

Abstract

Mindfulness has been receiving growing attention in the clinical literature. This article describes the background, applications, and mechanism of mindfulness, and describes how mindfulness can be used by the clinician.

Mindfulness in Clinical Practice: A Basic Overview

Much attention has been given in recent literature to the concept of mindfulness and mindfulness-based interventions (Denton & Sears, 2009). This article will present an overview of the definition, mechanisms, and applications of mindfulness, and will discuss the utility of the method for clinicians.

Background and Applications

Mindfulness involves learning to pay attention to and wisely working with our thoughts, bodily sensations, and emotions. The practice is learned through simple meditation exercises, through which one eventually comes to bring a richer awareness and presence into daily life. This reduces ruminating thoughts, helping to prevent stress, anxiety, and relapses of depression.

Interest in the use of mindfulness is booming in the scientific literature and in the clinical community. The applications of mindfulness in clinical work are receiving growing empirical support, particularly in the prevention and treatment of stress, anxiety, and depression. The use of mindfulness for clients dealing with stress and chronic pain was pioneered by Jon Kabat-Zinn, in a program known as Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 1990). Subsequently, mindfulness has been incorporated into a variety of treatments, such as Mindfulness-Based Cognitive Therapy

(MBCT) for prevention of depressive relapse (Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (DBT) for borderline personality disorder (Linehan, 1993), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999), and Mindfulness-Based Relapse Prevention (MBRP) for addictions (Witkiewitz & Marlatt, 2007). These programs are now considered evidence-based practices (Didonna, 2009; Germer, 2005).

Mindfulness-based groups (such as MBSR and MBCT) typically meet weekly for eight sessions. The meetings consist of education, discussion, practice of mindfulness, light stretching exercises, and homework assignments (Kabat-Zinn, 1990; Segal, Williams, & Teasdale, 2002).

Mindfulness has been called the “third wave” in cognitive-behavioral therapy (behavioral therapy is seen as the first wave, and cognitive therapy as the second) (Hayes, 2004; Segal, Teasdale, & Williams, 2004). Though it has historical roots in meditative disciplines, there are many studies showing evidence of changes in brain functioning in individuals who regularly practice mindfulness (Siegel, 2007, p. 221). Kabat-Zinn defines mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). Through systematic exercises, clients learn new ways of working wisely with their own thoughts and emotions.

Mechanism

The mechanism of mindfulness is thought to be exposure, operating on the same brain mechanisms that are affected by behavioral interventions for anxiety. Worry can be seen as a cognitive strategy for reducing anxiety (Orsillo, Roemer, Lerner, & Tull, 2004).

While thinking about all the possible things a person can change about a given situation, the person is attempting to avoid experiencing the anxiety in the moment, and the ruminations are maintained through negative reinforcement. In mindfulness, acceptance of whatever is present is learned. Although a person may choose to change undesirable circumstances, accepting the truth of the present situation is the first step. By allowing oneself to feel whatever physical sensations are present, whatever emotional reactions are occurring, and by observing what thoughts are in the mind, one can remove oneself from the sense of over-identification with them. This process is known as “decentering” (Segal, Teasdale, & Williams, 2004; Segal, Williams, & Teasdale, 2002, p. 38). This is similar to the shift from content to process that is frequently used in individual and group psychotherapy.

This decentering process may in fact be a crucial mechanism for the success of traditional cognitive-behavioral therapy. In learning to recognize thoughts, and in challenging irrational thoughts, the individual becomes less identified with the thoughts and feelings themselves. However, in mindfulness training, this process of moving back to view one’s own thoughts, feelings, and sensations is explicitly developed. Rather than fighting thoughts with thoughts, one recognizes that thoughts are not necessarily facts (even the ones that say they are) (Segal, Williams, & Teasdale, 2002).

Mindfulness for the Clinician

As a prerequisite to competently using mindfulness in clinical practice, the clinician must be able to effectively use the techniques personally (Segal, Williams, & Teasdale, 2002). Daily practice conditions the clinician to be more aware of how thoughts and feelings manifest and dissolve. Using the technique before and after seeing

a client can help to keep the clinician focused on being aware of the client's issues while diminishing the distraction of extraneous or irrelevant feelings of countertransference.

Mindfulness can also be important in therapist self-care. From early on in graduate school training, clinicians are given a double message: take care of oneself, but be a high achiever. Too much is squeezed into a day, while counseling others on how to reduce their stress.

As a simple introduction to mindfulness, therapists can practice the "three minute breathing space" (Segal, Williams, & Teasdale, 2002). In the first minute, one becomes aware of what is present in this moment. This includes any physical sensations, such as muscular tension, any emotional feelings present, and any thoughts one is having. During this phase, repeating to oneself, "whatever is happening right now, just let me feel it" may be helpful. In the second minute, one focuses one's attention on the breath. This allows one to stay focused on one simple thing in the present, and not get pulled off into ruminations. In the third minute, one then expands one's awareness to the body as a whole, with a sense of gently holding one's present experience in an accepting way.

Typically, clients are taught the three-minute breathing space after investing the time in doing each of the components as daily homework assignments for several weeks. The three-minute breathing space then becomes a "shortcut" for maintaining attention and presence. Using these exercises helps one to step out of the automatic pilot mode in which one too often lives, allowing old, unconscious, maladaptive patterns to be discarded.

Conclusion

In many ways, the concept of mindfulness is not new. However, the growing systematization of teaching the skills and attitudes, supported by a growing research base with diverse populations, may lead to more effective interventions that more fully bring out the best in clients and clinicians.

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