teach patients how to practice mindfulness” (p. 19).

Second, research has attempted to assess the affects on clinical outcomes when counselors and psychotherapists are practicing mindfulness while engaged during sessions with clients. Empirical examinations have provided mixed results. Wexler (2006) demonstrated significant correlations between therapist mindfulness, both in and out of therapy, and both therapist and client perceptions of the therapeutic alliance. However, when examining 23 doctoral-level students using manualized treatments with

clients, Stanley et al. (2006) found there was less reduction in symptom severity when high levels of therapist mindfulness were present. In another study, Stratton (2006) examined therapist mindfulness levels in relation to client mindfulness levels and was unable to support the notion that therapist mindfulness would significantly impact client outcomes.

Third, the bulk of research on mindfulness has examined the impact on clinical outcomes when counselors and psychotherapists train clients to use and practice mindfulness methods on their own. Baer (2003) conducted a meta-analysis of 21 studies that supported use of therapy based upon client practice of mindfulness methods. Bear also noted that an average of 85% of participants across studies completed mindfulness treatment programs, suggesting a high level of client interest in mindfulness (Dimidjian & Linehan, 2003). High compliance rates have been noted, for example, Miller, Fletcher, and Kabat-Zinn (1995) found high levels of compliance for clients three years after MBSR coursework.

Mindfulness methods are often taught as part of a treatment program or therapy, sometimes called treatment packages. The term treatment package reflects the way mindfulness is taught by introducing clients to a set of different mindfulness methods within a specific therapeutic context. For example, the Mindfulness Based Stress Reduction (MBSR) program trains clients to reduce stress by introducing various mindfulness techniques: bodyscanning (moving attention to parts of the entire body), following the breath, walking meditation, mindful eating, and mindfulness-based Yoga (Kabat-Zinn, 2005).

Mindfulness treatment programs use mindfulness as a core intervention, but are delivered in different therapeutic contexts. Some treatment programs focus on a specific mental health concern, such as stress, in the example above of Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 2003, 2005). In other applications, treatment programs incorporate mindfulness techniques into pre-existing therapeutic treatment modalities. One of these, Mindfulness Based Cognitive Therapy (MBCT), uses mindfulness methods in conjunction with Cognitive Therapy (CT) (Segal, Teasdale, Williams, & Gemar, 2002; Teasdale & Williams, 2000). Finally, some treatment programs are unique therapies that have mindfulness methods as a core component, some of which do not use traditional forms of mindfulness practice. Dialectical Behavior Therapy (DBT) is one of the best examples of this type (Linehan, 1993). Treatment packages have allowed for a more standardized and even manualized approach to mindfulness training, providing an easier path for research, dissemination, and adoption. However, there are noted limitations to generalizing research on these packages because of their uniqueness (Hayes & Shenk, 2004).

Rationale and Need for Mindfulness Competencies

As with many aspects of client work, professionals are ethically bound to be qualified and competent when applying interventions (American Counseling Association [ACA], 2005; American Psychological Association [APA], 2002). Dimidjian and Linehan (2003) noted the need for competencies in delivering mindfulness interventions. Others have asked about the “optimal amount and type of therapist training” for specific applications of mindfulness-based intervention programs (Roemer, Salters-Pedneault, & Orsillo, 2006, p. 72). Mindfulness competencies are needed in the field of counseling

and psychotherapy in order to ensure benefit and reduce harm to clients being trained to use these methods. The need for competencies has emerged because of its popularity, increase in use and lack of a comprehensive as well as a generalizable set of guidelines. A comprehensive set of guidelines would aid counselors and psychotherapists in better understanding what is necessary for, and also a means by which, to judge the limits of their competency around training others in mindfulness. Competencies would also provide support to programs that are educating counselors and psychotherapists in this new specialty area. Competencies are needed for the generalist and eclectic practitioner who may not have the guidance, support and training provided by educators of mindfulness-based treatment programs. Competencies would also encourage further adaptation from eastern spiritual origins to western mental health settings. As of yet, to the authors' best knowledge, an empirical study related to mindfulness competencies is yet to be published in the professional literature.

Reduce harm and ensure benefit

Mindfulness competencies may help ensure that first, no harm is being done and secondly, that counseling is beneficial. Promoting the welfare and avoiding harm are two important guiding principles of professional ethics in counseling and psychotherapy (ACA, 2005, A.4.a). Education programs for counselors and psychotherapists must provide safeguards to ensure that the training provided protects potential clients from harm resulting from students who have inadequate therapeutic skill (Kerl, Garcia, McCullough, & Maxwell, 2002). Furthermore, supervisors in these programs are also required to evaluate performance (Association for Counselor Education and Supervision, 2003, section 10). This includes methods and techniques used by supervisees, in this

case, mindfulness methods. Teasdale, Segal, and Williams (2003) noted, “The profession already knows that training can be unhelpful in certain situations, so clearer understanding of when and how it is helpful is important if we are to focus the therapeutic potential of this training effectively” (p. 157). The use of mindfulness methods in various circumstances may be costly and possibly harmful, notably that intensive use may exacerbate certain disorders (see Allen et al., 2006). On a less severe note, clients may use mindfulness practice to avoid distress, for example, by using mindfulness as a relaxation technique rather than as a way to be present and accepting (Roemer et al., 2006).

Stated competencies help in knowing what it means to be competent

Counselors and psychotherapists need guidance to know what education, training, and supervisory experience is necessary to be competent. A set of mindfulness competencies would help with this need. The *ACA Code of Ethics* (2005) states, “Counselors must practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience” (C.2.a). Professional competency for counselors and psychotherapists can be defined as the requirements these professionals must possess to properly and diligently perform their role. Requirements include a combination of knowledge, skills, behaviors, as well as beliefs, attitudes and dispositions. Beliefs, attitudes and/or dispositions may be vital to the performance of a job. For example, multicultural competencies included beliefs and attitudes, such as being, “aware of how their cultural background and experiences, attitudes, and values and biases influence psychological processes” (Sue, Arredondo, & McDavis, 1992, p. 477).

Competency may also refer to being qualified or capable of performing a specific role or task. Counselors and psychotherapists must be competent when adopting a new specialty area, such as mindfulness, to use with clients (ACA, 2005, 2.C.b).

Recommendations lack uniformity

Recommendations for becoming qualified and competent are varied, even when considering more standardized treatment packages. For example, MBSR experts recommend personal daily practice of mindfulness methods whereas DBT and also Acceptance and Commitment Therapy (ACT) do not require personal daily mindfulness practices (Dimidjian & Linehan, 2003; Kabat-Zinn & Santorelli, 2001; Roemer et al., 2006). This lack of uniformity may result from a healthy level of disagreement as these methods are adapted to the Western mental health system.

Competencies to inform pedagogy

Course offerings, training opportunities, and educational sessions are being offered at various academic institutions and other professional venues to train counselors and psychotherapists as a result of desire to learn these methods (Capuzzi & Stauffer, 2007; Newsome et al., 2006). Not surprisingly, a valuable question has emerged from the literature, “how should therapists be trained in order to deliver mindfulness interventions competently?” (Dimidjian & Linehan, 2003, p. 168). Before the field can address the valuable question of how to train a counselor or psychotherapist to be competent to train others in mindfulness methods, it is essential to define the parameters of what it means to be competent. Some professional literature and mindfulness-based training programs include recommendations that address competency, and also, certification (Kabat-Zinn, 2003). To the author’s knowledge, only one treatment program certifies trainers (i.e.,

MBSR) while others do not (Wagner, Rathus, & Miller, 2006). What is still absent for use in educational programs is a comprehensive set of mindfulness competencies related to the question, what are the necessary knowledge, skills, behaviors, and attitudes to be competent to train clients to use mindfulness methods?

Competencies may also provide help with the education process by providing benchmarks by which to judge progress toward mastery. The development and transmission of competencies also aids in understanding the complexity of issues and practices involved in mindfulness practice.

Competencies for generalist and integrative practitioners

Competencies may assist generalist and integrative mental health practitioners on their path professional development, especially those who do not receive training and guidance by enrolling in a treatment package educational program. The popularity and wide-spread use of integrative or eclectic modes of counseling and psychotherapy (Hollanders, 1999; McClure, Livingston, Livingston, & Gage, 2005) require mindfulness-based training such modes of clinical practice. Currently, the generalist and integrative practitioner may have to enroll in a treatment package education course as way to gain valuable instruction that will eventually be used for a different therapeutic context. A general set of competencies may be needed for those who do not have the guidance of such programs. As an example, 25% of the experts surveyed for this research project did not have formal training in any particular treatment package.

Transition from East to West

Providing coherent recommendations and competencies may encourage certification processes that are unique to the western mental health system. Clinicians

and researchers have reasonably argued that mindfulness can be applied within the western mental health setting without particularly advocating for a Buddhist philosophy (Baer, 2003). Others have cautioned that something might be lost if the field haphazardly alters mindfulness training in a significant way and thereby unknowingly leave out crucial elements (Dimidjian & Linehan, 2003, Olendzki, 2005). The authors carefully clarify, legitimacy in these traditions implies competence far beyond training others to use mindfulness techniques; it is often given after decades of practice in order to pass on the intricacies of these traditions. In contrast, institutions shape what it means to be competent and legitimate as a counselor or psychotherapist: educational institutions, state licensing boards, professional organizations, and accreditation bodies. It behooves the professions to derive replicable and responsible ways to make mindfulness methods available to the public as well as to train counselors and psychotherapists in their use.

Review of the Literature

The professional literature contains material related to being competent to provide mindfulness training (MT) for clients. This material is scattered throughout training manuals and research journals and covers applications in general as well as in specific contexts. The authors highlight some important areas of competency in the literature: counseling skills needed to support mindfulness training, personal practice of mindfulness, cross-cultural sensitivity with mindfulness training, knowing how to integrate mindfulness into daily life tasks, having knowledge of different mindfulness techniques, being able to integrate mindfulness methods with other techniques and therapeutic modalities, knowing mindfulness resources for client use, and engaging in

mindfulness-based retreats. The article also briefly reviews the use of experts as it relates to this study's participant pool.

Generally applied counseling competencies

The literature suggests that to be competent in mindfulness training counselors must possess certain counseling and psychotherapeutic skill sets that support mindfulness training as a therapeutic intervention. A few examples to clarify the types of education, training, awareness and skills sets that are necessary to support successful mindfulness training include: group facilitation skills when leading MT groups, cultural awareness of and appropriate interventions based on the needs of specific target populations (Roth & Calle-Mesa, 2006; Smith, 2006), and the ability of a counselor to motivate clients (Carson, Carson, Gil, & Baucom, 2006).

Ethical guidelines and practice standards not only provide direction for what it means to be competent when using any intervention, but also, in adopting new specialty areas of practice (ACA, 2005, C). Some of these general competency guidelines are worth reiterating and emphasizing because of their importance to being competent in mindfulness training. The ACA ethical guidelines state that, "counselors practice in specialty areas new to them only after appropriate education, training and supervision. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm." Counselors must also "recognize the need for continuing education to acquire and maintain a reasonable level of awareness of current scientific and professional information in their fields of activity" (ACA, C.2.f, p.9).

Personal practice of mindfulness

In contrast to many therapeutic techniques, the personal practice of mindfulness is seen as a necessary step in becoming competent to train others (see Baer, 2006; Germer et al., 2005). Applying these methods in clinical settings requires active mindfulness and meditation practice (Coffman, Dimidjian, & Baer, 2006). Active practice refers to frequently engaging in formal and informal practice. For example, Semple, Lee, and Miller (2006) recommended therapists dedicate “30 to 45 minutes everyday to mindfulness exercise,” and reported using a “20- to 30- minute personal practice session for the co-therapists before beginning each MBCT-C session” (p. 161). Some of the mindfulness literature suggests that mindfulness trainers should have persistent practice and may need a substantial period of time before training others (Kabat-Zinn, 2003; Rothwell, 2006).

Training counselors to teach basic concepts and procedures to clients may not take years of learning, however experiential learning with these methods is especially important, even transformative (Rothwell, 2006). Kabat-Zinn (1990) commented that with mindfulness, "acknowledging present-moment reality as it is, whether it is pleasant or unpleasant, is the first step towards transforming that reality and your relationship to it" (p. 261). Mindfulness is emphasized as a practice to be done so that the counselor can know from personal experiences the essential elements and value of the mindfulness therapy model, mindfulness process, and pathways of change. Hammer's (1972) comment is especially important to this rationale:

to be really effective, the therapist needs to know from *personal experience* what the “path” is that leads from internal conflict and contradiction to liberation. If you do not know how to liberate yourself from an internal conflict, fear or pain,

then you are not in a position to help others do it either. . . . What right does the therapist have to ask the patient to face his [her] rejected truths and anxiety and to take risks in terms of exposing himself [herself] and making himself [herself] vulnerable, if the therapist is not willing or able to do so? (p. 12)

Rothwell (2006) commented that therapists should make the same commitment to the practice that they are advising of their clients.

Insight into the nature of mind is possibly one of the key transformative aspects of mindfulness. An active mindfulness practice increases insight and an understanding of the territory of the human mind by increasing metacognitive awareness. Metacognitive awareness is a type of metacognition; *metacognitive awareness* is simply observing thoughts. Metacognitive awareness is not *metacognitive belief*, which is the thoughts (e.g., judgments, perceptions, labeling) about the observed mental events (Teasdale et al., 2002). Naturally, a counselor practicing mindfulness will have personally experienced the process of using a technique to increase self-knowledge. One study suggests that mindfulness correlates with higher levels of psychological mindedness, which, “in its broadest sense, involves awareness and understanding of psychological processes, such as thoughts, feelings, and behaviors” within oneself as well as with others and includes making meaning and connections between thoughts and affect (Beitel, Ferrer, & Cecero, 2005, p.740).

Personal practice of mindfulness appears to encourage the development of mindfulness in others and so is seen as important (Kabat-Zinn, 1990; Semple et al., 2006). Embodying mindfulness practice is also seen as valuable (Crane & Elias, 2006; Epstein, 1999; Rothwell, 2006). Carson et al. (2006) commented, “Teachers themselves

must have sufficiently experienced the value of persistent mindfulness practice...In the absence of this sort of groundedness in the mindfulness practice, teachers will not be able to embody the insightful clarity required to inspire others” (p. 327). In a qualitative study, May (2004) found that the embodiment of the teachings by the instructor was indeed an important theme for clients.

Cross-cultural sensitivity

Mindfulness training requires of trainers to have awareness of and respect for culture (Kabat-Zinn, 2003). Multicultural and cross-cultural competency guidelines (Sue, Arredondo, & McDavis, 1992) apply to mindfulness training. The cross-cultural competencies state in the section *Culturally Appropriate Intervention Strategies* that “culturally skilled counselors respect client’s religious and/or spiritual beliefs and values, including attributions and taboos, because they affect world view, psychosocial functioning and expressions of distress” (III.A.1). Using mindfulness as an intervention should be done in a way that is culturally sensitive and appropriate. The literature suggests that mindfulness training, because of its origins in Buddhism, must be applied carefully with clients of different religious and spiritual cultural values and practices. Kristeller, Baer, and Quillian-Wolever (2006) noted that mindfulness has to be taught in a non-threatening way to some clients, knowing that it might pose a threat to religious identity. A counselor must also know the potential for impact of mindfulness training on specific populations. For example, Smith (2006) found that falling was a concern for some older adults during walking meditation. Smith shared the observation that members who focused on “being present” while walking rather than focusing on the act of walking had less difficulty (p. 209).

Knowing how to integrate mindfulness into daily life tasks

The literature suggests that knowing how to integrate mindfulness techniques into everyday tasks, i.e., informal mindfulness practice, is important in helping clients (Baer & Krietemeyer, 2006; Germer, 2005b). Integrating mindfulness into daily life in a sporadic way is seen as important to success, but also one of the most challenging to accomplish. Though this may be true, informal practice exercises may be easier to apply in psychotherapy (Germer). Reasoning has it that as the usability of a coping strategy increases so will the ability to apply it increase. Integration allows for the transfer of knowledge and benefits across domains. Informal practice not only requires knowing how to apply mindfulness to an activity (i.e., listening to ambient sound), but also remembering to apply it. Knowing how to integrate mindfulness while not causing competition with important tasks may be a concern for the clinician (Stanley et al., 2006).

Knowledge of different mindfulness methods

Emphasis on informal practice implies that the counselor or psychotherapist know different mindfulness methods and how to apply them. Dimidjian and Linehan (2003) noted that “mindfulness training is not a unitary procedure. Different methods are used to teach mindfulness, and the practice of mindfulness comprises several component activities” (p. 168). Specific mindfulness methods may be preferred by or more beneficial for different clients and groups. For example, Wagner, Rathus, and Miller (2006), as a result of clinical experience, suggested that adolescents in DBT groups often prefer mindfulness techniques that involve movement, multiple sensory systems, and are brief in duration. Knowing which methods to use may mean a counselor knows how a specific mindfulness method is effective, ineffective, or even harmful to a client. Teasdale and

colleagues (2003) provided a caution about an apparent trend of teaching mindfulness to individuals and groups without respect to a specific disorder creating the potential for harm, if not, ineffective outcomes. Furthermore, some types of mindfulness techniques may be better suited than other mindfulness methods in treating specific cases and disorders. For example, Kabat-Zinn, Chapman, and Salmon (1997) found that students who reported more somatic related anxiety did well with mindfulness meditation and those who experienced more cognitive anxiety did better with mindfulness-based yoga. Finally, knowing a specific technique may mean practicing or becoming adept with it prior to training clients in that technique. Some informal practices such as being mindful of one breath, known as one breath meditation, may take a lot less practice than mindfulness-based yoga, which might require several years of specific training before being able to train clients with it.

Integrate mindfulness with other techniques

Teasdale et al. (2003) noted that successful uses of mindfulness may be owed partially to the “coherent context of understanding” that the therapies are embedded in (p. 171). For example, Coffman et al. (2006) recommended that a leader of an MBCT group for the prevention of depressive relapse should know how to “tie mindfulness practices and inquiry to the prevention of depressive relapse” (p. 46).

Knowing mindfulness resources for clients

Knowing mindfulness resources for clients is considered important in mindfulness training. Resources include written, audio and visual material, local groups for ongoing practice of mindfulness, local mindfulness teachers in various spiritual traditions, and opportunities for mindfulness retreats. Written and audio materials are especially

important for mindfulness home practice and to help clients integrate the practice and encourage initial adoption before practice habits have formed. Furthermore, providing written, audio and visual materials in the primary language of the target population can add to mindfulness and patient self-regulated practice of mindfulness (Roth & Calle-Mesa, 2006). Being able to provide inexpensive materials, or even how to create these resources to meet the needs of specific clients or populations, is valuable (Roth & Calle-Mesa). Other resources might include information on local groups that practice mindfulness at different spiritual, religious and non-religious settings.

Engaging in mindfulness-based retreats

Literature suggests that counselors and psychotherapists may need to engage in mindfulness-based retreats to gain advanced knowledge of mindfulness. Retreats are considered advanced practice and should be engaged in after some persistent daily practice (Allen et al., 2006). For example, instructor qualifications for MBSR require two silent 5-10 day retreats that are led by teachers of the Zen or Theravadan traditions (Baer & Krietemeyer, 2006). Retreats are encouraged because the intensive mindfulness practice of a retreat help counselors and psychotherapists thoroughly understand and embody the practice.

Use of experts

Research literature suggests that expertise, or perhaps complex, domain specific ability, may take time to formulate. Skovholt, Rønnestad, and Jennings (1997) commented on expert professionals, stating that, “a thousand hours of practice and an average of 15 years may be meaningful in comparison to the novice” (p. 180). For example, O’Byrne, Clark, and Malikuti (1997) suggested that advanced experts are

highly skilled in “allocating attention to important elements and patterns in both structured and unstructured problems (and skilled at avoiding unimportant or redundant elements)” (p. 322). Furthermore, experts rely on a large store of learned as well as automated knowledge in their particular area of expertise to better tackle typical and atypical problems (Ericsson & Smith, 1991). It seems that long term practice and study affords for more in depth integration and learning.

Materials and Methodology

Researchers of this study wanted to know more about mindfulness competencies for counselors and psychotherapists, specifically to answer the following research question, to what degree do experts agree with a set of proposed mindfulness competencies? After reviewing the literature related to mindfulness training, the authors created an online survey that proposed a set of 16 competency statements based on the literature. The researcher identified, contacted and invited experts to participate. Demographic questions and questions related to professional contributions on mindfulness were included to ensure that the respondents possessed adequate experience and knowledge and were indeed ‘information rich’ in the domain of mindfulness training.

This research clearly stated that results did not apply to competencies needed for those practicing standardized mindfulness-based treatments (e.g., MBSR, MBCT, DBT). Many of these treatment programs and therapies have developed independent requirements or recommendations for training and use mindfulness in a specific context. Instead, competencies were geared toward the general and integrative practitioner of counseling and psychotherapy. Finally, the study focused on competencies to train clients to use mindfulness methods on their own, and did not specifically address competencies

for therapist mindfulness in session as an intervention strategy. Researchers added three questions to gather additional information about personal practice for those new to mindfulness as a specialty area. These questions related to the personal practice of mindfulness by counselors outside of clinical practice.

Method

Assessment of experts occurred online via a secure web site using a survey method recommended by Dillman (2007) based on a “social exchange theory of why people respond or do not respond to surveys” (p. 4). It uses multiple contacts with the target population in a respondent-friendly manner. Participants were provided with a consent form and an explanation of the project. The survey consisted of three sections (see Appendix D): (1) demographic questions as well as questions related to construct expertise- i.e., personal and professional involvement with mindfulness practice (13 items); (2) competency statements with Likert-type agreement scales (16 items); and (3) questions to invite recommendations for personal practice for those new to mindfulness as a specialty area (3 items). Subject matter experts evaluated items for the authors to gain content related evidence and face validity. A pilot was also given to doctoral level counselor education faculty and students for item clarification. Descriptive analysis provided information on the expertise of participants and also recommended levels of personal practice of mindfulness. Descriptive analysis was also used (means, standard deviations, percentiles) to address the primary research question regarding the perceptions of experts on the proposed competencies. The authors conducted reliability estimates on the 16 competency statements by using Cronbach’s Alpha. Additionally, principle component analysis was run to ascertain the construct validity of the 16

statements. Finally, hypothesis testing was used to see if there were significant differences between responses on the 16 competency statements.

Item development

Competency statements and recommendation questions were developed in conjunction with the professional literature. Dimidjian and Linehan (2003) cautioned that something might be lost from the secularization of mindfulness-based techniques from its original source of Buddhism. In heeding this caution, statements and questions were examined in their online format for face and content validity by a group of six counselors and psychotherapists who all have long-term daily mindfulness practices and who regularly teach mindfulness and meditation in the Buddhist tradition. This group was asked to maintain, reject or modify statements. Another successive step in developing questions was conducting a pilot utilizing doctoral students and faculty members in a counselor education and supervision program at a Northwest research intensive university. They were provided with the entire survey in an online format for further refinement.

Participants

A list of names (N=259) of potential participants was generated from the professional literature on mindfulness related to counseling and psychotherapy by using Ebscohost, including PsychInfo. The next procedure was locating publicly posted email addresses by using contact information published in the professional literature and by utilizing internet search engines. As a result of searching, a few other experts were discovered who had not published, but were intensively involved in mindfulness training in academic settings and other professional venues as noted by professional websites and

brochures. Because this research was interested in the entire population of experts and because researchers used questions to verify expertise, this was allowed. In addition, another small group was referred to the researchers directly by study participants after the study was in progress. The expertise of this referred group was checked by using internet search tools to confirm professional contributions on mindfulness (e.g., involvement in clinical practice or training of others in mindfulness methods).

This list of names was then narrowed to those whose email addresses could be found, and additionally, were current and accurate. Of this refined pool (N=157), another 22 contacts were removed for several reasons. A group (N=11) was removed by their request from the survey because they felt they were inappropriate for the survey- i.e., not a 'mindfulness expert,' or not a counselor or psychotherapist. Still others were removed as a result of vacation or sabbatical (N=8) or because of technical problems such as login failure (N=3). In the end, 52 (38.5%) of 135 participated in the survey out of a final pool.

Data was gathered from participants (N=52; 23 Female, 29 Male) on mindfulness. The group comprised participants from the United States (57%), Australia (9.6%), United Kingdom (9.6%), Canada (5.7%), Germany (3.8%), and 1.9% from the following: India, the Netherlands, Belgium and Sweden. The researchers wanted to gather demographics similar to the U.S. approach to racial/ethnic enumeration for greater understanding while acknowledging the international composition of participants would limit the usefulness of such a question. In studying global approaches to ethnic enumeration, Morning (2005) used UN statistical data gathered in 114 countries and commented that the "United States is part of a small minority of nations that use the term *race* for its primary ethnicity question" (p. 24). Despite the international composition of the participants, the authors

attempted to include a racial/ethnic demographic question noted by the label “North American Demographic Format” following the question, “What best describes you?” Participants were allowed to mark multiple boxes and fill in another blank. Included was a box noted as international. Results are as follows: International (11.5%), American Indian/Alaska Native (0%), Asian/Asian American (1.9%), Black/African American (0%), Hawaiian/Pacific Islander (1.9%), Hispanic/Latino (0%), White/European (76.9%), no response (1.9%), other (13.5%). “Other” category for this question represented a group of self-described “White,” “Caucasian” or “Anglo” background.

Participant religious/spiritual orientation consisted of the following in alphabetical order: Agnostic (15.4%), Atheist (13.5%), Buddhist (32.7%), Catholic (7.7%), Christian (5.8%), Jewish (3.8%), “spiritual, but not religious” (28.8%), and no response or other without response (9.6%). Some participants expressed their spiritual/religious orientation in more than one category.

In order to confirm the expertise of participants, the authors gathered data on professional contributions and involvement. The authors define *experts* as those participants who are rich in information and experience on the topic of mindfulness related to counseling and psychotherapy. All participants had obtained or were completing advanced degrees directly or indirectly related to counseling and psychotherapy: MA/MS in counseling or psychology (19.2%), Ph.D. in Counselor Education (1.9%) or Psychology (61.5%), Psy.D. (3.8%), M.D. Psychiatric (3.8%), M.D. other (1.9%), and other (17.7%) which included advanced degrees in public health (3.8%), neurophysiology, creative arts in therapies, epidemiology, and educational

psychology. The category “Other” included a group of students completing doctoral degrees in counseling or psychology (5.7%).

Participants, in general, actively practiced various mindfulness methods for a substantial amount of years. As a group, the mean was 13.98 years of meditation with a standard deviation of 10.6 reflecting a wide range of experience in terms of years practiced. For the most part, they also had routine practices; 44 (84%) participants practiced mindfulness methods weekly, and over 40% practiced one or more times a day. This group frequently practiced meditation and a range of mindfulness methods: body scanning (25%), mindfulness-based Yoga (35%), meditation (single object, narrowed attention types) 27%, meditation (choiceless awareness types) (56%), mindfulness of breath (67%), mindfulness of sound (31%), mindfulness of eating (25%), mindfulness of feelings and emotions (46%), walking meditation (27%), other (15%).

The participant group had substantial training in various mindfulness-based methods and mindfulness-based treatment packages. They represented a range of understanding related to the use of mindfulness-based treatment programs. They received training in or practiced the following: ACT (26.9%), DBT (17.3%), MBSR (36.5%), MBCT (30.8%), and other (15.4%). Of participants, 25% of respondents did not have mindfulness training from a specific treatment package orientation. Furthermore, when asked if participants had been trained in nine of the most common mindfulness practices, only 2, or 3.8% of the population said they had not received any formal training, and 33.5% marked that they had received formal training in all nine, suggesting that this group also had expertise in an array of mindfulness techniques.

Participants reflected a range of professional roles distributed between academic/research work and clinical practice. When gathering information about the participant's primary job, the authors received the following results: health professional (11.5%), mental health professional (28.8%), academic professor/educator (53.8), other helping professional (0%), student in helping profession (3.8%), and other (19.2% total comprised of 13.8% research related, 1.9% retired, 1.9% mindfulness trainer, 1.9% psychologist in health field).

Data indicated high levels of professional contribution on mindfulness in counseling and psychotherapy. When asked, "what best describes your involvement in mindfulness based work?" they responded in the following manner: contribute to professional literature on mindfulness (81%), conduct research on mindfulness (76%), provide consultation/supervision to students or other professionals on mindfulness-based methods (59.6%), train individual clients in mindfulness-based methods (50%), train groups of clients in mindfulness-based methods (50%), train student counselors and psychotherapists in mindfulness-based methods for use with clients (48.1%), provide/organize/facilitate programs that focus specifically on training helping professionals on mindfulness (38.5%), conduct community workshops for the public on mindfulness-based methods (26.9%), and train couples and families in mindfulness-based methods (1.9%).

Results

Competency statements, in general, were more than modestly endorsed by the group. The possible responses to the competency statements were: *Strongly Agree-5, Agree-4, Neutral-3, Disagree-2, and Strongly Disagree-1*. The competency statements obtained an overall mean rating of 4.03, with ratings for individual statements ranging from 3.71 to

4.38. This suggests strong support of the entire set, and greater than moderate to excellent support of individual items. Furthermore, the standard deviations for scores on the 16 items ranged from .63 to 1.10 indicating there was a tight rather than wide degree of variance in scores. To reiterate the strong support, out of 52 participants, 5 of the 16 statements had one or no responses of either “disagree” or “strongly disagree.” See Appendix A for results computed by means, standard deviation, and percentages of agreement and disagreement.

Participants were also asked to provide recommendations for those counselors and psychotherapists new to mindfulness practice. Three questions were posed. The first question was, “For how many years, minimum, should counselors and psychotherapists engage in personal mindfulness practice before beginning to train clients in mindfulness methods?” Responses had a range from 0 to 5 years, a mean of 1.56 years with a standard deviation of 1.5 years. The second question asked about how much mindfulness practice on a daily or weekly basis was recommended during an initial phase of practicing mindfulness. In examining the second question, all responses to this question indicated at least a weekly practice of mindfulness: 32 (63%) at least once daily, 6 (9%) recommended more than once daily, 13 (25%) recommended several times a week and 1 (1.9%) once weekly. This question included an “Other” entry fill-in blank. Several comments noted that frequency of practice related to formal and informal mindfulness practice. For example, one response proposed “formal daily practice with 'informal' mindful activity at multiple points in the day.” Similarly, another respondent advised, “More than once daily: I mean not simply daily formal practice, but bringing mindfulness into daily life (informal practice).” This suggests that the frequency of mindfulness

practice should take into account both formal and informal practice. The third question asked, “During a counselor or psychotherapist's beginning phase of personal practice of mindfulness, how many minutes per practice period do you recommend?” Responses ranged from “less than 10” (11.5%) minutes to “41-45 minutes” (15.4%). The mode (19.2%) was for “25-29 minutes” with 31 (60%) responses falling between 15 and 34 minutes.

Psychometric analysis

Reliability

Reliability for an instrument in a social science setting refers to an instrument's expected stability of measurement, which is often expressed by internal consistency coefficients. As test results increase in stability, it indicates the extent to which similar results will be obtained testing the same persons at various points in time (Anastasi, 1988). Cronbach's (1951) Alpha is widely used to measure internal consistency of psychometric instruments that are not scored dichotomously.

Cronbach's Alpha was used to compute the reliability of the studies' competency statements. The median reliability was .93. This alpha value indicates excellent internal consistency. Nunnally (1978) stated that reliabilities of .70 or higher are sufficient except in cases where the instrument will be used to determine critical decisions about an individual's life. When used to make critical decisions, reliability scores of .90, preferably .95, are used.

Validity

A principal components analysis (PCA) of the 16 items was conducted. PCA determines the amount of variance found in principle components. It is distinguished

from common factor analysis in that PCA does not differentiate between common and unique variance (Preacher & MacCallum, 2003). A principle component is defined as “a linear function of a set of variables that explains the theoretical maximum amount of (remaining) total variance in the correlation matrix” (Bryant & Yarnold, 1995, p. 131). PCA is often used to discover patterns in data and to express the patterns in such a way as to distinguish similarities and differences (i.e., shielding out unimportant noise). One of psychometric uses of PCA is to validate an index or scale by demonstrating that items load on the same component. It can also be used to drop items that cross-load on more than one factor (Fabrigar, Wegener, MacCallum, & Strahan, 1999).

Preacher and MacCallum (2003) stated that a researcher who wants “to determine linear composites of [measurable variables] MVs that retain as much of the variance in the MVs as possible, or to find components that explain as much of the variance as possible, should use PCA” (p. 21). The number of components to extract was determined by the size of the eigenvalues (greater than 1), and also by using a subjective scree plot test (Garsuch, 1983; Kaiser, 1960). As is the case in this study, it is more appropriate to retain eigenvalues greater than one when derived from an unreduced correlation matrix as compared to a reduced one (Preacher & MacCallum, 2003). There were three eigenvalues greater than one. See Appendix C and D for tables related to this study’s PCA results.

Fifteen of the 16 statements were accounted for by the first component with one being accounted for by the second component. Importantly, the competency statement related to metacognitive awareness was accounted for by the second component. None of the statements were accounted for by the third component. After the process of

determining the three components, then a PCA limited to those three components was conducted on the 16 items. The first component alone accounted for 51.7% of the variance. The first two components accounted for 61.6% of the variance.

Hypothesis testing

A normal distribution two-tailed hypothesis test was conducted on the 16 competency statements to test for significant differences between responses, especially for the item related to metacognitive awareness that did not load onto the first component of the principle component analysis. The null hypothesis was set at zero, assuming there was no relationship between responses to the 16 competency statements. Analysis was computed at alpha levels .01 and then again at .05 (see Appendix B).

Discussion

Results suggest that participants were indeed experts and, in general, they agreed with the 16 mindfulness competency statements.

Expertise of participants

The usefulness of this study rested on the participant pool having rich experience and expertise on mindfulness. According to the descriptive statistics above, results indicate that participants as a group have both long term and currently active personal mindfulness practices. As a result, their perspective on mindfulness competencies represents first hand experience. It is assumed that their perceptions of competencies are formed by long term involvement and reflective learning. Participant expertise may also reflect knowledge of how mindfulness competency is developed. The balance that participants demonstrated between experiential realms, personal practice, and professional contributions suggest that the pool also understands mindfulness by both

inductive and deductive learning processes. The descriptive data also suggest that they heavily contribute to the professional field on mindfulness. Results depicted a group that could speak to many realms of professional counseling and psychotherapy on mindfulness. They were involved in clinical practice: 50% trained individuals, 50% trained groups of clients in mindfulness-based methods and 26.9% conducted community workshops for the public on mindfulness-based methods. Participants are also familiar with mindfulness as a construct and are familiar with the mindfulness literature. This is assumed because a large percentages of the pool contributed to professional literature on mindfulness (81%), and conducted research on mindfulness (76%). As a group it also appears that participants are knowledgeable about training counselors and psychotherapists in mindfulness, because 59.6% provide consultation and/or supervision to students or other professionals on mindfulness-based methods, 48.1% train student counselors and psychotherapists in mindfulness-based methods for use with clients, and 38.5% provide, organize and/or facilitate programs that focus specifically on training helping professionals on mindfulness. Indeed, this group is ideal for obtaining information about the educational needs of counselors and psychotherapists who wish to train clients in mindfulness.

Mindfulness competency

For brevity and for ease of discussion, the authors have bundled individual competency statements that were seemingly related by topic into longer statements for discussion:

Counselors and psychotherapists who train clients in the use of mindfulness methods (1) understand how to integrate mindfulness methods and skills into everyday

tasks and behaviors, (2) practice mindfulness methods on a regular basis, especially when training others in these methods, (3) engage in the process of metacognitive examination by way of mindfulness practices, and (4) personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods.

The authors wanted to examine and learn more about perceptions regarding the importance of personal mindfulness practice by counselors and psychotherapists. The findings in this study support the notion that regular personal practice is an important part of being competent to train clients in mindfulness methods. Results suggests that practicing mindfulness for years may be less important to being competent than persistent active practice where one learns to integrate mindfulness into daily life. The statement that received least agreement (57.1%) and the second most disagreement (11.5%) of all statements was, "...personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods." This is in conjunction with the results on the recommended years of personal practice. The recommended years of personal practice prior to training clients in mindfulness had a mean of 1.56 year, but with a standard deviation of 1.5. Moreover, 33 (63.4%) participants recommended less than one year, while 20 of these 33, or 38.4% of the entire population, recommended half a year or less of personal practice before beginning to train others.

In contrast, results indicate that those training clients should have an active mindfulness practice. When presented with the statement, "...practice mindfulness methods on a regular basis, especially when training others in these methods," 78.8% of the group agreed while only 1.9% disagreed with this statement ($M=4.12$, $STD=0.86$). Participants were also asked, "During a counselor's or psychotherapist's beginning phase

of personal practice of mindfulness, at least how much practice of mindfulness do you recommend?" All responses suggested at least weekly mindfulness practice: 32 (63%) at least once daily, 6 (9%) recommended more than once daily, 13 (25%) recommended several times a week and 1 (1.9%) once weekly. Weekly personal practice of any technique is considered active by the authors.

This study supported the notion that informal practice is especially important to developing competency as indicated by the strong support of the statement, "understand how to integrate mindfulness methods and skills into everyday tasks and behaviors." This statement did not receive a single mark of disagreement and garnered the highest level of agreement of all statements (92%). Informal practice is supported because the integration of mindfulness into daily life necessitates informal practice. Fill in responses by participants to the question, "During a counselor's or psychotherapist's beginning phase of personal practice of mindfulness, at least how much practice of mindfulness do you recommend?" also confirmed this notion. Four of the five fill-in responses conveyed the importance of informal practice: (1) "Ideally, mindfulness should be practiced when engaged in all daily tasks, but formal meditation, for example, practiced at least once a day;" (2) "Formal daily practice with 'informal' mindful activity at multiple points in the day;" (3) "Daily informal practice-formal practice is helpful, but not necessary;" (4) "More than once daily: I mean not simply daily formal practice, but bringing mindfulness into daily life (informal practice)." These responses also suggest that regular or active practice relates to both informal and formal practice, not to the exclusion of one or the other.

Another important area related to personal practice is retreat participation. 63% of participants agreed and 9% disagreed with the statement, "...seek opportunities for mindfulness-based retreats to explore, understand and increase mastery of mindfulness methods." Experts, in general, agreed that counselors should seek opportunities for mindfulness based retreats, however, it was one of the lesser endorsed statements. The intensity and time costs of retreat may effect endorsement. Furthermore, retreats may not be readily available in all locations and in formats that are not religiously oriented. Retreats of 5 to 10 days are advanced practice that may be quite beneficial to counselor development, and yet, may not be necessary in order to train clients. The item design may have been less than ideal because it qualified the purpose of retreat participation as, "to explore, understand and increase mastery of mindfulness methods." Hypothesis testing showed that responses to retreats were significantly different than responses to items related to 'knowing the effects of different methods' and 'knowledge of the literature' at the .01 level and "distinguish between psychological processes," "cross-cultural/multicultural competencies," and "integrating mindfulness methods with other psychotherapeutic techniques" at the .05 level. The authors loosely suggest that retreat attendance is less related to features of clinical professionalism and skill. It may be that what is gained from retreats effects the counselor at a more base level. Such a notion is not surprising.

Hypothesis testing highlighted overall difference between the statement, "...engage in the process of metacognitive examination by way of mindfulness practices," and 7 other mindfulness competency statements, with the remaining 8 registering close to the null hypothesis cutoff level of (>0.355). Given the descriptive

analysis, which showed this item had greater than moderate agreement ($M=4.10$, $STD=0.75$, Agree= 80.7%, Disagree=1.9%), the authors suspect that this statement clearly relates to mindfulness competency, but unlike the other 15 competency statements, reflects competency within the practice of mindfulness. In conjunction, this competency statement was the only one of the 17 accounted for in the second component when principle component analysis was conducted. This leads to an important observation that the literature at times asserts, to be competent to train others may mean that one is willing to do the internal work and be competent in the practice of mindfulness itself.

Counselors and psychotherapists who train clients in the use of mindfulness methods (1) respect clients' culture, including religious and/or spiritual beliefs and values, that relate to physical and mental functioning, (2) are aware of cross-cultural/multicultural competencies relevant to applying mindfulness-based interventions and training.

The authors wanted to understand perceptions about the importance of cross-cultural counseling to mindfulness competencies. The statement, "...respect clients' culture, including religious and/or spiritual beliefs and values that relate to physical and mental functioning" received the fourth highest level of support ($M=4.19$, $STD=0.97$, Agree= 78%, Disagree=5.8%). This statement was adapted for mindfulness from the multicultural competency statement, "Culturally skilled counselors respect client's religious and/or spiritual beliefs and values, including attributions and taboos, because they affect world view, psychosocial functioning and expressions of distress" (III.A.1). It may have been a better fit for underscoring the need and value of respecting cultural

differences in mindfulness training than was the second statement which received the moderate support (M=3.71, STD=0.98, Agree=61.5%, Disagree=13.5%).

Counselors and psychotherapists who train clients in the use of mindfulness methods: (1) are able to recognize the limits of their own professional competence when training clients in mindfulness methods, (2) seek continuing education opportunities on mindfulness and mindfulness related topics, (3) have a fundamental knowledge and remain current in both the professional literature and the popular literature related to mindfulness, (4) consult and seek training when integrating mindfulness methods with other psychotherapeutic techniques, and (5) know of available resources for continued practice of mindfulness, including audio/visual, local meditation/mindfulness teachers and online resources.

The authors wanted to gauge perceptions about the importance of learning from other professionals, continuing education and knowing the limits of one's competency in mindfulness training. It appears that experts agreed most with the idea that being competent entails knowing the limit of one's competency in mindfulness training (M=4.19, STD=0.93, Agree=80.7%, Disagree=7.7%) and entails continuing education (M=4.27, STD=0.72, Agree=88.4%, Disagree=1.9%). Learning a new specialty area is more than having experience and receiving academic training, but also includes consultation and other training related to mindfulness. Knowing resources for continued practice was least endorsed of this set of statements even though it received greater than moderate support (M=3.92, STD=0.79, Agree=77%, Disagree=5.8%).

Counselors and psychotherapists who train clients in the use of mindfulness methods (1) are able to distinguish between psychological processes related to

mindfulness and other mental processes critical to clinical practice (examples include compulsion, obsession, hypervigilance, mindlessness, psychotic features, dissociation, and thought blocking), (2) have knowledge of the various types and methods of meditation and mindfulness, (3) have knowledge of which types of mindfulness methods are effective, ineffective and potentially harmful for use in treating specific types of mental health disorders, and (4) practice each specific mindfulness technique prior to using that technique with clients.

Based on the results of this study, in order to train clients in mindfulness methods in a clinical setting, counselors and psychotherapists need to know about various mindfulness methods and how they can be applied with regard to specific clients and disorders. This knowledge includes personal experience with these methods and also knowledge of the empirically based research on these methods. Counselor training clients to use mindfulness should be able to distinguish between mindfulness-related states of mind and other states of mind, especially those that are clinically significant. Continued research is essential to developing a better understanding of the mental health effects of different mindfulness methods

Limitations

First, these competencies did not originate from a consensus panel nor were they derived from a qualitative study with in-depth description. A qualitative study would no doubt yield additional information that is unable to be tapped by this research project in its quantitative format. This research did not ascertain consumer perspectives on mindfulness competencies. It was also hoped that response and representation could have been gathered from experts in social work and nursing as it related to counseling and

psychotherapy; no participants held degrees in either of these two disciplines yet many who practice counseling and psychotherapy hold such degrees. The above stated competencies did not delve into coursework or coursework requirements. No items were rejected, which may mean the study has possible limitations in failing to include marginally related content for exploration. Response rate may have been lower as a result of an online survey method, in comparison to a paper and pencil version of a survey. Researchers cannot know the perceptions of those experts that did not take the survey or who had difficulty with technical components. Using experts has limitations as well. The much admired Zen text, *Zen Mind, Beginner's Mind*, overstates the limitation but gets the feel of the limitation across, "In the beginner's mind there are many possibilities; in the expert's mind there are few" (Suzuki, 1970, p. 21). The author suggests that those who are competent are information rich which may at times limit the wonderful insights produced from naivety. Furthermore, experts may also have certain biases because of their vested interest in the topic. Although international in composition, the group represented primarily White, Caucasian or Anglo ethnic/cultural backgrounds, providing limited racial/ethnic cultural perspective from experts.

Recommendations

The authors do not intend for this to be a reified set of standards or competencies, but rather a continuation of efforts previously launched. It is hoped that further discussion of competencies will lead to better training of counselors and psychotherapists, and also that Western mental health will continue to craft what it means to be competent to train others in these ancient methods that have so much current clinical promise. In this way the further exploration of competencies may be a precursor to consistent and replicable

mindfulness training for counselors and psychotherapists that creates results noticeable in the lives of clients. Furthermore, the authors recommend that more venues for mindfulness retreats be created outside of the Buddhist spiritual tradition for those who are not of that religious and spiritual tradition, but would like be involved in retreats. Finally, the field would do well to create competencies related to therapist mindfulness in session. Advocates of mindfulness-based treatment packages could continue to create defined sets of teacher qualifications and competencies. It is also advisable to note that there may be limitations to the application of professional competencies, especially when rigidly applied.

Conclusion

In conjunction with findings in the literature about what it means to be competent, this research suggests that experts on mindfulness in counseling and psychotherapy, in general, agreed with 16 statements related to mindfulness competency. Competent counselors and psychotherapists engage in specific education, training and supervisory experience in order to train clients in mindfulness methods. They know the limits of their competence and respect a client's culture. There is evidence to suggest that in order to educate counselors and psychotherapist in this new specialty area, a set of competencies would be beneficial.

Chapter 3 References

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Chapter 4: General Conclusion

This dissertation study created two manuscripts thematically linked together in the examination of the use of mindfulness in counseling and psychotherapy. To address this theme the author discussed the construct of mindfulness. Reviews of the literature indicated the benefits of mindfulness training and the need for mindfulness competencies for counselors and psychotherapist. This document provided empirical research on mindfulness competencies to train clients in mindfulness by tapping into expert perceptions.

Explorations into the question, what is mindfulness, is an important first step in addressing the topic of mindfulness use in counseling and psychotherapy. Both manuscripts examined mindfulness as a psychological process, a set of methods from the Buddhist tradition and a skill to be developed. Efforts to define mindfulness for research purposes are continuing to evolve. Mindfulness is a transliteration of the Sanskrit word *Sati*, it is a complex and difficult to define pre-scientific concept.

Interest in mindfulness education for counselors and psychotherapists has increased. Counselors and psychotherapists may find it beneficial to receive professional training in mindfulness for three primary reasons: (1) empirical research is continuing to demonstrate that mindfulness is efficacious for client physical and mental health, (2) counselors and psychotherapists receive the same benefits as clients from personally practicing mindfulness, and (3) mindfulness training for counselors and psychotherapists may actually enhance clinical outcomes because of changes to counselor and psychotherapist qualities of mind and performance variables. This perceived desire for

educational opportunities provides a rationale for the introduction of mindfulness competencies to help guide training.

Reviewing the literature and investigating the perceptions of experts on a proposed set of mindfulness competencies for counselors and psychotherapists is one of the most important elements of this dissertation research. Both manuscripts point to the need for competencies and discuss what the literature indicates, however, the manuscript in chapter 3 takes this theme one step further by presenting more detailed discussion of competencies, the value of competencies to counseling and psychotherapy and provides results from a survey of a group of experts about their perceptions of mindfulness competencies.

The initial impetus for undertaking this dissertation was to explore questions that the author encountered while instructing counseling students on mindfulness. Counselors new to mindfulness ask a variety of questions. For how long should I sit in one meditation period? Is it better to sit for a half an hour several times a week or ten minutes everyday? How do you train a specific population to use mindfulness on their own? Such questions seem to repeatedly and naturally arise. In order to teach mindfulness methods to counselors a question emerges, what are the necessary skills students need to be successful with clients? The research for this dissertation was initially conceived of as a way to discover whether or not the perceptions of the author reflected the mindfulness literature and also the perceptions of mindfulness experts in counseling and psychotherapy. The initial exploration of this topic revealed the need for more research on what it means to be competent so that researchers and educators can continue with the

task of operationalizing answers to the question how should one train counselors and psychotherapist to be competent.

Both manuscripts provided information for those who are new to or are considering the use of mindfulness in clinical practice. One of the first steps in learning a new specialty area is finding the resources that make it possible to learn. The first and second manuscripts both indirectly and directly presented ways and resources to start practicing and learning about mindfulness.

The author is also vitally interested in how Eastern and Western mental health philosophy and practice are converging. The author's belief is that these two cultural systems have a lot to offer each other. The author has pursued the practice and study of mindfulness professionally and personally for over a decade. Though only briefly discussed in each article, the entire research is an example of the ongoing process of integrating, albeit one component, Eastern mental health into the Western system of care. Some of the challenges of this process were explored in both articles. Mindfulness appears to be the most adopted and researched therapy to be integrated by the West. In observing the multicultural movement in the counseling related professions, mindfulness is an example of how Western mental health has much to gain from outside its own traditional.

Recommendations for Future Research

Research should examine the relationship between competency to train clients and counselor mindfulness attitudes and qualities of mind developed by practicing mindfulness. More research may change or solidify understandings about what qualities of mind and attitudes a counselor embodies as a trainer. This current study addressed

important attitudes about developing as a trainer. In short, these attitudes related to a willingness to receive instruction, supervision, consultation and professional help outside of oneself in the pursuit of being competent. Competency statements did not address or propose competencies related to specific attitudes and qualities of mind developed by mindfulness or accessed when mindful.

Empirical research on the effects of different mindfulness techniques would increase competency when applying specific techniques by case and for specific disorder. Participants endorsed the statement, “Counselors and psychotherapists who train clients in the use of mindfulness methods have knowledge of which types of mindfulness methods are effective, ineffective and potentially harmful for use in treating specific types of mental health disorders,” suggesting that it is important for counselors and psychotherapists to have accurate information about different types of mindfulness methods. Such information would encourage more competent and judicial use of techniques.

Little research has tackled the effects of retreat participation by counselors and psychotherapists. Recommendations in the professional literature and the results of the current mindfulness competency survey suggest that retreats play a part in being competent. However, as far as the author knows, no empirical evidence exists on how participation in retreats will specifically enhance one’s competency to train clients in mindfulness. Finally, research should also explore the effects of retreat participation in general. It is the author’s experience that colleagues speak of going on retreat, but little research is available about such its occurrence and impact.

Future research could highlight what education, training and supervision is necessary when first adopting mindfulness as a new specialty area. For example, many resources are available for understanding the personal practice of mindfulness and the clinical application of mindfulness, however, a more in depth review of resources available for those adding mindfulness as a new specialty area. On top of initial education, this study highlighted the importance of continuing education to competency. Future investigations could examine the necessary educational elements that ensure counselors and psychotherapists remain abreast and competent.

Research is needed to explore what elements and approaches to supervision and consultation are useful in helping counselors and psychotherapist become more competent. Seeing that supervision and consultation was apparently valued in the current research findings, studies of supervisees and supervisors might elicit useful information.

Research on competencies more specifically related to the use of mindfulness in therapy is needed. Germer and colleagues (2005) observed the following, “The question that seems to arise most often in the minds of clinicians is how to integrate mindfulness into our daily practice of psychotherapy” (p. xiv). Despite a perceived importance, literature on mindfulness has centered on the beneficial effects of mindfulness training, while minimally covering the effects of therapist mindfulness in session. Research on therapist mindfulness in-session is not yet conclusive. The current study did not address competencies needed for in-session therapist mindfulness practice.

Finally, researchers should also consider engaging qualitative, phenomenological, and mixed method studies to explore the topic of mindfulness competencies in more detail. Other possible research areas include: developmental paths for becoming

competent, research related to consumer or client perceptions of the counselor competence, integration of mindfulness methods into different counseling emphasis areas (e.g., school, vocational rehabilitation), valid and reliable assessment measures for supervisors to use with counselors in training, the use of current mindfulness assessment instruments with mindfulness competencies, the perceived needs and differences between informal and formal mindfulness practice, and finally, how clinicians are integrating mindfulness into general practice.

Future uses of results from this study

The express purpose of this research study was to review the literature on mindfulness in counseling and psychotherapy and also to gain perceptions of experts on mindfulness competencies. Of importance, the expertise was the main charge for gathering data related to professional contribution and personal practice. However, future explorations of this data set would shed light on the endorsement of competencies. Future studies could also address whether or not there are significant differences in how experts endorsed certain competencies based on demographic variables, personal practice of mindfulness, acquired mindfulness training and professional involvement on mindfulness. In many cases, sample sizes are not large enough to generalize results, for example, one respondent (1.9%) identified as training couples and families in mindfulness based methods whereas 26 (50%) identified as having experience training groups. As another example, conclusions related to demographic variables related to racial/ethnic identity are not feasible because of the overwhelming homogeneity of the group; however, investigating differences in responses as it relates to gender would be of value.

One of the main areas for exploring demographic differences would be related to how specific competencies were endorsed by those of different spiritual/religious traditions. From the author's perspective, because mindfulness comes from the Buddhist tradition, a critical question is whether there are significant differences in the way Buddhists respond to the stated competencies and recommendations for practice as compared to those who do not identify as Buddhists.

The author believes that examining responses to competencies related to professional differences will be of merit. When examining data for each the 16 mindfulness competency statements and the three recommendations for beginning practice of mindfulness, do significant differences exist based on the following: training in mindfulness treatment programs (e.g., MBCT vs. DBT), educational degree type (e.g., Ph.D. vs. M.A.), training in different types of mindfulness methods (e.g., bodyscan vs. mindfulness of eating), different settings where they received mindfulness training (e.g., spiritual/religious setting vs. academic setting), and involvement in mindfulness work (e.g., supervision of mindfulness vs. research on mindfulness)?

Summary

There is sufficient evidence to suggest that mindfulness is beneficial for clients and also for counselors. Practicing mindfulness may indeed improve counselor attributes that are beneficial to counseling and psychotherapy. The literature suggests that counselors and psychotherapists need to engage in specific education and training to deliver mindfulness interventions and to train clients to use mindfulness methods. In conjunction with findings in the literature about what it means to be competent, this research suggests that experts on mindfulness in counseling and psychotherapy, in general, agree with 16 statements related to mindfulness competency.

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APPENDICES

APPENDIX A

Competency Statements				
<i>Statement stem phrase:</i> Counselors and psychotherapists who train clients in the use of mindfulness methods...	Mean	STD	% Agree	% Disagree
...understand how to integrate mindfulness methods and skills into everyday tasks and behaviors.	4.38	0.63	92.3	0.0
...seek continuing education opportunities on mindfulness and mindfulness related topics.	4.27	0.72	88.4	1.9
...are able to recognize the limits of their own professional competence when training clients in mindfulness methods.	4.19	0.93	80.7	7.7
...respect clients' culture, including religious and/or spiritual beliefs and values, that relate to physical and mental functioning.	4.19	0.97	78.8	5.8
...practice mindfulness methods on a regular basis, especially when training others in these methods.	4.12	0.86	78.8	1.9
...engage in the process of metacognitive examination by way of mindfulness practices.	4.10	0.75	80.7	1.9
...are able to distinguish between psychological processes related to mindfulness and other mental processes critical to clinical practice (examples include compulsion, obsession, hypervigilance, mindlessness, psychotic features, dissociation, and thought blocking.)	4.10	0.85	76.9	3.8
...have knowledge of the various types and methods of meditation and mindfulness.	4.04	0.74	78.8	1.9
...have a fundamental knowledge and remain current in both the professional literature and the popular literature related to mindfulness.	4.00	0.93	73	7.7
...have knowledge of which types of mindfulness methods are effective, ineffective and potentially harmful for use in treating specific types of mental health disorders.	3.96	1.07	75	13.5
...practice each specific mindfulness technique prior to using that technique with clients.	3.96	1.07	67	9.6
...consult and seek training when integrating mindfulness methods with other psychotherapeutic techniques.	3.92	0.90	67.3	5.8
...know of available resources for continued practice of mindfulness, including audio/visual, local meditation/mindfulness teachers and online resources.	3.92	0.79	77	5.8
...personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods.	3.81	1.10	57.7	11.5
...seek opportunities for mindfulness-based retreats to explore, understand and increase mastery of mindfulness methods.	3.77	0.90	63	9.6
...are aware of cross-cultural/multicultural competencies relevant to applying mindfulness-based interventions and training.	3.71	0.98	61.5	13.5

APPENDIX B

Hypothesis Test Correlation Matrix																
	Limits	Cross-cultural	Culture	Cont.Ed.	Metacog Awareness	Mindful types	Effect of types	Know Literature	Integration daily task	Psych processes	Retreats	Regular Practice	Prior practice	Integrate Other therapies	Practice Specific Tech.	Resources
Limits	1.000															
Cross-cultural	0.710	1.000														
Culture	0.719	0.783	1.000													
Cont.Ed.	0.568	0.645	0.656	1.000												
Metacog Awareness	0.368	0.388	0.379	0.463	1.000											
Mindful types	0.388	0.341	0.399	0.460	0.135	1.000										
Effect of types	0.601	0.648	0.576	0.424	0.103	0.449	1.000									
Know Literature	0.477	0.454	0.370	0.294	0.056	0.542	0.693	1.000								
Integration daily task	0.573	0.502	0.517	0.547	0.169	0.472	0.518	0.468	1.000							
Psych processes	0.574	0.509	0.526	0.377	0.326	0.464	0.548	0.624	0.590	1.000						
Retreats	0.476	0.347	0.389	0.494	0.413	0.367	0.236	0.258	0.401	0.313	1.000					
Regular practice	0.489	0.440	0.681	0.556	0.381	0.396	0.328	0.222	0.461	0.418	0.647	1.000				
Prior practice	0.476	0.457	0.493	0.438	0.427	0.514	0.444	0.383	0.503	0.503	0.567	0.627	1.000			
Integrate Other therapies	0.554	0.707	0.665	0.486	0.388	0.415	0.689	0.490	0.534	0.522	0.315	0.367	0.516	1.000		
Practice Specific Tech.	0.562	0.535	0.614	0.450	0.325	0.375	0.482	0.297	0.489	0.483	0.523	0.521	0.627	0.546	1.000	
Resources	0.449	0.531	0.558	0.592	0.345	0.577	0.533	0.482	0.534	0.364	0.555	0.479	0.614	0.679	0.627	1.000

Hypothesis Test - Correlation										
	0.3550	52	50	2.6851	0.009811	0.01	2.6778	0	> .355 leads to rejection of H0	
	Correlation coefficient	Sample size	Degrees of freedom	Test statistic	p-value	alpha	Critical value (two-tail)	Correlation	Conclusion:	
0.2740	52	50	2.0146	0.049344	0.05	2.0086	0	> .274 leads to rejection of H0		

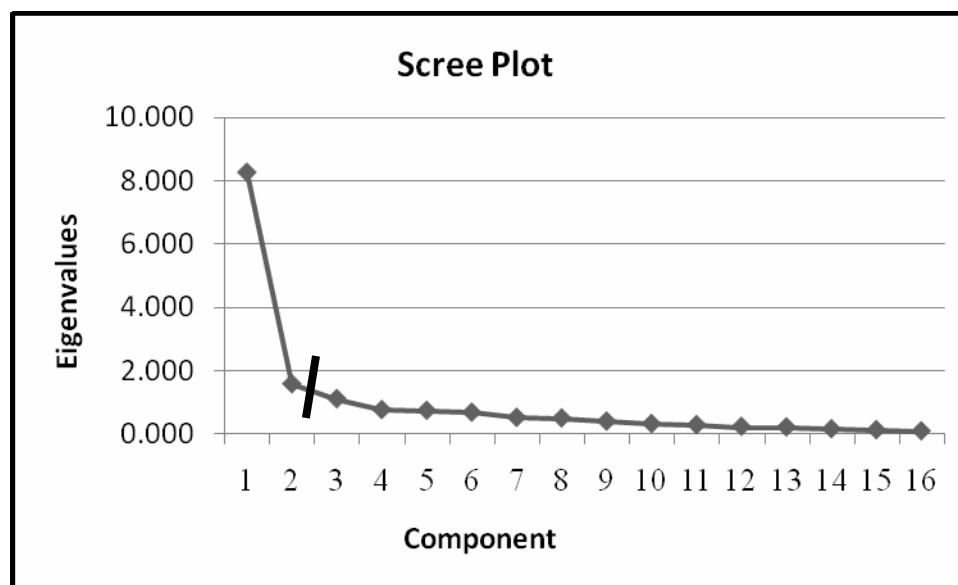
APPENDIX C

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	8.275	51.718	51.718	8.275	51.718	51.718
2	1.582	9.885	61.603	1.582	9.885	61.603
3	1.112	6.953	68.556	1.112	6.953	68.556
4	0.762	4.764	73.320			
5	0.741	4.634	77.954			
6	0.680	4.252	82.206			
7	0.518	3.239	85.445			
8	0.500	3.123	88.568			
9	0.399	2.491	91.059			
10	0.321	2.007	93.066			
11	0.285	1.783	94.849			
12	0.232	1.451	96.299			
13	0.217	1.356	97.656			
14	0.157	0.983	98.639			
15	0.127	0.791	99.429			
16	0.091	0.571	100.000			

Extraction Method: Principal Component Analysis. a. 3 components extracted.	Component		
	1	2	3
Q14. -Limits	0.791	-0.048	-0.253
Q15. -Cross-cultural	0.797	-0.091	-0.443
Q16. -Culture	0.826	0.069	-0.335
Q17. -CE Opportunity	0.739	0.230	-0.146
Q18. -Metacognitive	0.476	0.529	-0.263
Q19. -Mindful types	0.631	-0.189	0.494
Q20. -Effectiveness of types	0.733	-0.491	-0.101
Q21. -Knowing Literature	0.619	-0.584	0.219
Q22. -Integration daily tasks	0.728	-0.156	0.131
Q23. -Distinguish Psych processes	0.708	-0.266	0.038
Q24. -Retreats	0.626	0.477	0.330
Q25. -Regular Practice	0.697	0.429	0.139
Q26. -Prior practice	0.746	0.213	0.314
Q27. -Integrate Other therapies	0.783	-0.187	-0.225
Q28. -Practice Specific Tech.	0.744	0.163	0.045
Q29. -Know Resources	0.780	0.054	0.221

APPENDIX D

PCA Subjective Scree Plot



APPENDIX E

Survey Form

Introduction

General introduction

Answer questions and respond to statements from three sections related to mindfulness competencies for counselors and psychotherapists.

Section One: (13 questions) Information about you as a professional and your relationship to mindfulness practice and professional involvement with mindfulness training.

Section Two: (16 statements with Likert-type agreement scales) Respond to statements about mindfulness competencies for counselors and psychotherapists.

Section Three: (3 questions) Basic recommendations for counselors and psychotherapists who intend to train clients in the use of mindfulness methods.

Once again thank you!

1. What is your gender/gender identification?
 - Male
 - Female
 - Other

2. What is your nationality?
 - Australia
 - Belgium
 - Canada
 - Germany
 - India
 - Netherlands
 - New Zealand
 - Japan
 - United Kingdom
 - United States
 - Other

3. How do you describe your? (North American demographic format) Check one or more options-if you are not from a North American nation please mark "International" and use the "other" box to elaborate on ethnicity. All participants may use the "other" box to respond.)
 - International
 - American Indian or Alaska Native
 - Asian or Asian American
 - Black or African American
 - Hawaiian or Other Pacific Islander
 - Hispanic or Latino/a
 - White (Non-Hispanic) or EuroAmerican
 - No response
 - Other

4. How do you describe your religious orientation/affiliation? (please check one or more options to best describe you)
- Agnostic
 - Atheist
 - Buddhist
 - Catholic
 - Christian
 - Hindu
 - Jewish
 - Muslim
 - Spiritual but not religious
 - Other
5. What education degree do you hold?
- M.S. or M.A. in Counseling
 - M.S. or M.A. in Psychology
 - M.S. or M.A. in Social Work
 - Ph.D. in Counselor Education/related
 - Ph.D. in Psychology
 - Ph.D. in Social Work
 - Psy. D.
 - M.D. psychiatric
 - M.D. Other
 - Advanced Nursing Degree
 - Other
6. My primary job is:
- Health professional
 - Mental health professional
 - Academic professor/ Educator
 - Other helping professional
 - Student in helping profession
 - Other

Personal Involvement

7. What types of mindfulness methods have you received training in? (check all that apply)
- Body Scanning
 - Mindfulness-based Yoga
 - Mindfulness meditation (Single object, narrowed attention types-e.g., focused on breath, transcendental meditation[TM], Koan)
 - Meditation (Choiceless awareness types-e.g., shikantaza, shamatha without an object)
 - Mindfulness of Breath
 - Mindfulness of Sound
 - Mindfulness of Eating
 - Mindfulness of feelings and emotions
 - Walking meditation
 - Other

8. What best describes the frequency of your personal practice of mindfulness?
- More than once daily
 - Once Daily
 - Several times a week
 - Once weekly
 - Rarely
 - Never
9. What types of mindfulness methods do you frequently practice?
- Body Scanning
 - Mindfulness-based Yoga
 - Mindfulness meditation (Single object, narrowed attention types)
 - Meditation (Choiceless awareness types)
 - Mindfulness of Breath
 - Mindfulness of Sound
 - Mindfulness of Eating
 - Mindfulness of feelings and emotions
 - Walking meditation
 - Rarely practice
 - Other
10. For how many years have you practiced mindfulness methods? (e.g., 4.5=four and a half years)
11. In what settings did you receive training in mindfulness? (check all that apply)
- Academic
 - Work
 - Religious
 - Community-non-professional
 - Personal therapeutic or health setting
 - Other
12. What best describes your involvement in mindfulness based work? (check all that apply)
- Train individuals in mindfulness-based methods
 - Train groups in mindfulness based methods
 - Train couples and families in mindfulness-based methods
 - Train student counselors and psychotherapists in mindfulness-based methods for use with clients
 - Conduct research on mindfulness
 - Contribute to the professional literature on mindfulness
 - Provide Consultation/supervisions to students and other professionals on mindfulness-based methods
 - Provide Supervision of other professionals on mindfulness based methods
 - Provide/organize/facilitate programs that focus specifically on training helping professionals on mindfulness
 - Conduct community workshops for the public on mindfulness-based methods
 - Other

13. Do you professionally practice or teach the following mindfulness based therapeutic treatment packages? (Check all that apply)
- Acceptance and Commitment Therapy (ACT)
 - Dialectical Behavior Therapy (DBT)
 - Mindfulness Based Stress Reduction (MBSR)
 - Mindfulness Based Cognitive Therapy (MBCT)
 - None
 - Other (fill in text box)

Section 2 Instructions

Please respond to statements about mindfulness competencies by using the likert-type agreement scale.

The section below is intended to draw on your professional knowledge, practice and perception of basic competencies counselors and psychotherapists should have before beginning train clients in mindfulness methods.

NOTE: Statements in sections 2 are:

1). not intended for those training in mindfulness-based treatment packages that already provide a suggested course of training and related competencies (e.g., DBT, MBCT, MBSR)

2). not related to counselor and therapist mindfulness with clients as an intervention.

Important: all statements of section 2 begin with the sentence stem:

"Counselors and psychotherapists who train clients in the use of mindfulness methods..."

14. Counselors and psychotherapists who train clients in the use of mindfulness methods...are able to recognize the limits of their own professional competence when training clients in mindfulness methods.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
15. Counselors and psychotherapists who train clients in the use of mindfulness methods...are aware of cross-cultural/multicultural competencies relevant to applying mindfulness-based interventions and training.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree

16. Counselors and psychotherapists who train clients in the use of mindfulness methods...respect clients' culture, including religious and/or spiritual beliefs and values, that relate to physical and mental functioning.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
17. Counselors and psychotherapists who train clients in the use of mindfulness methods...seek continuing education opportunities on mindfulness and mindfulness related topics.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
18. Counselors and psychotherapists who train clients in the use of mindfulness methods...engage in the process of metacognitive examination by way of mindfulness practices.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
19. Counselors and psychotherapists who train clients in the use of mindfulness methods...have knowledge of the various types and methods of meditation and mindfulness.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree

20. Counselors and psychotherapists who train clients in the use of mindfulness methods...have knowledge of which types of mindfulness methods are effective, ineffective and potentially harmful for use in treating specific types of mental health disorders.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
21. Counselors and psychotherapists who train clients in the use of mindfulness methods...have a fundamental knowledge and remain current in both the professional literature and the popular literature related to mindfulness.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
22. Counselors and psychotherapists who train clients in the use of mindfulness methods...understand how to integrate mindfulness methods and skills into everyday tasks and behaviors.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
23. Counselors and psychotherapists who train clients in the use of mindfulness methods...are able to distinguish between psychological processes related to mindfulness and other mental processes critical to clinical practice (examples include compulsion, obsession, hypervigilance, mindlessness, psychotic features, dissociation, and thought blocking.)
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree

24. Counselors and psychotherapists who train clients in the use of mindfulness methods...seek opportunities for mindfulness-based retreats to explore, understand and increase mastery of mindfulness methods.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
25. Counselors and psychotherapists who train clients in the use of mindfulness methods...practice mindfulness methods on a regular basis, especially when training others in these methods.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
26. Counselors and psychotherapists who train clients in the use of mindfulness methods...personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
27. Counselors and psychotherapists who train clients in the use of mindfulness methods...consult and seek training when integrating mindfulness methods with other psychotherapeutic techniques.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree

28. Counselors and psychotherapists who train clients in the use of mindfulness methods...practice each specific mindfulness technique prior to using that technique with clients.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree
29. Counselors and psychotherapists who train clients in the use of mindfulness methods...know of available resources for continued practice of mindfulness, including audio/visual, local meditation/mindfulness teachers and online resources.
- Strongly Agree
 - Agree
 - Somewhat Agree
 - Somewhat Disagree
 - Disagree
 - Strongly Disagree

Basic Recommendations

Section 3 instructions: The next three questions are recommendations for generalist counselors and psychotherapists who intend to train clients in mindfulness methods.

30. For how many years, minimum, should counselors and psychotherapists engage in personal mindfulness practice before beginning to train clients in mindfulness methods? (Denote partial increments with a decimal point-e.g., .5 equals half year.)
31. During a counselor's or psychotherapist's beginning phase of personal practice of mindfulness, at least how much practice of mindfulness do you recommend?
- More than once daily
 - Once Daily
 - Several times a week
 - Once weekly
 - Rarely
 - Never
 - Other

32. During a counselor or psychotherapist's beginning phase of personal practice of mindfulness, how many minutes per practice period do you recommend?

- Less than 10
- 10-14
- 15-19
- 20-24
- 25-29
- 30-34
- 35-40
- 46-50
- 51-60
- 1:00-1:15
- 1:15-1:30
- 1:30-2:00
- More than 2 hours