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Clinician Mindfulness Practice and the Implications for Burnout Mitigation: Mindfulness as a Values Component of Self-Care

Stephanie Wachter

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Mindfulness as a Values Component of Self-Care

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Abstract

Over 40 years after Freudenberger (1975) introduced the term, burnout remains a critical concern among mental health clinicians. Many researchers in recent decades have focused their attention upon burnout prevention, exploring the practices of clinicians, and proposing the possible factors at-play in counselor, therapist, and social workers' resiliency in the face of vicarious trauma, and other burnout factors. Mindfulness is a growing area of interest in this course of study, with yoga, meditation, and visualizations as some of the exercises associated with the practice and its apparent benefits. This qualitative study examined mindfulness as a component of mental health clinician self-care and burnout prevention. In so doing, this study assessed clinician mindfulness practice through a survey and qualitative interviews, and then deployed the Maslach Burnout Inventory (1981) to triangulate findings and consider future study on this topic. The findings illuminate mindfulness practice as a valued component in the clinician's arsenal of burnout prevention tactics.

Key words: mindfulness, burnout, self-care, Maslach, values

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Burnout is a theme of growing interest, as evidenced by a growing body of research, a topic of focus in counselor education curriculum, as well as mental health clinician workshops and venues for continuing education credits. Prevention appears to be at the heart of research explorations with reams of articles dedicated to the study of clinician stress (Barnett and Hillard, 2001), environment-specific concerns (Ohrh and Cunningham, 2012; Oser, Biebel, Pullen, and Harp, 2013; Vilardaga et al, 2011), and the self-care practices of the professionals that may be at risk for burnout (Barnett, Baker, Elman, Schoener, 2007), including psychotherapists, and mental health and drug and alcohol counselors. Counselor impairment, identified as “physical, mental, or emotional problems”, and the risks of continued practice in the face of such incapacitation, is a related concept emphasized within the American Counseling Association’s (ACA) Code of Ethics (2014, p. 9). The standards note that it is the duty of mental health professionals to detect such deficiencies within one’s self, as well as colleagues, and intervene with those identified as at-risk. At the same time, a 2004 survey by the ACA’s Task Force on Impaired Counselors uncovered some unsettling numbers. Of the counselors surveyed, over 63 percent admitted to knowing at least one counselor that they deemed impaired. Of those reported cases, fewer than 78 percent were disciplined, with less than 74 percent receiving intervention (2004).

Therefore, this qualitative research will focus on interviews of mental health clinicians, so as to explore their use of mindfulness for self-care and burnout-prevention. Further, this study will consider the impact these mindfulness activities have on clinical practice; as well as the potential implications these present for burnout mitigation among currently practicing mental health professionals. The purpose of this study is to enhance understanding of mindfulness as a

component of counselor self-care and how the practice of mindfulness might impact burnout, a chief concern among the mental health working population.

Literature Review

Freudenberger coined the term “burnout” and continued to write on the subject for years to come; he defined it in terms of physical, behavioral and psychological symptoms, and cited exhaustion, and described the burned-out professional as “disenchanted...discouraged...and negative” (1975, p.p. 73-79), among other things. Researchers have since endeavored to advance their understanding of this definition, while determining the effects of burnout as it pertains to professionals working in human services, such as in the medical and mental health fields. Newer research has emphasized similar concepts such as distress, impairment (Barnett and Hillard, 2001; Lawson, 2007), secondary trauma (Everall and Paulson, 2004), and compassion fatigue (Sprang, Clark, and Whitt-Woosley, 2007). Within this scope, experts have sought to pinpoint the causes and risks of counselor fatigue as well as a means for preventing these concerns (Venart, Vassos, and Pitcher-Heft, 2007; Oser et al, 2013; Newsome, Waldo, and Gruszka, 20012). Varying theories have contributed to strategies aimed at thwarting burnout and include Acceptance and Commitment Therapy-based interventions (Hayes et al, 2004), narrative exercises (Warren, Morgan, Morris, and Morris, 2010), and mindfulness and stress-reduction training (Chambers-Christopher et al, 2011; Salyers et al, 2011; Shapiro, Brown, and Biegel, 2007).

Indeed, at the very heart of these research efforts is the desire to prevent the very real consequences of clinician burnout (Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler 2012). This has resulted in a number of interventions targeted at identifying and addressing burnout. One of the assessments utilized within this research effort is Maslach, Jackson, Leiter, Schaufeli,

and Schwab's (1981) Burnout Inventory (MBI) (see Appendix A for info on the Burnout Self-Test Maslach Burnout Inventory adapted for this study). The authors indicated that burnout can be measured by examining three aspects of the mental health clinician's personal experience, including exhaustion, depersonalization, and personal achievement. High measures in the first two categories, exhaustion and depersonalization specified potential for burnout, while low numbers in the final grouping, personal achievement, were indicative of burnout risk. In other research, Lee, Cho, Kissinger, and Ogle (2010) add to this, and described the five core elements of burnout as "exhaustion, incompetence, negative work environment, devaluing client, and deterioration of personal life" (pp. 131-132). It seems mental health clinician impairment is not only an issue of competence, but also a concern that impacts counselor-client relationships (Chambers-Christopher et al, 2011), personal health, counselor efficacy and productivity (Lambie, 2006; Salyers et al, 2011), and even ethical behavior (Everall and Paulson, 2004). As such, the ACA's Task Force on Counselor Wellness and Impairment noted that a number of factors can contribute to diminished efficacy among mental health clinicians, and cited substance abuse, the presence of an untreated mental illness, and personal crisis, not limited to trauma and burnout, as well as health concerns (2004).

What much of the current research on mental health clinician burnout and burnout prevention has in common is an interest in mindfulness-type interventions and practices that appear to neutralize burnout symptoms. Many elements of Kabat-Zinn's Mindfulness-Based Stress Reduction (MBSR) can be found within these ongoing research efforts. As such, it seems there is no better resource from which to pull this study's understanding of mindfulness. In Kabat-Zinn's (1994) effort to make mindfulness accessible, he answered the question "what is

mindfulness?” by noting that it involves questioning and remaining in the present moment, this was summed up succinctly, stating that, “Most of all, it has to do with being in touch” (p. 3).

Thus, it seems, there are many ways an individual can practice mindfulness; current research reflects this with hundreds of articles dedicated to the study of mindfulness practices, which examined the effectiveness of mindfulness exercises such as yoga and journaling, and strove to understand the usefulness of such practices through the lens of physical, cognitive, emotional, and spiritual perspectives. For the purpose of this literature review, varying forms of mindfulness activities were examined, covering four basic areas of practice: (a) Visual-Focused Approaches, encompassing visualizations, guided imagery and focused-attention; (b) Spiritual Methods, including varying forms of spirituality and prayer (i.e. salat); (c) Other Language-Oriented Pursuits, such as gratitude expression, and journaling exercises; and (d) Movement-Based Mindfulness, which involves yoga, tai chi, and qigong, and incorporates breathing exercises, body scan, and acupoint pressure. Much overlap can be found among these categories (e.g. gratitude expressed through prayer, breathing exercises incorporated into yoga); such classifications were designed expressly for the purpose of discussing commonalities within the research regarding mindfulness and burnout-symptom reduction.

Visual-Focused Approaches

Guided imagery, and focused techniques, according to Utay and Miller (2006), are practices that stretch back to the beginning of civilization; citing the utilization of such customs in ancient religious traditions. Practical applications of visual-focused mindfulness approaches within the treatment setting are not so new wave either, as the authors noted the practices’ prevalence among some of psychotherapy’s forefathers (e.g., Freud and Wolpe). The efficacy of guided imagery and focused techniques as a part of treatment has garnered much attention in

recent decades with research concentrated on the stress-reducing properties of the practices as well as the potential benefits for cognition and emotional regulation (Lippelt, Hommel and Colzato, 2014). Guided imagery incorporates visualization and imagery suggestions, and can be utilized in problem-solving, according to Utay and Miller, so as to picture various strategies and the resulting implications. Focused attention comprises of meditating on an object and/or fixating on one's breathing or body sensations. Whereas open monitoring is more expansive, according to Lippelt and co-researchers, a monitoring state that involves "remaining attentive to any experience that might arise, without selecting, judging, or focusing on any particular object" (2014, p. 1). All approaches discussed here, according to their researchers, have evidence-based merit within the treatment setting.

Spiritual Methods

The number of individuals who do not practice organized religion has increased in United States (US) with 16 percent of the population referring to themselves as non-religious in 2007, increasing to 23 percent in 2015 (Pew Research Center). Still, research indicates that spirituality continues to be an important component of counseling and therapy. A Morrison, Clutter, Pritchett, and Demmitt (2009) study found this to be true with counselors rating spirituality as an acceptable, effective, and important component of therapy. At the same time, it seems the counseling profession struggles to incorporate this as a wellness intervention within treatment, as only half of those surveyed within the Morrison et al. study reported that they integrate spirituality into their work. Noting spirituality as a component of wellness, Myers and Williard (2003) argued that religious values have a place in counselor education programming. With a broad approach, including God, higher power, and other cultural traditions, the same researchers indicated that counseling students might be better prepared to holistically incorporate religion

and spirituality within treatment in order to meet the unique needs presented by their clients. From prayer, worship, salat and evening vespers, to mantras and compline, there are a number of mindful salutations that go along with religious and spiritual practice. As a part of multicultural awareness, Al-Krenawi and Graham (2000) noted that mental health clinicians must come from a place of understanding when it comes to their client's spiritual practices, not only to incorporate these into sessions, but also maintain attentiveness to client values.

Other Language-Oriented Pursuits

Linking the growing practice of gratitude to the emergence of positive psychology, Young and Hutchinson's (2012) research endorsed the inclusion of grace and goodwill (towards self and others) within therapy. The results are profound; people who practice gratitude reported improved well-being and happiness, relationship satisfaction, and improved sleep (Young and Hutchinson, 2012). While the researchers noted that these may be a mechanism of positive reframing, they touted gratitude as a protective factor, finding that those who incorporate gratitude into their lives are less at risk for both "internalizing" and "externalizing disorders" (Young and Hutchinson, 2012, pp. 103-106). In addition, they identified several means for incorporating gratitude into individual's lives, such as visual reminders and journaling.

Indeed, journaling and creative writing can be powerful instruments in the counselor self-care tool kit (Warren et al, 2010). As an outlet for compassion fatigue, Warren and co-researchers argued that "monitoring well-being is an ethical imperative"; this further underscores the impairment components of the ACA's Code of Ethics (2012, p. 111). The researchers asserted that writing allows for expression of the counselor's experience, a nonjudgmental, in-the-moment examination of thoughts and emotions; the very definition of mindfulness. Through journaling, an activity often assigned by mental health clinicians to their clients, the therapist can

increase his/her own awareness and give words to the sometimes challenging work of the helping professional.

Movement-Based Mindfulness

The benefits of yoga, qigong, and tai chi have long been touted for their stress-reducing benefits. Further, Schmalzl, Crane-Godreau, and Payne (2014) noted the expanded benefit of reducing mental illness symptoms. Moreover, evidence from the field of positive psychology noted a correlation between the practice of yoga and perceptions of wellbeing (Ivtzan and Papantoniou, 2014). While much debate surrounds the elements of yoga practice that result in this experience (i.e. focused breathing, poses), Ivtzan and Papantoniou (2014) cited a holistic perspective, stemming from self-discipline, expanded awareness, and gratitude, without downplaying the subjective experience of the individual practicing yoga. This is an important piece in the overall prevention of mental health clinician burnout, according to Valente and Marotta (2005), who noted the ability of yoga practice to slow one down; an antidote, they note, to the high-stress, high-demand life of the psychotherapist.

Mindful breathing is a staple of mindfulness practice, and is often used in conjunction with walking meditation and body scans and slow movement exercises such as yoga, qigong, and tai chi. Mindful breathing has also long been an accepted component of stress-reduction and pain-control (e.g., Lamaze); yet, emotional regulation is another potential benefit of the slow breath practice (Arch and Craske, 2006). As such, mindful or focused breathing is a constant in many mindful-type practices, in which the individual expands beyond shallow breathing into long, deep, controlled belly breaths. When incorporated into an education program for undergraduate students planning to enter the helping profession, Newsome and co-researchers

(2012) found that these same mindfulness practices resulted in increased awareness, reduced stress, and improved self-compassion; vital self-care elements for the mental health clinician.

Last, this review of mindfulness approaches examines acupoint pressure and stimulation. Beyond the realm of energy psychology, this practice is not without its naysayers, with many devaluing practices, such as tapping, as viable treatment interventions. Tapping, according to Feinstein (2010), involves the manual, vigorous, repetitive prodding of “acupuncture points (acupoints) which are believed to...send signals to the exposure-aroused limbic system that...reduce limbic hyperarousal” (p. 3). Evidenced-based research on this mindfulness modality is scant; however, with increasing emphasis on tapping as a possible solution to the physiological arousal symptoms of Post-Traumatic Stress Disorder (PTSD), acupoint stimulation is gaining attention. While the reported benefits of this rhythmic striking exercise continue to accrue, Feinstein (2012) noted that the key to this practice is the expression of feelings, problems, and perceptions at the time of the tapping. As a stress-disorder intervention, acupoint stimulation appears to be a mindfulness practice that enables an individual to distance one’s self from distressing cognition and silence anxious thoughts.

Mindfulness, Empathy, and Stress Reduction

Empathy is defined by Birnie, Speca, and Carlson (2010) as “accurately imagining another’s viewpoint...[along with] the corresponding emotions” (p. 360). This empathetic experience is a vital component in the therapeutic relationship and at the very heart of Carl Rogers’s (1957) necessary and sufficient conditions of the Person Centered approach to counseling. Empathy, however, may be compromised in the burned out or impaired clinician. In contrast, a search of current literature on the topic of empathy sprouts numerous studies on the positive impact of mindfulness practices on self-compassion (Bernie et al. 2010; Patsiopoulos

and Buchanan, 2011), empathy (Bentley-Greaseon and Cashwell, 2009; Block-Lerner, Adair, Plumb, Rhatigan, and Orsillo, 2007), awareness (Chambers-Christopher et al, 2011), and stress reduction (Shapiro et al, 2007), both inwardly and outwardly expressed. These studies examined both general populations and mental health professionals and reported measurable effects of the practice of mindfulness, including Mindfulness-Based Stress Reduction (MBSR), within these populations. Specifically, Shapiro and collaborators' (2007), who work with mental health therapists in-training, noted diminished stress and anxiety, as well as growth in self-compassion/empathy following a ten-week MBSR program. There are many components in this practice of mindfulness and stress reduction that merit a part in professional self-care, which are not limited to acceptance (Block-Lerner et al, 2007) and emotional regulation (Shapiro et al, 2007). Further, Bentley-Greaseon and Cashwell's (2009) research indicated that these practices lent themselves to self-efficacy, in that mental health clinicians who practice mindfulness tend to be more self-aware and in-tune with the therapeutic relationship.

The Impact of Mindfulness Practice on Clinician-Client Relationships

This review of current literature confirms the efficacy of mindfulness practices among mental health clinicians as well as growing interest in the implications of mindfulness on the counselor-client relationship. What information is available within this area of study, points to promise in the practice of mindfulness within the clinical setting, promoting therapeutic alliance and counselor presence, acceptance, and awareness (Chambers-Christopher et al, 2011). From the Counselor Education classroom to supervision, mindfulness practice among newer mental health clinicians appears to increase self-efficacy and reduce the risk of compassion fatigue in their work with clients (Schomaker and Ricard, 2015; Chrisman-Campbell and Chambers-Christopher, 2012). In training future mental health clinicians, Rothaupt and Morgan (2007)

emphasized that mindfulness has a place in the Counselor Education setting; as do Chrisman-Campbell and Chambers-Christopher (2012), who called for the inclusion of mindfulness in Counselor Education programming. In so doing, they cited longitudinal research in which counselors-in-training in an elective mindfulness course, reported increases in awareness, empathy, and attentiveness within the therapist-client relationship, with effects that lasted well into the duration of the seven-year study. In taking this research beyond the classroom, Chambers-Christopher along with Maris (2010) found that mindfulness-practicing students (counselors and psychotherapists) brought heightened self-awareness and reduced defensiveness to the supervisory relationship. Anecdotal evidence from Chambers-Christopher and Maris suggested that these clinicians just entering the mental health profession were able to quickly adapt and as a result, likely experienced less distress, putting them at a reduced risk for burnout. In studying the therapeutic relationship, Schomaker and Ricard (2015) found notable increases in counselor-client rapport despite the inexperience of the counselors-in-training studied within their research. That is to say, the beginner counselors within this study who received the mindfulness intervention, scored higher in attunement despite having less experience than the non-mindfulness-trained comparison group.

In sum, as awareness of mindfulness practices such as meditation and yoga have grown in recent decades, so too has researcher curiosity on the efficacy of mindfulness as a part of the therapeutic process in treatment. These theories and practices consider the counselor's use of mindfulness and the impact these efforts may have on practitioner wellbeing and burnout risk factors. A review of the literature available on this topic in the past two decades finds numerous studies that promoted the benefits of mindfulness and encouraged additional research into the efficacy and evidence-based status of these practices. Spanning counselor education graduate

programs, and continuing education credits and workshops, these researchers' findings boasted the benefits of mindfulness-type practices in increasing counselor empathy and compassion, work-satisfaction, and burnout prevention (Bentley-Greason and Cashwell, 2009; Sprang et al, 2007; Lambie, 2006).

Methodology

The expectation of this qualitative research study was to learn more about mindfulness practices among mental health clinicians, burnout, and how these two factors might connect. Therefore, the qualitative research questions defining this study were:

- 1) How does the utilization of mindfulness impact mental health clinician practice?
- 2) How might this practice of mindfulness relate to counselor burnout?

Mindfulness has been purported to increase self-efficacy (Bentley-Greason and Cashwell, 2009), and thus, decrease burnout symptoms (Villardaga et al, 2012). In an effort to assess the experiences of mental health clinicians, and the perceived relationship between mindfulness and burnout, qualitative interviews were proposed. Following Institutional Review Board approval, and the initial recruitment work, several methods were deployed to answer the research questions, including an initial survey sent to mental health clinicians to gauge for mindfulness practice, a qualitative interview of participants meeting the inclusion criteria, a follow-up survey in which subjects took the Burnout Self-Test of the Maslach Burnout Inventory (1981), and a week-long review period in which participants and two external judges, were asked to triangulate the data, assessing for the validity of the themes uncovered in the research.

Role of the Researcher

The principal investigator (PI) in this research, presents as a second year Graduate Counselor Education student, pursuing Licensed Professional Clinical Counselor credentials via

a Council of Accreditation of Counseling and Related Educational Programs (CACREP) recognized program at a Midwestern public university. The PI was supervised by a faculty member within the Counselor Education program. At the onset of this research endeavor, the researcher presented with two years of clinical work as a licensed substance abuse counselor in the state of Wisconsin. It is through this work that the researcher became familiar with a number of local and regional programs to support clients. It is through this community awareness, and enhanced within the Practicum/Internship phase of her degree pursuit, that this researcher became acquainted with several practicing clinicians, many of whom were ultimately invited to be a part of this research. In addition, the PI credits professors' and Practicum/Internship clinical supervisor's emphasis upon self-care as a tremendous source of inspiration for interest in this topic.

While becoming familiarized with mindfulness through ten years of sporadic yoga practice, the researcher also notes the inclusion of this topic in her Bachelor's level work through a Midwestern private university, where mindfulness was promoted as a clinical intervention for substance use disorders. Acceptance and Commitment Therapy reinforced the potential usefulness of mindfulness in clinical work. The PI acknowledges this therapy, and its emphasis on values, as a likely influence upon her research work, and the lens through which she views her findings and research themes. Further, this researcher admits to her own growth in mindfulness utilization over the course of her practice and education, seeking additional information and research into its efficacy within the therapeutic setting, and practicing mindfulness skills as a means to center and relax. The PI's preferred methods of mindfulness include yoga, gratitude exercises, visualizations, and mindful journaling. As a result of her interaction with the mental health clinicians featured in this research, she is taking on new forms

of mindfulness promoted by these participants, including focused breathing, mindful driving, and other bodily-focused mindfulness practices.

Sampling and Recruitment Method

Following an in-depth review of recent literature on mindfulness and mental health clinician burnout, a research design was presented for approval by the Institutional Review Board where the PI attends graduate school. The next step in this endeavor was to seek out potential participants who practice as mental health clinicians. Licensed graduates from the researcher's university's Counselor Education Department, supervising clinicians engaged with the university's internship program, as well as familiar mental health practitioners working within the region were sought. These interested professionals were then asked to refer additional clinicians to the student researcher; deploying snowball sampling in accumulating participants for this research. Internship students, clinical supervisors, and professional relationships were tapped for mental health clinicians (i.e., mental health counselors and therapists, substance abuse counselors, social workers, and others currently practicing in the mental health field) willing to participate in this study.

A list of 31 possible individuals was collected and each was given a corresponding identification number. Potential participants were then contacted via email with an initial letter probing for interest in the research project (see Appendix B for solicitation letter samples). One week later, a follow up letter requested participation in the study, directed clinicians to a Qualtrics survey that assessed for individual mindfulness practices and willingness to engage in the interview portion of the research (see Appendix C for initial questionnaire sample). Follow up letters were sent at intervals of two and three weeks, pursuing non-responding members of the possible participants' list, again directing them to the Qualtrics survey. The initial questionnaire

netted 21 responses with a total of 12 participants who agreed to continue on to the qualitative interview portion of the study. Of those, ten completed the qualitative interview and follow up survey.

Inclusion and exclusion criteria. Inclusion criteria was set to include mental health clinicians, identified as social workers, counselors, therapists, psychologists, and psychotherapists, currently working in the mental health and/or substance abuse treatment field. Education requirements were set at a minimum of a Bachelor's degree for this research. Individuals not currently practicing in the mental health and/or substance abuse field were excluded; as were those not currently holding a minimum of a Bachelor's degree. Potential participants not currently holding licensure by their state of practice (e.g., the State of Wisconsin) had initially planned to be excluded from the research; however, due to limited response, non-licensed mental health workers, including degree-holding Behavioral Health Specialists were included in the study so as to ensure a well-rounded pool of practicing participants currently engaged in mental health work. To that end, exclusion criteria was firm on disqualification of individuals whose licensure was listed as currently in jeopardy due to ethical complaints or violations.

Instrumentation

Qualtrics, an online survey software was utilized to gather subjects' questionnaire responses for an original demographic questionnaire and for the Maslach Burnout Inventory, bookending the research at the beginning and end of the study respectively.

Demographics questionnaire. The initial questionnaire, posted for exclusive participant use, was the survey that gauged for education, practice, licensure, and current mindfulness utilization, as well as willingness to participate in the qualitative interview portion of the study.

The primary considerations that guided the creation of this survey were informed by the review of current literature on the topics of mental health clinician burnout and mindfulness practices. This demographics assessment was further established by the inclusion/exclusion criteria identified above. The PI's expectation was to be able to first, identify currently practicing mental health clinicians, in good standing, that might be willing to participate in the qualitative interview portion of the study. Further, the researcher's goal was to conduct an initial assessment of each participant's current mindfulness practice; gauging for education and/or training in a specific mindfulness exercise, the type(s) of mindfulness currently utilized by the mental health professional, and the quantity of time spent in-practice of their preferred mindfulness activities each week. Next, the aim of the survey was to evaluate the clinicians' use of mindfulness in their clinical practice and which mindfulness exercises made the leap from personal practice to implementation in the clinical setting. Finally, the questionnaire asked the survey-taker whether they were willing to extend their study participation into the qualitative interview phase of the research, at which point the participant was directed to provide contact information.

Maslach Burnout Inventory survey. The second, and final survey, was an adapted version of the Burnout Self-Test of the Maslach Burnout Inventory (1981). The burnout inventory was utilized within this study in order to get a snapshot of individual burnout symptomology so as to compare these measurements with the themes unearthed within the mindfulness utilization exploration. The Maslach Burnout Inventory (MBI), according to its creators, is designed to assess whether an individual (within the helping professions) may be at risk for burnout. The assessment pulls from three areas in order to measure burnout criteria; these are exhaustion (labeled as burnout), depersonalization, and personal achievement. The

directions on the survey note that a high score in the first two areas (exhaustion/burnout and depersonalization) and a low score in the last unit (personal achievement) may suggest burnout. While the two available reviews of the MBI from the Buros Center for Testing emphasize some of the shortcomings of the assessment, the overall findings of Fitzpatrick (2005) and Wright (2005) find the MBI to be adequate in its measurements. Primary concerns cited by the two reviewers lie with the assessment's moderate reliability (Fitzpatrick) and the untested viability of the MBI with culturally diverse populations (Wright). At the same time, the assessment gets high marks for internal consistency; although Fitzpatrick states, "evidence for validity is not strong", while simultaneously noting that the assessment, nonetheless has merit for its purpose (2005, p.7). To the MBI authors' credit, in a final note, they emphasize that the assessment should not be utilized for "scientific analysis or assessment", indicating that the tool should be used instead to get a general understanding for one's potential for burnout concerns (Maslach et al, 1981, p.2).

Procedure

This study, following several rounds of planning and organization, was born from the themes unearthed in the literature review portion of the initial research proposal. From this, noting a need for more study of mindfulness as a component of burnout-prevention, two research questions surfaced: 1) How does the utilization of mindfulness impact mental health clinician practice?; and 2) How might this practice of mindfulness relate to counselor burnout? With the groundwork laid, a research plan was referred to the principal investigator's university Institutional Review Board (IRB). Once IRB conditions for human subjects were satisfied, participants were enlisted utilizing the snowball technique, pulling from a small, local network of clinicians and educators to fill out the ranks of the initial survey. An email blast was sent out to

all accumulated names, seeking individuals' interest in participating in a thesis research project studying the impacts of mindfulness on burnout among mental health clinicians. One week later, a second email followed, directing the pool of potential participants to a Qualtrics survey. The initial questionnaire assessed for basic demographic information, assessing education, licensure, and engagement in mindfulness practices. Within this survey, individuals were asked to share their personal contact information if they were willing to take their study engagement to the next level; of these, 12 clinicians indicated their interest in participating in the qualitative interview and follow up survey, with a total of ten completing the qualitative interview and final assessment process. Two participants that completed the demographics survey and indicated their interest in further participation, were unable to complete their study engagement, citing scheduling concerns, and personal conflicts.

Following the sample recruitment period, participants were contacted via email or phone (dependent upon individual preference indicated within the initial survey) and a date and time were scheduled to conduct the qualitative interview. The interview format utilized a set list of qualitative questions, probing for individual mindfulness practices and perspectives on the impacts of these (see Appendix D for the list of qualitative interview questions). The interviews were audio recorded and later transcribed. Immediately following each interview, participants were provided a link to the follow-up survey and completed the Maslach Burnout Inventory (1981) (see Appendix A for a sample of the Maslach Burnout Inventory adapted for this study). Names were removed from the data; then the audio recorded interviews and the Maslach Burnout Inventory scores were documented with assigned individual identification numbers in order to preserve confidentiality.

Theme and subthemes. The researcher approached data analysis and interpretation with a phenomenological methodology. Specifically, the researcher aligned to Creswell (2009), who recommends viewing the predominant statements of the qualitative research, in order to make meaning, and pulling any major themes that surface from this exercise. This style allowed the PI to take an empathic stance, so as to see and understand the phenomena described by the participants from their perspective, then apply and transfer this understanding to mindfulness-practicing clinicians.

Themes outlined within this exploration into mental health clinician mindfulness practice were sought with the intention of answering the guiding questions of this research; asking 1) how utilization of mindfulness impacts mental health clinician practice; and 2) how might this practice of mindfulness relate to counselor burnout. In addition, in separating the overarching theme and sub-themes the researcher asked herself, what do these themes say; how do I rationalize this; what might another researcher think about these as themes; and how do I justify maintaining my stance as these themes stand? In order to do so, the transcribed interviews were pared down to their basic elements (removing extraneous words such as “umm”). Next, these components were trimmed down to single thoughts, ranging from a simple sentence affirming one’s application of mindfulness activities within treatment plans, to a paragraph describing an individual’s reasoning for utilizing mindfulness for self-care.

The participants’ statements were then coded according to what the participant was conveying in his/her statement. From there, themes or commonalities between the clinicians’ testimonials surfaced. This presented the researcher with the initial subthemes of the study; as such, in noting the trajectory of the materializing subthemes, the overarching theme of the research took shape. These processes took place over the course of two months, in which the

researcher took various avenues for approaching the themes, observing the emerging information, and then exploring these through the data provided by the participants' Maslach Burnout Inventory results. At last, with the participants' accounts crystalized into four themes, the larger umbrella theme noting the clinicians' values was solidified and the information was combined with MBI assessment results so as to best answer the research questions at the heart of this study.

Study Soundness

To establish soundness of the findings, Lincoln and Guba's (1985) four constructs were utilized, assessing for credibility, transferability, dependability, and confirmability. As such, it was of vital importance in sorting the collected data to include others in the confirmability of these themes. This was executed by testing these premises with outside evaluators. The first of these was the researcher's graduate thesis advisor, who assisted in checking thinking errors, and holding the researcher accountable to her initial goals in this study. The second and third, respectively, were two Masters in Clinical Mental Health Counseling program classmates, who knew the general trajectory of the thesis work. Simultaneously, the proposed themes were presented to the study's participants, asking for feedback and confirmation on the accuracy of the noted tracks of the research. Participants were given one week to review the collected themes and verify their legitimacy or correct any inaccuracies. Following this brief evaluation period, responding participants confirmed the accuracy of the themes and noted their recognition of themselves in the findings. The PI's classmates brought additional insights to the research work, applying theory, and questioning the findings so as to shore up the researcher's argument.

In addition to confirmability, Lincoln and Guba identify credibility, transferability, and dependability as key components of reliable and valid qualitative research. The two Cs of the

constructs, credibility and confirmability, were achieved through the triangulation of data, utilizing three outside judges, as well as verifying the data through the subjects, themselves. Dependability is noted within the Findings and Discussion sections of this paper as the author synthesizes her findings, and notes the limitations of this research work. Last, transferability can be found in the potential applications of this study and the call for additional research found in the recommendations and future study segment towards the end of this thesis.

Findings

The overarching theme uncovered within this study is one of valuing; specifically, the counselors participating in this research identified mindfulness as a value that guides both personal and professional pursuits. Beneath this primary theme there are four corresponding categories that surfaced over the course of the qualitative interview process. The first of these is the mental health clinicians' perspectives on wellness, self-care, and burnout-prevention. The next value is one of expertise and personal growth. The third category includes clinical practice and the counselors' value of mindfulness and flexibility within this setting. The last subset finds the counselors describing the efficacy of mindfulness beyond the therapeutic setting, and the benefits they perceive as a result of mindfulness applied to an individual's change process. Finally, participants' burnout inventory results are examined through the lens of the clinicians' personal and professional mindfulness practices and perspectives.

Mindfulness as a Value

The predominant theme of this research work underscores mindfulness as a value for clinical mental health counselors interviewed in this study. Values, as core principles, are defined as "chosen life directions...[that] give life meaning"; with Acceptance and Commitment Therapy trainer, D.J. Moran, Ph.D. citing relationships, employment, education, and spirituality

as examples of common values (personal communication, March 23, 2016). Within this qualitative study, mindfulness emerged as a value as the participating clinicians articulated their appreciation for mindfulness and the outcomes they noted for themselves, as well as their clients with whom they utilize mindfulness. The mental health clinicians engaged in this study not only identified mindfulness itself as a value, but also a value that supports and upholds other values in their personal and professional lives. This became clear as the counselors discussed their reason for incorporating mindfulness and the benefits (e.g., presence, balance) identified as individual values;

It really pulls you to the moment – because I think oftentimes we get caught up in the past or the future, which really takes us away from who we are as a person. And when we’re caught up in the past or future we may become unsettled – not happy and we may miss opportunities or miss what’s really going on, what’s really important, what our values really are. So I think mindfulness helps reel us back in to be in the moment and focus on who we are in the here and now and what is most important to us. (Participant 31, 2016)

Other values that arose within the qualitative interview process included mindfulness as a source of patience, as well as a sense of presence, balance and tranquility, maintaining that it “gives me a sense of peace even when things feel overwhelming or chaotic, it can give me a grounded feeling, even for just a few moments; [it] allows me to stay present, which I think is so important” (Participant 12, 2016). Mindfulness, and its practice, was identified as a perspective-shifter; a basis for theoretical application; a means for connection with others, especially clients, with the mental health clinicians emphasizing the importance a brief mindfulness break between client sessions, “Especially if it’s been a hard day [I] remind myself that ’this next person

deserves the best version of me' versus what is the lowest baseline I can get away with. Sometimes you need a few minutes...to get back to that" (Participant 15, 2016).

Still, others value the non-judgmental, in-the-moment-awareness of mindfulness that enables them to be fully invested in their client's unique therapeutic experience, it is "just such a joy to be a part of someone's process of change and for me it's just so much more productive to have that [mindful] self be front and center and non-judgmental" (Participant 13, 2016). For the clinicians of this study, mindfulness is a source of intentionality, authenticity, and a means for focusing on what is truly important. This was best summed up by one clinician, who noted,

There's no greater skill than doing what you're doing while you're doing it, and knowing that you're doing what you're doing while you're doing it. Because if you're always in the present moment then you are experiencing that, as opposed to always reviewing what's already happened or worrying about what's going to happen, which is where we spend all of our time in our unhealthy thinking.

(Participant 15, 2016)

The counselors identified mindfulness as a mainstay of their self-care practice and a component of their personal wellness. Mindfulness, many found, is also an element of their connectivity with self, others, and spirituality.

Theme I: Clinicians value mindfulness, self-care and burnout-prevention. The clinicians' shared their perspectives on their incorporation of mindfulness exercises into their personal routines, as well as the values of self-care and burnout-prevention that are supported by their preferred mindfulness practices. Many of the counselors acknowledged some form of daily mindfulness practice; the counselors identified movement or body-awareness-type exercises, such as yoga and body-scanning, as well as deep-breathing and breath-awareness-type

mindfulness, visualizations and imagery, mindful eating, and mantras. Half of the clinicians engaged in this study reported some degree of anxiety, and emphasized the importance of mindfulness in managing these symptoms,

I have anxiety myself and I've been using various relaxation skills for more than 20 years to cope with that. Each evening before I go to bed I go through a compassion meditation and centering breath and I think the more you're exposed to it, the more you utilize it, the more aware of things around you in various ways. (Participant 29, 2016)

Overall, the subjects cited mindfulness as the antidote to stress and burnout concerns, and a vital component in their self-care and personal wellness practices. One participant noted that mindfulness keeps stressors from accumulating:

Literally from dying inside – that sounds drastic but if you don't pay attention to it and you let it all pile up, something's going to leak out, something's coming out sideways – and it usually doesn't work too well for you. So, the most important part I think - I take great pride in what I do and I want to be a better person the next day, and I want to help each day. Every single minute I want to be useful, I want to be giving something positive, so I do this to be more open, to wash away all of the stuff that comes from [clients'] childhood and trauma and what you learn and what you see on a daily basis – just try to clean that all out. (Participant 14, 2016)

Another clinician, citing advice received early in their graduate program, remarked, “You can't pour from an empty cup” (Participant 4, 2016).

Counselors also noted that they practice their preferred mindfulness activities to calm, relax, and sleep, “At night if I really can't fall asleep, or I wake up, I do deep breathing or visualizations because that helps me to put myself back in that present moment, and sometimes

that's enough to relax me to be able to fall asleep again" (Participant 4, 2016). For others, mindfulness is their go-to to slow down, cope, attain centering and balance, and decompress between or before sessions, "When you have two minutes between seeing somebody," one participant stated, "you've got do something to feel you can calm a bit, otherwise that rubs off on the next person – people can tell" (Participant 25, 2016). The counselors connected their mindfulness practice with increased personal wellness and decreased stress; as one participant put it, a counselor must, "take care of yourself – to try to de-stress – if people in this field don't do that I don't think they'll last long because there's so much stuck in there – secondary stress and trauma that you hear every day and if you can't relax and let stuff go I don't think it would be good to continue the work" (Participant 25, 2016).

Theme II: Mental health clinicians' value expertise and personal growth. Expertise, within this study, surfaced as value in knowledge, personal growth, and theoretical orientation for the participating counselors. Expertise and experience among the participating clinicians ranged from three to over twenty years of mindfulness practice. All counselors identified some form of training in mindfulness via workshops and other training sessions, as well as their respective Masters or Doctoral programs. As one participant reported, "I had one professor who was really into it. Before every class we would do a kind of loving kindness meditation or mindfulness breathing exercise, and so I really started to notice the benefits of it" (Participant 12, 2016). Further, the counselors delved into personal research to bolster their mindfulness understanding and practice, "my standard method is to read about – then try something out" (Participant 14, 2016). While not all counselors identified their theoretical inclinations within the interview process, several therapeutic orientations were cited as being relevant to the respective clinicians' mindfulness practice or use of specific mindfulness strategies within

sessions, “we integrate it with [Dialectical Behavior Therapy] in facilitating DBT groups. We integrate it and teach patients how to use it as a skill” (Participant 9, 2016). DBT, Cognitive Behavior Therapy (CBT), and Acceptance and Commitment Therapy (ACT) were cited as influences, as were both Trauma-Focused CBT and Rogerian/Person Centered orientations; with much overlap among the theories as clinicians took a transtheoretical approach, incorporating more than one perspective within their practice.

Conversely, within the qualitative interviews, several of the counselors downplayed their mindfulness practice, either minimizing their use of mindfulness or emphasizing the need to increase their mindfulness practice, relating,

I’ve wanted to get more of a pattern – I’ve thought about getting into group meditation just as a way to keep me accountable for it. Because I know in the past when I have practiced it more consistently it has been tremendously helpful. But I haven’t done a lot lately – intentional taking time out of my day to have a space for it – it’s more catching myself. (Participant 12, 2016)

While some of the counselors insisted that they do not do nearly enough, others specifically noted the difficulties or challenges in maintaining their mindfulness practice. One such example of the former comes from a clinician who, at the onset of the interview, argued, “I’m really bad at it [practicing mindfulness]. I tell my clients to work on it and I don’t” (Participant 14, 2016). Yet this same therapist then went on to describe in great detail her daily personal use of visualization and yoga, as well as some creative centering endeavors that involved art and music. Meanwhile, other mental health clinicians, who disclosed their personal challenges in maintaining a regular mindfulness schedule with young children in the home, still found time to practice brief moments of deep breathing and centering in order to be fully present for clients,

self, and others, it is “more in the moment when I’m noticing my anxiety or I’m needing to slow down – I’ll notice my breath, I’ll pay attention to things right in front of me, slowing it down a little bit” (Participant 12, 2016).

The mental health clinicians’ perspectives of their personal mindfulness practice contrasted with their expectations of their clients. The theme of client use and benefit from mindfulness will be explored under a later heading; however, it is worth noting here that while the counselors praised their clients’ efforts with the practice, they conveyed less compassion for themselves, “Obviously I know that I’ve benefitted from it [mindfulness practice] in the past so it’s about having a more standard practice of sorts” (Participant 12, 2016). In sum, the mental health clinicians, all of which presented for this study with years of mindfulness experience, minimized their own expertise, despite their self-reported evidence of their proficiency, and daily use of mindfulness.

Theme III: Counselors value the flexibility mindfulness presents in clinical practice.

The counselors in this study bridged their personal mindfulness practices with the clinical setting; valuing the impact of mindfulness in individual and group sessions, and recommending mindfulness exercises within homework and treatment plans. The mental health clinicians pointed to the usefulness and flexibility of mindfulness with broad application within a variety of settings, with a diverse population of clients, and diagnoses. They identified several diagnoses and clinical concerns in which they adopt mindfulness exercises to intervene, such as Post-Traumatic Stress Disorder, Substance Use Disorders, Eating Disorders, Depression, Attention Deficit/Hyperactivity Disorder, and Anxiety, as one clinician stated, “I don’t know any person that mindfulness couldn’t benefit” (Participant 12, 2016).

The therapists also remarked on their professional use of mindfulness to address anxiousness in sessions, client irritability, avoidance, emotional regulation, as well as a means to address behavioral concerns among child and adolescent clients,

When I'm trying to help them with focusing behaviorally and things they can do to tune in or tune extraneous things out, I start with the raisin. I give them a raisin, we hold the raisin, we smell the raisin, then we experience the raisin in various ways – I start with that basic exercise. (Participant 29, 2016)

Within the clinical setting, mindfulness activities, according to the participants, are often included in their clients' treatment plans, goal work, or assignments; with the counselors assisting their clients with the mindfulness exercises in session,

I try to teach clients [that] it doesn't have to be something you're doing frequently – it's in those moments when you're needing to ground yourself for a second – just something for a minute to kind of experience it in the moment. It's a really important tool. I actually really like when I have to do it with a client – walk them through a body scan or something like that – I find it to be relaxing myself. (Participant 12, 2016)

The counselors, in their professional practice, tailor the mindfulness activities to meet their clients' requirements, and address the concerns they bring to counseling, "Deep breathing, imagery, stress management, it's really based on the person and what they need" (Participant 31, 2016). Further, they strive to make mindfulness accessible, "I emphasize picking something you do every day – even if it's just brushing your teeth – and practice being mindful for that couple of minutes and then trying to integrate that into larger aspects of your life" (Participant 9, 2016). More than one clinician endorsed mindful listening for increased connection with clients in

session, with one therapist commenting that this is an exercise implemented both in the professional and personal realms, noting that it is practiced within sessions, in order to “stay with [the] client, or my wife” (Participant 15, 2016).

Many of the counselors’ favored mindfulness exercises made the jump from their personal lives to the clinical setting; these included deep breathing or breath-awareness practices, and visualization techniques or other use of imagery,

We do guided imagery – kids tend to like that too – we do a magic carpet ride ‘what would it feel like? What do you think it feels like right now in this moment if you were on a magic carpet ride? What would you be feeling on your face? Would you feel the wind on your face? What would you smell? What would you see? What would you hear?’ So it’s really in that present moment. (Participant 4, 2016)

Many of the clinicians also endorsed applying body awareness techniques with clients including yoga, mindful walking, tapping and/or bilateral processing, other non-food/drink-based sensory experiences, and body scan, “often in the moment, breathing exercise or body scan, if they’re agitated or if I see their anxiety is escalating – I do a lot of trauma work – so it’s important to teach them how to regulate the body” (Participant 12, 2016). Many therapists echoed this, noting “We’re constantly working with them to bring them back to their body...There’s always that theme of ‘what’s going on in your body from the neck down?’” (Participant 1, 2016). Mindful eating was another mindfulness practice that saw some carryover from the counselors’ personal lives into the clinical setting, with mindful, sensory experiencing of food within the session or as an at-home assignment, “mindful eating, I’ll do that with certain people – if an eating disorder is

present I'm a bit more careful how I implement that but a lot of [clients] stress eat and so we work on that" (Participant 15, 2016).

A number of clinicians practice mindful breathing and present-moment awareness in the clinical setting, "I try to remind myself when I'm with a patient to be with the patient instead of being in my own head" (Participant 9, 2016). Counselors emphasized this in sessions with particularly challenging clients, stating "I sit peacefully and I try to be really quiet on my insides which...in the moment helps me to be mindful of what's in front of me" (Participant 13, 2016). In this, the counselors achieved expansiveness and awareness,

I value having all information to make decisions, and I think mindfulness allows me to have access to a lot of inside information. I think mindfulness diminishes blind-spots in my personal and professional decision-making by increasing the amount of inner information that I'm aware of instead of just using suppression to push it aside. More connected and able to reason more fully, rather than just very cognitively. I'm able to make informed decisions because of my use of mindfulness because I have the body and the mind information. (Participant 1, 2016)

Others cited balance, and/or grounding through their own use of mindfulness skills applied in session; thus, modeling healthy use of mindfulness for their clients. The counselors related this to their appreciation for the non-judgmental aspects of mindfulness within the therapy room, with one counselor noting that it is "very Rogerian in many ways, treating our clients with respect and kindness...and open-mindedness" (Participant 13, 2016).

The clinicians sharing their stories within this study spoke to the present-moment aspects of their application of mindfulness, they also cited authenticity as a value they associate with the exercises, prompting them to promote the practice both in their personal and professional work.

For example, one participant shared, “One of the things I talk about [with clients] is living a life of honor and integrity, and I don’t know how I can even pretend to preach that if I can’t practice it” (Participant 13, 2016). This points to a sort of “parallel process”, identified by Friedlander, Siegel, and Brenock (1989) as the replication of behaviors within the counselor-supervisor relationship. In this case, the mental health clinicians’ practice of mindfulness transfers across environments as the counselor practices mindfulness at home, and with the client in session; the client practices mindfulness in session with the counselor, leading to the client practicing mindfulness at home.

Theme IV: Counselors value the efficacy of mindfulness beyond the clinical setting.

The counselors’ value of mindfulness was often described in terms of its perceived benefits and the meaning the mental health clinicians’ ascribed the practice of mindfulness. From the counselors’ perspectives, they noted the transfer of in-session skills to their clients’ practice of mindfulness beyond the walls of the clinic,

They use it as well when you’re not in session. That’s when you know that they’re ready to move on to the next step, when they start to use the coping skills outside of the session. It’s a way to gauge that readiness. Are they able to use some of those tools? (Participant 4, 2016)

This same counselor teaches her clients mindfulness that they can do outside of session without anybody noticing, “We practice deep breathing [in session] and it’s like, ‘you can do it any time of the day, nobody looks at you if you’re deep breathing because everybody has to breathe anyway!’” (Participant 4, 2016). In comparing their client’s behavior pre-and-post-mindfulness practice, one therapist emphasized the impact of the bilateral processing of mindful walking with clients. The therapist noted that the client was immobile in treatment prior to the mindfulness

exercise, stating that with the use of mindful walking “they get unstuck...they’re more aware” (Participant 1, 2016).

The mental health clinicians value mindfulness for the benefits they noted the exercises presented for their clients. The counselors endorsed mindfulness for its capacity to increase client awareness, connectivity, emotional regulation, or balance, noting that it is about “getting them much more grounded into the moment because that helps them to not re-experience the trauma” (Participant 4, 2016). In emphasizing the significance of meditation, the clinicians underscored the slippery slope of getting trapped by one’s thoughts or feelings, citing mindfulness as the remedy, noting “There’s a lot of research to support that people that are more mindful and present, and aware of what’s going on in front of them, rather than in their own head, tend to be happier and have better relationships” (Participant 9, 2016).

Maslach Burnout Inventory measures. For this research, the Maslach Burnout Inventory was employed for the triangulation of the mental health clinicians’ discussion of their mindfulness practice for stress-reduction, and burnout-prevention. Overall, the participants’ MBI burnout measurements presented as relatively low. The clinicians in this study self-reported, utilizing a Likert Scale, rating their levels of burnout, depersonalization, and feelings of personal achievement. Within the burnout category a very small fraction of participants indicated feelings of high-level burnout (10%, $n = 1$). The clinicians’ experience of depersonalization was somewhat more mixed, with an even split between participants counting low levels within the depersonalization category and the others ranking moderate to high levels (50% low level, $n=5$; 30% moderate, $n=3$; 20% high, $n=2$). The personal achievement measurements identified a majority of the mental health clinicians aligning with positive feelings of personal achievement, with a smaller number noting a moderate level of concern in this area,

with no respondents identifying within the high-level burnout measurement in this category (70% identifying feelings of high personal achievement, n=7; 30% scoring themselves in the moderate range for personal achievement, n=3). The combined results of the MBI identified a very small number of the counselors in the area for high-level burnout by the assessment's measures with the greatest portion of the counselors citing little to no experience of burnout symptoms (10% ranking high-levels of overall burnout, n=1; 90 moderate to low burnout measures, n=9). Again, the authors of the inventory emphasize "different people react to stress and burnout differently. This test is not intended to be a scientific analysis or assessment. The information is not designed to diagnose or treat your stress symptoms of burnout" (Maslach et al, p. 2, 1981). In sum, these results appear to reinforce the mental health clinicians' self-reports of the positive impacts of mindfulness in decreasing stress and increasing counselor wellness.

Discussion

The purpose of this qualitative study was to enhance understanding of mindfulness as a component of counselor self-care and how the practice of mindfulness might impact burnout, a chief concern among the mental health working population. As such, the questions defining this research asked: 1) how does the utilization of mindfulness impact mental health clinician practice? And, 2) how might this practice of mindfulness relate to counselor burnout? The findings of this effort, utilizing qualitative interviews and the Maslach Burnout Inventory (1981), find that burnout is a concern among mental health clinicians and, perhaps as a result, these participants cited burnout prevention as a value. In that way, this qualitative research effort illuminates values as both the source and sustainer of mindfulness practice among mental health clinicians; with those participating in this study identifying their values as they relate to their personal mindfulness practice for wellness, self-care and burnout-prevention. These themes

were assessed in light of the participants' burnout evaluations, incorporating the counselors' perceptions of expertise and personal growth; clinical practice incorporating mindfulness exercises within this setting; and the benefits and efficacy the mental health professionals' observe in their clients as a result of mindfulness meditations.

The counselors involved in this study, relegated to mental health clinicians practicing within a regional area encompassing Wisconsin and Minnesota, demonstrated a commitment to some form of daily mindfulness practice for self-care and burnout-prevention. These clinicians' mindfulness practices were overlaid with their individual results of the Maslach Burnout Inventory (1981) to evaluate for the influence of their mindfulness practice on the potential for burnout. The mental health practitioners identified their value in expertise, accumulating years of mindfulness practice through education, training, and theoretical orientation. Finally, the clinicians share this mindfulness expertise with their clients in the form of in-session exercises, as well as activities given as homework and/or included in client treatment plans; noting the positive impacts of mindfulness activities both in and out of the clinical setting.

Values are a Source and Sustainer of Mindfulness

Again, in examining the influence of values emphasized by participants within this study, this researcher must concede her own practice of Acceptance and Commitment Therapy, an approach renowned for the weight it gives values as a means for motivating change and creating a life guided by these personal values. While few of the participants expressly identified this construct, that is, they did not specifically use the word "value"; many articulated the importance of mindfulness in their lives, and described their core reasons and rationale for incorporating these activities in their personal and professional lives. Mindfulness, they emphasized, is a means for accessing information, clarity, and guiding decision-making; a method of self-care so

as to be able to give more of their selves to others in their change process; a part of their spiritual practice; being fully present and patient; a source of peace; and an element of living an authentic and balanced life. These values, highlighted by the mental health clinicians, seem to relate both to these mental health clinicians' calling to practice mindfulness, as well as mindfulness's ability to enhance their values.

Mindfulness is a Vital Component of Self-Care and Burnout Prevention

Burnout prevention appears to be at the heart of the counselors' mindfulness commitment, with participants placing value on the stress-reducing benefits of mindfulness, and citing its vital role in their decompression, relaxation, and pre-sleep practices. The clinicians' appraisal of their personal practice of mindfulness indicate that mindfulness is gaining value as an important component of self-care, as emphasized by the American Counseling Association's (2014) concern for clinician burnout, as well as other studies cited within this thesis's literature review (Barnett et al, 2007; Chambers-Christopher and Maris, 2010; Chrisman-Campbell and Chambers-Christopher, 2012; Lambie, 2006; Morse et al, 2012; Newsome et al, 2012; Shapiro et al, 2007; Vilardaga, et al, 2011; and Warren et al, 2010). The counselors also noted the benefits of brief mindfulness during their workday for centering and balance between and before sessions. The value at the center of this revelation appears to be the mental health clinicians' assertion that each client deserves the best from their counselor; relating to authenticity, congruence, and staying in the present moment. These efforts at self-alignment point to increased wellness among counselors, and decreased stress.

The burnout measures pulled from the participants' Maslach Burnout Inventory (1981) results appear to largely complement the mindfulness findings discussed within this study; with all participants endorsing some form of mindfulness practice, either in their personal lives, in

their clinical work, or in both areas. There are discrepancies, however, with one clinician acknowledging limited mindfulness practice and scoring low in the burnout inventory; while another clinician endorsed an extensive daily mindfulness practice yet outranked all other participants in the measures for burnout risk. At the same time, even this clinician's measures for burnout placed, overall, in the moderate range, rather than the high-high range. Overall, burnout measurements ran the gamut, and few participants met criteria for any considerable concern for burnout by the MBI's measurements. Similarly, participants presented with varying degrees of mindfulness utilization; while it may be argued that those with lesser practice of mindfulness should therefore show a higher risk for burnout within the MBI, this cannot be entirely qualified. While the qualitative information presented is ample to establish transferability of the identified themes, the sample size does not allow generalization of the MBI results. Even so, the findings and results of the MBA may indicate that even brief moments of mindfulness, unplanned, and scattered through the day, translate into big results for mental health clinicians, a theory supported by some of the researchers listed within this paper's review of the current literature (Birnie et al, 2010; and Newsome et al, 2012).

Mental Health Clinicians Value Expertise

The mental health clinicians participating in this research came into the study with years of mindfulness expertise; emphasizing the fact that such exercises are being highlighted in a variety of academic and professional venues. Indeed, this is encouraging as researchers call for more focus on mindfulness, as well as self-care and burnout prevention in professional development settings (Barnett et al, 2007; Chambers-Christopher et al, 2011; Chambers-Christopher and Maris, 2010; Chrisman-Campbell and Chambers-Christopher, 2012; Myers and Williard, 2003; Newsome et al, 2012; Rosthaupt and Morgan, 2007; Schomaker and Ricard,

2015; and Shapiro et al, 2007). Among this study's participants, mindfulness experience was garnered in Master's and Doctoral-level programs, trainings for DBT and CBT, and emphasized in supervisor sessions, and conference symposiums. The mental health professionals that participated in this research work appeared to gain much from these immersion opportunities and many spoke of seeking more information by researching additional mindfulness strategies in order to expand their repertoire beyond the required continuing education credits. Further, in gaining mindfulness training and expertise, counselors appear to be reaping the benefits of this growing knowledge, practicing the skills they learn, and then taking these lessons into the clinical setting. In their work with their clients, clinicians teach and practice mindfulness exercises in-session, while using mindfulness skills within sessions in order to focus themselves, and remain present with their clients for their own balance and therapeutic productivity.

Still, while citing the many applications of mindfulness with their clients, and extolling the value of these practices in their personal and professional lives, an overwhelming majority of participants appeared to minimize their mindfulness practice within the qualitative interview process. Many of these clinicians downplayed their engagement in mindfulness exercises and noted that they needed to do *more* mindfulness in the interest of self-care. Interestingly, several of the participants who at first minimized their use of mindfulness went on, within the span of the interview, to expand upon the many uses they make of mindfulness, sharing a litany of activities and practices both in-and-outside of the therapeutic setting. In citing the need to increase mindfulness practice, and insisting that they do not do nearly enough, these clinicians underscored the difficulties or challenges in maintaining their mindfulness practice, specifically with families, busy schedules, and demanding workdays; yet strived to include brief moments to collect themselves, center, and decompress throughout their days.

In dissecting this theme of the counselors' minimization of the mindfulness expertise, it seems that a discrepancy emerges in the mental health clinicians' perspectives of their personal mindfulness practice in contrast with their expectations of their clients. While the counselors celebrated their clients' mindfulness efforts, they conveyed less compassion for themselves. This may be incongruent with research findings that point to increased self-compassion among individuals practicing self-care, and mindfulness in its various forms (Birnie et al, 2010; Newsome et al, 2012; and Patsiopoulos and Buchanan, 2011). At the same time, this curious finding supports research that indicates that counselors who maintain a self-care practice, including mindfulness exercises, tend to be more compassionate (Sprang et al, 2007), are more in-tune in the clinical setting (Schomaker and Ricard, 2015), and exude more empathy towards their clients (Bentley-Greason and Cashwell, 2009), in that the counselors within this study extended kindness and affirmed their clients' early forays into mindfulness. These mental health clinicians infused mindfulness into sessions, and encouraged their clients to be self-compassionate in small, incremental steps towards practicing mindfulness.

This minimization on the counselors' part is, perhaps, best illuminated by Chambers-Christopher et al. (2011) who studied the longitudinal impacts of mindfulness training as a part of counselor self-care. The researchers' study reinforced the incredible, long-term effects of mindfulness practice; finding that the mindfulness training paid off in dividends, as the counselors reported expansive awareness. This awareness, the authors noted, resulted in the clinicians' heightened consciousness of their own inner experiences; resulting in decreased reactivity, and increased acceptance. The mental health practitioners of the current study similarly reported their value in awareness had been augmented by mindfulness practice. They identified increased connectivity with their inner experience, which may have illuminated the

conscious need for mindfulness practice for self-regulation, grounding, and balance. This in turn would lead to these counselors' hungering for more mindfulness, and thus indicating the desire for more mindfulness activities in their daily lives.

In sum, the mental health clinicians, all of which presented for this study with years of mindfulness experience, minimized their own expertise, despite self-reported evidence of their proficiency, and daily use of mindfulness. While mental health clinicians are currently utilizing mindfulness daily, practice the exercises with their clients, and value the benefits of these practices, they deduce the need for more of this in their lives; perhaps related to an increased awareness of their inner experience. Overall, high measurements of personal achievement within the MBI indicate that these mental health clinicians are largely aware of their successes and accomplishments, thus indicating that these subjects were not merely being self-effacing, or modestly downplaying their perceptions of their mindfulness practice. Therefore, mindfulness's impacts upon clinician wellness must be a positive one so as to foster awareness and increase participants' thirst for more of this healthy activity within their lives.

Mindfulness has Positive Implications as a Flexible Component of Clinical Practice

These findings suggest mental health practitioners apply several mindfulness practices in a variety of settings with a diverse array of clients, and promote mindfulness as flexible and effective with a number of diagnoses, citing the benefits of this beyond the clinical setting. Specifically, the participants of this study practice in various venues of mental health treatment and intervention including licensed substance abuse counselors, credentialed behavioral health specialists, Masters-attained therapists, psychologists and counselors, and Doctoral level mental health practitioners. These clinicians work with diverse populations within drug and alcohol therapy, PTSD treatment, and focus on special populations ranging from children, veterans, in-

and-outpatient settings, sex-offenders, and students. Many clinicians appeared to apply their preferred mindfulness practices to meet their clients' needs within the session, practicing body-scans, deep breathing, and visualizations, as well as recommending mindful eating, mindful communication for connection, and meditation as homework. While this study did not go into the therapy room to evaluate the benefits of mindfulness from the clients' perspectives, Schomaker and Ricard (2015) found their participants' personal assessment of their use of mindfulness with clients appears to be a positive one, with the mental health professionals participating in this study asserting value in the flexibility of the practice with a number of diagnoses and presenting concerns, which support other research findings (Arch and Craske, 2006; Feinstein, 2010; Feinstein, 2012; and Utay and Miller, 2006). In sum, the counselors valued the positive outcomes they associated with their clients' use of mindfulness, including increased capacity, awareness, and emotional regulation; laying the groundwork for meaningful change and life satisfaction.

The Research Questions: How Does the Utilization of Mindfulness Impact Mental Health Clinician Practice? How Might this Practice of Mindfulness Relate to Counselor Burnout?

This study's defining question, "how does the utilization of mindfulness impact counselor practice?" is best understood through the mental health clinicians' valuing of their mindfulness practice, and the reciprocal relationship this practice seems to share with their other presenting values (i.e., burnout prevention, expertise, clinical flexibility and efficacy). The mental health clinicians resoundingly praised mindfulness as the antidote to stress, a central component in burnout prevention, and a chief practice in their self-care and personal wellness practices. Over and over, the counselors related mindfulness to self-care and self-care to burnout-prevention. This connects to decreased stress and increased wellness. Counselors seem to agree that their

preferred mindfulness activity is an excellent means for grounding, calming, relaxing, enhancing sleep, decompressing between/before sessions, and an excellent way, overall, to slow down, cope, and attain centering and balance. So, how does this translate to their practice as mental health clinicians? Counselors note the positive impact of mindfulness in their personal and professional lives, and articulated the value of mindfulness in these various realms of their existence. The clinicians engaged in this research associated this with the transfer that so often appears to take place in the clinical setting, as they strive to stay in the present moment with their clients and share these same mindfulness exercises with their clients; with counselors fully practicing what they preach. These clinicians spoke loud and clear about their values, stating that mindfulness is imperative to their practice, and an excellent means for calming and centering between client sessions, so as to give 100 percent to each individual on their schedule.

Finally, in asking, “how might this practice of mindfulness relate to counselor burnout?”; the counselors’ burnout measurements (incorporating burnout, depersonalization, and personal achievement) that ranked within the high-level burnout range, reach significant levels that cannot be overlooked; however, the measurements for low concern are overwhelming within this assessment, dwarfing all other burnout rankings among the participating mental health clinicians. The small fraction (10%) of this study’s participants’ high burnout measures, when compared to Morse et al’s (2012) research that points to 21-67% of mental health clinicians experiencing “high level burnout” symptoms (p. 342), indicates that mindfulness may in-fact have very positive influences on clinician burnout symptomology, decreasing exhaustion, and increasing the counselors’ sense of balance and self-efficacy. As such, these combined findings, merging these understandings of mindfulness practices and Maslach burnout measurements, point to clinician mindfulness practice having a not insignificant impact on burnout symptoms. In

answering the research question, this study indicates that mindfulness may very well be a valuable component in clinician burnout mitigation. Other possible contributors, such as caseload, environmental and organizational stressors or unique client concerns, as identified within the literature review (Lawson, 2007; Morse et al, 2012; Ohrt and Cunningham, 2012; Oser et al, 2013) may very well impact counselor burnout, but were not discussed in participant interviews. Still, these qualitative findings illustrate clinician implementation of mindfulness as one element useful for self-care to decrease burnout.

Confirmability. Within the triangulation and confirmability process of this research work, the participants of this study were contacted to review the themes and findings noted within this process. Overall, the responding participants acknowledged the accuracy of these conclusions and noted seeing themselves in the research outcomes. At the same time, while some mental health clinicians reported their surprise at the clinicians' minimization of their mindfulness efforts, they also indicated that this was, indeed, a truth; with Participant 25 noting this discrepancy, stating the "theme of counselors downplaying their own skills and use of mindfulness, that seems so usual for the people in our field to do" (2016). Others spoke to their admiration in the prevalence of mindfulness practice among their colleagues, and discussed their amazement for the impacts of these mindfulness exercises. Another participant noted that, as a result of her participation in the study, she had increased her burnout-prevention practices, "I made some pretty big changes in my mindfulness and self-care, and I believe the burnout survey was some part of that process" (Participant 14, 2016). The counselors' confirmation of these themes and findings points to the very real implications of clinician mindfulness practice, both in and out of the professional setting, for wellness, burnout prevention, and self-care.

Limitations

There are several limitations that somewhat restrict the potential application of these research findings. In regard to sampling, self-selection bias is noted as likely, in that this study may have attracted only mental health clinicians interested and engaged in mindfulness exercises; while those disinterested in, or not participating in any form of mindfulness practice, may have disregarded the initial request for involvement or declined to contribute beyond the initial survey. Further, as with non-responsive sampling bias, clinicians concerned about their personal risk for burnout may have opted out of involvement with this research, as the intent of the study was not concealed from potential participants in the recruitment stage. In addition, this study was rather geographically limited, with mental health clinicians confined within a 250-mile radius, encompassing Wisconsin and Minnesota. While many demographics and other variables were accounted for, this study did not measure for factors such as gender, ethnicity, culture, place of professional practice (e.g. hospital, rural programming), or personal histories that may have impacted individuals' needs, such as trauma, history of substance abuse or anxiety. In retrospect, including circumstantial or agency factors, such as small non-profit organizations, mental health clinicians working in rural areas, or individuals working with highly traumatized clients (e.g. sex offender treatment, dual diagnoses, abused/neglected children) may have provided for a richer, more in-depth understanding of the circumstances of the clinicians, their mindfulness practice, and presenting burnout symptoms. Finally, a study is only as strong as its instrumentation, and the Maslach Burnout Inventory (1981) warns against utilizing the assessment for diagnosis purposes; further, this inventory falls short by the Buros Center for Testing's standards. To that end, the MBI is a subjective set of questions, with responses set up on a Likert scale, which are strictly limited to the interpretation of the individuals taking the

assessment. Information gleaned from the Maslach Burnout Inventory should be deemed preliminary, as a much larger sample would be needed for the results to be useful beyond simple triangulation of subjects' interviews for this qualitative study.

Future Study and Recommendations

For future study, or expansion of this research work, more longitudinal data may be necessary. Prospective research may explore, over the years, how mindfulness practices persist among these individual clinicians and how these, as well as burnout measures, might change over time. Further, an investigation of how these mindfulness practices translate to the clinical setting, the impacts on client wellness and outcome measures, could further expand the understanding of this as it pertains to clinician practice, as well as mindfulness as an intervention. Do certain forms of mindfulness have a greater impact on the therapeutic relationship/counselor or client wellness/burnout mitigation? Ongoing inquiries into mindfulness should include consideration of environmental factors, such as caseload; the practices of rural and urban counselors; and the clientele represented within the therapists' client roster. Another examination, looking into the impacts of mindfulness practices on mental health clinicians, could be a fruitful pursuit, assessing for the impact of mindfulness trainings, conferences, and sessions on mindfulness practice and burnout symptomology. Finally, studies held in other locations, tracking for demographics show different results from this research work, may be beneficial.

Finally, this study illuminates the importance of prevention when it comes to addressing and treating clinician burnout. In this way, this study should not only encourage additional research, but also the development of programming that targets burnout prevention. This, and other current studies, set the groundwork for these efforts in ensuring a holistic approach to

counselor self-care. From the perspective of Counselor Education programming, this could mean coursework and lifework-type assignments prior to graduate students entering the Practicum phase of their education. Such training would infuse self-care and mindfulness within its curriculum, and ensure continued measurement of these throughout student placement. Beyond this, an ongoing focus on self-care and mindfulness in continuing education and post-education professional development and training could be a tremendous step in ensuring a healthy, mindful, and values-focused field of mental health clinicians.

Conclusions

This qualitative study set out to illuminate the impact of mental health clinician mindfulness practice on burnout measurements, as established through qualitative interviews and the Maslach Burnout Inventory (1981). The goal for exploring mindfulness and burnout was to learn more about the potential correlation between mitigated burnout symptoms and clinician mindfulness practice. This is significant, as establishing an association between burnout prevention and mindfulness as a valued self-care practice could have repercussions for counselor education programs and supervisory practices, in addition to expanding mental health clinician awareness of the importance of mindfulness as a component of their self-care practices. While small in scope, the results of this study imply the legitimacy of this relationship, pointing to limited burnout symptomology among clinicians most inclined to include mindfulness practice in their life and clinical work.

In sum, through the qualitative interview and burnout assessment, this study's findings emphasize the importance of mental health clinician self-care in burnout symptom mediation and prevention. Further, these findings point to the legitimacy of mindfulness as a component of counselors' self-care practices. Because of the clinicians' belief in its effectiveness, they place

value on mindfulness as a component of self-care and burnout prevention. Mindfulness as a value, and a value that supports and upholds other values, both in-and-out of the counseling setting, is one important instrument in the counselor's toolbox, supporting and sustaining clinical practice and the self-care efforts of today's mental health professionals.

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Appendix A

Maslach Burnout Inventory

Q1 Burnout Self-Test Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is the most commonly used tool to self-assess whether you might be at risk of burnout. To determine the risk of burnout, the MBI explores three components: exhaustion, depersonalization and personal achievement. While this tool may be useful, it must not be used as a scientific diagnostic technique, regardless of the results. The objective is simply to make you aware that anyone may be at risk of burnout. Researcher note: Data collected during the course of this study will be kept strictly confidential, with all information coded in order to ensure privacy; further, information obtained through this study will be destroyed at its culmination. If the results of this study are published or presented, no names will be associated with the data cited. Any information that is obtained in connection with this study that can be identified with you will be disclosed only with your permission. While these researchers do not anticipate the need to release confidential information to others, information shared within this study that suggests imminent danger to self or others may be reported. For questions about this research project, contact Stephanie Wachter, _____, _____ (student researcher) or Dawnette Cigrand, PhD, PSC, _____, _____ (faculty project advisor). For questions about research subjects' rights or research-related injuries, contact Human Protections Administrator, Brett Ayers at _____. Please remember that your consent to participate in this study is completely voluntary. You may withdraw at any time without prejudice. By selecting "Continue to questionnaire" from the below choices you indicate that you have read the information above, had an opportunity to ask questions about the study, and have decided to continue your participation.

Appendix B

1st: Advanced Notice Email

Dear name of potential participant,

We are writing to request your participation in a mental health practitioner mindfulness study to be conducted as a part of a thesis research project via the Winona State University Counselor Education Department. The purpose of this research effort is to explore mental health clinician practices and perceptions of mindfulness and the impact of these exercises on burnout. A second email will follow in one week with a link to a Qualtrics survey. This survey will take approximately 10-15 minutes of your time.

In the meantime, if you have any questions regarding this research please contact the student researcher, Stephanie Wachter (email: _____) or the faculty research advisor, Dawnette Cigrand, PhD, PSC (email: _____, office phone: _____).

This research project has been approved by the Institutional Review Board (IRB) at Winona State University.

Thank you for your time and consideration. We look forward to hearing from you.

Sincerely,

Stephanie Wachter (graduate student researcher)

Dawnette Cigrand, PhD, PSC (faculty research advisor)

2nd: Official Solicitation Email (1 Week)

Dear name of potential participant,

We are writing to request your participation in a mental health practitioner mindfulness study to be conducted as a part of a thesis research project via the Winona State University Counselor Education Department. The purpose of this research effort is to explore mental health clinician practices and perceptions of mindfulness and the impact of these exercises on burnout.

Please follow this link to a Qualtrics survey and consent form: _____

It is estimated that this survey will take approximately 10-15 minutes of your time.

Thank you for your interest in this research project.

If you have any questions regarding this research please contact the student researcher, Stephanie Wachter (email: _____) or the faculty research advisor, Dawnette Cigrand, PhD, PSC (email: _____, office phone: _____).

This research project has been approved by the Institutional Review Board (IRB) at Winona State University.

Thank you for your time and consideration. We look forward to hearing from you.

Sincerely,

Stephanie Wachter (graduate student researcher)

Dawnette Cigrand, PhD, PSC (faculty research advisor)

3rd: 4-8 Day Follow-Up Reminder

Dear name of potential participant,

We are following up with you in regards to your participation in a mental health practitioner mindfulness study to be conducted as a part of a thesis research project via the Winona State University Counselor Education Department. The purpose of this research effort is to explore mental health clinician practices and perceptions of mindfulness and the impact of these exercises on burnout.

If you are interested and willing to participate in this study please follow this link to a brief Qualtrics survey and consent form: _____

Please know that your insight is valuable to this research and that we appreciate your consideration of this proposal. However, your participation in this study is completely voluntary. Your determination will have no impact on your relationship with Winona State University, its faculty, or students.

If you have any questions regarding this research please contact the student researcher, Stephanie Wachter (email: _____) or the faculty research advisor, Dawnette Cigrand, PhD, PSC (email: _____, office phone: _____).

This research project has been approved by the Institutional Review Board (IRB) at Winona State University.

Thank you for your time and consideration. We look forward to hearing from you.

Sincerely,

Stephanie Wachter (graduate student researcher)

Dawnette Cigrand, PhD, PSC (faculty research advisor)

4th: Thank You to Participants + Invitation for Additional Interview

Dear participant,

Thank you for participating in the research effort exploring mental health clinician practices and perceptions of mindfulness and the impact of these exercises on burnout.

You indicated within the survey that you are interested in participating in a follow up qualitative interview. Thank you for your willingness to further this research effort!

Please respond with your availability and preferred method for the qualitative interview process (phone/in-person).

It is estimated that the interview itself will take approximately 10 – 20 minutes of your time.

If you have any questions regarding this research please contact the student researcher, Stephanie Wachter (email: _____) or the faculty research advisor,

Dawnette Cigrand, PhD, PSC (email: _____, office phone: _____).

This research project has been approved by the Institutional Review Board (IRB) at Winona State University.

Thank you for your valuable time donation to this research effort. We look forward to hearing from you.

Sincerely,

Stephanie Wachter (graduate student researcher)

Dawnette Cigrand, PhD, PSC (faculty research advisor)

5th: Thank You to Participants + Invitation for Final Survey

Dear participant,

Thank you for participating in the research effort exploring mental health clinician practices and perceptions of mindfulness and the impact of these exercises on burnout.

As a follow up to the qualitative interview we ask that you please complete one last questionnaire as a part of this research effort. The survey should only take five to ten minutes of your time. Follow this link to the final question inventory: _____

An additional email may follow as a reminder in order to ensure completion of this final survey.

We apologize for the intrusion.

If you have any questions regarding this research please contact the student researcher, Stephanie Wachter (email: _____) or the faculty research advisor, Dawnette Cigrand, PhD, PSC (email: _____, office phone: _____).

This research project has been approved by the Institutional Review Board (IRB) at Winona State University.

Thank you for your valuable time donation to this research effort.

Sincerely,

Stephanie Wachter (graduate student researcher)

Dawnette Cigrand, PhD, PSC (faculty research advisor)

Appendix C

Mental Health Clinician Mindfulness Demographics Survey

Q1 CONSENT FORM You are invited to participate in a research study designed to study counselor practice of mindfulness. We hope to learn how mental health clinicians' practice of mindfulness impacts measurements of burnout. While there are no appreciable risks or benefits from participating in this study concerns involving the unforeseeable possibilities of issues such as burn-out, vicarious trauma, and negative feelings should be considered before consenting to participate in this research. The study will begin 11/13/2015 and end 4/30/2016 and will comprise of approximately eight to ten total participants. We estimate involvement in the study will require no more than three to four hours of your time. If you decide to participate, you will be asked to complete a brief questionnaire and make a small time commitment to meet for one, approximately one hour, interview. Data collected during the course of this study will be coded in order to ensure confidentiality; further, information obtained through this study will be destroyed at its culmination. If the results of this study are published or presented, no names will be associated with the data cited. Any information that is obtained in connection with this study that can be identified with you will be disclosed only with your permission. While these researchers do not anticipate the need to release confidential information to others, information shared within this study that suggests imminent danger to self or others may be reported. For questions about this research project, contact Stephanie Wachter, _____, _____ (student researcher) or Dawnette Cigrand, PhD, PSC, _____, _____ (faculty project advisor). For question about research subjects' rights or research-related injuries, contact Human Protections Administrator, Brett Ayers at _____. Participation in this study is voluntary. A decision not to participate will involve no penalty or

loss of benefits to which you are entitled. You may discontinue participation at any time without penalty or loss of benefits. A decision not to participate or withdraw will not affect your current or future relationship with Winona State University. You may request a copy of this form to keep.

AGREEMENT TO PARTICIPATE

You are making a decision whether or not to participate in the study described above.

Participation is voluntary. You may withdraw at any time without prejudice after signing this form. By selecting "yes" from the below choices you indicate that you have read the information provided above, had an opportunity to ask questions about the study, and have decided to participate. Thank you for your time.

- Yes, I have read the consent form and agree to participate in this research project. (1)
- No, I am not willing to consent &/or participate at this time. (2)

Q2 Do you currently practice as a counselor, therapist, or other mental health clinician?

- Yes (1)
- No (2)

Q3 What is your job title/state licensure?

- SAC/SAC-IT (1)
- LPC/LPCC (2)
- LADC (3)
- LP (4)
- M/L/C/SW (5)
- PsyD (6)
- PhD (7)

- CSAC (8)
- MD (9)
- Other (10) _____

Q4 What is your degree?

- Bachelors Science/Arts (1)
- Masters Science/Arts (2)
- Doctorate (PhD, PsyD, EdD) (3)
- Other (4) _____

Q5 What is your degree (BS/MS/PhD/PsyD) in _____?

- Psychology (1)
- Substance Abuse/Alcohol and Drug Counseling (2)
- Community/Mental Health Counseling (3)
- Social Work (4)
- Other (5) _____

Q6 In what state are you licensed to practice?

- Minnesota (1)
- Wisconsin (2)
- Iowa (3)
- Illinois (4)
- North Dakota (5)
- South Dakota (6)
- Other (7) _____

Q7 Is your license current (not lapsed)?

Yes (1)

No (2)

Q8 Is your license to practice currently in jeopardy due to ethics or other legal violations?

Yes (1)

No (2)

Q9 Do you practice mindfulness in your personal life?

Yes (1)

No (2)

Q10 On average how many minutes per week do you practice mindfulness?

_____ Click to write Choice 1 (1)

Q11 What types of mindfulness do you practice? Please check all that apply.

Yoga (1)

Mindful Breathing (2)

Sitting Meditation (3)

Walking Meditation (4)

Mindful Eating (5)

Body Scan (6)

Visualizations/Guided Imagery (7)

Tai Chi (8)

Qi Gong (9)

Tapping (10)

Focused Attention (11)

Inversion (12)

- Prayer (13)
- Meditation (14)
- Mantras (15)
- Salat (16)
- Gratitude Exercises (17)
- Other (18) _____

Q12 Do you integrate mindfulness into your professional work?

- Yes (1)
- No (2)

Q13 Are you trained in a form mindfulness?

- Yes (1)
- No (2)

Q14 If applicable, please check all forms of mindfulness in which you are trained:

- Yoga (1)
- Mindful Breathing (2)
- Sitting Meditation (3)
- Walking Meditation (4)
- Mindful Eating (5)
- Body Scan (6)
- Visualizations/Guided Imagery (7)
- Tai Chi (8)
- Qi Gong (9)
- Tapping (10)

- Focused Attention (11)
- Inversion (12)
- Prayer (13)
- Meditation (14)
- Mantras (15)
- Salat (16)
- Gratitude Exercises (17)
- Other (18) _____

Q15 Would you be willing to meet with this researcher for an approximately 60 minute qualitative interview? Note: Phone interviews may be an option.

- Yes (1)
- No (2)

Q16 If willing to participate in this research, please enter your name, contact information, and preferred method for contact below (email, phone number, mailing address, etc.).Note: Not all willing to submit to an interview will be selected to participate in this process.

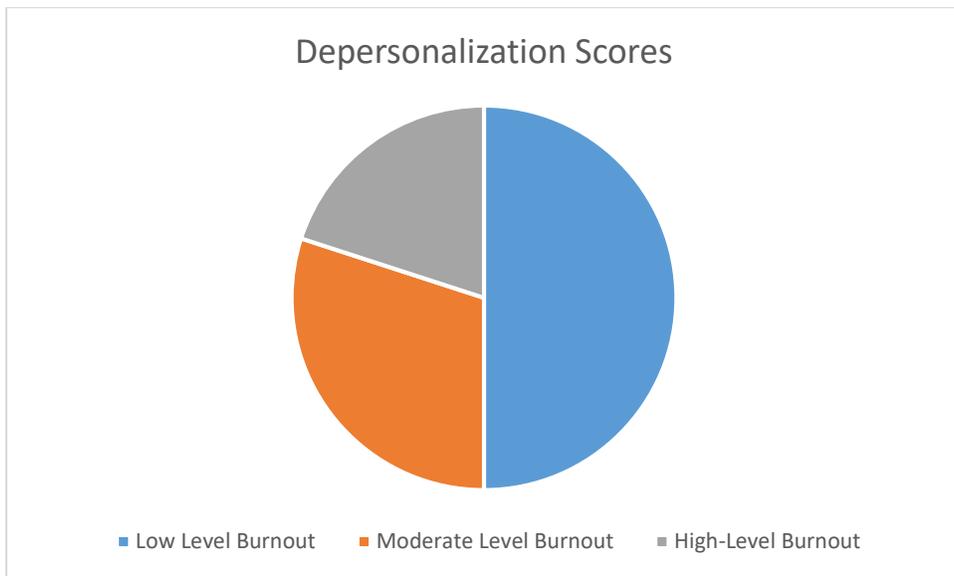
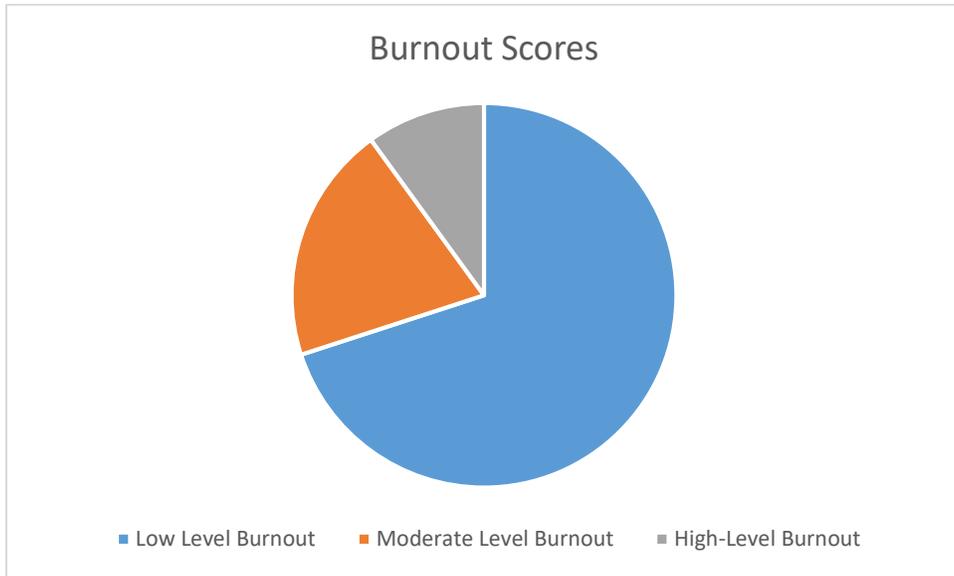
Appendix D

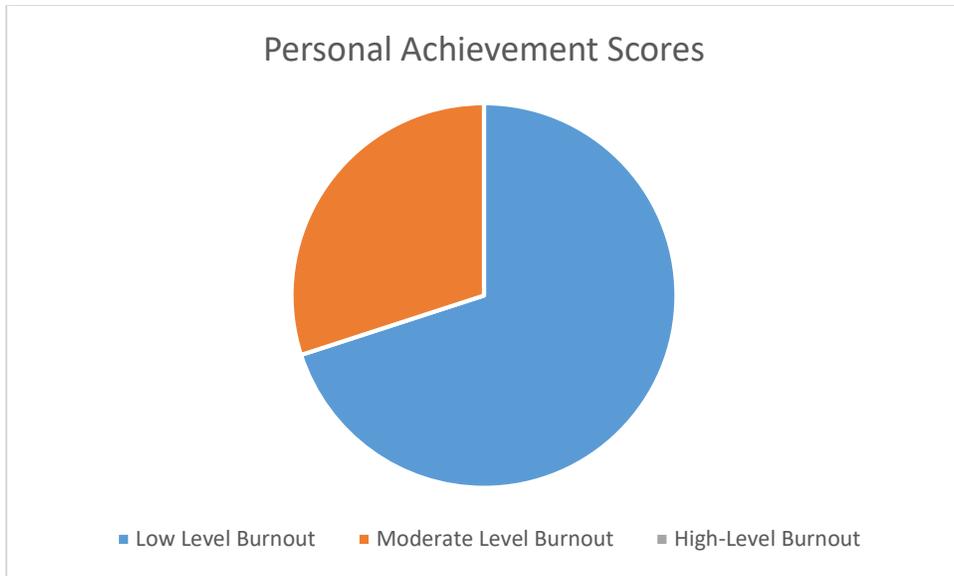
Qualitative Interview Questions

1. May I audio record this interview?
2. What type of mindfulness do you practice?
3. How long have you been practicing mindfulness (this type/others)?
4. What brought you to your preferred method of mindfulness?
5. How regularly (daily, weekly, monthly, yearly) do you practice this/these specific mindfulness skills? How long per activity/session?
6. Did you undergo any training for mindfulness? If so, what/which type(s)?
7. Do you teach your clients mindfulness? If so, what/which type(s)?
8. Do you include mindfulness practices within your clients' treatment plans?
9. Do you practice mindfulness with your clients within sessions?
10. How does your mindfulness training/practice of mindfulness impact your work as a mental health clinician?
11. What do you think is the most important element of your mindfulness practice (e.g. what would you tell others to explain your reason for practicing mindfulness)?

Appendix E

Scores Segmented by Criteria: Burnout, Depersonalization, and Personal Achievement





Overall Burnout Scores:

