Mindfulness Practices in Counseling

A History and Literature Review

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Mindfulness exercises, practices related to meditation and long used within religious contexts, are increasingly being used in counseling.[1] "Mindfulness" is an English translation of the Pali word *satipatthana*, from *sati* which means "attention" or "awareness" and *patthana* which means "placing near" or "keeping present." The mindfulness practices used in counseling have been derived primarily from Buddhist traditions and involve focusing one's attention and awareness on what is happening in the present moment, being deliberately attentive to the here and now, without being distracted by evaluating or intellectualizing what is experienced (Nyanaponika, 1962).

Although much research has been published on the question of whether such practices have positive effects when used by the clients of counselors, less has been devoted to the equally important question of whether mindfulness practices undertaken by counselors can improve their counseling abilities. Presently counselor training relies primarily on the development of interpersonal skills (e.g., microcounseling skills such as eye contact and reflection of client statements) and cognitive skills (e.g., the ability to conceptualize cases); empirical research on the effectiveness of such training for improved client outcomes is sparse and the results have been inconclusive albeit encouraging (Buser, 2008). There is, however, another dimension of counselor competence that has not been addressed in training programs: the ability to be attentive and remain "present" to a client, to maintain focus, and to notice details about what is happening at the moment. These are key counseling skills that mindfulness practices target and claim to strengthen, and if these practices could be shown to be effective in that goal they would be an important addition to counselor training programs. In addition, counselors already in practice could further develop these skills by taking up mindfulness

[1] In this paper, the words "counselors" and "counseling" are used to represent all practitioners and practices of talk therapy, including professional counselors, social workers, and clinical psychologists.

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practices

The impetus for the use of mindfulness practices in counseling came primarily from the modern Western encounter with Asian spiritual traditions, particularly Buddhism.[2] Western scholars began seriously studying Asian religions in the early 19th century, but interest escalated in the mid-20th century when international conditions following World War II facilitated increased contacts between East and West. Spurred by the writings of D.T. Suzuki, a Japanese translator, author and lecturer who taught at Columbia University in the early 1950s, Western intellectual and artistic circles of that time became especially interested in Zen Buddhism, a Japanese Buddhist tradition that emphasizes meditation (Abe, 1986; Mitchell, 2002; Verhoeven, 1998).

Although Suzuki and a few other pioneering Japanese scholars had brought a modern psychological approach to the study of Zen early in the 20th century (Akishige, 1977; Kato, 2005; Sato, 1968), the interest of Western psychologists and psychoanalysts lagged until after the war. The psychoanalyst Karen Horney was among the first to take notice, citing Suzuki in a 1945 work and in 1952, at Suzuki's suggestion, traveling to Japan to pursue her interest in studying Zen (Horney, 1945; Kora & Sato, 1958). Carl Jung, who wrote a foreword for the 1948 republication of Suzuki's *Introduction to Zen Buddhism,* was another (Jung, 1948/1954). In 1951 Albert Stunkard published an article comparing the master-disciple relationship in Zen to the therapist-client relationship in psychoanalysis (Stunkard, 1951), a theme later echoed by Lederer (1959), and the French psychiatrist Hubert Benoit published a well received book relating Zen concepts to his philosophy of human psychology (Benoit, 1951/1955). Erich Fromm organized a conference on Zen Buddhism and psychotherapy in the summer of 1957 (Wolf, 1957) and published some the proceedings a few years later (Fromm, Suzuki, & DeMartina, 1960). In 1958 a new English-language Japanese psychology journal *Psychologia* began publishing articles on Zen and Western psychology from both Eastern and Western authors (Kora & Sato, 1958; Sato, 1958; Van Dusen, 1958a; Van Dusen, 1958b), with

[2] Langer has published research on "mindfulness" defined as increased attention due to the expectation or perception of novelty, a concept derived from psychological research and not Buddhism (Langer, 1989, 1993; Langer, Bashner, & Chanowitz, 1985; Langer, Blank, & Chanowitz, 1978; Langer & Imber, 1980). Her research has not been applied to counseling.

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both Fromm and Harold Kelman, Horney' successor at the American Institute of Psychoanalysis, contributing articles the following year (Fromm, 1959; Kelman, 1959). Kelman's article, in turn, inspired a brief editorial on the topic in the *Journal of Clinical Psychology* (Thorne, 1960), while articles on Zen began to appear in other Western psychological publications as well (Ben-Avi, 1959; Maupin, 1962).

Up to this point the research was primarily focused on theoretical issues, such as interpreting Zen concepts and comparing them to those of Western psychological theories, rather than on experimentation utilizing Zen practices. A prominent theme was that the Zen concept of *satori* (awakening, or enlightenment) pointed to the universal aim of human psychological development and that Zen practices and psychoanalysis were different methods for moving people toward this; there was also general agreement that psychotherapists could benefit from studying Zen. Thorne went a step further, urging that all clinical psychologists should obtain "direct first hand experience with the things which Zen Buddhism…deals with" (Thorne, 1960, p. 453), and Berger (1962) amplified this point by discussing how the Zen practice of avoiding subject-object duality in favor of "no thought" perception and action could be related to the counseling practice of experiencing and responding to the client as a person rather than as an object of analysis. Although he does not use the term "mindfulness," which was not in general usage at the time, the Zen approach to experience that Berger is describing reflects the Buddhist concept of mindfulness.

Japanese researchers, meanwhile, had begun experiments on the effects of Zen training, particularly physiological effects such as on respiration, body temperature, brain waves, and pulse rate, but also psychological effects as measured by Rorschach tests and a "self-consciousness" test (Akishige, 1977; Kasamatsu & Hirai, 1963; Kato, 2005). Aside from Maupin (1965), this line of research was not immediately pursued in the West. What changed everything, however, was the sudden and unexpected explosion of interest in meditation due to the spread of Transcendental Meditation (TM). TM was initially presented to Westerners in the early 1960s as a Hindu religious path, was soon adapted to attract followers from the counter-cultural youth movement, and took off when the Beatles briefly but famously became disciples in 1968. With the waning of the

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counter-culture at the start of the new decade, the organization promoting TM again shifted its strategy. A doctoral dissertation had claimed positive health benefits for the practice, allowing the movement to revitalize as a purveyor of a “scientifically validated,” non-religious technique for physical and mental health (Woodrum, 1982). This triggered voluminous subsequent studies attempting to test these claims, with the first of many research reviews on the psychological effects of meditation appearing in 1975; the reviewer found that meditation seems to have beneficial psychological (as well as physiological) effects, particularly in reducing anxiety, but the methodological shortcomings of published research prevented a definitive judgment (Smith, 1975). Other early literature reviews on the psychological effects of meditation supported this judgment, adding that meditation does not seem to have any greater beneficial effects than other self-regulation techniques such as biofeedback, hypnosis, and progressive relaxation, except that meditators are more likely to report positive subjective states (Shapiro, 1982, 1984; Shapiro & Giber, 1978) and meditation seems to increase perceptual sensitivity (Walsh, 1979).

Three experiments from the 1970s are of particular interest because they focused on the use of meditation to improve counseling abilities by increasing empathy. Lesh (1970) reported the results of an experiment with a pre-/post-treatment design indicating that counseling students who practiced Zen meditation (sitting and repeatedly returning attention to the breath whenever the mind wanders) for a half-hour a day over a four-week period significantly improved their ability to be empathic as compared to control groups. However, the control groups were not equivalent to the experimental group (one control group was composed of counseling students who refused to meditate, and the other control group had non-counseling majors in it), which means the subjects in the experimental group could have been more prone to increases in empathy and/or more responsive to meditation than the other subjects. Leung (1973) reported a post-treatment only experiment in which undergraduate students who practiced a cumulative seven hours of meditative deep breathing or attentiveness to external stimuli, techniques adapted from Zen meditation, were found to have greater empathy and greater responsiveness to particular verbal statements than a control group. Presumably the

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students were randomly assigned to experimental or control groups (the author did not specify assignment method), but the experiment was vulnerable to the "Hawthorne" effect because the experimental groups received more attention from the experimenter than the control group. Keefe (1979), using a pre-/post-treatment design, randomly divided graduate students in social work into three groups: one receiving training in therapeutic communication utilizing role plays, a second receiving training in Zen meditation and practicing a half-hour daily for three weeks, and the third a control group. Keefe reported no significant increase in empathy in the first group and a significant increase in the second group, although the magnitude of increase was not beyond that of a non-significant positive increase in the control group. He added that when group two was also given the therapeutic communication training and retested, the increase in empathy was even greater, suggesting that increases may be affected by repeated testing for empathy. Keefe also found that levels of skill in meditation, as ranked by three experienced meditators assessing self-reports of the subjects in group two, were significantly correlated with the magnitude of positive changes in the empathy scores. These three experiments used somewhat different treatments (all were based on Zen meditation, but instructions and length of practice differed) and different tests for empathy, making comparisons of results problematic, and all three used subject responses to videos of counseling clients (or actors portraying clients) to measure empathy, raising the question of whether skills in performance under such circumstances are transferable to actual counseling situations. The experiments did, however, suggest a potentially fruitful line of inquiry.

By the 1970s, due largely to government funding of training programs and the spread of health insurance as a method of paying for mental health services, there were more counselors from a greater variety of professional orientations practicing than there had been at the end of World War II (Engel, 2009). More significantly for our topic, many of these counselors were or became active participants in Eastern spiritual disciplines of various kinds, some with years of training in meditation and similar practices. Researchers were learning to discriminate between these disciplines, utilizing a traditional Buddhist two-fold categorization of mental training exercises:

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(1) concentration meditation, such as TM and some other forms of meditation, in which the subject continually returns attention to a select focal device (e.g., a mantra, a visualization, the breath) in order to achieve mental tranquility and "one-pointed" concentration, and (2) mindfulness practices, in which the subject focuses attention on an action (e.g., breathing, walking, eating) or the stream of perceptions (e.g., sounds, thoughts, feelings) in the here and now in order to achieve insight into reality (in Sanskrit, *vipassanā*). In Buddhism these two types of methods are used in tandem as a means of coming to awakening (Goleman, 1972).

Although mindfulness techniques are used in Zen, the term came into general usage through the exposure of Westerners to Theravada traditions of Buddhism in Sri Lanka, Burma (now also called Myanmar), and other parts of southeast Asia. In the early 20th century a Burmese monk, reflecting on the Buddha's discourse on "The Foundations of Mindfulness" in the Buddhist scriptures, revived mindfulness practices based on his own experimentation and began teaching them to others; the practices soon began to spread and reached nearby countries as well. A German who became a Buddhist monk in Sri Lanka published a handbook on these practices in 1954 which was later translated into English for wider distribution (Nyanaponika, 1962), and around the same time an Englishman published his experience of a mindfulness training course in Burma, possibly the first English-language book with "mindfulness" in the title (Shattock, 1958). Contributors to *Psychologia* began taking note of mindfulness practices in the 1960s (Dumoulin, 1962; Pe, 1966; Sato, 1965), followed by articles touching on the topic in the new Western psychological journal, the *Journal of Transpersonal Psychology* (Deatherage, 1975; Goleman, 1972a, 1972b; Kornfield, 1979; Maquet, 1975; Walsh, 1977, 1978; Washburn, 1978). Thich Nhat Hanh, a Vietnamese monk trained in both Zen and Theravada traditions, wrote a letter on the practice of mindfulness which was revised, translated, and in 1975 published as a book which became read around the world, bringing the term "mindfulness" to wide usage (Hanh, 1987). Also in 1975, three Westerners who had received mindfulness training in Southeast Asia founded the Insight Meditation Society to teach insight (or *vipassanā*) meditation and other mindfulness techniques, with centers eventually established in Massachusetts, California and over a

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hundred other locations across the United States (Mitchell, 2002). Thus by the 1980s, mindfulness practices had become widely known within the community of Westerners interested in Eastern spiritual disciplines.

Mirroring the earlier interest in Zen, the initial literature on mindfulness by counseling professionals was primarily descriptive, experiential or theoretical in nature. An article by Deatherage (1975) was an exception, presenting five case studies of the successful use of mindfulness techniques in the treatment of anxiety, depression, anger management, and alcohol abuse; Deatherage made a point of cautioning that counselors should have personal experience with these techniques before attempting to train or guide clients in using them. But the pivotal event in putting mindfulness practices to clinical use was the 1979 founding of a mindfulness-based stress reduction (MBSR) program at the University of Massachusetts Medical School by Jon Kabat-Zinn, a professor of medicine and practitioner of Zen meditation (Gazella, 2005). In 1982 Kabat-Zinn published the first of several research articles indicating beneficial effects of MBSR for a variety of physical and psychological conditions, particularly chronic pain and anxiety (Kabat-Zinn, 1982; Kabat-Zinn et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1998), and eight years later published a best-selling book on MBSR which recently went into its fifteenth edition (Kabat-Zinn, 1990/2005b). The MBSR program has since treated thousands of patients, served as the model for hundreds of similar programs, and inspired a continually expanding stream of research on clinical applications of mindfulness practices.

The most influential applications of mindfulness practices in the field of counseling have been those combining mindfulness practices with cognitive-behavioral therapy. Mindfulness-based cognitive therapy (MBCT), an approach combining elements of MBSR with cognitive therapy, has been shown to be effective in the prevention of relapse into depression (Kuyken et al., 2008; Ma & Teasdale, 2004; Segal, Williams, & Teasdale, 2002; Teasdale, 1999; Teasdale, Segal, & Williams, 1995; Teasdale et al., 2000). The developers of MBCT initially resisted Kabat-Zinn's insistence that therapists be mindfulness practitioners but eventually found this to be essential (Kabat-Zinn, 2003, 2005a; Seagal et al., 2002). Marsha Linehan, a psychology professor and student of Zen,

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developed dialectical behavior therapy, which has shown positive results in treating borderline personality disorder, substance abuse, and eating disorders (Linehan, 1993; Linehan et al., 1999; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; Telch, Agras, & Linehan, 2001). Acceptance and commitment therapy (ACT) also includes a mindfulness component, although it was derived from contextual psychology rather than Buddhist practices. ACT has had results in treating psychosis and other conditions (Bach & Hayes, 2002; Blackledge & Hayes, 2001; Hayes & Wilson, 2003). Several more recent literature reviews of the mushrooming research on the use of meditation and mindfulness practices in counseling and health care have been conducted and generally show a broad consensus that the research still has methodological shortcomings (e.g., small sample sizes, lack of randomized control groups, failure to separate different components of treatments such as mindfulness practices and cognitive therapy) but is continually improving, that theoretical issues on the mechanisms of change remain unsettled, and that the topic is worthy of further research (Allen et al., 2006; Baer, 2003; Bogart, 1991; Chiesa & Serritti, 2009; Coelho, Canter, & Ernst, 2007; Orme-Johnson, 2008; Ospina, 2008; Perez-de-Albeniz & Holmes, 2000; Praissman, 2008; Toneatto & Nguyen, 2007; Williams, Russell, & Russell, 2008).

Given that the possible benefits of counselors practicing meditation/mindfulness techniques were first suggested decades ago, and how common it is for writers on the clinical applications of mindfulness practices to advise that counselors using mindfulness techniques with clients should be practitioners themselves, there has been scant research to determine what the effects of meditation/mindfulness practices on counselors' counseling abilities actually are. Including the articles on empathy discussed above (Keefe, 1979; Lesh, 1970; Leung, 1973), the present author has identified a little more than a dozen articles addressing this question. Three of these articles are essentially brief literature reviews which draw upon the larger body of research to speculate about effects of meditation and mindfulness techniques which would be useful for counselors to cultivate (Addison, 2002; Fritz & Mierzwa, 1983; Keefe, 1975). For example, Keefe (1975) identified three such hypothesized effects: an increased awareness of one's own feelings, a capacity to set aside complex cognitive processes in favor of direct perception,

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and the ability to maintain focus on present events. Fritz and Mierzwa (1983) added several others, such as reduced anxiety and greater tolerance of difficult emotions. Their conclusions are well summed up by Addison (2002), who stated that there is “a scarcity of research studies looking directly at the effect of meditation upon therapists” and “[p]artly because of a lack of methodological rigor and partly due to the difficulties inherent in investigating the phenomenon, we are not very much closer to understanding the processes and effects of meditation than when the research first began in the 1960s” (pp. 90 & 102). Two other articles are theoretical and, like the literature reviews, offered no new empirical information: Schuster (1979) proposed that mindfulness meditation would be a good training method to promote empathy in counselors, and Schmidt (2004) argued that mindfulness practice can help physical and mental health care practitioners create an “optimal healing environment.”

Most of the other articles rely on qualitative data in one form or another. Four draw upon the authors’ personal experiences: Chung (1990) referred to his experience of Zen meditation in proposing that meditation and mindfulness practices can contribute to the personal growth of counselors, Kelly (1996) proposed a model for both clients and counselors to use meditation based on his counseling practice, and Dubin (1991, 1994) discussed his use of meditation and mindfulness exercises with counseling supervisees to increase their ability to “be with” their clients and to understand psychodynamic theory. Sweet and Johnson (1990) presented a few case studies indicating that a concentration meditation technique derived from Tibetan Buddhism is effective in increasing (clients’) empathy, but devoted most of their article to showing how this technique fits the Structural Analysis of Social Behavior criteria for empathic interactions. The final two qualitative articles used more systematic research designs than those discussed above. Nanda (2005) interviewed eight counselors from four different theoretical orientations who are long-term meditators and reported that they have similar experiences of improved client interactions due to their meditation experience: they are better able to connect compassionately and empathically with clients, they feel more grounded and able to stay with clients’ experience, and they feel more present to the process and aware of their own reactivity. Schure, Christopher and Christopher (2008) had graduate-level

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counseling students practice various mindfulness exercises during the course of a class and found that the students reported increased ability to deal with difficult emotions, greater self-awareness and self-acceptance, increased empathy, improvement in their interactions with clients by helping the student to become more comfortable with silence and attentive to process, and a broadened view of therapy.

Finally, three additional articles used quantitative research designs. Pearl and Carlozzi (1994) presented a very brief research report on an experiment in which sixty volunteers from among the students, faculty, and staff of a university were randomly assigned to either a treatment group (undergoing eight weeks of practice in Clinically Standardized Meditation) or a control group; they found the treatment group to have had a decrease in anxiety but not a significant increase in empathy (measured by a method similar to the earlier studies on empathy). Shapiro, Schwartz, & Bonner (1998) used a matched wait-list control with pre/post tests design to study the effects of a seven-week MBSR-like program on medical and premedical students. They reported that the treatment group showed improved psychological symptomatology and increased empathy and spirituality; empathy was measured by administering the Empathy Construct Rating Scale to the subjects. This was a particularly well-designed study, although of course it had some limitations; for example, one cannot generalize from medical and premedical students to other populations such as counselors. Shapiro, Brown and Biegel (2007), interested in mindfulness as it relates to counselor self-care, reported that graduate-level counseling students undergoing MBSR training had significantly increased mental health indicators while a cohort control group did not (pre/post design). Subjects for the different groups were recruited from different counseling classes rather than randomly assigned to the groups, but a correlation of increased mindfulness (as measured by the Mindful Attention Awareness Scale) with increases in the mental health indicators suggest that the latter were due to the former and not to other differences between the groups.

To sum up, many beneficial effects of mindfulness practices for counselors' counseling abilities have been hypothesized by different researchers, and there is a little evidence suggesting that this could be true, but the research is far from conclusive. Much

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of the qualitative evidence is anecdotal rather than systematically obtained, while the pertinent quantitative evidence has been vulnerable to methodical problems, and some results from quantitative studies (notably those regarding meditation and empathy) thus far seem ambiguous. Research on the topic could best be described as still exploratory, with much more data needed in order to clarify the possible relationships between mindfulness practices and counselors' counseling abilities as well as to better specify future research questions.

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Clinical Applications of Mindfulness Practices

Post-WW II interest in meditation:

- 1940s-1960s: Some psychoanalytic interest in Zen Buddhism and Zen meditation
- Late 1960s-1970s: spread of Transcendental Meditation
- Research: meditation reduces stress & anxiety, creates positive subjective state

Awareness of mindfulness practices grows:

- 1970s: more researchers become aware of distinctions between forms of meditation (i.e., concentration meditation and mindfulness practices)
- 1975: Thich Nhat Hanh publishes *The Miracle of Mindfulness*; three Westerners establish the Insight Meditation Society

Clinical applications developed:

- 1979: Jon Kabat-Zinn founds the **Mindfulness-Based Stress Reduction** (MBSR) program at the U. of Massachusetts Medical School; targets chronic pain & stress
  - Eight to ten weekly 2 ½ hour (plus one all-day 7-8 hour) group training sessions using mindful eating exercise, body scan, mindfulness of breath, mindful walking, yoga, other exercises
  - 1990 publication of Kabat-Zinn's best-selling *Full Catastrophe Living* on MBSR
- 1990s: mindfulness practices combined with other psychotherapeutic techniques
  - Mindfulness practices combined with cognitive-behavioral techniques to develop **Dialectical Behavioral Therapy** for treatment of women with bipolar disorder, also used with eating disorders. Uses individual therapy in conjunction with group skills training over one-year period.
  - Elements of MBSR combined with cognitive therapy to develop **Mindfulness-Based Cognitive Therapy** to treat depression; uses eight weekly sessions.
  - **Acceptance and Commitment Therapy** has mindfulness component although not derived from Eastern practices; involves mindful acceptance of emotions and thoughts with commitment to working toward personal goals.

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