Mindfulness and Self-Mastery

Applications of Mindfulness in Counseling

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> *The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgment, character, and will. No one is compos sui (master of himself) if he have it not. An education which should improve this faculty would be the education par excellence. But it is easier to define this ideal than to give practical instructions for bringing it about.*
>
> William James (1890)

> *Irrigators channel waters; fletchers straighten arrows; carpenters shape wood; the wise master themselves.*
>
> The Buddha (Cleary, 1995)

Despite the fact that William James considered attention to be fundamental to education and other qualities of character, he was doubtful about the practicality of cultivating it directly. However, James' (1890) description of "voluntarily bringing back a wandering attention over and over again" is the foundation of mindfulness practice (Kabat-Zinn, 2013). The incorporation of mindfulness practices into healthcare over the last few decades has provided a concrete method of improving attention that was not previously conceivable. According to Linehan (2015, p. 152), founder of Dialectical Behavior Therapy (DBT), which was one of the first and most important psychotherapies to include mindfulness, "Mindfulness as a practice is the repetitive act of directing our attention to only one thing. And that one thing is the one moment we are alive." By focusing on aliveness in the present moment, mindfulness not only improves attention, but it has also been shown to be effective for improving quality of life and decreasing distress (Brown,

Creswell, & Ryan, 2015). Mindfulness entails increasing non-judgmental awareness of the interactions of thoughts, emotions, physical sensations, preferences, desires, and communication to increase enjoyment and quality of life while decreasing habitual reactions that lead to unhappiness. Thus, in essence, mindfulness was seen as the key to self-mastery by both the Buddha and William James, although the latter was not aware of the formal practice of mindfulness as it is widely known today.

The power of mindfulness has been confirmed in research over the last 35 years. This research has shown mindfulness-based interventions (MBIs) to be effective in (1) promoting optimal wellness by increasing learning capacity and emotion regulation, (2) decreasing levels of distress from anxiety and depression, and (3) treating various DSM disorders including generalized anxiety disorder, social anxiety disorder, panic disorder, relapse in major depressive disorder, attention-deficit and hyperactivity disorder, and addictions including binge eating disorder (Brown et al., 2015; Didonna, 2009). Mindfulness has been applied and researched most frequently within psychoeducational programs and third-wave cognitive behavioral therapies (i.e. cognitive-behavioral therapies that incorporate mindfulness, acceptance, and dialectics) including Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT), Acceptance and Commitment Therapy (ACT), and Dialectical Behavior Therapy (DBT; Hayes, Follette, & Linehan, 2004).

Mindfulness has many applications in individual and group psychotherapy. These applications can been divided into the broad categories of therapist mindfulness, mindfulness-based therapy, and mindfulness-informed therapy (Davis & Hayes, 2011). This overview of mindfulness in psychotherapy is organized by these three overarching applications preceded by a section that provides background information including the history of mindfulness, definitions of

mindfulness, and evidence for its efficacy in healthcare. Following the initial background section, the second section focuses on therapist mindfulness and summarizes benefits of mindfulness practice by therapists. The third section covers mindfulness-based therapy and describes mindfulness practices that can be taught in therapy and outlines models for including mindfulness in both individual and group therapy. Finally, the fourth section focuses on mindfulness-informed therapy and describes of how mindfulness can be incorporated into various theories of psychotherapy to inform conceptualization, treatment planning, and in-session communication. Thus, based on 35 years of evidence, mindfulness has been shown to significantly improve health and reduce distress, and it can be applied through therapist mindfulness practice, mindfulness-based therapy that entails client participation in mindfulness practice, and mindfulness-informed therapy where mindfulness is applied to communication and conceptualization within various theoretical orientations.

History of Mindfulness

Although mindfulness is typically presented in healthcare as a completely secular approach with no religious content, it was derived from Buddhism (Kabat-Zinn, 2013). The Buddha's first and most important sermon consisted of the Four Noble Truths: (1) dissatisfaction and suffering pervade human life, (2) suffering is caused by misconception and unhealthy desire (3) liberation from suffering is possible, and (4) liberation can be attained by following the Noble Eightfold Path (Walpola, 1974). The Buddha's primary concern with liberation from human suffering is sympathetic to the mission of medicine and healthcare. Kabat-Zinn (2009) notes that the Buddha's first sermon follows a medical model including diagnosis, etiology, prognosis, and a treatment plan. Despite the fact that his life founded a religion that later incorporated a variety of metaphysical beliefs, the original intent was simply to apply a practical method to relieve

suffering. This knowledge may help demystify mindfulness, especially for those who may have aversion to learning practices associated with Buddhism.

Mindfulness and meditation were essential elements of the Buddhist path to liberation from suffering. In the *Satipatthana Sutta*, or Four Foundations of Mindfulness Sutra, which was composed 2,500 years ago and is one of the most important writings in the Buddhist tradition, the Buddha describes mindfulness as "the direct path for the purification of beings, for the surmounting of sorrow and lamentation, for the passing away of pain and dejection" (Bodhi, 2005, p. 290). In this sutra the Buddha describes numerous ways of developing mindfulness in order to achieve liberation from suffering. The *Satipatthana Sutta* inspired the 2500-year-old Buddhist tradition of mindfulness practice including many documents and various schools that potentially offer a tremendous amount of background information to help guide the emerging field of mindfulness in Western healthcare. Again, although mindfulness is taught as a completely secular approach, many developers, teachers, and researchers of mindfulness stress the importance of continuing to incorporate information and approaches from the Buddhist tradition (Kabat-Zinn, 2009).

Mindfulness in Western Mental Health

Jon Kabat-Zinn, Ph.D. has had the greatest influence in the origins and expansion of mindfulness as a mental health intervention and the scientific study of its efficacy. He realized the potential of mindfulness as an intervention in healthcare during a mindfulness retreat led by Zen monk and Nobel Peace Prize nominee, Thich Nhat Hanh (Thompson, 2012). Afterward, he decided to teach mindfulness practices in a completely secular program designed to promote health and provide a basis for scientific research into the efficacy of mindfulness.

In 1979, Kabat-Zinn began the program that has become known as MBSR. His early research focused on the efficacy of mindfulness as an intervention for chronic pain and anxiety. Research into mindfulness has increased since the preliminary results were published in 1982, and published papers on mindfulness have recently exceeded 50 per year (Kabat-Zinn, 2009). The MBSR course is now taught in many locations internationally and has influenced many other evidence-based mindfulness programs that target various disorders. Numerous books on mindfulness have also begun to appear and in 2010, Springer began publishing *Mindfulness,* a peer-reviewed quarterly journal.

Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness is Kabat-Zinn's quintessential overview of the MBSR program (Kabat-Zinn, 2013). It was first published in 1990 and is cited in many publications on mindfulness, The Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School was founded in 1995 to continue MBSR administration and research (Center for Mindfulness, n.d.).

Mindfulness has been incorporated into numerous other MBIs. MBCT was designed to prevent relapse of major depressive disorder and was based on MBSR with the addition of elements of cognitive therapy (Segal, Williams, & Teasdale, 2013). Both programs follow an eight-week psychoeducational group format with similar mindfulness practices and homework assignments (Kabat-Zinn, 2013). In addition to these psychoeducational programs, mindfulness has been incorporated into psychotherapies. Mindfulness, acceptance, and dialectics are considered to be key components that define the third wave of cognitive behavioral therapies, which include DBT and ACT (Hayes et al., 2004). Mindfulness practices derived from Zen Buddhism are a core component of DBT, which was developed to treat borderline personality

disorder and has since been expanded to treat a variety of other disorders (Linehan, 2015). While Acceptance and Commitment Therapy (ACT) does not include formal mindfulness practice, it entails in-session interventions derived from perspectives that arise from mindfulness (Hayes, Strosahl, & Wilson, 2012). ACT has been shown to be effective in treating anxiety disorders and is currently being researched in other contexts (Vøllestad, Nielsen, & Nielsen, 2012). In summary, MBSR, MBCT, DBT, and ACT are the four most prominent psychoeducational and psychotherapeutic MBIs. Many other MBI have been developed and researched, and these often target specific disorders, such as Mindfulness-Based Eating Awareness Training (MB-EAT) for binge eating disorder (Kristeller, Wolever, & Sheets, 2013).

Finally, a recent meta-analysis included 115 randomized controlled trials (RCT) of MBSR and MBCT with 8,683 total participants (Gotink et al., 2015). This meta-analysis provides an example of the number of studies and participants in mindfulness research over the last few decades. The number RCTs, recent publications, and new therapeutic approaches demonstrate the increasing influence of mindfulness in western healthcare over the last 35 years.

Definitions of Mindfulness

Mindfulness can be defined as a practice that a person does or as a quality that arises from mindfulness practice. Without knowing it, William James (1890) summarized the first definition of mindfulness as a practice: "voluntarily bringing back a wandering attention over and over again." This practice is known as focusing meditation, in which practitioners anchor their attention on particular sensory input such as the sensation of breathing, notice when distraction occurs, and bring their attention back to the anchor (Linehan, 2015). Focusing is often emphasized at the beginning of mindfulness education because it provides new practitioners with a clear awareness of distraction versus presence. Anchors such as the breath

and physical sensations are typically used because they help anchor attention in the present and also promote awareness of sensations, emotions, and other aspects of present-moment organic aliveness. Thus, both the practice of returning attention to the anchor and the nature of the anchor are important. Bringing attention back to anchors such as the breath and the body promote Linehan's (2008) definition of mindfulness as "the repetitive act of directing your attention to only one thing. And that one thing is the one moment you are alive."

Kabat-Zinn (2013), the founder of mindfulness in healthcare and originator of MBSR, defines mindfulness as "the awareness that arises by paying attention on purpose, in the present moment, and non-judgmentally." This definition focuses on the *quality* of awareness that develops though mindfulness practice rather than the *process* of the practice itself. Once the quality of mindfulness has developed through focusing meditation, a practitioner may begin to meditate by observing changes from moment-to-moment rather than refocusing attention on a single anchor. Opening meditation, or *choiceless awareness*, are names for these types of meditation in which the practitioner does not choose an anchor as in focusing practice, but simply remains aware of the movement of mind (Kabat-Zinn, 2013; Linehan, 2015). Practitioners of choiceless awareness may be able to observe the arising and passing of thoughts without significant distraction or the need to purposefully redirect attention.

Measures of Mindfulness

Several scales for measuring mindfulness as a quality have been developed. One that is used in the MBSR program is the Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). The five facets measured by this scale include observing both inner and outer experience, describing experience, acting with awareness, non-judging, and non-reacting. This scale demonstrates that mindfulness entails the development of a variety of

related qualities of observation and regulation that extend into all aspects of life. Thus, through the specific practices of returning attention to an anchor or maintaining present awareness, a person cultivates general abilities to observe and describe mental phenomena, avoid judgment and reactivity, and act with greater awareness.

Finally, it is important to note that since non-judgment is an important aspect of mindfulness, scales and other measurements should be applied with caution (Kabat-Zinn 1990/2013). Although these tools are essential to measuring the efficacy of mindfulness, it is important for students to be able to take up the practices with a sense of exploration rather than self-judgment that can arise from trying to cultivate specific qualities. In order to underscore this point, mindfulness is typically taught as a practice of focusing, noting distraction, and returning. It is important for teachers of mindfulness to address the common misconception that meditation and mindfulness practice require avoiding thought. Instead, the practice is to observe the arising and passing of thought with openness and acceptance.

Theories of Mindfulness

Mindfulness practice was not derived from theories of psychotherapy. Instead, interventions were adapted from the Buddhist tradition and tested in clinical trials. Therefore, the interventions and the evidence for their efficacy precede theories about how mindfulness works. Following the success of MBIs, however, various theories to explain the efficacy of mindfulness have been developed. Hölzel et al. (2011, p. 137) propose that mindfulness is effective through the processes of "(a) attention regulation, (b) body awareness, (c) emotion regulation (including reappraisal and exposure, extinction, and reconsolidation), and (d) change in perspective on the self." Attention regulation is the ability to stay on tasks and avoid distraction. Consequently, mindfulness has been demonstrated to have positive effects in the

treatment of ADHD (Van der Oord, Bogels, & Peijnenburg, 2012; Zylowska et al., 2008). Body awareness is increased sensitivity to physical sensation and can increase empathy and emotional awareness and regulation. Mindful emotion regulation also entails reappraisal, or the ability to reframe and take a more positive perspective toward emotional experience. Emotion regulation also includes exposure, extinction, and reconsolidation, which is the process of allowing emotions to arise and pass without repression, unskillful expression, or judgment until the sensations and emotions no longer affect behavior. Finally, mindfulness promotes a change in the perspective of the self that moves away from a static sense of self toward an awareness of the self as being contextual and as an unfolding process.

Neurology of Mindfulness

Neuroimaging studies of meditators have been conducted for many years. Garrison and Brewer (2013) sought to identify specific brain networks where the effects of meditation and mindfulness could be identified and measured. They focused on the default mode network (DMN), a group of structures in the brain producing a characteristic pattern that is deactivated during task-oriented behavior and activated during the absence of task-oriented behavior, particularly during mind wandering. More specifically, the posterior cingulate cortex (PCC), which is part of the default mode network, is associated with self-referrential processing, past and future thinking, cognitive distortions, emotional processing, anxiety, depression, and addiction. Garrison and Brewer list previous studies demonstrating reduced overall PCC activity in meditators and the ability of meditators to intentionally decrease PCC activity when faced with negative stimuli or challenging tasks. Their study included real-time fMRI neurofeedback to compare PCC activity with subjective reports of meditation experience. The study found that the PCC was inactive during periods of mindful awareness and active during thinking.

Additionally, experienced meditators were able to intentionally decrease PCC activity in real-time fMRI when viewing neurofeedback. This research demonstrates that the DMN and the PCC are areas where counteractive effects of mindfulness on cognitive distortion, rumination, and addictive craving can be observed. Additionally, experienced meditators demonstrate reduced overall PCC activity and are able to reduce PCC activity intentionally. Finally, real-time neurofeedback may be a means to increase students' ability to access states of mindful awareness.

Neurological Evidence for the Benefits of Mindfulness

Evidence for the efficacy of mindfulness is derived from both neurological imaging and psychometric studies from randomized controlled trials (RCTs) and other experimental designs. This section provides a brief overview of evidence for positive health benefits of mindfulness followed by a review of the most relevant meta-analyses, RCTs, and other studies of MBIs in the treatment of mental distress and disorders. Holzel et al. (2011, p. 36) provide an example of neurological evidence demonstrating positive health effects of mindfulness.

> Anatomical magnetic resonance (MR) images from 16 healthy, meditation-naïve participants were obtained before and after they underwent the 8-week (MBSR) program . . . (The study) confirmed increases in gray matter concentration within the left hippocampus . . . posterior cingulate cortex, the temporo-parietal junction, and the cerebellum in the MBSR group compared with the controls. The results suggest that participation in MBSR is associated with changes in gray matter concentration in brain regions involved in learning and memory processes, emotion regulation, self-referential processing, and perspective taking.

In accord with this study showing increase in gray matter in areas of the brain associated with learning and memory, a variety of other studies have demonstrated improvements in attention, perception, memory, and cognitive functioning resulting from mindfulness meditation (Van Vugt, 2015). Finally, studies demonstrate that mindfulness improves regulation of negative emotion and awareness of positive affect (Arch & Landy, 2015). These studies demonstrate that mindfulness cultivates greater ability to learn, adapt, and enjoy experience.

Evidence for Mindfulness as a Mental Health Intervention

In addition to these studies focusing on positive health benefits of mindfulness, numerous randomized controlled trials (RCTs) have been completed for MBSR, MBCT, DBT, and ACT showing effectiveness in treating distress and various disorders. Table 1 provides an overview of three meta-analyses that provide effect sizes for changes in anxiety and depression.

Table 1: Meta-analyses of MBI effects on anxiety, depression, and other health concerns

Lead author	Year	Studies	N=	Effect sizes: Cohen's d (Gotink), Hedge's g (Others)				
				Anx.	Dep.	Stress	Quality of life	Physical functioning
Gotink	2015	115	8683	0.49	0.37	0.51	0.39	0.27
Vøllestad	2012	19	491	1.08	0.85	Above only measured by Gotink		
Hofmann	2010	39	1140	0.97	0.95	For participants with disorders		
				0.63	0.59	For all participants		
Average				0.79	0.69			

Sources: (Gotink et al., 2015; Hofmann, Sawyer, Witt, & Oh, 2010; Vøllestad et al., 2012)

Gotink et al. (2105) included only RCTs of MBSR and MBCT, whereas Vøllestad et al. (2012) and Hoffman et al. (Hofmann et al., 2010) included various mindfulness and acceptance-based therapies including ACT and a mix of RCTs with other research designs. The average of the effect sizes of the three studies was large for reduction of anxiety (0.79) and medium to large

for the reduction of depression (0.69, Cohen, 1988). Hofmann et al. included analysis of follow-up studies demonstrating that effect sizes were 0.60 (medium to large) for both anxiety and depression at follow-up with an average follow-up interval of 27 weeks. Vøllestad et al. noted slightly higher effects for treatments including psychotherapy (such as ACT rather than MBSR and MBCT). Larger effect sizes (0.97 and 0.95) were observed for participants with specific disorders in Hofmann's analysis. Disorders represented in Hoffman's and Vøllestad's analyses included generalized anxiety disorder, social anxiety disorder, panic disorder, major depressive disorder, and ADHD. The studies within the meta-analysis typically measured changes in levels of anxiety and depression and did not report whether or not participants continued to meet diagnostic criteria following treatment. Overall, the three meta-analyses concluded that MBIs had significant effects in treating anxiety, depression, and other health concerns.

The meta-analyses cited above generally included studies that were targeted toward anxiety disorders with measurement of anxiety and depression. Several studies have been completed regarding effects of MBCT in the treatment of major depressive disorder (MDD). These studies showed that further relapse rates for group of people with three or more previous episodes of MDD were roughly half (37% compared to 66% in 2000 and 36% compared to 73% in 2004) for groups that received MBCT compared to treatment as usual (Ma & Teasdale, 2004; Teasdale et al., 2000). Further studies have demonstrated that MBCT is as effective in preventing relapse as continued antidepressant treatment once individuals have stabilized (Kuyken et al., 2008; Segal et al., 2010). In other words, participants who received MBCT followed by antidepressant discontinuation had similar relapse rates to participants who continued medication. These studies demonstrate that although antidepressants and cognitive therapy are the first-line interventions for major depressive disorder, mindfulness can aid in

preventing relapse and maintaining health during eventual transition away from antidepressant therapy.

Finally, mindfulness has been applied with success in the treatment of addictions, eating disorders, ADHD, and other disorders in various studies (Brown et al., 2015; Didonna, 2009; Kristeller et al., 2013; Van der Oord et al., 2012; Zylowska et al., 2008). More evidence is needed to address the efficacy of mindfulness in many of these areas, but studies to date show that mindfulness is a promising aspect of treatment for many disorders.

In summary, MBIs are highly effective for reducing levels of stress, anxiety, and depression and treating anxiety disorders (Gotink et al., 2015; Hofmann et al., 2010; Vøllestad et al., 2012). MBCT has been demonstrated to effectively reduce relapse in MDD, but cognitive therapy and medication are considered essential for treating MDD (Segal et al., 2013). MBIs that cultivate attention have shown promise in treating disorders based on attention regulation including ADHD and bipolar disorder, but more evidence is needed (Holzel, Lazar, et al., 2011). One of the major effects of mindfulness is increased emotion regulation. Thus, mindfulness is a core component of DBT and has been used effectively in the treatment under-regulation of emotion in borderline personality disorder and also shows potential to treat over-regulation of emotion in obsessive-compulsive disorder (Lynch, Lazarus, & Cheavens, 2015). Finally, MBIs demonstrate improvements in physical health and reduction of mental and physical distress stemming from physical illness (Gotink et al., 2015). Therefore, mindfulness has the potential to significantly reduce anxiety and depression and offers a variety of other benefits to increase the efficacy of therapy and improve quality of life.

Therapist Mindfulness

Based on this background information including history, definitions, theories, and evidence for the efficacy of mindfulness, the following sections will describe applications of mindfulness in therapy in the domains of therapist mindfulness, mindfulness-based therapy, and mindfulness-informed therapy (Davis & Hayes, 2011).

Therapist mindfulness involves personal mindfulness practice by therapists and applying qualities and principles of mindfulness to the therapeutic alliance and in-session communication (Davis & Hayes, 2011). Many of the mental health benefits derived from mindfulness practice are beneficial for therapists. In addition to benefits such as decreasing anxiety and depression that have been shown from studies on general and clinical populations, benefits that are particularly important for therapists have been shown in studies on participants in the medical and helping professions. Davis and Hayes (2011) list a variety of studies that demonstrate that mindfulness increases empathy and compassion and improves development of counseling skills based on self-report by therapists and medical students and analysis of interviews by therapists with long-term mindfulness practice. One particular study found strong correlations between the mindfulness-based qualities of non-judging and non-reacting and the qualities of self-compassion and empathy, including the ability to take the perspective of others (Kingsbury, 2009, dissertation cited in Davis & Hayes, 2011). Another study found that mindfulness was positively correlated with counselor self-efficacy and suggested that "mindfulness is a significant predictor of counseling self-efficacy and that attention is a mediator of that relationship" (Greason & Cashwell, 2009, p. 2). This demonstrates the power of attention regulation derived from mindfulness training as it applies to attending to clients. Finally, Davis and Hayes (2001) list several studies that have investigated effects of mindfulness practice by counselors on outcomes

based on client reports and progress. These studies have had conflicting results. Therefore, research demonstrates that mindfulness can provide many benefits to therapists and increase therapists' feelings of wellbeing, empathy, compassion, and efficacy; but these changes have not been shown to be obvious to clients in comparison with therapists who do not practice mindfulness.

Another aspect of therapist mindfulness includes incorporating qualities of mindfulness into the therapeutic communication and process. Kabat-Zinn (2013) describes seven qualities of mindfulness that include non-judging, patience, beginner's mind, trust, non-striving, acceptance, and letting go. Students of mindfulness are encouraged to apply these qualities to practice. Over time, mindfulness practice may increase and deepen these qualities. Finally, embodiment of these qualities that have been cultivated through years of practice is considered a prerequisite for teaching MBSR.

Additional qualities considered important in teaching mindfulness are outlined in the Minfulness-Based Intervention Teachning Assessment Criteria (MBI-TAC, Crane et al., 2012). This outline of competencies for teaching MBSR and MBCT covers relational skills and teacher embodiment of mindfulness. Relational skill competencies include authenticity and potency, connection and acceptance, compassion and warmth, curiosity and respect, and mutuality. Embodiment of mindfulness includes conveying mindfulness through the teacher's way of being, present-moment focus and responsiveness, calmness, and vitality. Therapist mindfulness can entail applying these qualities of a competent MBI teacher within the context of therapy.

In summary, therapist mindfulness includes mindfulness practice by therapists and communication and embodiment of qualities of mindfulness in therapy. These practices have therapeutic benefits that do not require explicitly teaching mindfulness to clients.

Mindfulness-Based Therapy

Mindfulness-based therapy entails teaching and assigning mindfulness practice to clients (Davis & Hayes, 2011). This section outlines formats for group and individual mindfulness training. It also includes descriptions of mindfulness practices that are typically part of MBSR, MBCT, DBT, and ACT and may be taught and practiced by clients.

Group and Individual Formats

Mindfulness has been demonstrated to be effective in both group and individual settings (Vollestad, Nielsen, & Nielsen, 2012). Teaching mindfulness in groups may help control treatment costs for clients because of the number of students that can be taught by a single professional and the likelihood of subsequent reductions in appointments and medication (Miller, Fletcher, & Kabat-Zinn, 1995). MBSR and MBCT are designed for large psychoeducational groups. Referrals to MBSR and MBCT may help augment individual counseling. In DBT, clients typically attend groups to learn mindfulness and other skills and also attend individual therapy. ACT contains therapeutic interventions derived from mindfulness that can be applied in individual or group therapy, but explicit mindfulness training is not involved. In addition to these well-known programs, there are many other treatment designs that incorporate mindfulness in individual, group, and combined contexts.

Mindfulness Practices

> *All of humanity's problems stem from man's inability to sit quietly in a room alone*.
>
> Blaise Pascal, Pensées (1995)

Mindfulness practices can be divided into formal and informal practices (Kabat-Zinn, 2013). Formal practices include meditation, body scan, yoga/stretching, walking, and eating. MBSR and MBCT include homework of 45 minutes of body scan, meditation, or yoga once per

day for six days per week (Kabat-Zinn, 2013; Segal et al., 2013). Informal practices include pausing to become aware of the present moment during the day, focusing on short tasks such as showering, and noticing sensations, emotions and thoughts as they arise during pleasant and unpleasant experiences during the day. MBSR and MBCT include a variety of informal practices as homework assignments.

The body scan entails sequentially bringing attention to physical sensations in sections of the body (Kabat-Zinn, 2013). All sensations, both pleasant and aversive, are ideally treated with curiosity and acceptance. Although relaxation may occur during the body scan, it is not a goal. Instead, practitioners notice sensations as they are without trying to change anything. This is a fundamental difference between the body scan and behavioral relaxation techniques. Over time, the body scan increases awareness, tolerance, and acceptance of sensations and emotions and promotes emotion regulation (Holzel, Lazar, et al., 2011).

Meditation can be divided into focusing meditation and opening meditation (Linehan, 2015). MBSR and MBCT include both types (Kabat-Zinn, 2013; Segal et al., 2013). Focusing meditation includes anchoring attention on the breath, physical sensations, ambient sound, and other anchors. Distractions are briefly noted and then attention is returned gently, yet firmly, to the anchor. Opening meditations consist of observing the phenomena such as sensations and thoughts as they arise in the present moment without returning to a specific anchor. MBSR and MBCT start by introducing brief breath meditation and work up to a 45-minute meditation sequence including both focusing and opening meditations later in the 8-week program. Meditation may particularly promote adaptive changes in relationship to thinking and perspectives of self (Holzel, Lazar, et al., 2011).

Stretching/yoga is a core component of MBSR and MBCT (Kabat-Zinn, 2013; Segal et al., 2013). As with the body scan, the emphasis is on present-moment awareness and sensitivity to sensation rather than achieving goals such as relaxation or athleticism. Non-striving and non-forcing are emphasized in mindful yoga. MBSR includes two 45-minute yoga sequences that are taught in class and assigned as homework. Although some poses may be challenging, the program is designed so that most people can participate mindfully and explore their boundaries regardless of physical limitations, even in a medical context.

Mindfulness Practices in DBT and ACT

Compared to MBSR and MBCT, mindfulness practices in DBT are generally shorter, more varied, and were originally adapted from Zen practice to help populations with high suicidality (Linehan, 2015). The practices focus on "what" and "how" skills. "What" skills include observing without reacting, describing experiences in words, and participating without self-consciousness. "How" skills include taking a non-judgmental stance, focusing "one-mindfully," and being effective: Doing what works rather than trying to be right. Related practices include observing and describing the breath and other sensations, guided imagery to help clients relate the stream of thinking and changes in mood to rivers and oceans, participating through singing and dance, and many other practices. DBT clients are trained in mindfulness in group settings and complete mindfulness homework to be discussed in individual therapy.

Although ACT does not include formal mindfulness homework, it includes in-session practices designed to increase mindful awareness (Hayes et al., 2012). For example, thoughts may be repeated until it becomes clearer that thoughts are linguistic patterns occurring in the present rather than facts about the past or future. Slowing down the pace of action and repeating thoughts slowly also helps clients distinguish the difference between thought and fact. Other

techniques include comparing getting "caught up" in maladaptive thinking to becoming involved in an internet phishing scam and asking clients to imagine that they are bus drivers with thoughts, emotions, and sensations as passengers. These and many other in-session interventions are used in ACT to create mindful awareness.

Loving-Kindness and Compassion

MBSR and other mindfulness programs include loving-kindness meditation. Loving kindness practices generally involve generating thoughts and feelings of loving kindness toward oneself and others. These practices promote self-compassion, which has become a new mindfulness-related field of psychological research and treatment (Neff & Dahm, In press). Researchers on self-compassion have observed that many people treat themselves poorly compared to their treatment of others. Self-compassion helps reverse this tendency. A recent meta-analysis of 14 studies of the effect of self-compassion on anxiety and depression demonstrated a large effect size (MacBeth & Gumley, 2012). Therefore, loving-kindness and compassion are important aspects of mindfulness practice, and self-compassion has become a growing therapeutic field on their own.

In summary, mindfulness-based psychotherapy can be conducted in group and individual formats and includes teaching and assigning a variety of formal and informal mindfulness practices. Since mindfulness has been demonstrated to promote optimum health and learning and to treat many disorders, these practices consist of a relatively simple set of interventions that can be applied to many situations.

Mindfulness-Informed Therapy

Mindfulness informed therapy entails incorporating perspectives from mindfulness into therapy in case conceptualization and in-session communication (Davis & Hayes, 2011).

Mindfulness is often considered a core component of third-wave cognitive behavioral therapies such a DBT and ACT. Additionally, MBCT is a combination of mindfulness interventions based on MBSR and psychoeducation based on cognitive therapy (Segal et al., 2013). Mindfulness is also considered an intervention that can be applied within the context of traditional CBT (Dimidjian & Linehan, 2008). However, mindfulness is applicable to other therapies outside of the context of CBT including experiential therapies. This section will explore mindfulness in the context of various theoretical orientations.

Behaviorism, Mindfulness, and DBT

Behaviorism and mindfulness are highly compatible. Researchers have noted many similarities between behaviorism and Buddhism (Garrison & Brewer, 2013). Codependent origination is a Buddhist concept stating that all things arise because of causes and conditions and pass when the causes and conditions change (Brazier, 2003; Walpola, 1974). Karma is often considered to be psychological cause, effect, and conditioning. Many Buddhists aspire to remove themselves from the cycle or karma or the cycle of conditioning. Although some Buddhists have metaphysical views concerning this process, many view it simply as raising psychological awareness through mindfulness practice to reduce habitual and conditioned reactions. Therefore, psychological cause, effect, and conditioning based on the interactions of thoughts, sensations, and emotions are fundamental concepts in behaviorism, mindfulness, and Buddhism.

Marsha Linehan was a behaviorist who developed DBT by adding elements of mindfulness derived from Zen Buddhism to a behavioral approach (Linehan, 2015). The first mindfulness skills used in DBT include observing and describing. This is one of the most important ways that mindfulness can augment a behavioral approach. Through mindfulness

practice, clients observe their present-moment experience and become more attuned to the interactions of thoughts, sensations, emotions, and communication. Then they learn to describe these aspects of experience with greater clarity. Since thoughts, sensations, emotions, and communications are all considerations in behavior analysis, greater awareness and ability to describe these components of experience by the client leads to greater client choice and control, clearer communication both within and outside counseling, and greater counselor understanding of influences on client behavior.

Another major aspect of mindfulness that augments a behavioral approach is non-judgment and non-reaction (Holzel, Lazar, et al., 2011). In addition to helping clients observe and describe components of experience such as thoughts, sensations, and emotions; mindfulness emphasizes allowing these experiences to arise, exist, and pass without judgment or reaction. Therefore, mindfulness practice cultivates the ability to pause and avoid immediate, habitual reactions. This breaks the chain of automatic behavioral reacting and the delay provides practitioners with time to develop new choices and choose more adaptive responses. Finally, observing the arising of experience without reacting is a form of exposure leading to extinction of conditioned behavior. Therefore, mindfulness promotes non-reactivity that can lead to the ability to delay response that facilitates less reliance on habit and conditioning. This non-reactivity can also lead to the extinction of habitual response to stimuli after sufficient exposure.

In summary, mindfulness can augment behavioral approaches by increasing awareness and ability to describe components of experience including thoughts, emotions, and sensations that affect behavior; and by increasing non-judgment and non-reactivity leading to more adaptive responding and extinction of maladaptive conditioning.

Cognitive Defusion, Mindfulness, and ACT

ACT provides an overarching therapeutic model that elucidates effects of mindfulness on cognitive awareness and identity (Hayes et al., 2012). In ACT, six core clinical processes are identified that include (1) present-moment awareness, (2) defusion, (2) acceptance, (3) dimensions of self, (5) connecting with values, and (6) committed action. The first four are directly related to mindfulness practice. As with most approaches to mindfulness, good present-moment awareness (1) is considered an essential quality of health and a benchmark for observing the process of attention, distraction, observation, and returning.

Defusion (2) involves differentiating cognitive and verbal processes from direct experience in order to become aware of problems created by compulsive thinking. Decentering is a similar term that is derived from cognitive therapy (CT) and emphasized in MBCT (Segal et al., 2013). Decentering is considered the most important therapeutic element of MBCT, and the process of decentering is more thorough and significant in MBCT compared to CT. Whereas in CT, decentering indicates the identification of thoughts to make change in the form of new thinking, decentering in MBCT means observing the fact that thinking consists only of language and images arising in the mind during the present moment. Intense observation of the process of thought during mindfulness practice leads to an increased awareness of thoughts as present-moment mental language and images rather than past and future realities. This decreases the felt significance of thought. When people are able to defuse from thinking in this way, they become less invested in their thinking and better able to evaluate their thoughts. Therefore, the traditional CT practice of changing thoughts becomes less important. This underscores one of the major differences between traditional CBTs and third-wave CBTs. Whereas traditional CBTs focus on stopping, changing, and replacing thoughts, third-wave CBTs emphasize

defusion from thought by observing the present-moment arising and passing of thoughts as mental language and images. This disempowers thoughts, and therefore, it becomes less important to replace them because they have already lost their effect over the thinker.

Acceptance (3) is an important element of cognitive defusion and the behavioral elements of mindfulness. Whereas self-judgment and reactivity to thought perpetuate obsessive thinking, acceptance of the process of thinking by allowing thoughts to arise promotes clear observation that leads to defusion. Similarly, acceptance of sensations and emotions leads to reduced reactivity and extinction of conditioning.

Once a person begins to defuse from thinking, changes in self-perspective occur. Dimensions of self as a therapeutic focus of ACT involves reducing identification with the (a) conceptual self and increasing awareness of the (b) self as an ongoing process through continuous self awareness and the (c) self as context through the ability to take perspective. Thus, ACT is a therapeutic theoretical orientation that parallels the general theory by Hölzel et al. (2011) that changing the perspective of self is a major process underlying the efficacy of mindfulness practice.

Cleary, mindfulness practice is highly applicable within CBT including behavioral approaches that entail reducing reactivity and extinction of conditioning and cognitive approaches that entail defusion from thinking and creating more adaptive self-perspective. This change in self-perspective will continue to be a theme in the following outline of applications of mindfulness in experiential theories.

Existential, Humanist, and Experiential Therapies and Mindfulness

"One of the basic tenets of Zen . . . . empahtically states all beings are intrinsically perfect and complete, lacking nothing" (Loori, 2013, p. XVII). Sixteenth-century Zen master Han-Shan (2012) elaborates on this perfection by saying, "

> It is originally inherent in everyone, actually complete in each individual, lacking nothing at all, nevertheless for beginingless ages the seeds of the root of attachment, subjective ideas, and emotional thinking have become so deeply ingrained as habits that they block and cover the subtle light.

This idea that people possess unconditional wholeness that is obscured by habitual thoughts and emotions contains elements of both humanist and behavioral perspectives. This section will explore affinities between mindfulness and traditional humanist/experiential theories of psychotherapy including person-centered, *Gestalt*, and existential therapy. Humanist and existential aspects of third-wave CBTs will also be described to further elucidate experiential aspects of mindfulness. Finally, mindfulness practice in Buddhism was informed by humanist perspectives and conducted toward the resolution of existential questions. Many of these elements have been lost in the secularization of mindfulness, but they are important is describing affinities between mindfulness and experiential theories.

One of the themes of this exploration of mindfulness in experiential therapies is the difference between the observation of components of experience that characterizes CBT and the emphasis on full participation in the wholeness of experience in humanism. In DBT, this resolution of this dichotomy is sought thought the cultivation of wise mind, which is seen as the balance of rational mind and emotional mind and also a balance of *doing mode* and *being mode*, which are terms used frequently in MBCT. Linehan (2015, p. 153) describes these modes as

follows: “There are also two stances one can take in practicing: either getting distance by pulling back and watching, or moving forward and becoming ‘what is.’” In addition to mindfulness skills that promote observing without reacting, DBT includes skills that promote full participation without self-consciousness. This is a shift away from the observational skills that facilitate cognitive defusion and reduced reactivity toward an active stance that is more phenomenological in nature. This emphasis on full participation and phenomenological experience is one of the major affinities between traditions of mindfulness and humanism.

Person-Centered Therapy and Mindfulness

In developing person-centered therapy, Rogers proposed that the necessary and sufficient conditions of change are psychological contact between two people in which the client, who is in a state of incongruence, moves toward congruence through the communication of accurate empathetic understanding and unconditional positive regard from the therapist, who is congruent (Rogers, 1957, p. 95). There is evidence that mindfulness helps promote these core conditions. Clearly, the Zen principle that “all beings are intrinsically perfect and complete, lacking nothing,” is a strong foundation for unconditional positive regard (Loori, 2013, p. XVII). One practice that is introduced in ACT involves asking clients to slowly repeat the words, “I’m whole, complete, perfect,” and then process reactions and resistance to this affirmation. Hanshan’s observation that “habits . . . cover the subtle light” demonstrates the perspective that inherent perfection is already within a person to be discovered and actualized. A common theme in Zen is that a person cannot *become* enlightened because enlightenment is both a quality that is already possessed and the *process of becoming itself*, rather than a final destination. This act of becoming what one already is and identifying with the process of becoming has congruence with Roger’s (1995) concept of “becoming a person.”

In addition to providing a foundation for unconditional positive regard, mindfulness also promotes empathy, psychological contact, and congruence. Studies have shown increased empathy in self-reports by populations of mindfulness practitioners in the medical and helping professions (Davis & Hayes, 2011). Similar studies have also shown self-reported improvements in counseling skills and self-efficacy.

Rogers defined incongruence as "a discrepancy between the actual experience of the organism and the self picture of the individual insofar as it represents that experience." Since mindfulness practice entails paying attention to actual experience and letting go of the self-picture, this suggests that mindfulness is fertile ground for cultivating congruence. Particularly, practices like the daily 45-minute body scan assigned in MBSR strongly promote awareness of actual experience consisting of sensation and emotion (Holzel, Lazar, et al., 2011; Kabat-Zinn, 2013). Further, defusion and changes in self-perspective brought about by mindfulness involve "letting go of the self-picture." Rogers, (1995, p. 187) describes "the good life, from the point of view of my experience, (as) the process of movement in a direction which the human organism selects." Rogers emphasis on the good life as a process rather than a state parallels the increased identification with the contextual and processual self and decreased identification with the conceptual self, which is a core process that is cultivated by mindfulness and elucidated in ACT.

Now that affinities between mindfulness and the person-centered qualities of positive regard, empathy, congruence, process, and organismic living have been described, an exploration of similarity between Gestalt therapy and mindfulness will focus on bringing organismic experience into full participation in life.

Gestalt Therapy and Mindfulness

> Experience occurs at the boundary between the organism and its environment, primarily the skin surface and the other organs of sensory and motor response . . . We speak of the organism contacting the environment, but it is the contact that is the simplest and first reality. You may feel this at once if, instead of merely looking at the objects before you, you also become aware of the fact that they are objects in your oval field of vision, and if you feel how this oval of vision is, so to speak, close up against your eyes — indeed, it is the seeing of your eyes. Notice, then, how in this oval field the objects begin to have aesthetic relations, of space and color-value. And so you may experience it with the sounds "out there": their root of reality is at the boundary of contact, and at that boundary they are experienced in unified structures. (Perls, Hefferline, & Goodman, 1994, p. 3)

These lines begin Perls' discourse on *Gestalt* therapy. Perl's theory is founded on contact through the senses as being the fundamental reality, with the observation that even the conceptualization of this contact as being between an organism and an external reality is secondary. Mindfulness practices such as the body scan emphasize this observation on the level of repeated experience rather than simply as an intellectual observation. In the *Four Foundations of Mindfulness Sutra*, the Buddha describes a meditator as follows: "He understands the ear, he understands sounds . . . He understands the nose, he understands odors . . . He understands the tongue, he understands flavors . . . He understands the body, he understands tactile objects" (Bodhi, 2005, p. 288). This illustrates the focus on sensory experience in mindfulness practice, which has the potential to increase awareness, understanding, and the appreciation of the significance of sense contact for Gestalt therapists and clients.

A *gestalt* is sense contact that arises like a visual figure standing out on the background of an artist's paper or canvas. The canvas, known as the *ground* in Gestalt therapy, is the overall field of organismic experience. The formation of a figure of contact on the ground of organismic experience is similar to the arising of thoughts, sensations, and emotions as objects within overall awareness, which is observed repeatedly during mindfulness practice. The object of gestalt therapy is to make clear contact in which the ground of organismic experience increases the vividness of the gestalt. Therefore, in contrast to emphasizing being mode, or simply observing arising phenomena, Gestalt therapy focuses on full participation with affinity to Linehan's (2015, p. 153) approach to mindfulness as "moving forward and becoming 'what is.'" Therefore, a Gestalt approach may help emphasize the participatory aspect of mindfulness in contrast to the observational quality emphasized in CBT.

Additionally, Gestalt therapy and mindfulness share emphasis on the "here and now" (Perls et al., 1994). Mindfulness practices involving focusing on present moment experience have the potential to increase one's ability to remain in the "here and now." Finally, Gestalt therapy involves conducting experiments within therapy, and mindfulness practices may fit seamlessly into this structure.

Existentialism and Mindfulness

Although mindfulness has been applied primarily as a health intervention in the West, in Buddhism it was directed toward answering existential questions about suffering, death, and the self. Therefore, mindfulness in its original context and existentialism share a common goal of coming to terms with suffering and the givens of human existence. Yalom (1980) proposed the four givens of existence as an essential focus of existential therapy. These include death, meaninglessness, existential isolation, and freedom and responsibility. Buddhism proposes a

similar list of the three marks of existence, which include impermanence, suffering, and selflessness/emptiness (Walpola, 1974). These lists are similar, yet the four givens focuses on the big picture, whereas the three marks focus on details of experience. For example, death is perhaps the most devastating aspect of impermanence, which occurs constantly on a subtle level throughout human experience. Mindful attention to moment-by-moment impermanence is intended in Buddhism to promote insight into death. Likewise, the given of meaninglessness and the mark of selflessness/emptiness both hold that life and phenomena are not intrinsically meaningful. Instead, humans create meaning and significance. Mindfulness practitioners observe how attention and thinking create significance and meaning on a moment-to-moment basis. These examples demonstrate that mindfulness practice has the potential to provide insight into overarching existential concerns through the detailed observation of experience. The great Buddhist teacher Padmasambhava summed this up by saying, "Though your vision is as vast as the sky, your attention . . . should be as fine as a grain of barley flour" (Salzberg & Goldstein, 1996, p. 57).

In accord with Yalom's existential given of freedom and responsibility, Buddhism underscores the importance of ethical and intentional living. Freedom and responsibility within all conditions are emphasized in both existentialism and Zen (Batchelor, 1983; Frankl, 1969). ACT connects mindfulness and existentialism by including values clarification and committed action in the six major therapeutic domains (Hayes et al., 2012).

Several previous explorations of existentialism, mindfulness and Buddhism have been conducted. Batchelor (1983) describes relationships between Buddhism and existential philosophy with an emphasis on the paradox of existential isolation and interdependence. Nanda (2009) proposes mindfulness-based existential therapy with and emphasis on the

phenomenological approach characteristic of both traditions. Due to the strong emphasis on existential themes in Buddhism, there is ample common ground for further exploration of mindfulness and existentialism.

This overview of mindfulness in humanist/experiential/existential therapies has focused on the role of mindfulness practices such as the body scan to raise awareness of one's organism and sensory contact, which are emphasized in person-centered and Gestalt therapy. Mindfulness also promotes a shift toward identification of the self as a process, paralleling Roger's theory of "becoming a person" (Rogers, p. 187). Mindfulness emphasizes full participation in life similar to creating vivid contact in Gestalt therapy. The Buddhist tradition employed mindfulness toward exploring existential themes and achieving liberation from suffering, and this provides potential applications for existential therapy. Finally, Buddhism and existentialism emphasize authenticity and responsibility, and this approach has bee integrated in ACT. Overall, there are many affinities between mindfulness and humanism that warrant further exploration.

Summary

In summary, this paper has explored applications of mindfulness in therapy including background information such as history, definitions, theories, and evidence for the efficacy of mindfulness. Therapist mindfulness was described including benefits of mindfulness practice for therapists and the therapeutic alliance and ways to embody qualities of mindfulness in session. Mindfulness-based therapy was outlined including mindfulness practices that can be taught to clients and models of individual and group programs. Finally, mindfulness-informed therapy was explored in the context of mindfulness as it applies to CBT and humanist therapies. Overall, it is clear that there is ample evidence for the benefits of mindfulness in mental health and many ways that mindfulness can be applied.

Conclusion

In closing, this overview of mindfulness began with assertions by William James and the Buddha that mindfulness leads to self-mastery. Indeed, understanding and mastering the self are the major task of the great religious and psychological traditions started by these forefathers. Mindfulness has expanded psychological perspectives on the self. Through mindfulness practice, it is possible to defuse from thinking, reduce identification with the conceptual self, and increase identification with contextual, processual, and organismic aspects of self. These perspectives of self promote increasing awareness, openness to experience, and contact with others and the world. Eihei Dogen, the great Zen master of 13th century Japan, summarized this change in perspective of the self with these lines that have grown to define the Zen tradition:

> *To study the Way is to study the self.*
>
> *To study the self is to forget the self.*
>
> *To forget the self is to be enlightened by all things of the universe.*
>
> (Kim & Leighton, 2004)

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