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Mindfulness has been referred to as (a) a psychological process; (b) a method or technique; and (c) a skill that can be acquired (Alien, Blashki, & Gullone, 2006; Hayes & Shenk, 2004; Hayes & Wilson, 2003). As a psychological process, mindfulness has been described as being intentionally present to internal and external events (stimuli) occurring in momentary experience (Baer, 2003; Bishop et al., 2004; Kabat-Zinn, 1990). Mindfulness necessitates that one "monitor the focus of attention"- in other words, self-regulate attention-which requires metacognition (knowledge or observing of thoughts; Alien et al., 2006, p. 286). For this reason a method of instruction is provided: First, practitioners place conscious, nonjudgmental attention on an object of focus (e.g., breath, sight, sound, or bodily sensation). Second, when they notice that attention has drifted, practitioners bring it back to the object. Training clients in mindfulness methods therefore means training them to practice a technique grounded in a philosophy that is oriented toward certain psychological processes that with practice can be developed as a skill.

Germer (2005) and Kabat-Zinn (2003) distinguished between formal and informal mindfulness practice. Formal practice refers to structured mindfulness meditation (sitting in meditation for 20 minutes several times a week) and is associated with "sustained, disciplined introspection" (Germer, 2005, p. 14). Informal practice is about bringing mindfulness processes to ordinary daily activities. For example, one self-regulates attention to listen to ambient sounds at a bus stop, notice taste while drinking a glass of water, or observe the warmth of the water while washing dishes.

MINDFULNESS IN COUNSELING

The literature offers promise that mindfulness-based methods are both professionally

and personally beneficial for counselors and are efficacious for helping clients deal with symptoms of mental and physical disorders (Baer, 2003; Christopher, Christopher, Dunnagan, & Schure, 2006; Grossman, Niemann, Schmidt, & Walach, 2004; Newsome, Christopher, Dahlen, & Christopher, 2006; Shigaki, Glass, & Schopp, 2006). The quality and volume of research devoted to mindfulness suggest that it is considered relevant for professional training in counseling and psychotherapy; and texts and manuals for mental health professionals on use of mindfulness in clinical settings attest to its popularity as an intervention (see Baer, 2006; Germer, Siegel, & Fulton, 2005; Hayes, Follette, & Linchan, 2004; Orsillo & Roemer, 2005; Segal, Williams, & Teasdale, 2002).

There seem to be three types of research into the utility of mindfulness in counseling and psychotherapy. The first studies the effect on client outcomes when counselors personally practice mindfulness outside of sessions (Aiken, 2006; Christopher et al., 2006; Germer et al., 2005; Wexler, 2006). Germer (2005) introduced the term "mindfulness-informed psychotherapy" to describe psychotherapists who "identify with a frame of reference based on mindfulness, but ... do not explicitly teach patients how to practice mindfulness" (p. 19). The second attempts to assess the effect on outcomes when counselors and psychotherapists practice mindfulness during sessions with clients, though here empirical examination has been limited (Stanley et al., 2006; Stratton, 2006; Wexler, 2006). Finally, most research on mindfulness (see Davis & Hayes, 2011; Keng, Smoski, & Robins, 2011) examines the impact on clinical outcomes when mental health professionals train clients to use mindfulness methods on their own. Our research focused on competencies related to training clients in mindfulness methods.

TRAINING CLIENTS

As counselors and clients rapidly embrace mindfulness as a path to wellbeing, concern has risen about competency in training. Dimidjian and Linchan (2003) asked, "How should therapists be trained in order to deliver mindfulness interventions competently?" (p. 168). Others have asked about the "optimal amount and type of therapist training" for specific mindfulness-based interventions (Roemer, Salters-Pedneault, & Orsillo, 2006, p.72). Our investigation found no empirical studies related to a comprehensive set

of mindfulness competencies.

MATERIALS AND METHODOLOGY

To find out more about mindfulness competencies for counselors and psychotherapists, we specified the following research question: To what degree do experts agree on a set of proposed mindfulness competencies? To find an answer, we created an online survey that proposed 16 competency statements based on the literature related to mindfulness training, identified experts, and invited them to participate. 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 of their areas to better tackle problems, whether typical or atypical (Ericsson & Smith, 1991). For this reason, demographic questions and questions related to professional contributions on mindfulness were asked to ensure that respondents possessed adequate experience and knowledge and were indeed "information rich" in the domain of mindfulness training.

Method

Experts were assessed online via a secure website. We created an initial participant list of 259 published authors of empirical and theoretical studies related to use of mindfulness in counseling and psychotherapy by searching Ebscohost, which includes Psychlnfo. We gathered contact information from journal-provided data and by using Internet search engines to locate publicly posted e-mail addresses (e.g., faculty pages). A few other experts were added from Internet search results and referral by other participants. The pool size narrowed to 157 after eliminating those without current and accurate e-mail addresses. Another 1 1 removed themselves as not being mindfulness experts, 8 were on vacation or sabbatical, and 3 had technical problems. That left 135 names. To increase participation, we made multiple pleas by e-mail (Dillman, 2007). Of the pool of 135, 52 (38.5%) participated.

The survey had three sections: (a) demographic questions and questions related to

personal and professional involvement with mindfulness practice (1 3 items); (b) competency statements with Likert-type agreement scales (16 items); and (c) questions to invite recommendations for personal practice for those new to mindfulness as a specialty area (3 items).

Item development. First, competency statements and recommendation questions were drafted based on more than 162 studies published in professional journals from 1987 through 2007 and on mindfulness-based therapy books. Next, six subject matter experts (SMEs; professional counselors and psychotherapists who are teachers in the Buddhist tradition) evaluated items to provide us with content-related evidence and face validity. This group accepted, rejected, or modified competency statements. Finally, doctoral students and faculty in a counselor education and supervision program provided qualitative feedback on the survey.

Analysis. Descriptive analysis provided information about the expertise of participants and recommended levels of personal practice of mindfulness. Descriptive analysis (of means, standard deviation, percentiles) was also used to address the primary research question about what experts thought about the proposed competencies. Cronbach's alpha was then used to estimate the reliability of the 16 competency statements. We also used principal component analysis (PCA) for construct validity for the competency statements.

The Expert Participants

Data on mindfulness were gathered from the participants (N = 52; 23 female, 29 male), who were from the United States (57%), Australia (9.6%), the United Kingdom (9.6%), Canada (5.7%), and Germany (3.8%); India, the Netherlands, Belgium, and Sweden each had 1.9% representation.

For this study, experts were defined as those rich in information and experience on how mindfulness related to counseling and psychotherapy. To confirm the expertise of participants beyond their publication records, information was gathered about their professional contributions and involvement. All participants had or were completing advanced degrees directly or indirectly related to counseling and psychotherapy:

M.A./M.S. 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 therapies, epidemiology, and educational psychology, as well as students completing doctoral degrees in counseling or psychology (5.7%).

Most participants had actively practiced mindfulness methods for a number of years. The mean was 1 3.98 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, their mindfulness practices were routine: 44 (84%) practiced weekly, and over 40% practiced at least once a day. The group used a range of methods: body scanning (systematic attention to body parts, 25%); mindfulness-based yoga (35%); single-object, narrowed-attention types of meditation (27%); choiceless awareness types of meditation (56%); mindfulness of breath (67%); mindfulness of sound (31%); mindfulness of eating (25%); mindfulness of feelings and emotions (46%); walking meditation (27%); and other (15%).

Participants reported substantial training in mindfulness-based methods and treatment packages, and a range of understanding of their use. They had received training in or practiced Acceptance and Commitment Therapy (ACT, 26.9%); Dialectical Behavior Therapy (DBT, 17.3%); Mindfulnessbased Stress Reduction (MBSR, 36.5%); Mindfulness-based Cognitive Therapy (MBCT, 30.8%); and other (1 5.4%). Twenty-five percent did not have mindfulness training from a specific treatment orientation. When asked if they had been trained in nine of the most common mindfulness practices, only two (3.8%) said they had not received any formal training, and 33.5% reported formal training in all nine, suggesting that members of this group were expert in an array of techniques.

The academic and clinical roles of participants were as follows: health professional (11.5%); mental health professional (28.8%); academic professor/educator (53.8%); student in a helping profession (3.8%); and other (19.2%- 13.8% research-related, 1.9% retired, 1.9% mindfulness trainer, and 1.9% psychologist in health field).

Asked, "What best describes your involvement in mindfulness-based work?" participants

responded as follows: 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 on mindfulness-based methods (1.9%).

RESULTS

The competency statements in general were more than modestly endorsed by participants. Possible responses to the statements were: Strongly Agree-5, Agree-4, Neutral-3, Disagree-2, and Strongly Disagree-1. The overall mean rating was 4.03, with ratings for individual statements ranging from 3.71 to 4.38. The ratings suggest strong support of the entire set, and more than moderate to excellent support for individual items. The fact that the standard deviations for scores on the 16 items ranged from .63 to 1.10 indicated a tighter rather than wider variance in scores. Moreover, 5 of the 16 statements had just one or no response of either "disagree" or "strongly disagree" (see Table 1).

Psychometric Analysis

Using Cronbach's alpha, the median reliability for the competency statements was .93, indicating excellent internal consistency. Nunnally (1978) stated that except where critical decisions must be made about someone's life, reliabilities of .70 are sufficient.

PCA may be used to validate an index or scale by demonstrating levels of agreement among components (Preacher & MacCallum, 2003). Our PCA results suggest these 16 items had a uni-dimensional agreement level, except for one item, metacognitive awareness. After both scree plot and eigenvalues greater than 1 provided three possible components, PCA revealed that the first component alone accounted for 5 1 .7% of the variance, and the first two for 61.6%, suggesting strong component agreement. Thus, the

data suggest that the statements have merit as a set.

Participants also provided recommendations for counselors and psychotherapists new to mindfiilness practice. Three questions were posed:

* For how many years, minimum, should counselors and psychotherapists engage in personal mindfiilness practice before beginning to train clients in mindfulness methods? Responses ranged from O to 5 years, with a mean of 1.56 and a standard deviation of 1.5.

* In the initial phase of learning mindfulness practice, how much practice is necessary daily or weekly? All responses indicated practice at least weekly: 32 (63%) recommended at least once daily; 6 (9%) more than once daily; 13 (25%) several times a week; and 1 (1.9%) once weekly. This question allowed for comments; several distinguished frequency in terms of formal and informal practice. For example, one respondent proposed, "formal daily practice with 'informal' mindful activity at multiple points in the day." Another advised, "more than once daily: I mean not simply daily formal practice, but bringing mindfulness into daily life (informal practice)." These comments suggest that frequency should take into account both formal and informal practice.

* 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 minutes" (11.5%) to "41-45" (15.4%). The mode (19.2%) was for 25-29 minutes with 31 (60%) responses falling between 1 5 and 34.

DISCUSSION OF MINDFULNESS COMPETENCIES

This study found substantial agreement with a preliminary list of mindfulness competencies for counselors among experts in the application of mindfulness to counseling. For discussion purposes, we have bundled each of the 16 competencies with related competencies into four areas: (a) integrated and engaged practice; (b) cultural competency and mindfulness use; (c) competency limits and continuing education; and (d) clinical considerations.

Integrated and Engaged Practice

Discussed in this section are the following competencies: Counselors and psychotherapists who train clients in the use of mindfulness methods (a) understand how to integrate mindfulness methods and skills into everyday tasks and behaviors; (b) practice mindfulness methods regularly, especially when training others in these methods; (c) engage in metacognitive examination by way of mindfulness practices; and (d) personally practice mindfulness methods for a sufficient length of time before training others in these methods.

With regard to perceptions about the value of personal mindfulness practice to counselors, the resulte suggest that experts may perceive that practicing mindfulness for years is less important than persistent active practice where one leams to integrate mindfulness into daily life. The statement that received the least agreement (57.1%) and the second most disagreement (11.5%) was "personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods." This fib with the seemingly short length of personal practice recommended before training others, which had a mean of 1.56 years, with a standard deviation of 1.5. Moreover, 33 (63.4%) participants recommended no more than one year, and 20 of these 33-38.4% of the entire study population- recommended half a year or less of personal practice before training others.

Despite some lack of agreement about length of previous personal practice, other resulte strongly suggest that those training cliente should have an active mindfulness practice. Presented with the statement "practice mindfulness methods on a regular basis, especially when training others in these methods," 78.8% agreed and only 1.9% disagreed (M = 4.12, SD = 0.86). Participante 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 practice at least weekly; 32 (63%) recommended at least once daily, 6 (9%) more than once daily, 13 (25%) several times a week, and 1 (1.9%) once weekly. We consider weekly personal practice of any technique to be active.

This study maintained that informal practice is especially important to developing competency as indicated by the statement, "understand how to integrate mindfulness

methods and skills into everyday tasks and behaviors." The statement did not receive a single mark of disagreement and garnered the highest level of agreement of all statements (92%). The implication is that informal practice is important because it is necessary for integrating mindfulness into daily life. Commente by participante 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?" confirmed this perspective. Four of the five commente conveyed the importance of informal practice: (a) "Ideally, mindfulness should be practiced when engaged in all daily tasks, but formal meditation, for example, practiced at least once a day." (b) "Formal daily practice with 'informal' mindful activity at multiple pointe in the day." (c) "Daily informal practice- formal practice is helpful, but not necessary." (d) "More than once daily: I mean not simply daily formal practice, but bringing mindfulness into daily life (informal practice)." These responses suggest that regular or active practice is both informal and formal.

The experts agreed in general that counselors and psychotherapists ought to seek opportunities for mindfulness-based retreats; however, this was one of the lesser endorsed statements. Using retreab to improve competency may be unique to mindfíilness as an important practice of Buddhism. Clinicians and researchers (e.g., Baer, 2003) have reasonably argued that mindfulness can be applied within the Western mental health setting without associated Buddhist practices. Others have cautioned that there may be serious losses if mental health professionals haphazardly alter mindfulness training in a significant way, unknowingly leaving out elements that are essential (Dimidjian & Linchan, 2003; Olendzki, 2005).The intensity and time costs of retreat participation may affect endorsement. Furthermore, retreats may not be accessible in all locations and in formats that are not religiously oriented. Though 5-10day retreats may provide advanced practice that is beneficial to counselor development, retreats may not be necessary for training clients.

The item design may have been less than ideal because it qualified the purpose of retreat participation as being "to explore, understand, and increase mastery of mindfulness methods." Based on this finding and our combined participation in more than 50 week-long retreats, we suggest that retreat attendance may be less related to features of

clinical professionalism and skill but may affect counselors and psychotherapists at a core level as well as in the task of integrating mindfulness practices.

There was more than moderate agreement (M = 4.10, SD = 0.75, Agree = 80.7%, Disagree = 1.9%) with the statement "engage in the process of metacognitive examination by way of mindfulness practices." Though it clearly relates to mindfulness competency, we suspect that, unlike the other 1 5 competency statements, it may reflect competency within the practice of mindfulness itself (e.g., noticing thoughts). This competency statement was the only one of the 16 accounted for in the second component when PCA was conducted. 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.

Cultural Competency and Mindfulness Use

Items discussed in this section are the following: (a) respect clients' cultures, including religious and/or spiritual beliefs and values that relate to physical and mental functioning; and (b) be aware of cross-cultural/multicultural competencies relevant to mindfulness-based interventions and training.

We wanted to understand perceptions about the importance of multicultural counseling to mindfulness competencies. The first item received the fourth highest level of support (M = 4.19, SD = 0.97, Agree = 78%, Disagree - 5.8%). This statement was adapted for mindfulness from the multicultural competency statement "culturally skilled counselors respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect world view, psychosocial functioning and expressions of distress" (Sue, Arredondo, & McDavis, 1992, section III.A.1). The item may have been a better fit for underscoring the need and value of respecting cultural differences in mindfulness training than the second statement, which received less support (M = 3.71, SD = 0.98, Agree = 61.5%, Disagree = 13.5%).

Competency Limits and Continuing Education

Items discussed in this section are the following: (a) are able to recognize the limits of

their own professional competence when training clients in mindfulness methods; (b) seek continuing education opportunities on mindfulness and mindfulness-related topics; (c) have a fundamental knowledge and remain current in both the professional literature and the popular literature related to mindfulness; (d) consult and seek training when integrating mindfulness methods with other psychotherapeutic techniques; and (e) know of available resources for continued practice of mindfulness, including audio/visual, local meditation/mindfulness teachers, and online resources.

The experts agreed most with the idea that being competent entails knowing the limit of one's competence in mindfulness training (M = 4.19, SD = 0.93, Agree = 80.7%, Disagree = 7.7%) and requires continuing education (M = 4.27, SD = 0.72, Agree = 88.4%, Disagree = 1.9%). Learning a new specialty area is more than gaining experience and receiving academic training; it includes consultation and related training. Knowing resources for continued practice was the least endorsed of this set of statements, although it received more than moderate support (M = 3.92, SD = 0.79, Agree = 77%, Disagree = 5.8%). These competency statements agree with what is already mandated by mental health professional codes (American Counseling Association, 2005; American Psychological Association, 2002).

Clinical Considerations

Items discussed in this section are the following: Counselors and psychotherapists who train clients in the use of mindfulness methods (a) 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); (b) have knowledge of the various types and methods of meditation and mindfulness; (c) 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 (d) practice each specific mindfulness technique before using that technique with clients.

The results show that to train clients in mindfulness methods in a clinical setting, counselors and psychotherapists need to know how various mindfulness methods can be applied for specific clients and particular disorders. This knowledge includes personal

experience with these methods and knowledge of relevant empirically based research. Counselors training clients to use mindfulness should be able to distinguish between mindfulness-related and other states of mind, especially those that are clinically significant. Continued research is essential for a better understanding of the mental health effects of different mindfulness methods.

LIMITATIONS AND RECOMMENDATIONS

The mindfulness competency statements cannot be separated from the heuristic way we created the list of statements. Though such a heuristic process is often necessary when distilling complex phenomena, the approach is subject to bias. While we were careful to include all related and exclude unrelated competency items, the item construction process did not reject any items. This may suggest a failure to include marginally related content for exploration. Also, although international in composition, the group represented primarily White, Caucasian, and Anglo ethnic/cultural backgrounds- a rather narrow perspective. And while PCA was chosen to examine scale agreement, other analyses might provide other important information on construct validity.

Our proposed competencies are not a reified set of standards but rather a continuation of previous efforts by mental health professionals. Western mental health proponents should continue to craft statements about what it means to be competent to train others in these time-proven ancient methods. We recommend more research to refine the necessary and sufficient elements of competent mindfulness practice. A qualitative study would no doubt yield additional information about competencies. Furthermore, experts from social work and nursing should be represented in future studies since the final pool for this study unintentionally lacked representation from those fields. Nor did this research ascertain consumer perspectives on mindfulness competencies. As the expert participant pool was gathered by journal authorship (or in a few cases referral by an author), future research might examine competencies from other points of view, such as practicing counselors, students, and clients. Further exploration of competencies may be a precursor to consistent and replicable mindfulness training for counselors. Competencies could also be used to improve curriculum development. Finally, because competency is an ethical mandate, the best use of these statements may be in helping

practitioners examine how to use mindfulness methods to better care for clients.

References:

Aiken, G. A. (2006). The potential effect of mindfulness meditation on the cultivation of empathy in psychotherapy: A qualitative inquiry. Dissertation Abstracts International, 67, 2122B. (UMI No: 3217528)

Alien, N., Blashki, G., & Gullone, E. (2006). Mindfulness-based psychotherapies: A review of conceptual foundations, empirical evidence and practical considerations. Australian and New Zealand Journal of Psychiatry, 40, 285-294. doi:10.1111/j.l440-I614.2006.01794.x

American Counseling Association. (2005). Code of ethics and standards of practice. Alexandria, VA: Author.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. Washington, DC: Author.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. Clinical Psychology: Science (5 Practice, 10, 125-143.

Baer, R. A. (Ed.). (2006). Mindfulness-based treatment approaches: Clinicians guide to evidence base and applications. Burlington, MA: Academic Press.

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., ... Devins, G. (2004). Mindfulness: A proposed operational definition. Clinical Psychology: Science 6· Practice, 11, 230-241. doi:10.1093/clipsy.bph077.

Christopher, J., Christopher, S., Dunnagan, T., & Schure, M. (2006). Teaching self-care through mindfulness practices: The application of yoga, meditation, and qigong to counselor training. ioumal of Humanistic Psychology, 46, 494-509. doi:10.1 177/002216780629021 5

Davis, D. M., & Hayes, J. A. (201 1). What are the benefits of mindfulness? A practice review of psychotherapy-related research. Psychotherapy, 48, 198-208.

doi:10.1037/a0022062

Dillman, D. A. (2007). Mail and internet surveys: The tailored design method 2007 update with new internet, visual, and mixed-mode guide. Hoboken, NJ: Wiley & Sons, Inc.

Dimidjian, S., & Linehan, M. M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. Clinical Psychology: Science 0· Practice, 10, 166-171. doi: 10.1093/clipsy/bpg019

Ericsson, K. A., & Smith, J. (Eds.). (1991). Toward a general theory of expertise: Prospects and limits. Cambridge, UK: Cambridge University Press.

Germer, C. (2005). Mindfulness: What is it? What does it matter? In C. K. Germer, R. D. Siegel, & P. R. Fulton (Eds.), Mindfulness and psychotherapy (pp. 3-27). New York, NY: Guilford Press.

Germer, C. K., Siegel, R. D., & Fulton, P. R. (2005). Mindfulness and psychotherapy. New York, NY: Guilford Press.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. Journal of Psychosomatic Research, 57, 35-43. doi: 10. 1016/80022-3999(03)00573-7

Hayes, S., Follette, V., & Linehan, M. (Eds.). (2004). Mindfulness and acceptance: Expanding the cognitive-behavioral tradition. New York, NY: Guilford Press.

Hayes, S. C., & Shenk, C. (2004). Operationalizing mindfulness without unnecessary attachments. Clinical Psychology: Science 6· Practice, U, 249-254. doi:10.1093/clipsy.bph079

Hayes, S. C., & Wilson, K. G. (2003). Mindfulness: Method and process. Clinical Psychology: Science and Practice, 10, 161-165. doi:10.1093/clipsy/bpg018

Kabat-Zinn, J. (1990). FuW catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. New York, NY: Delacorte.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. Clinical Psychology: Science and Practice, 10, 144-156. doi:10.1093/clipsy/bpg016

Keng, S., Smoski, M. J., & Robins, C. J. (201 1). Effects of mindfulness on psychological health: A review of empirical studies. Clinical Psychology Review, 31, 1041-1056. doi:10.1016/j.cpr.201 1. 04.006

Newsome, S., Christopher, J. C., Dahlen, P., & Christopher, S. (2006). Teaching counselors selfcare through mindfulness practices. Teachers College Record, 108, 1881-1900. doi:10.1111/ J.1467-9620.2006.00766.X

Nunnally, J. C. (1978). Psychometric theory (2nd ed.). New York, NY: McGraw-Hill.

O'Byrne, K., Clark, R. E., & Malakuti, R. (1997). Expert and novice performance: Implications for clinical training. Educational Psychology Review, 9, 267-278.

Olendzki, A. (2005). The roots of mindfulness. In C. K. Germer, R. D. Siegel, & P. R. Fulton (Eds.), Mindfulness and psychotherapy (pp. 241-261). New York, NY: Guilford Press.

Orsillo, S. M., & Roemer, L. (Eds.) (2005). Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment. New York, NY: Springer.

Preacher, K. J., & MacCallum, R. C. (2003). Repairing Tom Swift's electric factor analysis machine. Understanding Statistics, 2, 13-32.

Roemer, L., Salters-Pedneault, K., & Orsillo, S. M. (2006). Incorporating mindfulness- and acceptance-based strategies in the treatment of generalized anxiety disorder. In R.A. Baer (Ed.), Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications (pp. 51-74). Burlington, MA: Academic Press.

Segal, Z., Williams, J., & Teasdale, J. (2002). Mindfulness-based cognitive therapy for depression. New York, NY: Guilford Press.

Shigaki, C. L., Glass, B., & Schopp, L. (2006). Mindfulness-based stress reduction in

medical settings. Journal of Clinical Psychology in Medical Settings, 13, 209-216.doi:10.1007/sl0880-0069033-8

Stanley, S., Reitzel, L. R., Wingate, L. R., Cukrowicz, K. C., Lima, E. N., & Joiner, T. E., Jr. (2006). Mindfulness: A primrose path for therapists using manualized treatments? Journal of Cognitive Psychotherapy, 20, 327-335. doi:10.1891/jcop.20.3.327

Stratton, P. (2006). Therapist mindfulness as a predictor of client outcomes. Dissertation Abstracts International, 66 (11), 6296B.

Sue, D., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession, journal of Multicultural Counseling 6· Development, 20, 64-89. Retrieved from EBSCOhost.

Wexler, J. (2006). The relationship between therapist mindfulness and the therapeutic alliance. Dissertation Abstracts International, 67 (05), 2848B.

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