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Laying Groundwork for the use of Acceptance and Commitment Therapy Constructs to Enhance the Identity Development of Counselors-in-training: An Exploratory Quantitative Analysis

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To the Graduate Council:

I am submitting herewith a dissertation written by Emma Christine Burgin entitled "Laying Groundwork for the use of Acceptance and Commitment Therapy Constructs to Enhance the Identity Development of Counselors-in-training: An Exploratory Quantitative Analysis." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

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Emma Christine Burgin
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Dedication

This document is dedicated to any person who started a journey with something in their hands only to drop it along the way. To individuals who either found a way to pick it back up or had to go all the way back to the starting line to retrieve another. To those who, after all that, finished or didn't. There are lessons to be cherished on either path.

Let this document be encouragement of that.

In short, this is dedicated to my own damn self.

Acknowledgement

At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us.

-Albert Schweitzer

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Abstract

Counselor educators aid counselors-in-training (CITs) in the process of professional identity development, which has its own challenges, such as managing anxiety and increasing self-awareness. One way proposed to enhance these therapeutic challenges is mindfulness. However, most research examining mindfulness in counselor education to-date lacks a standard theoretical framework, which may cause counselors to diminish the value of mindfulness in counselor training. One theory-driven concept of mindfulness comes from ACT, an empirically validated approach to counseling. It is possible that ACT could serve as a common language for educators to use when implementing mindfulness into counselor training, and thus, there is need for more support for the use of ACT tenets within counselor education. Being present, defusion, and emotional acceptance are constructs that feed into the ACT overall goal of psychological flexibility. Explicitly, these elements of ACT – which focus on opening up the individual – could be helpful in progressing CIT development. A needed first step is to determine whether or not the enactment of ACT principles differ in CITs who have a mindfulness practice versus those who do not. Additionally, this quantitative study assessed how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility. First, it was determined there is no difference between mindfulness practitioners and non-practitioners on ACT constructs except for mindfulness. Overall, CITs demonstrated high levels of mindfulness. Second, a correlational analysis identified that there was a significant relationship between mindfulness, cognitive fusion, emotion regulation, and psychological flexibility, all in the predicted directions. Third, a standard multiple regression identified mindfulness, cognitive fusion, and emotion regulation as predictor variables of psychological

flexibility. Discussion includes findings, implications for education, clinical practice and future research.

Keywords: mindfulness, Acceptance and Commitment Therapy, professional development, counselor education

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Chapter 1: Introduction

While mindfulness is a practice that started more than 2,500 years ago, researchers and practitioners in the helping professions today are still looking at mindfulness as an approach to reduce psychological suffering. During the past 30 years, investigators suggested mindfulness is effective in the treatment of a variety of psychological and emotional issues, including chronic stress, anxiety, depression, borderline personality disorder, eating disorders, and substance abuse (Brown, Marquis, & Guiffrida, 2013; Grepmair, Mitterlehner, Rother, & Nickel, 2006; Hayes, Stroshal, & Wilson, 1999; Kabat-Zinn, 2003; Linehan, 1993; Schuster, 1979). Considering the solid evidence base for mindfulness-based treatments for clients, some scholars started to examine the use of mindfulness by professionals and students in the helping professions.

The research yields generally consistent support for counselors' use of mindfulness, producing a range of benefits including enhanced physical and mental health and interpersonal relationships (Brown, Ryan, & Creswell, 2007). Counselors-in-training especially can benefit from this practice, as they often exhibit high levels of anxiety as they learn and grow in their clinical practice (Stoltenberg & McNeill, 2010). Research demonstrates that high levels of anxiety decrease counselor's self-efficacy (Greason & Cashwell, 2009) and mindfulness is an effective way to work with anxiety and enhance other therapeutic attributes in counselors-in-training (CITs) (Bohecker, Wathen, Weils, Salazar, & Vereen, 2014; Newsome, Waldo, & Gruska, 2012).

However, there is still a lot to discover about mindfulness in the context of counselor education. Bohecker et al. (2014) called for more quantitative explorations of mindfulness as a potential tool to reduce CIT anxiety, increase efficacy, and improve the therapeutic relationship, noting that a good portion of the research to-date utilized qualitative methodology. Additionally,

Borders and Willse (2015) encouraged research as to whether or not the mindfulness of either the supervisor or supervisee contributes to changes or growth in supervisees' counseling effectiveness, skill development, or client outcomes.

Also, the research examining mindfulness in counselor education and training uses various operational definitions of mindfulness but no unified approach to implementation. Fulton and Cashwell (2015) reported 37% of their sample of CITs reported exposure to mindfulness training within their counselor education programs. The American Counseling Association Code of Ethics (2014) calls for counselors to work within the boundaries of their competence within the clinical setting which suggests they need to have a basis for their practice; thus, researchers need to develop theory-driven and empirically supported approaches to implementing mindfulness into their training.

One of the most profound ways to use mindfulness in counselor training relates to aiding CITs in the development of a professional identity as a counselor. To do this, CITs must receive training that provides challenges on both personal and professional levels (Skovholt & Rønnestad, 2003). Some of these challenges include high levels of anxiety early on in their training (McAuliffe & Eriksen, 2011) and developing self-awareness, specifically in the exposure to and recognition of strong emotional responses (Harrowood, Paramand, & Wilde, 2011; Wagner & Hill, 2015).

Acceptance and Commitment Therapy (ACT) is a counseling theory that suggests the use of mindfulness to enhance client's present moment awareness and emotional acceptance (Harris, 2009). ACT posits that value-driven and mindful action help clients accept what is out of their control and commit to taking action that enriches their lives. A few studies link ACT tenets to positive outcomes for helping professionals. For example, increased mindfulness correlated with

decreased burnout and stigma toward clients (Hayes et al., 2004), created a stronger working alliance with clients (Stafford-Brown & Pankenham, 2012), and increased self-compassion (Stafford-Brown & Pakenham, 2012), therapeutic presence (Ponton, 2012), and emotional attunement (Cacciatore & Flint, 2012) in CITs. This study aimed to explore whether ACT tenets might provide a theory-driven guide for using mindfulness to enhance CIT professional identity development.

Counselor Development

One of the major tasks of counselor education is to ensure CITs develop a professional identity as a counselor. The Council for Accrediting Counseling and Related Education Programs (CACREP) suggests counselor education programs accomplish this by providing coursework in core areas and supervised counseling practicum and internship experiences. These CACREP requirements are in place to help CITs identify with the counseling profession. The literature, however, points to a lack of a standardized professional counselor identity development model, perhaps due to the many specializations in counseling (e.g., mental health, school, rehabilitation; Prosek & Hurt, 2014).

In an effort to streamline counselor training, Gibson, Dollarhide, and Moss (2010) researched tasks crucial to professional identity development for counselors. They outlined three transformational tasks CITs must complete as part of the professional identity development process: develop an individual definition of counseling, engage in professional growth throughout different phases of training, and relate their own identity to the professional community (Gibson et al., 2010). Their approach of looking at CITs work on both personal and professional domains becomes a theme in the literature surrounding professional identity.

Despite how it is conceptualized, many sources cite the development of a shared professional identity as perhaps the critical issue facing counselors (Gibson et al., 2010; Spurgeon, 2012). To this end, there are many stage models of counselor development, which dictate that CITs require a qualitatively different approach and response from instructors and supervisors depending on where they are in their training (Stoltenberg & McNeill, 2010). The developmental perspective of counselor development helps supervisors and counselor educators identify some of the challenges CITs face in cultivating professional identity. Upon investigation, the research shows two dominant themes that could be addressed by incorporating mindfulness into counselor training: anxiety and self-awareness, specifically related to emotional intelligence.

Mindfulness

A degree of ambiguity surrounds the definition and conceptualization of mindfulness; in fact, "mindfulness is sometimes treated as a technique, sometimes as a more general method or collection of techniques, sometimes as a psychological process that can produce outcomes, and sometimes as an outcome itself" (Hayes & Wilson, 2003, p. 161). Kabat-Zinn (2003), a pioneer in implementing mindfulness into health care, explained mindfulness as a two-part process: a focused attention on the here and now and a non-judgmental acceptance of thoughts, emotions, and sensations as individuals experience them in the moment. To date, the practice now exists beyond its Eastern spiritual roots and is consistently touted as an effective aspect of treatment for a number of psychological and emotional issues (Brown, Marquis, & Guiffrida, 2013; Grepmair, Mitterlehner, Rother, & Nickel, 2006; Hayes, Sroshal, & Wilson, 1999; Kabat-Xinn, 2003; Linehan, 1993; Schuster, 1979).

Mindfulness and Counselor Development

Research shows mental health practitioners and CITs incorporate mindfulness as a tool for personal well-being (McGarrigle & Walsh, 2011), self-care (Christopher & Maris, 2010) and professional development (e.g., therapeutic presence, identity development; Ponton, 2012). Bishop et al. (2004) claimed counselors who practiced mindfulness were better able to observe thoughts, feelings, and sensations without attachment, which enabled them to react more reflectively. Additional findings surrounding mindfulness link it with beneficial outcomes for counselors, including present moment awareness (Christopher & Maris, 2010) and acceptance (Cacciatore & Flint, 2012; Fatter & Hayes, 2013). These examples demonstrate how mindfulness serves as a way of being with the client therapeutically, a fact that suggests mindfulness is more than a skill set and might be a crucial component to therapeutic growth and change (Martin, 1997).

If mindfulness is a core process in all of psychotherapy and counseling, as Martin (1997) suggests, it should be added to a list of hypothesized core processes of the therapeutic relationship, which includes Carl Rogers' core conditions, expectations, confronting problems, mastery, and attribution of outcome. Rogers' core conditions – empathy, genuineness, and unconditional positive regard (UPR) – are firmly established as common factors for positive outcomes within all counseling and psychotherapy (Frank, 1974; Lambert & Cattani-Thompson, 1996; Duncan, Miller, & Hubble, 1997; Weinberger, 1995). As defined by Rogers (1957), empathy is "an accurate, empathic understanding of the client's world as seen from the inside" (p. 284). Rogers (1957) defined genuineness as the therapist's ability, within the therapeutic relationship, to be able to be freely and deeply him- or herself; the opposite of presenting a façade. Finally, UPR is a feeling of acceptance for the client's expression of any feelings; caring

for clients as separate people with permission to have their own feelings and experiences (Rogers, 1957). While the core conditions are established as crucial therapeutic factors from the humanistic school of thought, Eastern traditions hold that mindfulness is another way for a counselor to become fully present with clients and might be an essential counselor quality in therapeutic relationships (Dollarhide, Shavers, Baker, Dagg, & Taylor, 2012).

Schuster (1979) was one of the first authors to link mindfulness to the core condition of empathy: he said mindfulness "inadvertently or deliberately move[s therapists] into direct moment-to-moment contact with their clients" (p. 76). Christopher and Maris (2010) pointed out that mindfulness practice helped students embody the Rogerian core conditions in all their relationships and be fully present with themselves and their clients. Bien (2006) argued that by focusing on mindfulness (and thus the core conditions), therapists could enhance their therapeutic presence with clients; in another work, Bien (2008) explained the three core conditions could be found in the practice of mindfulness. More recently, Keane (2014) conducted a mixed methods study that found mindfulness practice positively related with two self-report measures of empathy in practicing psychotherapists, suggesting mindfulness might be a way to internalize concepts that are difficult to teach such as empathy. Fulton and Cashwell (2015) also found mindfulness to be related to empathy and suggested counselor educators consider mindfulness training as a way to develop dispositional empathy and protect against empathy fatigue. As discussed here, mindfulness seems to be a particularly useful activity to incorporate in training to target the core conditions, specifically; however, there is research to attest to its other benefits to CITs.

Indeed, other recent research links mindfulness and general counselor development. Several studies reported mindfulness practice or training helped participants become more self-

aware (Felton, Coates, & Christopher, 2013; Keane, 2014), especially of emotions (Fatter & Hayes, 2013; Gokhan, Meehan, & Peters, 2010). In his study, Keane (2014) found mindfulness practice fostered non-judgment in practicing psychotherapists on both personal and interpersonal levels. Mindfulness appears to have a place in the counselor development process, but a theoretical foundation for this inclusion is missing. One of the therapeutic approaches that might help describe how the practice of mindfulness connects to the practice of counseling is ACT, described in the following section.

Acceptance and Commitment Therapy (ACT)

The premise of ACT is to combine mindful and acceptance processes with commitment and behavior change processes to create psychological flexibility (Harris, 2009). The theoretical underpinnings of ACT is derived from functional contextualism, which manifests in ACT's concept of workability (Hayes et al., 2009). Workability asks the question, "Is what you're doing working to make your life rich, full, and meaningful?" (Harris, 2009, p. 22). Since ACT is a cognitive behavioral theory, the therapist focuses not on whether a client's thought or behavior is true or false, wrong or right, but instead questions if it is workable. ACT encourages the therapist to use UPR when approaching clients since there is no need to judge their thoughts or behavior (Harris, 2009).

There are six core processes that aim to advance individuals toward psychological flexibility: acceptance, cognitive fusion, being present, self-as-context, value, and committed action (Harris, 2009). Wilson (2009) spoke as these six tenets as facets of a gem, all reflective of one another within an individual. He also spoke of mindfulness as the convergence of acceptance, cognitive fusion, being present, and self-as-context. The goal of ACT is to increase psychological flexibility in the individual, defined as a number of dynamic processes that unfold

over time, including (1) adapting to fluctuating situational demands; (2) reconfiguring mental resources; (3) shifting perspectives; and (4) balancing competing desires, needs, and life domains (Kashdan & Rottenberg, 2010). Hayes, Luoma, Bond, Masuda, and Lillis (2006) defined psychological flexibility as: "the process of contacting the present moment and the thoughts and feelings it contains, without needless defense, fully as a conscious human being and, depending on what the situation affords, persisting or changing behavior in the service of chosen values" (p. 9).

The Triflex

ACT is a complex model with many moving pieces; thus, this study narrows the scope to focus on what the most important aspects of the theory for counselors who are still in training. Mindfulness, in its simplest form, means being fully connected to the present moment (Harris, 2009). Defusion, or the ability to step back and be mindful, allows us to watch our thinking, make room for feelings, and sit with them instead of avoiding them, which is termed emotional acceptance (Harris, 2009). As discussed previously, psychological flexibility is the end result of successfully going through these processes.

Defusion and acceptance, along with mindfulness and psychological flexibility, are part of what Harris (2009) termed the ACT Triflex (see Figure 1.1); he grouped defusion and acceptance together as they describe the process of separating from thoughts and feelings, evaluating them, and then being able to work with them instead of trying to avoid them. Self-as-context represents the second side of the triflex, while values and committed action make up the third side. This study focused on the first side of the triflex, which demonstrates ACT's goal of opening up and includes mindfulness, defusion, and acceptance. Further, Harris (2009) also talked about using the acronym ACT to sum the entire model: "A" represents accepting your

thoughts and feelings; "C" refers to choosing a valued direction, and "T" stands for taking action. This study looked at the "A" section of this conceptualization of ACT. All of the elements of the "A" section – mindfulness, defusion, and acceptance – are relevant to counselor development, as outlined in the next section.

ACT in Counselor Development

Although limited research exists related to ACT with CITs, there are studies that can help connect mindfulness, defusion, and acceptance to counselor education and training. For example, in a review of qualitative studies conducted over a nine-year period, Christopher and Maris (2010) examined the use of mindfulness practices in counselor and therapist training and found mindfulness training did enhance the physical and psychological well-being of CITs. One of the ways it did so was to increase the students' present moment awareness. Christopher and Maris (2010) found as students were able to remain present in the moment, they were able to be less reactive, feel less defensive, and remain more emotionally open. In another study, Chrisman, Christopher, and Lichtenstein (2009) found mindful practices increased CITs' acceptance of themselves and others around them. Additionally, Cacciatore and Flint (2012) stated mindfulness embraces acceptance of all of a person's thoughts and feelings, which then might lead to a higher level of intrapersonal awareness. Master's level graduate students in counseling discussed their ability to adopt a more accepting stance, allowing them to face difficulties, engage in self-forgiveness, and decrease their emotional reactivity as a result of being enrolled in a course that taught mindfulness (Felton, Coates, & Christopher, 2013). This acceptance of one's own thoughts and feelings seemingly expands the person's capacity for acceptance of others.

Much of the research presented so far examined mindfulness itself as the mechanism that influences outcomes for client or counselors; again, there is little, if any, empirical support for

specifically using ACT within counselor education. However, since the ACT method itself is empirically validated (American Psychological Association, 2013; A-Tjak et al., 2015; Öst, 2014; Smout, Hayes, Atkins, Klausen, & Duguid, 2012), researchers have started to turn their gaze toward the theory as a potentially useful tool for training. The existing empirical literature examining the use of the theory with helping professionals shows ACT had a positive impact on stigma and burnout among substance abuse counselors (Hayes et al, 2004); increased psychological flexibility among substance abuse counselors (Varra, Hayes, Roger, and Fisher, 2008); and reduced stress and improved therapist qualities such as self-efficacy and self-compassion (Stafford-Brown & Pakenham, 2012).

While there is a paucity of both descriptive and empirical literature about ACT in counselor development, there is dialogue about the benefits of the supervisee using ACT within the context of the therapeutic relationship. Wilson and Sandoz (2008) discussed incorporating ACT in sessions between counselors and clients, speaking to the benefits of "mindfulness for two," which they defined as "deliberate, focused listening and speaking, which make it possible to approach the sensitive area of values and vulnerabilities in alliance and with permission" (p. 96). The authors argued it was difficult to do this in session if the therapist did not engage in ACT exercises in their own life. Although the literature does not specifically link ACT with counselor development, many aspects of counselor training are directly related to ACT tenets, making this connection appear, in ACT language, workable.

Statement of the Problem

In addition to teaching counseling skills, counselor educators aid CITs in the process of professional identity development. CITs face unique challenges, such as managing anxiety and increasing self-awareness, including their emotional intelligence. One way proposed to enhance

these therapeutic challenges is mindfulness; indeed, some of the literature strongly links mindfulness to developing core conditions required to perform counseling. Researchers who examined mindfulness in the context of training counselors and therapists consistently believe there is need for more empirical work examining mindfulness-based approaches (MBAs) such as ACT. Davis (2012) looked at an overview of MBAs and identified a lack of evidence for these approaches individually within educational psychology programs. Ryan et al. (2012) noted most mindfulness research focused on client outcomes; the authors suggested the value of future studies examining mindfulness as a skill that could be cultivated in the course of counselor training. Specifically, Fatter and Hayes (2013) called for research looking into the link between meditation and CITs' self-insight, empathy, and self-integration.

However, most research examining mindfulness in counselor education to-date lacks a standard theoretical framework, which may cause counselors to dismiss the value of mindfulness in counselor training. One theory-driven concept of mindfulness comes from ACT, an empirically validated approach to counseling. Since this theoretical approach has been proven useful in a number of training contexts (Hayes et al., 2004; Stafford-Brown & Pakenham, 2012; Varra, Hayes, Roget, & Fisher, 2008), it is possible that ACT could serve as a common language for educators to use when implementing mindfulness into counselor training. Thus, there is need for more support for the use of ACT tenets within counselor education. Being present, defusion, and emotional acceptance are constructs that feed into the ACT overall goal of psychological flexibility. Explicitly, these elements of ACT – which focus on opening up the individual – could be helpful in progressing CIT development since, again, there is strong evidence for positive outcomes and strengthening of the core conditions among CITs and therapists who practice mindfulness (Christopher & Maris, 2010; Felton, Coates, & Christopher, 2013; Fulton &

Cashwell, 2014; Keane, 2014; Fatter & Hayes, 2013; Gokhan, Meehan, & Peters, 2010). A needed first step is to determine whether or not the enactment of ACT principles differ in CITs who have a mindfulness practice versus those who do not.

Purpose of the Study

This study aimed to explore empirical support for mindfulness as a tool for counselor development, engaging in a theory-driven guide to implementing mindfulness into counselor training. Specifically, this quantitative study assessed how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility, which has been associated with lower levels of anxiety and increased emotional acceptance. This study focused on CITs who were enrolled in or recently graduated from a mental health and/or school counseling program, examining how the tenets from ACT might influence psychological flexibility, which in turn relates to decreased anxiety and emotional acceptance. The specific research questions were:

1. What are the levels of awareness, defusion, acceptance, and psychological flexibility in CITs?
    a. Are there differences in these constructs between those who practice mindfulness and those who do not?
    b. Are there differences in ACT constructs on those who practice mindfulness on a weekly basis versus less frequently? For less than six months versus six months or more?
2. What is the relationship between the constructs of awareness, defusion, and acceptance in CITs?

3. Do levels of awareness, defusion, and acceptance predict levels of psychological flexibility in CITs?
    a. Are there differences in predictive levels in these based on whether or not they practice mindfulness, frequency, and/or duration of mindfulness practice?

Definitions of Terms

Acceptance and Commitment Therapy: A third wave cognitive behavioral therapy that aims to undermine the grip of the literal verbal content of cognition that causes experiential avoidance and to construct an alternative context where behavior is in align with one's values (Hayes, 2004); the main goal is psychological flexibility and it has six tenets: acceptance, cognitive fusion, being present, self-as-context, value, and committed action (Harris, 2009)

Acceptance: The process of making room for unpleasant thoughts and feelings without trying to avoid them or fight against them; one of the six core processes in ACT (Harris, 2009)

Cognitive fusion: Stimulus functions from relational frames typically dominate over the other sources of behavioral regulation in humans without any awareness of the process involved, making the person less in contact with the here-and-now experience (Hayes, 2004)

Emotional regulation: The concept that individuals can implement strategies to regulate their emotions, in particular what emotions they have and when they have them; Gross and John (2003) defined two common strategies that represent positive and negative ways to regulate emotions, respectively: cognitive reappraisal and expressive suppression

Experiential avoidance: The attempt to escape or avoid private events, even when the attempt to do so causes psychological harm (Hayes, 2004)

Mindfulness: The awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment (Kabat-Zinn,

2003); one of the six core processes in ACT, referred to as present moment awareness (Harris, 2009)

Psychological flexibility: A number of dynamic processes that unfold over time, including (1) adapting to fluctuating situational demands; (2) reconfiguring mental resources; (3) shifting perspectives; and (4) balancing competing desires, needs, and life domains (Kashdan & Rottenberg, 2010)

Self-as-context: In ACT, this is known as the observing self; the part of us that is aware of what we are thinking and/or doing in any given moment (Harris, 2009)

Delimitations

For this study, I chose to explore mindfulness as a tool for counselor development, trying to inform a theory-driven method for using it in counselor education. I chose this topic because I am aware of the growing trend of mindfulness in training and convinced this exploration would contribute to the literature on this subject. I chose to only focus on the ACT principles of present moment awareness, cognitive defusion, and acceptance, and how they contribute specifically to psychological flexibility; these concepts make up the ACT Triflex (see Figure 1.1) and describe the process of separating from thoughts and feelings, evaluating them, and then being able to work with them instead of trying to avoid them. This aspect of ACT in particular, I believe, contributes to counselor development.

This study was limited to CITs or recent graduates who have been exposed to the clinical practice portions (i.e., practicum, internship) of school or mental health counseling master's programs; it did not investigate mindfulness or ACT tenets among counselors in earlier (i.e., pre-practicum) or later phases of development (i.e., licensed). Additionally, students were affiliated with CACREP-accredited program. Of the students who met these requirements, I appealed to

those who were likely to practice mindfulness either personally and/or professionally. This guided me to target specific listservs I determined CITs who practice mindfulness might belong (e.g., Association for Creativity in Counseling, neuroscience network).

There also is a significant variety of definitions and conceptualizations of mindfulness. Hayes and Wilson (2003) write mindfulness, depending on the source, is a technique, a method, a collection of exercises, a psychological intervention, or an outcome. I defined mindfulness according to Kabat-Zinn (2003), who is quoted in the ACT literature (Harris, 2007): the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment. Additionally, there are many approaches to measuring mindfulness; for this study, I used the Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) because it is based on a factor analysis developed from five independently developed mindfulness questionnaires and represents the accepted conceptualization of mindfulness among researchers in the field.

Limitations

There were several foreseeable limitations to the proposed study. First, in empirical work, it is necessary to show that any intervention (i.e., mindfulness) leads to improvements in outcomes and to the best of our abilities, how this improvement occurs. Baer (2011) said this is especially difficult when examining mindfulness-based approaches (MBAs), stating the ideas behind the approach evolved long before Western scientific method. I can anticipate the difficulties in examining mindfulness experienced by researchers who have ventured ahead of me.

Methodologically, the CITs in this study had a limited range of experiences. In addition, the participants were aware of their participation in a research study and this, in turn, could have

influenced their responses. In collecting the data, I surveyed the participants which means my results will be reliant on the participants' self-report; this can have disadvantages including impression management, relying on memory, and cultural limitations. (Paulhus & Vazire, 2009). The participants also might have chosen to respond to my survey request because they are more familiar with mindfulness or ACT language.

Organization of the Study

This chapter provided an overview of the current research proposal, including a glossary of terms, delimitations, and limitations. Again, the primary purpose of this study was to produce quantitative support for the use of mindfulness as defined by ACT in the context of counselor education as a way to enhance counselor development. In Chapter 2, I present a review of the literature, including professional counselor identity development, mindfulness research, and ACT outcomes research. Then, Chapter 3 contains a detailed proposal of data collection and analysis procedures while Chapter 4 outlines results of these analyses. Finally, Chapter 5 provides context in the form of a Discussion as well as Limitations and Implications for future research, CITs, and counselor educators.

Chapter 2: Review of the Literature

The purpose of this chapter is to review the relevant literature for the current study. It is divided into three major areas: professional development of counselors, mindfulness, and Acceptance and Commitment Therapy. This literature review provides a theoretical and research framework from which this study emerged and is founded.

Professional Development of Counselors

One of the major tasks of counselor education is to ensure CITs develop a professional identity as a counselor. CACREP (2016) suggests counselor education programs accomplish this by providing coursework in eight core areas: professional counseling orientation/ethics, social and cultural diversity, human growth and development, career development, counseling and helping relationships, group work, assessment and testing, and research and program evaluation . In addition to this, students are required to complete a supervised counseling practicum totaling a minimum of 100 clock hours and a supervised internship experience for 600 hours in settings relevant to the CITs' specialty area. Counselor educators design these experiences to ensure all CITs have a set curriculum leading to an emerging counselor identity.

As mentioned above, these CACREP requirements are in place to help CITs identify with the counseling profession. There is a consensus on the definition of counseling, laid out by the organizations that developed the "20/20: A Vision for the Future of Counselling": this initiative defines counseling as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 92; Kaplan, Tarvydas, & Gladding, 2013). Mellin, Hunt, and Nichols (2011) provided a more nuanced definition after surveying 238 counselors who had taken the National Counselor Examination for Licensure and Certification within the past 10 years: these participants pointed out that

professional counselors can demonstrate proficient knowledge in mental health, psychological, and developmental issues that occur in counseling and can address them with cognitive, affective, behavioral, or systematic interventions that address not only pathology but also wellness, personal growth, career concerns. Given this, there is consensus on what counseling is and this provides counselor education an end goal for which to strive.

While the 20/20 definition of counseling is generally adopted by CACREP-accredited programs, the literature points to a lack of an explicit professional counselor identity development model. This is perhaps due to the many specializations in counseling (e.g., mental health, school, rehabilitation) or the lack of advocacy for counselors within the public policy realm (Prosek & Hurt, 2014). The first step is to come to a consensus on a definition of professional identity, something that has proven elusive. But Reiner, Dobmeier, and Hernandez (2013) surveyed 378 counselor educators about professional identity issues in which the participants promoted a distinct professional identity to differentiate counselors from other helping professions, regardless of specialty. While the counselor educators promoted this idea, again there is no established road map to help CITs achieve professional counselor identity.

Nugent and Jones (2009) provided one definition for professional identity: the application of counselor training and personal dispositions in the professional setting. However, there are other conceptualizations of professional identity; indeed, professional identity is a popular and controversial topic in the counseling field today. While much discussion and focus centers on helping students develop professional identity, again, Gibson, Dollarhide, and Moss (2010) noted there is disagreement among scholars about what professional identity for counselors is, how to measure it, and how it develops.

To this end, Gibson, Dollarhide, and Moss (2010) used a grounded theory method to describe the tasks that are crucial to professional identity development for counselors. They interviewed 43 students in an effort to provide empirical support for a theory of professional identity development, denoted by a successful integration of personal attributes and professional training (Gibson et al., 2010). The authors conducted focus groups in an effort to examine the collective experience of the participants and then went through a coding process to determine categories and determine the basis of a theory that captured the story told by the interviewees (Gibson et al., 2010). This led to the elucidation of three transformational tasks CITs must complete to complete the professional identity development process: develop an individual definition of counseling, engage in professional growth throughout different phases of training, and relate their own identity to the professional community (Gibson et al., 2010). Their approach of looking at CITs work on both personal and professional domains would become a theme in the literature surrounding professional identity.

While Gibson et al. (2010) argued for common tasks within counselor education to achieve this goal, the nature of the field causes some dissention among those trying to define professional development. For example, Mellin, Hunt, and Nichols (2011) also conducted a qualitative study to examine professional identity, interviewing 238 counselors working in the field. A majority of these participants identified with a unified counselor identity; however, they also voiced concern over challenges presented by their specialty training (e.g., school, substance abuse). Despite these hurdles, the authors noted that participants came together to agree that wellness, prevention, and concern for developmental processes were defining for the counseling profession (Mellin et al., 2011).

Despite the varying conceptualizations and challenges, many sources have cited the development of a shared professional identity as perhaps the critical issue facing counselors (Gibson et al.,2010; Spurgeon, 2012). To this end, there are many stage models of counselor development, which dictate that CITs require a qualitatively different approach and response from instructors and supervisors depending on where they are in their training (Stoltenberg & McNeill, 2010). Rønnestad and Skovholt (2003) identified differences in professional identity based on this idea: novice counselors rely on external references (e.g., textbooks) for understanding their role as a counselor whereas more advanced counselors incorporate more personal dispositions into their identity. Rønnestad and Skovholt (2003) argued the important task for moving from beginning CIT to advanced CIT and then to counseling professional is the gradual integration of professional knowledge and personal attributes to create an overarching professional counselor identity.

To this end, Rønnestad and Skovholt (2003) laid out four phases of early counselor development: the lay helper phase, beginning student phase, advanced student phase, and the novice professional phase. The two phases relevant to this current study are the beginning student and advanced student phases. This model indicates that the beginning student needs high levels of structure in and out of the classroom as well as modeling in the field through demonstrations, field observations, and watching video sessions (Rønnestad & Skovholt, 2003). Students at this phase also are learning to take a reflective stance, fighting the urge to engage in impression management in an attempt to do something the "right" way (Rønnestad & Skovholt, 2003).The advanced student phase is marked by practicum or internship experiences, where they feel vulnerable, have grown internally and rely less on external guidance, and start to handle ambiguity more skillfully, among other tasks (Rønnestad & Skovholt, 2003). Perhaps the first

prominent literature to outline an explicit stage-based developmental model, Rønnestad and Skovholt (2003) paved the way for other conceptualizations.

For example, Healey (2009) developed the Professional Identity and Values Scale (PIVS), which denotes commitment to the profession and solidifying of one's identity within the profession and conceptualizes this process into three stages (Prosek & Hurt, 2014). According to the PIVS, Stage 1 individuals understand counseling philosophy but cannot yet apply it to practice, Stage 2 CITs can articulate professional identity and use counseling philosophy in practice, and Stage 3 counselors demonstrate congruence in professional and personal identity (Healey, 2009). Prosek and Hurt (2014) conducted an important study on CIT development using the PIVS. They surveyed master's counseling students to find out if there were differences in professional identity among novice students and advanced students. They surveyed 85 novice counselors (enrolled in their first or second semester of a counseling program) and 76 advanced CITs (enrolled in practicum or internship course). The authors found a statistically different difference between novice and advanced CITs in professional development, as measured by a subscale of the PIVS. According to Prosek and Hurt (2014), the advanced CITs had progressed further in the stages of professional development compared to new CITs, which caused the authors to speculate the clinical experiences within counselor training function as a catalyst for professional development, underscoring the importance of support for CITs during this time. The existence of the PIVS makes it easier to operationalize professional counselor identity, and thus makes it easier to study.

Another widely studied conceptualization of professional development, the Integrated Developmental Model (IDM) suggests the trainee is conceptualized as an individual who is embarking on a course of development that will culminate in the emergence of a counselor

identity (Stoltenberg & McNeill, 2010). The goal of professional development includes the integration of skills, theory, and a more complete awareness of oneself and others and takes into account the different motivations, needs, and potential resistances of counselors at different levels or stages of development (Stoltenberg & McNeill, 2010). Level 1 CITs are brand new to the profession and have limited direct experience and thus are hyper aware of their performance as counselors; Level 2 supervisees shift their primary focus toward more of a focus on the client, which is generally accompanied by a decrease in anxiety (Stoltenberg & McNeill, 2010). Finally, Stoltenberg and McNeill (2010) indicated the Level 3 supervisee is more stable, autonomous, and reflective through increased experience, reflection on that experience, and facilitative feedback.

To summarize, there is a consensus on the definition of counseling and thus researchers and scholars are in the process of establishing a universal professional identity model for CITs to follow. This model likely will account for the major task for CITs of integrating personal and professional domains. Additionally, the literature has established professional identity development happens in stages, with CITs needing more structure and support from counselor educators and supervisors toward the beginning and gaining more autonomy as their training progresses. Given all of these considerations, it is no wonder there are challenges unique to the professional identity development process, which some researchers have explore and are discussed in the next section.

Challenges in Counselor Identity Development

The developmental models, especially the IDM, help supervisors and counselor educators identify some of the challenges counselor educators and supervisors might face in cultivating professional identity among CITs. Researchers highlighted some of these challenges that are

salient no matter the approach to their education, training, and supervision. Upon investigation, the research shows emerging themes across the literature addressing counselor development; these include anxiety, self-awareness, skills acquisition, self-efficacy, and lifelong learning. I describe elements of professional counselor development in more detail below.

Anxiety. Much of the literature examining professional development of CITs discusses the anxiety they experience as they encounter novel material and then try to apply their learning to the clinical setting. McAuliffe and Eriksen (2011) echoed Rønnestad and Skovholt (2003) when they stated new counselors need high structure through step-by-step instructions and modeling skills and theories because of the strong presence of anxiety within CITs. The reality of being evaluated, the high stakes of working with distressed individuals, and the ambiguity inherent in the act of counseling come together to fuel this anxiety (McAuliffe & Eriksen, 2011). McAuliffe and Eriksen (2011) give a general overview of how to approach CITs' anxiety; other researchers have tried to be more specific about the CIT experience.

Some works demonstrate the early phase of counselor training is when the anxiety is highest. For example, Woodside, Oberman, Cole, and Caruth (2007) interviewed eight CITs who had yet to participate in any clinical work (pre-practicum) in the hopes of understanding more deeply the process of counselor development. The first author interviewed each participant, asking them about their early experience of learning to be a counselor. All of the participants vocalized doubt about the decision to become a counselor, citing lack of ability and fear of not knowing what to expect during clinical practice. Indeed, the participants in this study that seemed to voice this doubt most were CITs who had yet to meet their first client and were anticipating what it would be like (Woodside et al., 2007). The authors suggested that counselor

educators normalize these experiences since, as many have found before and since, anxiety and self-doubt among novice counselors is expected.

As Bandura (1977) explains, a manageable level of anxiety, such as the one described by the participants in Woodside et al. (2007), serves as a motivating factor for CITs in their quest for professional identity. Other studies have found similar results (Barbee, Scherer, & Combs, 2003; Binkley & Leibert, 2015) and even proposed ways to address these tendencies in CITs. For example, Barbee, Scherer, and Combs (2003) proposed service learning as a way to help students overcome anxiety, which they pointed out had an inverse relationship to counselor self-efficacy. Binkley and Leibert (2015) found that while CITs in practicum have high anxiety and low confidence, they could reduce the risk centered on client suicide by providing hands-on crisis skills training before students enter the field. Finding ways, as these researchers did, to help new CITs overcome this anxiety becomes the job of the counselor educator so students can progress in their professional identity development.

Auxier, Hughes, and Klein (2003) used grounded theory to develop a theory about anxiety and CITs, selecting eight master's degree students from CACREP accredited schools and conducting interviews and focus groups. Auxier et al. (2003) identified a recycling identity formation concept, which included three different processes: conceptual learning, experiential learning, and external evaluation. The participants reported experiencing anxiety centered on external evaluation; indeed, this feeling was evident when the CITs first started learning counseling skills, as they received feedback about interpersonal behaviors during the small group experience, and other times during individual and group meetings (Auxier et al., 2003). The anxiety was quelled when the evaluation was interpreted as positive or validating. The researchers noted this process of receiving feedback that perhaps evokes anxiety leads to the

recycling process of identity formation and thus is integral to professional development for CITs (Auxier et al., 2003).

Even if not the focus of the study as in Auxier et al. (2013), anxiety is mentioned consistently throughout the literature on counselor development. For example, Harrawood et al. (2011) found high levels of anxiety throughout a course designed to teach students about family systems, even though instructors stressed the learning nature of role-play exercises. In another study, Wagner and Hill (2015) found that entry level CITs required clearer expectations and less ambiguity in order to lessen their fear and level of anxiety. Considering the almost inevitable presence of anxiety – especially early in the training process – it is important to consider how, if left unmitigated, it might affect CITs' clinical work.

Indeed, Wei, Chao, Tsai, and Botello-Zamarron (2012) categorized trainee anxiety as potentially influencing both the personal and professional domains. Personally, trainees are concerned about not being good enough, negative evaluation from counselor educators, and personal issues seeping into their work; professionally, trainees are concerned about building rapport with their clients and competence in using their counseling skills (Wei et al., 2012). As Tsai (2015) pointed out, there is a discrepancy between the pervasiveness of anxiety among CITs and interventions counselor educators have in place to address the issue. As presented here, anxiety is an expected, even unavoidable aspect of the counselor training process that can be managed with structure and support early in the process.

Self-awareness. Another potential challenge for CITs relates to self-awareness. Beyond acquired skills, CITs also integrate their self into clinical practice and additionally are expected to monitor their personal and professional lives themselves (Wilkinson, 2011). CACREP (2009) recognized the importance of self-awareness in its standards for counselor education programs,

stating the presence of self-awareness is fundamental for CITs' fitness for the profession. They define a self-aware counselor as one that "demonstrates the ability to recognize his or her own limitations and to seek supervision or refer clients when appropriate" (CACREP, 2009, p. 31). In the most recent set of standards, CACREP (2016) calls for counselor educators to provide information about strategies for self-evaluation, both on a personal and professional level.

Easton, Martin, and Wilson (2008) reported findings that suggested one of the most important aspects of counselor development is awareness of one's own emotions. The researchers examined the role of emotional intelligence in 52 CITs in the process of completing practicum or internship. They found a strong correlation between emotional intelligence and counseling self-efficacy; specifically, CITs with high counselor self-efficacy also rated themselves as highly emotionally intelligent. Easton et al. (2008) explained that emotional intelligence meant CITs were aware of emotions, could identify one's own and others' emotions, as well as manage them, used them in problem solving, and expressed them adaptively (Easton et al., 2008). Sackett, Lawson, and Burge (2012) reported findings that echoed the importance of emotions in the counselor training process. Sackett et al. (2012) asked master's degree counseling students in practicum class about meaningful experiences during training; most of the CITs stated that insight centering on emotions was especially important. Specifically, the CITs found that avoidance or lack of emotion led the clients away from experiencing their emotions in session and keep things on the superficial level (Sackett et al., 2012). Easton et al. (2008) and Sackett et al. (2012) provide support for focus on emotional intelligence within counselor education.

Like Easton et al. (2008), other researchers interested in CITs recognize that a significant aspect of self-awareness is the exposure to and recognition of strong emotional responses to the

reflective and interpersonal work of counseling. Especially early on in counselor training, Wagner and Hill (2015) discussed the fear and excitement continuum the eight master's students they interviewed faced to varying degrees, adding the experience was dictated by their awareness of their lived experience and identity development prior to training. Rønnestad and Skovholt (2003) stated intense personal experiences could lead to an increased ability to relate to clients and greater awareness of what constitutes effective counseling. It appears that if CITs can reflect on their own intense emotions, whether related to their training as a counselor or their personal lives, they can maximize their learning through personalization of the material (McAuliffe & Eriksen, 2011). This personalization takes time, however; McAuliffe and Eriksen (2011) said often, during the early phases, CITs direct these feelings toward the instructors and supervisors who are evaluating their work. As training progresses, however, Rønnestad and Skovholt (2003) found CITs start to integrate awareness and emotions about their lived experience with their counselor training to become more effective in clinical work.

Harrawood, Parmanand, and Wilde (2011) explored one way they found to enhance self-awareness and emotional intelligence within counselor education. The authors wrote a descriptive account of master's students participating in a 10-week role play in a family theories course; Harrawood et al. (2011) were interested in implications for training of counselors, particularly the range of emotions that CITs experience while engaging in experiential learning. The students worked as co-counselors and role-played a session with a family using a pre-determined family counseling theory (Harrawood et al., 2011). When they were not serving as the co-counselor, they rotated among the other roles, such as family member, reflecting team member, and observer. To gather information about the CITs' emotions, the instructors videotaped the sessions as well as recorded reflecting team sessions during which the CITs were

asked about their emotions while playing each role. Harrawood et al. (2011) wrote the students reported a wide array of emotions; while being the co-counselor, the CITs experienced the most emotion, reporting predominantly fear, excitement, and comfort. The authors concluded the intensity and range of emotions the CITs experienced contributed to the learning of the course material, perhaps because learning is enhanced during critical incidents that occur when CITs perform less than perfectly (Harrawood et al., 2011).

In summary, self-awareness is a key ingredient to the development of professional identity for CITs. Some researchers highlight emotional intelligence as crucial to self-awareness. Indeed, the research shows emotional awareness and even acceptance helped CITs learn course material, improve clinical work, and feel more efficacious during counseling sessions. Other scholars claim emotions CITs experience contribute to the intensity of the counselor education experience. While the concepts of emotional intelligence and self-awareness go hand-in-hand in their role in professional identity development, there are a few other concepts in the literature that are needed for CITs, and they include skill acquisition, self-efficacy, and lifelong learning.

Other important considerations. Students entering counseling programs expect to learn basic skills to help them work with clients in clinical practice; they also are expected to extend these skills in an effort to model wellness to clients and others (Wagner and Hill, 2015). Research findings show skill acquisition, in addition to fostering self-awareness, as a major task for CITs; for example, Woodside et al. (2007) interviewed eight students in a master's in counseling degrees who named learning counseling skills and using this knowledge in their practice as a major task in development. The subthemes of classroom and practice described the ways in which the CITs were learning these things (Woodside et al., 2007). These skills are the foundation of counselor training and many other important aspects of professional identity

development stem from them (e.g., evaluation of skills, anxiety about evaluation, self-efficacy at utilizing skills).

As CITs learn the practice of counseling, they oftentimes gain in self-efficacy, which Bandura (1977) defined as an individual's belief about his or her ability to accomplish a given task. Buser (2008) suggested the sole goal of counselor education should be bolstering self-efficacy; indeed, he presented the Skilled Group Counselor Training Model as a current, empirically supported approach to counselor training. Based on Bandura's concept, this interpersonal skill training model distributes the training process into three parts: exploring clients' presenting problems, understanding the problem so goals can be developed, and acting in ways that work toward goals (Buser, 2008). He explained the theory is rooted in the idea that belief in the ability to counsel a client will significantly influence the counselor's performance. Mullen, Uwamahoro, Blount, and Lambie (2015) did find that as CITs received more training, their self-efficacy, as measured by the Counselor Self-Efficacy Scale, did increase. Further, the studies mentioned here also discuss how anxiety impacts CITs' ability to integrate learned skills and personal growth (i.e., self-awareness) in an effort to become effective counselors and, as described briefly below, engage in lifelong learning, which is a goal set forth by CACREP (2016).

CACREP (2016) requires programs to facilitate students' ability to identify with the counselor profession through lifelong learning after graduation, which means participating in professional counseling organizations (e.g., American Counseling Association) and by engaging in continuing education (e.g., seminars, workshops) that contribute to personal and professional growth. While Gibson et al. (2010) found early stage CITs focused on skill acquisition, they

found those in practicum or internship phase thought more about their professional identities, specifically in terms of how to engage in the community of professional counselors.

In conclusion, there are many issues facing counselor educators and CITs as they work together for the common aim of helping students develop a professional counselor identity. Some of these include learning the "how to" of counseling skills, increasing feelings of self-efficacy, and motivating CITs to engage in lifelong scholarship. Of the issues outlined here that are relevant to professional development of counselors, this study was most concerned with two in particular: anxiety and self-awareness, specifically emotional intelligence. Both of these issues facing CITs may be addressed through the practice of mindfulness, which is explored in the next section.

Mindfulness

Mindfulness emerged from Eastern spiritual teachings, specifically those from the Buddha; however, many scholars identify the practice as transcendent and not limited to a specific religion (Miller, Fletcher, & Kabat-Zinn, 1995). Clinicians and clients increasingly incorporated mindfulness into mental health care during the past 30 years while researchers and scholars continue to examine its effectiveness in treatment of myriad of psychological, physical, and emotional issues. The focus of this section is to present various definitions of mindfulness and provide an overview of the literature surrounding effectiveness of mindfulness and mindfulness-based therapy on client outcomes. Finally, given the unique needs of CITs discussed in the previous section, I will discuss the use of mindfulness in counselor education and training.

Mindfulness Defined

A pioneer in the Western adaptation of mindfulness in medicine and mental health, Kabat-Zinn (2013) defined mindfulness as the awareness that emerges through paying attention

on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment. While the exact definition of mindfulness remains a moving target, there is a consensus that the two elements of open attention and nonjudgment should be present (Bishop et al., 2004; Brown, Marquis, & Guiffrida, 2013; Kabat-Zinn, 2013). Martin (1997) takes this definition a step further when he stated paying attention allows "psychological freedom" (p. 293) from others' views as well as one's own view of self and the world. He described mindfulness through the concept of figure-ground dynamics; an individual sees each idea or option at the exclusion of all others. Mindfulness enables people to shift their attention and observe each alternately possible figure and the freedom to choose among them (Martin, 1997).

Mindfulness is a complex concept, and researchers explain it in the context of several different dimensions: method, perspective, subjective experience, and cognitive process (Davis, 2012). The method of mindfulness is meditation and is a particular way of paying attention and the awareness that rises from this practice (Kabat-Zinn, 2013). Mindfulness offers perspective on direct experience and encourages individuals to confront emotional discomfort, which Kabat-Zinn (2003) posited was the cause of negative psychological outcomes. Next, Davis (2012) described mindfulness as leading to subjective states of well-being, such as calm, free, and possessing vitality. Additionally, Davis (2012) refers to mindfulness as a cognitive process, specifically as a meta-cognition and then as cognitive flexibility. Thus, experts consider mindfulness both a state of being and a cognitive process.

Kabat-Zinn (2013) and Davis (2012) do not offer the only ways to conceptualize mindfulness. Khoury, Lecomte, Gaudiano, and Paquin (2013) discussed two dimensions of mindfulness, cognitive and affective. Within the cognitive realm, mindfulness is equal to self-regulation of attention, decentering, and awareness; the affective realm includes calmness, non-

reactivity, kindness, and compassion. Other terms associated with mindfulness include self-regulation, values clarification, body awareness, attention regulation, and self-transcendence (Gu, Strauss, Bond, & Cavanagh, 2015). These definitions illuminate the fact that one must learn about mindfulness and how to implement it in order to gain the biopsychosocial benefits, some of which are discussed later, associated with the practice.

While mindfulness practice in counseling includes a didactic component of teaching clients how to implement mindfulness in their daily lives (Linehan, 1993; Kabat-Zinn, 1990; Hayes et al., 1999), Martin (1997) suggested mindfulness transcends these treatment modalities and instead serves as a common factor that underlies a variety of therapeutic approaches. Several researchers suggest mindfulness surpasses a skill set or a practice and serves as a *way of being* therapeutically. One such author, Schuster (1979), explained mindfulness facilitates and enriches one's access to empathy and helps counselors "inadvertently or deliberately move into direct moment-to-moment contact with their clients" (p. 76). Similarly, Cacciatore and Flint (2012) described mindfulness as a way to maintain constant engagement with the client throughout a counseling session by functioning as a way to quiet the helper's mental chatter and turn the mind toward to the most important component of therapy: the client in the here and now. Based on the theoretical underpinnings and conceptualization of mindfulness mentioned here, there are several understandings about how the approach works; I explore these in the next section.

How Mindfulness Works

To understand how change occurs during the practice of mindfulness, some investigators conducted mediation analyses to demonstrate the mechanisms at work when individuals practice mindfulness. Baer (2011) outlined some ideas about how mindfulness leads to therapeutic change during mental health treatment, which included exposure, cognitive change, self-

management, relaxation, and acceptance. Kabat-Zinn (1982) first stated the mindfulness-based stress reduction (MBSR) practice encourages prolonged exposure to the physical and emotional sensations, most often for instances of chronic pain but also for anxiety and panic, which in turn leads to desensitization and an ability to experience these sensations without experiential avoidance. This has been especially helpful in treating patients with emotional dysregulation issues or Borderline Personality Disorder through Dialectical Behavior Therapy (DBT) since these individuals often seek out maladaptive coping mechanisms (e.g., self-injury, parasuicide) to avoid negative emotions (Harned, Korslund, & Linehan, 2014; Neacsiu, Eberle, Kramer, Weisman, & Linehan, 2014). Thus, research demonstrates mindfulness works, in part, by helping practitioners gain exposure to stimuli they might be avoiding.

When individuals are exposed to negative emotions in particular, mindfulness helps them to take a "nonjudgmental, decentered view" (p. 129) so they can come to a place of acceptance (Baer, 2003) instead of avoidance. This act of acceptance has been associated with improvements in outcome in some of the empirical research centered on acceptance of pain and values-based action (McCracken & Gutiérrez-Martínez, 2011). The entire change process of exposing one's self to the unpleasant emotion and then accepting it nonjudgmentally occurs through the process of decoupling, or eliminating the normal relationships between internal experiences and behavior (Levin, Luoma, & Haeger, 2015).

Germer, Siegel, and Fulton (2016) added that, when we evaluate whether or not mindfulness works, we are indeed looking into whether people benefit from being with the discomfort imminent in their lives rather than avoiding or trying to remove the problem. These authors state the data overall suggest by practicing mindfulness, individuals can improve their physical health, mental health, and overall well-being (Germer. Siegel, & Fulton, 2016). In the

next section, I will look at how mindfulness is used in treatment of clients and then juxtapose that to how it is starting to be used in counselor education.

Mindfulness in Treatment

The literature shows encouraging evidence that mindfulness-based approaches are efficacious, specifically when they follow the format of Mindfulness-Based Stress Reduction or Mindfulness-Based Cognitive Therapy (Coelho, Canter, & Ernst, 2007; Hoffman, Sawyer, Witt, & Oh, 2010). Most of the empirical research available for the effectiveness of mindfulness uses the Mindfulness-Based Stress Reduction (MBSR) program developed by Jon Kabat-Zinn. He developed this curriculum in 1979 as a training vehicle for the relief of stress, pain, and illness with which his patients were dealing (Kabat-Zinn, 2003). He has since found that an eight-week outpatient course produces positive changes in brain functioning, immune system, and emotional processing (Kabat-Zinn, 2003).

Khoury, Sharma, Rush, and Fournier (2015) recently conducted a meta-analysis to evaluate the efficacy of MBSR for nonclinical populations. The researchers looked at any quantitative study that used the intervention with healthy adults, totaling 29 studies and 2,668 participants. The effect sizes ranged from 0.53 to 0.55 (Hedge's *g*) and the results were maintained for almost 20 weeks post-intervention. Khoury et al. (2015) reported large effects for stress, moderate effects on anxiety, depression, distress, quality of life, and small effects on burnout. Interestingly, the authors reported the target population that might have benefited the most from MBSR was healthcare professionals; they speculated this might be due to the high level of stress within this profession. Baer (2003) reviewed 22 studies that also used MBSR; he found the MBSR protocol was associated with positive outcomes on anxiety, depression, binge eating, chronic pain, among other things. These two large-scale studies made a case for the

effectiveness of mindfulness among a variety of biopsychosocial issues; however, both articles called for more research into the matter.

On a less global scale, Goldberg, Davis, and Hoyt (2013) conducted a study to determine the mechanism through which mindfulness-based interventions operated to produce positive client outcomes. They analyzed the working alliance, mindfulness, and psychological functioning in a sample of 37 people participating in a mindfulness-based smoking cessation intervention group based on MBSR. The researchers posited that, even though mindfulness is an introspective activity, practicing together would form some degree of alliance between the client and the group leader that, in turn, would influence treatment outcomes. Results from their quantitative analysis, while tentative due to the small sample size, showed high level of therapeutic alliance between the client and instructors which the authors suggest contributed to significant improvements in self-reported mindfulness and treatment compliance but did not impact smoking cessation (Goldberg et al., 2013). Goldberg et al. (2013) were one set of researchers to start looking at the use of mindfulness in tandem; as mindfulness research expands, more scholars are taking up this vein of thought.

Ryan et al. (2012) looked into the relationship between mindfulness and therapist self-affiliation, therapeutic alliance, and treatment outcome, investigating 26 patient-therapist dyads from a psychiatry department in a hospital in New York City. Each therapist completed measures assessing mindfulness, attitudes toward self, and the working alliance; patients, diagnosed with a variety of mental illnesses, completed the Working Alliance Inventory and a symptom checklist (Ryan et al., 2012). Therapist mindfulness was positively associated with both therapist and patient ratings of the working alliance as well as overall changes in the clients' interpersonal functioning. Ryan et al. (2012) and Goldberg et al. (2013) both found that practicing mindfulness

in therapy led to positive outcomes for clients. In addition to these findings, research specifically associates mindfulness with improvements in self-awareness and decreases in experiential avoidance, which are relevant to the unique needs of CITs and elements of ACT.

Self-awareness. Kabat-Zinn (2013) stated awareness is paying attention to things as they are; thus, self-awareness is paying attention to the self as it is. The ability to do this has been associated with positive outcomes, such as developing new skills, coping with weakness, developing decision-making skills, decreasing stress, and increasing motivation (Wilson, 2009). Specifically for CITs, Stella (2016) stated teaching techniques that enhance self-awareness, such as mindfulness, could potentially bolster CITs' abilities to attune to clients' internal processes.

Some research shows mindfulness helps individuals pay attention to themselves in the present moment. Allan, Bott, and Suh (2015) conducted a study to find out if mindfulness and finding meaning in life were correlated and determining if authenticity (divided into four components: awareness, unbiased processing, behavior, and relational orientation) was a mediator. Self-determination theory identifies meaning in life as the integration of the self, demonstrated by internally driven, value-directed engagement with the world. After surveying 305 undergraduate students, the authors found that mindfulness was positively correlated with meaning in life; most significantly, Allan et al. (2015) found the only component of authenticity that positively mediated the relationship between mindfulness and meaning in life was awareness, which was defined as knowledge and trust in one's own experience of self. Thus, the authors concluded increased self-awareness could explain the positive association between mindfulness and life meaning.

Another study explored the impact of mindfulness on internally driven experiences. Saunders, Rodrigo, and Inzlicht (2016) developed a procedure to test the influence of

mindfulness on performance monitoring, present-moment attention, and awareness toward affective and cognitive experience. The 49 undergraduate students in this study were told to direct attention toward their current emotional and cognitive states without judgment. Each group went through an initial mindfulness exercise and then one group received emotion-focused instructions designed to facilitate momentary awareness of feelings in the mind and body, whereas the other group received thought-focused conditions and were instructed to attend to the information content of the thoughts running through their mind at that moment (Saunders et al., 2016). After these experiences, each participant performed an image-based task that exhibited four negative emotions (anger, disgust, fear, and sadness). Saunders et al. (2016) asked the emotion-focused participants to report their feelings in relation to the picture, while the thought-focused participants were asked to report their thoughts in reaction to the image. Then each participant completed the MAAS (Brown & Ryan, 2003) to test for differences in mindfulness between the conditions. Saunders et al. (2016) reported the thought-focused group became faster and less accurate after the induction, whereas the emotion-focused group became significantly slower and numerically more accurate as the task went on. Thus, the researchers concluded that emotional processing is an important aspect of performance monitoring and cognitive control (Saunders et al., 2016). This study, while interested in present-moment awareness of its participants, started to explore the role of emotions in mindfulness and its associated outcomes.

Emotions. There is a strong vein of research that investigates the role of emotions in mindfulness practice, whether as mediators toward another goal (e.g., distress) or as an outcome itself. Alda et al. (2016) investigated the association of mindfulness with biological outcomes as well as multiple psychological variables, including experiential avoidance. The researchers defined experiential avoidance, as Bond et al. (2011) did, as the unwillingness to experience

thoughts and emotions and the inability to be in the present moment when negative emotions are present. Alda et al. (2016) recruited 20 expert meditators and compared them to their health relatives who did not meditate on all the variables. The investigators found the absence of experiential avoidance to be a mediator in maintaining the health of the participants' DNA. The authors make the conclusion that the absence of experiential avoidance of negative emotions is crucial to the positive biological benefits of meditation.

Doll et al. (2016) also took a biological approach to studying mindfulness. The researchers trained 26 healthy volunteers with no meditation or yoga experience in mindfulness-based attention-to-breath meditation for two weeks. Doll et al. (2016) thought the meditation practice might increase participants' emotion regulation ability, or their use of strategies to influence which emotions arose, how long they occurred, how they are experienced, and how they were expressed. After the training, the participants viewed pictures designed to elicit aversive emotions during both attention-to-breath and passive viewing while undergoing fMRI (Doll et al., 2016). The researchers found that meditation was effective in regulating the aversive emotions that resulted from viewing the pictures; the fMRI results suggested a combined effort by the amygdala and dorsal prefrontal cortex as a potential neural pathway of emotion regulation by mindfulness practice (Doll et al., 2016). These results suggest there is a link between mindfulness practice and emotion regulation.

Dubert et al. (2016) examined this link explicitly when they gave 80 undergraduate nursing students self-report measures to examine the relationship between mindfulness and emotion regulation. Qualitative data analysis showed mindfulness had a small but significant positive correlation with reappraisal, one component of emotional regulation (Dubert et al., 2016). Reappraisal when related to emotions is the act of changing the way one experiences or

thinks about an event that stimulates the person emotionally and has been related to healthy functioning, well-being, and interpersonal functioning (Dubert et al., 2016). Additionally, mindfulness had no significant relationship with suppression, another aspect of emotion regulation that involves inhibiting one's response to events that elicit emotions that is associated with negative well-being and poor interpersonal functioning (Dubert et al., 2016). These studies start to investigate the connection between emotions and mindfulness practice; the importance of this connection becomes evident as the literature focused on mindfulness and counselor education is explored in the section below.

Mindfulness in Counselor Education and Training

While the evidence supporting the use of mindfulness in the treatment of mental health problems and disorders is burgeoning, there also is research that investigates how counselors use mindfulness in their personal and professional lives. Rothaupt and Morgan (2007) conducted semistructured interviews with six counselors and counselor educators about how they incorporated mindfulness into their personal and professional lives. The participants revealed the practice of mindfulness helped them be more aware of their body, cultivated patience, and promoted mindful environment, while the outcomes of their practice included things such as intentionality, gratitude, connectedness, and inviting others (i.e., clients) to engage in mindfulness (Rothaupt & Morgan, 2007). At face value, these parallel skills, values, and dispositions that counselor educators try to foster in CITs; Rothaupt and Morgan (2007) called for more research into why and how benefits of mindfulness could serve counselors.

While Rothaupt and Morgan (2007) interviewed individuals who already practiced mindfulness, Rocco, Dempsey, and Hartman (2012) conducted a thematic analysis of participant interviews after they underwent an eight-week calm-abiding meditation course for mental health

service workers in Australia. Their nine participants reported meditation helped them recognize and manage stress responses and improved their outlook, lifestyle choices, and well-being. Specifically, the participants reported being less reactive than in the past and able to recover from stressful experiences more quickly. Also, the participants expressed a sense of respect for themselves and others, citing the interconnectedness of being aware of how actions and attitudes impact others. Given these findings, Rocco et al. (2012) concluded the meditation intervention offset the demands of working in a mental health service facility and could serve practitioners globally in their work.

Additionally, Vega et al. (2014) conducted a quantitative study on a course based on MBSR offered to psychiatry and clinical psychology residents from Spanish and Latin American hospitals. The analyses focused on emotional and attentional variables and results showed mindfulness training improved anger management and attentional control. The investigators concluded mindfulness presence can help therapists manage difficult moments by allowing them to step back and evaluate the situation, avoiding their automatic reactions to clinical situations (Vega et al., 2014). If mindfulness is associated with positive outcomes for counselors such as these, it might behoove counselor educators to implement the practice into training. Indeed, there are scholars and researchers who already are doing this. The literature investigates both the CITs' professional and personal uses of mindfulness, and understanding both facets are necessary according to the discussion surrounding professional identity development.

One way mindfulness can aid CITs' professional development is by enhancing specific clinical skills; for example, Greason and Cashwell (2009) conducted an exploratory study with master's and doctoral level counseling students to examine the predictive relationship between mindfulness, attention, empathy, and counseling self-efficacy. A total of 179 participants

completed the survey that included measures of mindfulness, counselor attention, empathy, and counselor self-efficacy; the authors conducted a path analysis to explore predictive relationships among the variables (Greason & Cashwell, 2009). Findings showed mindfulness as a predictor of counseling self-efficacy and empathy in both master's and doctoral students. Greason and Cashwell (2009) believed practicing mindfulness encouraged individuals to accept and allow rather than try to change current experience, to focus on being rather than doing. This implies mindfulness might be a useful and important tool to help students be present with clients.

This study echoed a finding from Keane (2014), who conducted a mixed methods study on the influence of mindfulness practice on therapists' work; the first study was a survey completed by 40 psychotherapists that showed a positive relationship between mindfulness practice and self-reported empathy. Additionally, 90% of respondents stated mindfulness practice had improved their attention levels and self-awareness with clients, their level of self-compassion, and their attention to their own self-care (Keane, 2014). During follow-up qualitative interviews, Keane (2014) identified seven themes about participants' thoughts on mindfulness: enhanced awareness and attention, benefits of mindfulness, challenges of heightened awareness, embodying mindfulness, therapist self-care, mindfulness as an intervention, and perspectives on mindfulness in psychotherapy. One of the main objectives of the study was to relate mindfulness to empathy; Keane (2014) found a significant positive relationship between the two variables; the qualitative responses revealed mindfulness supported non-reactivity, "a way of 'being empathic without getting lost or overidentifying with the pain of the client' (p. 699). This and the other studies mentioned so far investigated CITs or practitioners who are using mindfulness already, pointing out how mindfulness can improve clinical skills and therapeutic presence for counselors.

However, there are questions surrounding how best to teach mindfulness to CITs; to this end, several groups of counselor educators have taken the step of developing mindfulness trainings or courses in the hopes of learning more how the practice can help CITs. A group of researchers implemented a mindfulness course for counseling master's students and asked questions over the course of several studies about the impact of mindfulness practice on first- and second-year students in mental health, school, and marriage and family counseling programs, specifically about its impact on their personal lives and professional work with clients (Chrisman, Christopher, & Lichetenstein, 2009; Felton, Coates, & Christopher, 2013; Maris, 2009; Schure, Christopher, & Christopher, 2008). The course, loosely based on MBSR, included two 75-minute mindfulness practices (e.g., hatha yoga, qigong, sitting meditation) and participants were required to practice for 45 minutes outside of class four times per week. Instructors asked students to complete research on related empirical studies and a journal reflecting on the entire experience. The purpose was twofold: first, the instructor aimed to familiarize students with mindfulness and its relevance for the counseling field, and, secondly, it provided CITs with practical tools for self-care (Schure et al., 2008).

Schure et al. (2008) published results from a four-year qualitative inquiry of this MBSR-based course. Researchers used the students' journals as data and used a qualitative coding method to found five general themes that emerged in response to how the course impacted the students: (a) physical changes, (b) emotional changes, (c) attitudinal or mental changes, (d) spiritual awareness, and (e) interpersonal changes. Notably, the majority of students reported an increased ability to deal with "strong and threatening emotions" (Schure et al., 2008, p. 50) and learned techniques to be less reactive in their emotional responses. All students in the course were seeing clients in a supervised clinical setting and reported mindfulness practice allowed

them to be more comfortable with silence, focus more on their clients and the therapeutic process, and changed their view of the scope of the healing process. The researchers concluded mindfulness practice has the potential to make CITs less reactive to stress or anxiety, including situations when clients are in crisis or discussing painful emotions, and can increase their awareness and tolerance (Schure et al., 2008).

In a further iteration of this research, Chrisman et al., (2009) completed a qualitative content analysis on journal responses that centered on the experience of qigong, a moving meditative practice, during the MBSR course. Three themes about the students' experience were present during the start of qigong and after their final experience: physical changes, emotional changes, and mental changes; additional themes emerged at the end of the course and included familiarity and awareness, or consciousness of the group (Chrisman et al., 2009). Specifically, under the theme of mental changes, the participants reported an increased ability to focus and quiet their minds. The researchers concluded that participating in the qigong overall helped students achieve increased flexibility and quieter minds.

Maris (2009) was a student in the above mentioned 15-week course (Chrisman et al., 2009) and wrote a first-person narrative account of her experience in the MBSR course. She described a newfound ability to "choose curiosity over reactivity" (p. 233) after incorporating mindfulness practice into her daily life, explaining that she gained awareness of when her anxiety was rising and was able to counterbalance these reactions by refocusing and "opening herself to the present moment without judgment of either myself or the client" (p. 233). Maris (2009) also reported an increased tolerance for her clients'' negative emotions without feeling the need to soothe him or her.

Lastly, in 2013, Felton et al. published a more updated account of the participants' experience – this time focusing on stress and burnout – in the 15-week MBSR course. Again, the participants were master's counseling students in mental health, school, and marriage and family counseling. The content analysis revealed themes shifted across the semester as students reflected different perspectives on stress in the beginning compared to the end of the semester; the data showed an improved ability to be less negatively impacted by stress and more resources to combat burnout (Felton et al., 2013). Specifically, Felton et al. (2013) stated the students reported the mindfulness course enabled them to be more present with their clients, experience more empathy for them, and be less emotionally reactive during sessions. The research surrounding this one course described many benefits, both personal and professional, of implementing mindfulness into counselor education and training. The personal gains included self-care, reduced anxiety, and quieting of the mind. In summary, the research on this MBSR-based course demonstrated mindfulness could be an asset to counselor education curriculum insomuch that it helped CITs gain not only personally but professionally as well, specifically aiding them in being present with their clients, experiencing more empathy, and not avoiding negative emotions.

There are other studies that demonstrate the impact mindfulness can have on CITs. Another group of researchers used MBSR to guide a six-week mindfulness group consisting of 31 students training for careers in the helping professions who were offered academic credit for their participation (Newsome, Waldo, & Gruszka, 2012). Two MBSR groups occurred, one in the fall and one in the spring; the students were taught techniques for MBSR that could be incorporated into their work with clients. After examining results from repeated-measures ANOVAs, the researchers concluded the students' perceived stress levels, self-compassion, and

mindfulness changed after participating in the MBSR group; also, these changes remained stable when measured one month later. Newsome et al. (2012) concluded the study offered compelling evidence for incorporating mindfulness groups as part of training curriculum for helping professions.

The aforementioned studies delivered mindfulness training to CITs in a group format, just as Bohecker et al. (2014) did when they developed a Mindfulness Experiential Small Group (MESG) as part of the group course in a counseling program. Mindfulness was infused in the small group experience; the focus on mindfulness was present only in this component of the course, with the aim of allowing CITs to engage in mindfulness practice as an orientation to the group process. The investigators conducted a pilot study of students' experiences to inform further MESG research. The study used intensive interviewing and open and axial coding to determine themes about the participants' experience of MESG (Bohecker et al., 2014). The researchers posited the experiential nature of mindfulness would help CITs to change their perspective of thoughts and feelings applied to a wide range of activities and practices. Overall, the researchers found MESG provided an outlet for managing CITs' stress and anxiety and that, at the one-year follow up point, CITs were consistently using mindfulness practice in their personal and professional lives.

Summary. The research conducted on these small samples of CITs or mental health professionals participating in a mindfulness-based course strongly supports using mindfulness within counselor education and training. The positive outcomes associated with mindfulness included enhancing specific clinical skills such as therapeutic listening and empathy. Additionally, research showed mindfulness helps help therapists manage difficult moments by allowing them to avoid automatic reactions to clinical situations, improved ability to combat

burnout, and foster feelings of self-efficacy. As a reminder, the literature around professional counselor development highlighted the importance of reducing anxiety and increasing self-awareness among CITs. Most of the studies reported an increase in some form of self-awareness, whether it was being more aware of their body, environment, how their actions impact others, and/or the need for self-care. In addition, a handful of the studies mentioned here established the practice of mindfulness as a way to make CITs less reactive to stress or anxiety, including situations when clients are in crisis or discussing painful emotions.

Among these studies, the researchers and instructors implemented mindfulness in unique ways, not worrying about finding a standardized way to incorporate the practice into counselor education. MBSR was the most commonly used basis for mindfulness; however, even some of the researchers pointed out that the stringent nature of the MBSR curriculum might be limiting in some ways. Additionally, there is little empirical work done on implementing mindfulness into the supervision context, an important and valued aspect of counselor education. In the following section, I outline ACT and attempt to elaborate the benefits of using this theory as a basis for implementing mindfulness into counselor education contexts.

Acceptance and Commitment Therapy

ACT is a third-wave cognitive behavioral therapy, along with dialectical behavior therapy and other mindfulness-based approaches (Salande & Hawkins, 2016); these treatments view behavior as functional and contextual in a more nuanced way while adding an appreciation for the benefits of meditation and mindfulness. Harris (2009) stated ACT gets its name from its core message: "*accept* what is out of your personal control and *commit* to taking action that enriches your life" (p. 2). ACT focuses on the idea of acceptance instead of change, recognizing the mind is useful for many activities but it can also hurt us if we do not handle change effectively (Harris,

2009). Thus, the six core therapeutic processes of ACT help us handle our mind; these include contacting the present moment, defusion, acceptance, self-as-context, values and committed action (see Table 1.1). The therapy is summed up in the "hexaflex" (Figure 1.2), the center of which shows psychological flexibility, the ultimate goal of the ACT process.

The hexaflex as pictured shows the order in which a person learns about the constructs included in the ACT method (Harris, 2009). The first and foundational learning is the definition of mindfulness and how to use it in their everyday life. Secondly, a person learns about acceptance, which involves being aware of one's thoughts without attempts to change either their frequency or form. One example of how this works is accepting the feelings of nervousness when speaking publicly about a cause that matters to you. Accepting the nerves helps you move past them and accomplish something that you value. Defusion is the process that allows us to enact acceptance when needed; specifically, it encompasses techniques (a lot of them based in mindfulness) to change the way a person relates to thoughts by creating contexts where they are not helpful (i.e., the construct of self-as-context). For example, identifying one's self as an addict might make the person feel shame and guilt about the behavior; Harris (2009) suggests that defusing from this label allows the person to be psychologically flexible in the goal of living out personal values (i.e., the constructs of committed action and values).

Harris (2009) further reduced ACT to three functional units, known as the triflex (Figure 1.1). Harris (2009) grouped defusion and acceptance together since they both focus on separating oneself from thoughts and feelings, seeing these cognitions and emotions for what they truly are, and making room for them in daily life. Self-as-context represents the second side of the triflex, while values and committed action make up the third and final aspect of the model. As stated previously, this study focused on the first side of the triflex, which demonstrates ACT's goal of

opening up, and includes mindfulness, defusion, and acceptance. Clinically**,** ACT works to create a "rich, full, and meaningful life while accepting the pain that inevitably goes with it" (Harris, 2009; p. 7), termed psychological flexibility; it does this through the previously mentioned six core therapeutic processes enacted during the duration of treatment. The primary clinical uses of ACT include helping individuals manage negative experiences, such as anxiety and negative emotions, more effectively through increasing present moment awareness (Harris, 2009). Throughout this section, I will outline the history of ACT, evidence for its clinical effectiveness – especially the components that make up the first side of the triflex, mindfulness, acceptance, and cognitive defusion – and the use of ACT in the context of counselor education.

Development of ACT

As previously mentioned, ACT is considered a third-wave behavior therapy; Hayes (2004) explained the first wave of behavior therapy focused directly on problem behavior and emotion using conditioning principles whereas the second wave was an attempt to deal more directly with thoughts and feelings (i.e., cognitive approach). The third wave of behavioral therapy emerged as constructivism and post-modernist thought allowed leaders to reject the absolutes suggested by scientific theories and take an approach more focused on context (Hayes, 2004). Researchers defined third-wave approaches as "grounded in an empirical, principle-focused approach … Sensitive to the context and functions of psychological phenomena, not just their form, and thus [tend] to emphasize contextual and experiential change strategies in addition to more direct and didactic ones" (Hayes, 2004; p. 658). The focus on context paved the way for theories such as Dialectical Behavioral Therapy, mindfulness-based cognitive therapy, and ACT, built upon the philosophies surrounding functional contextualism and Relational Frame Theory (RFT); each are outlined below, followed by a discussion about the clinical application of ACT.

Functional contextualism. Biglan and Hayes (1996) outlined functional contextualism, an extension of radical behaviorism, as a way to approach research on human behavior. Hayes (2004) stated the core components of the theory included (a) focus on the whole event, (b) sensitivity to the role of context in understanding the event, (c) emphasis on pragmatism, and (d) specific scientific goals against which pragmatism will be applied. In their description, Biglan and Hayes (1996) explained *actions in context* are the basic unit of behavior analysis. The individual evaluates these actions in an effort to predict and influence behavior (Biglan & Hayes, 1996). There is an absolute truth; however, people sees this truth differently based on their contextualized way of seeing the world (Biglan & Hayes, 1996). In practice, thoughts are related to these actions in context insomuch as they are precursors and results of the action in context. The thoughts, and their *function* in the context of someone's life – namely to help them accomplish a goal - become the clinical focus in ACT (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013).

Relational Frame Theory. The first wave of behavioral theory ignored cognitions (Hayes 2004); as part of the third wave of behaviorism, ACT is built on a functional contextualism approach to language and cognition, known as RFT. According to this theory, humans learn language and cognition through bringing events under contextual control (Hayes, 2004). Hayes and Bunting (2005) explained most animals can distinguish when one object looks the same or bigger than another; however, humans can further abstract the features of an object and bring them under contextual control based on social cues. A common example of this is when a young children recognize that a nickel is bigger than a dime but, as they grow, they recognize that the nickel is smaller than the dime based on societal context (Hayes, 2004). Hayes et al. (2013) explained that *relational frames* begin in infancy and enable humans to develop

normal language; if these frames do not develop properly, theorists believe individuals can develop cognitive deficits or clinical disorders.

Within ACT, practitioners use the word "mind" as a metaphor for "human language" (Harris, 2009; p. 6). Harris (2009) explained that, using RFT as a theoretical base, we use our language to dwell on painful events of the past, worry about unpleasant futures, compare ourselves to others, and otherwise create rules for ourselves that can be destructive. Harris (2009) describes this:

> "…Typical human beings commonly handle their pain ineffectively. All too often when we experience painful thoughts, feelings, and sensations, we respond in ways that are self-defeating or self-destructive in the long run. Because of this, one major element of ACT is teaching people how to handle pain more effectively through the use of mindfulness skills" (p. 8).

ACT uses mindfulness specifically to help clients bring awareness or attention to experience in the moment to prevent a person becoming caught up in thoughts, thus encouraging an open and curious attitude and a flexibility of attention (Harris, 2009). Mindfulness is an essential instrument to increasing psychological flexibility, the ability to be present in the moment, with full awareness and openness to experience and to take action guided by personal values (Harris, 2009). In other words, it is the mechanism through which individuals can prevent experiential avoidance, which is how humans attempt to escape unpleasant events and paradoxically increase cognitive and emotional contact with such events (Bowden & Bowden, 2012). Additionally, mindfulness helps individuals address certain strategies that keep them trapped in maladaptive cognitive and emotional states (Bowden & Bowden, 2012). Within the next section, I explore the

overall treatment efficacy of ACT and these specific processes and then the details about the use of ACT in the clinical setting.

Empirical Evidence for ACT

Multiple studies exist that focus on the treatment efficacy of ACT. An early meta-analysis examined the third wave of behavioral therapies in general, reviewing methodology and efficacy of studies conducted from 1985 to 2007 to evaluate these treatments as empirically supported (Öst, 2008). The study examined ACT, Dialectical Behavior Therapy, Cognitive Behavioral Analysis System of Psychotherapy, Functional Analytic Psychotherapy, and Integrative Behavioral Couple Therapy. Öst (2008) reported 13 randomized control trials (RCTs) with a total of 677 participants using ACT solely or in combination with another treatment. The meta-analysis yielded a mean effect size of 0.68 for the ACT studies, which translates into a significant and moderate effect size across studies that looked a wide variety of presenting problems (e.g., depression, psychosis, stress). However, Öst (2008) held the methodology was lacking in these early studies and thus did not endorse ACT as an empirically supported treatment modality. This study showed ACT was effective as treatment but not above and beyond already established treatment methods.

Other groups of researchers have examined ACT as a treatment method. In 2009, Powers, Vörding, and Emmelkamp followed up Öst (2008) with a meta-analysis focused only on ACT studies that compared the treatment to wait lists trials, psychological placebos, treatment as usual, and established therapies. They examined 18 RCTs with a sample of 917 individuals; effect size was 0.42, which was considered a medium effect size (Powers et al., 2009). After closer examination, Powers et al. (2009) found ACT was superior to waiting lists and placebos (effect size = 0.68) and treatment as usual (effect size = 0.42). However, again ACT was no more

effective than established treatments (i.e., exposure therapy and CBT). Another group had similar results: Smout, Hayes, Atkins, Klausen, and Duguid (2012) conducted a meta-analysis that looked at ACT studies published after 2008 that employed random assignment of participants with clinical diagnoses, using ACT as one treatment approach with the other being a wait list or comparative approach. The investigators concluded there was sufficient evidence to use ACT when treating OCD, chronic pain, and anxiety disorders, specifically in Australia (Smout et al., 2012); however, they also hesitated to generalize ACT's efficacy further.

Öst (2014) updated his meta-analysis of ACT to compare earlier RCTs of ACT to more recent ones. He found 60 studies with a total of 4,234 participants with psychiatric disorders, somatic disorders, and stress at work; the results from these showed the approach is likely efficacious for chronic pain, tinnitus, and possibly effective for depression, psychotic symptoms, OCD, mixed anxiety, drug abuse, and stress at work. Öst (2014) found the mean effect size across all RCTs examined was moderate (0.42); he again concluded that an evidence base for ACT had not been firmly established based on his meta-analysis. Öst (2014), in explicit hope of establishing the efficacy of ACT, offered 15 recommendations (e.g., include one-year follow ups in the studies, tape all relevant therapy sessions) for future researchers in an effort not to discredit the method, but to highlight the need for more rigorous research on ACT.

Öst (2014) also points out the American Psychological Association has listed ACT as an evidence-based practice. To this point, A-Tjak et al. (2015) conducted a meta-analysis of efficacy of ACT in mental health and physical health problems, looking at 39 RCTs. The researchers looked at 39 studies that included random assignment to an ACT intervention, an active or inactive control group, and diagnosis of a clinical disorder. Participants in these studies had to have a relevant clinical disorder (e.g., anxiety, depression). They found ACT

outperformed control conditions during a post-test and at follow-up assessments and also was superior to waitlist, placebo, and treatment-as-usual conditions.

In summary, mixed results exist from the meta-analyses examining the effectiveness of ACT. Smout et al. (2012) noted most research has been in pilot form and thus this vein of research is likely in its nascent stage. Despite this, there are promising results for using ACT with anxiety disorders, depression, addiction, and somatic health problems, among other mental disorders. Proponents of this third-wave behavioral therapy approach suggest it also can provide positive outcomes with symptom reduction and goal setting (A-Tjak et al., 2015). Within several of these studies, ACT was described as a "transdiagnostic model" (Smout et al., 2012, p. 106; A-Tjak et al., 2015, p. 35) that can be applied to a broad range of issues. Since ACT does not focus on the diagnosis, A-Tjak et al. (2015) suggested the method might be associated with broader changes in psychological functioning rather than specific symptom reduction. Some of these benefits of ACT become clearer as we delve into the effectiveness literature.

Clinical Effectiveness of ACT

Given meta-analyses findings, ACT is listed as an evidence-based practice within the American Psychological Association (2013), with strong support for chronic pain and modest support for depression, mixed anxiety, Obsessive Compulsive Disorder, and psychosis (APA Division 12, 2013). Additionally, ACT is listed in the National Registry for Evidenced-based Programs and Practices (NREPP; SAMSHA, 2015). The NREPP lists ACT as effective for OCD symptoms, depression, rehospitalization, and general mental health for a range of individuals, including those living in rural and urban environments, within inpatient, outpatient, and workplace settings, and from varying racial and ethnic backgrounds (SAMSHA, 2015). The

specific research studies that build the case for ACT, especially for treatment of anxiety and other psychosocial issues, are detailed below.

Anxiety. There are a handful of studies that investigate ACT as a treatment for various anxiety disorders. For example, Dalrymple and Herbert (2007) wanted to develop a protocol of ACT plus exposure treatment for adults diagnosed with Social Anxiety Disorder (SAD) and thus followed 19 participants through a four-week no-treatment period and 12 one-hour weekly sessions of ACT at a university-based anxiety clinic. The treatment presented four of the main tenets of ACT: creative hopelessness, acceptance, mindfulness, and values and goals. Each participant completed a pre-treatment phone call, a diagnostic interview, pre-, mid-, and post-treatment assessments, and a three-month follow-up assessment (Dalrymple & Herbert, 2007). The results of this pilot study showed participants agreed the ACT treatment reduced avoidance when it came to social situations; Dalrymple and Herbert (2007) remind us that ACT does not aim to reduce symptoms, but there was significant improvement in SAD symptom reduction from pre-treatment to follow-up as well as increase in quality of life.

More generally, Eifert, Forsyth, Arch, Espejo, Keller, and Langer (2009) showed interest in adapting ACT to treat anxiety disorders; to this end, they examined three individuals who were already participating in a RTC comparing ACT and CBT. These participants were enrolled in the ACT for Anxiety program, a treatment protocol that guides therapists in applying ACT principles specifically for anxiety disorders (Eifert et al., 2009); the approach posits ACT can help clients with unwanted emotions and thoughts, changing their function (rather than trying to eradicate them) so the individual can move forward in valued action. Eifert et al. (2009) reported the three clients experienced shifts in targeted processes of change (e.g., reductions in experiential avoidance, defusion from thoughts), reported less distress at the end of treatment,

and developed skills to let go of trying to control their thoughts. Additionally, the clients -- while there was no significant increase in scores -- reported feeling empowered by ACT's emphasis on valued living and value-directed action (Eifert et al., 2009).

Eifert et al. (2009) found ACT to be an effective alternative to CBT; Meuret, Twohig, Rosenfield, Hayes, and Craske (2012) suggested ACT for individuals with panic disorder because some of these individuals have been resistant to techniques of CBT (e.g., cognitive restructuring). Meuret et al. (2012) assessed a brief ACT protocol that was divided into skill training and skill applications phases; the 11 female participants were diagnosed with panic disorder and attended weekly individual therapy sessions that focused mostly on acceptance but also addressed defusion and values-based action. This pilot study demonstrated ACT was a feasible and likely intervention for panic disorder, with the participants experiencing a reduction in panic symptom severity, cognitive misappraisals, and anxiety sensitivity as well as increase in mindfulness (Meuret et al., 2012). The authors suggested ACT might work for this population due to the therapy's focus on acceptance of thoughts instead of their correction.

In 2013, Dehlin, Morrison, and Twohig evaluated ACT for yet another anxiety disorder, Obsessive Compulsive Disorder characterized by scrupulosity, or intrusive thoughts about religious or moral issues accompanied by compulsive thoughts and/or behaviors meant to quell anxiety. The five participants received eight sessions of ACT targeting their scrupulosity and researchers performed a multiple baseline data analysis across participants. Dehlin et al. (2013) found that participants reported reduction in compulsions and avoided value behaviors, and these reductions remained at the three-month follow-up assessment. The ACT treatment was associated with significant reductions in scrupulous symptoms without a notable change in religious faith among the participants (Dehlin et al., 2013). The results suggest ACT might be

promising as a treatment to OCD characterized by scrupulosity because ACT does not address religious content and thus helps therapist avoid invalidating clients' faith; participants in this study with the disorder rated it as a highly acceptable form of treatment (Dehlin et al., 2013).

As Smout et al. (2012) mentioned, some of the studies presented here are pilot studies for using ACT with anxiety disorders; however, each study found ACT treatment related to anxiety issues was associated with positive outcomes. All of the research with anxiety disorders suggests targeting individuals' experiential avoidance since it seems to be a prime mechanism (similar to the concept of exposure treatment) in ACT's treatment of anxiety.

Other mental health disorders. The empirical evidence shows that experiential avoidance is also a common problem in individuals with other mental disorders, and thus some researchers have set out to explore what benefits it might have for various mental health issues. Callaghan et al. (2012) investigated the use of behavioral principles with individuals that struggle with Body Dysmorphic Disorder (BDD), specifically the relationship between intrapersonal and interpersonal factors that might impact body image disturbance. The researchers approached intrapersonal variables through an experiential avoidance perspective, as defined by ACT, and interpersonal variables through a functional analytic psychotherapy perspective (Callaghan et al., 2012). The sample of 544 undergraduate students at a diverse university completed a questionnaire packet; 55 of these participants who listed weight as their main concern, but who were not overweight according to Body Mass Index, were interviewed to determine if concerns were perceived or imagined (Callaghan et al., 2012). Focusing on the results relevant to ACT, researchers found a correlation between experiential avoidance (as measured by the Acceptance and Action Questionnaire-II) and body image disturbance. Further, Callaghan et al. (2012) conducted a regression analysis to determine that higher body image disturbance predicted

higher level of experiential avoidance. This suggests that experiential avoidance, which is not a diagnostic criterion for BDD, might be a signifier of the illness and a treatment target beyond that.

Pearson, Follette, and Hayes (2012) had similar findings from their pilot study on a one-day ACT workshop for women who were dissatisfied with their bodies. Seventy-three overweight or obese females from a university in the Western United States participated and were randomly assigned to either the waitlist control condition or the ACT workshop (Pearson et al., 2012). Women in both groups self-monitored hunger, satiety, binging, and purging for one week; the waitlist group monitored themselves before participating in the workshop whereas the treatment group received the ACT workshop before self-monitoring (Pearson et al., 2012). The workshop was an eight-hour day divided into the following segments: creative hopelessness, control of the problem, mindfulness and acceptance, values clarification, barriers to values, and committed action (Pearson et al., 2012). Participants in the ACT workshop condition experienced a greater reduction in disordered eating attitudes and body-related anxiety. Like other studies, the authors suggested identifying values was an important component of ACT; the intervention allowed the women to let go of the struggle with weight and body image by focusing on other identified values in their lives (Pearson et al., 2012).

There is also promising support for using ACT with severe mental illness, such as schizophrenia spectrum disorders and personality disorders. For example, Morton, Snowdon, Gopold, and Guymer (2012) found that ACT might reduce number of impulsive acts among individuals with borderline personality disorder, a disorder characterized by self-destructive impulsive action. Morton et al. (2012) ran a pilot study of a brief outpatient group treatment in Australia; the group specifically targeted 21 individuals diagnosed with borderline personality

disorder (BPD) assigned to the ACT condition (while 20 participants with BPD were assigned to the TAU condition, which consisted of public mental health services).The ACT group, called Wise Choices, included all the standard components of ACT (Morton et al., 2012). Outcomes showed improvements beyond TAU for overall BPD symptoms, BPD-related thoughts and feelings, BPD negative behaviors, hopelessness, and anxiety symptoms. The addition of ACT to treatment also produced significant differences in psychological flexibility, emotional regulation, mindfulness, and fear of emotion, all considered process variables; not only were these processes found to be mediators for BPD symptoms, providing support for the improvements being associated with these, but the improvements also were largely maintained at the three-month follow-up assessment (Morton et al., 2012).

Clinically, some researchers understand that private events, such as distorted thinking, cravings, bodily states, contribute to substance use and relapse; ACT targets these private events through mindfulness, cognitive defusion, and experiential avoidance. With this in mind, Twohig, Shoenberger, and Hayes (2007) wanted to study the impact of a brief ACT intervention for adults with marijuana dependence. Three participants recruited through postings on a university campus and undergraduate psychology classes; they completed oral swab tests, self-monitored their marijuana intake, and received eight 90-minute sessions of ACT tailored for marijuana use (Twohig et al., 2007). The results provide limited evidence that ACT might be helpful in the treatment of marijuana dependence; Twohig et al. (2007) pointed out the ACT approach is unique and perhaps promising in that it does not attempt to control private events but instead helps the individual experience thoughts and cravings centered on marijuana without having to act on them.

Relatedly, Stotts, Masuda, and Wilson (2009) looked at a case study of a 57-year-old Hispanic American male's experience with a methadone reduction period combined with weekly individual sessions that used ACT. Like Twohig et al. (2007), these researchers found ACT's efforts to increase the patient's willingness to be open to negative private events to be an important component of the treatment. The participant received treatment at a university substance abuse research center where the ACT protocol was drawn from existing manuals and modified to reflect specific issues around methadone detoxification (Stotts et al., 2009). The participant in the case study was successful in the detox program, not using any substances during the entire program or at the one-month follow up as measured by a urine drug screen (Stotts et al., 2009). Stotts et al. (2009) explained the ACT model is designed to increase the client's willingness to be open about thoughts around the presenting problem (i.e., detox and drug use) and this reportedly made a difference in the participant's success.

Petersen and Zettle (2009) examined substance abuse treatment on a group level, working with inpatients in a chemical dependency unit also diagnosed with depression, examining their participation in either treatment as usual (TAU) or individual sessions of ACT. Twelve individuals were assigned to TAU and 12 were assigned to ACT (Petersen & Zettle, 2009). The researchers reported equivalent reductions in depression for each group but the ACT participants met discharge criteria sooner than those receiving TAU, an outcome Petersen and Zettle (2009) stated might maximize long-term gains since these individuals would spend less time in the hospital before returning home.

Luoma, Kohlenberg, Hayes, and Fletcher (2011) investigated another group-based intervention using ACT principles to work with individuals who struggle with substance abuse. Specifically, Luoma et al. (2011) targeted shame in a group of patients in a 28-day residential

addiction treatment facility. The study included 133 adults who received TAU (five or six therapy groups per day, six days a week) or three two-hour ACT group sessions during one week. These ACT sessions followed a manual and targeted overcoming shame, stigmatization, and judgement of self and others (Luoma et al., 2011). Using quantitative data analysis methods, Luoma et al. (2011) found ACT participants were more than 2 ¼ times more likely to not use substances during the treatment than TAU subjects; additionally, the ACT intervention led to continuous treatment gains in social measures such as general mental health, quality of life, and social support.

Finally, some of the research on ACT as treatment uses the method to address stress associated with physical, psychological, or social issues. For example, one group of researchers assessed the effectiveness of ACT group intervention for adults who stutter (Beilby, Byrnes, & Yaruss, 2012), specifically assessing if the program helped improve psychosocial functioning, readiness for therapy and change, the effectiveness of mindfulness skills and psychological flexibility, and the frequency of stuttering. Beilby et al. (2012) recruited 10 adult males and 10 adult females at a university based stuttering treatment clinic who participated in weekly two-hour group therapy sessions that addressed all six of ACT's core processes. Findings showed statistically significant improvements in the effects of stuttering on participants' lives, increase in readiness for change, improvement in mindfulness skills, and a reduction in frequency of stuttering; additionally, these results maintained at three-month follow-up assessment (Beilby et al., 2012). Bielby et al. (2012) noted the ACT-based treatment produced significant changes in each of the 20 participants, suggesting helping people who stutter focus on their values through the ACT framework might be able to aid a wide range of people who stutter.

While these studies found some of the ACT tenets to be helpful in treating these populations, Crosby, Dehlin, Mitchell, and Twohig (2012) found the overall goal of ACT, psychological flexibility, was helpful in treating trichotillomania. Crosby et al. (2012) replicated a study that combined ACT and habit reversal training (HRT) to treat trichotillomania (TTM), a psychological disorder that involves pulling hair to the point of noticeable loss, in order to better standardize the treatment approach for this disorder. The researchers followed five participants as they received both ACT and HRT over the course of eight weekly 60- to 90-minute sessions (Crosby et al., 2012). From before treatment to posttreatment, all five participants decreased in number of hairs pulled but only two individuals maintained these gains at the 12-week follow-up. Process measures demonstrated that improvements to psychological flexibility were correlated with reductions in hair pulling (Crosby et al., 2012).

Summary of Evidence

To date, there is a strong foundation of research establishing the effectiveness of ACT for clients dealing with a myriad of issues. However, many of the studies looking into ACT as treatment are pilot or preliminary studies, indicating the research base for the treatment modality with clients and patients is still growing. Still, ACT treatment is mostly associated with positive outcomes for the variety of psychological, social, and physical issues mentioned here. The precise mechanisms of ACT are still being explored, with some early evidence among the research presented here that mindfulness, acceptance, and cognitive defusion are important factors in therapeutic change (Callaghan et al., 2012; Eifert et al., 2009; Meuret et al., 2012; Pearson et al., 2012). Importantly for the current study, ACT appears to be highly effective when treating anxiety-related issues and clients with emotional avoidance concerns. And while the

exploration of this particular treatment modality with clients is still ongoing, an even more fledgling vein of research is the use of ACT within the realm of counselor education.

ACT in Counselor Education

Some researchers worked to establish ACT as a framework to guide the development of individuals training to be helping professionals, both in its ability to manage stress (Baer, 2003) and benefit therapist outcomes (Shapiro & Carlson, 2009). This work is based on earlier evidence that ACT is associated with better mental and physical health outcomes than control groups (Öst, 2014; Pearson et al., 2012; Stafford-Brown & Pakenham, 2012). Since mindfulness-based approaches enhanced positive therapist characteristics (Wilson, 2009), investigators hypothesized ACT – which incorporates mindfulness – has a similar effect. I describe below the available literature outlining the work done with ACT and those training to be in the helping profession.

Walser and Westrup (2006) detailed their experience in training therapists in how to use ACT with clients in a descriptive account; they explained that one of the key elements of practicing ACT competently is the ability to apply the approach's principles in one's own life. They added therapists must be willing to experience their difficult emotions and thus they use the supervisory process to (1) develop a sense of personal wholeness and relate that same sense to the client who is avoiding trauma; (2) focus on acceptance of emotions and thoughts, both their own and their clients'; and (3) assess the cost of avoidance as it relates to the individual's ability to live a life guided by personal values (Walser & Westrup, 2006). In their experience, supervisors must create an open and willingness-based atmosphere to work with ACT; Walser and Westrup (2006) suggest supervisors model this by sharing their positive and negative experiences in therapy. A particular challenge during ACT supervision is to address when a

supervisee is avoiding some experience, often anxiety; Walser and Westrup (2006) stated role playing has been a powerful tool to confront this issue. Lastly, the authors suggested including a discussion about values about therapy with supervisees; in this way, the supervisor is creating a parallel process of developing psychological flexibility in the supervisee just as they are working to create it within the client (Walser & Westrup, 2006).

This is similar to literature from Stafford-Brown and Pakenham (2012), who identified that ACT involved a parallel process component that encouraged the practitioner to use its principles for both skill enhancement and self-care. Stafford-Brown and Pakenham (2012) investigated the use of ACT with clinical psychology trainees (CPTs), who often experience elevated stress. Fifty-six interns from psychology training programs participated in a group comprising a sequence of ACT concepts, exercises, and interventions over the course of four weeks. Comparing a treatment and control group on changes from pretreatment to posttreatment, the results showed professional self-doubt decreased significantly while psychology self-efficacy increased significantly for the treatment group compared to the control group (Stafford-Brown & Pakenham, 2012). Participants who went through the ACT group also reported a stronger bond with their clients than the control group. Treatment group participants also noted greater improvements on ACT process measures, including acceptance and action, mindfulness, thought suppression, and valued living. Finally, the researchers found all treatment effects maintained at the 10-week follow up. Mediation analyses suggested the ACT processes had a role in changes on the outcome measures of psychological distress, self-compassion, and self-efficacy. In conclusion, it was mindfulness, acceptance, and action that emerged as the mechanisms through which the desired outcomes were achieved, which corresponds with the ACT triflex previously mentioned.

Pakenham and Stafford-Brown (2012) continued to explore this data, wanting to further investigate CPTs' perceptions of the ACT group experience and examine their level of satisfaction with the training. Forty-four of the same interns from the previous study completed a social validation questionnaire and questions about satisfaction with the graduate clinical training. Using a thematic analysis, Pakenham and Stafford-Brown (2012) reported the CPTs would recommend the intervention to other trainees, felt it should be offered annually, and believed it was useful personally and professionally. About 91% of the participants said they would use ACT personally; one participant said, "I can see how the ACT strategy of being mindful has helped in keeping me connected to the environment when things get really stressful" (p. 61). Pakenham and Stafford-Brown (2012) said this finding helps trainees in their clinical practice due to the ACT "practice what we preach" approach (p. 63). Between these two studies, the authors provided support for implementing ACT as a way to serve CITs in their goals of connecting with clients and reducing stress.

Other researchers also used ACT with populations of trainees in the helping profession. For example, Varra, Hayes, Roget, and Fisher (2008) examined whether ACT principles directed toward service providers would increase their willingness to incorporate the use of pharmacotherapy with their clients. The study followed 59 drug and alcohol counselors who were attending a continuing education conference, administering surveys to the participants at the beginning and the end of the conference and then again at three-month follow up. Half of the participants sat through a day-long ACT training while the other half experienced an educational control training. The group of counselors who learned about ACT demonstrated a large and long-lasting change in their willingness to offer evidence-based pharmacotherapy; the researchers posited ACT increased the participants' flexibility in actions while concurrently experiencing

difficult thoughts and feelings. Similar to Stafford-Brown and Pakenham (2012), Varra et al. (2008) demonstrated that trainees in the helping profession can benefit from ACT in similar ways as do clients.

Luoma and Vilardaga (2013) conducted a pilot study to examine the effects of ACT on psychological flexibility among therapists who were learning ACT. The authors used a randomized between-group design to compare the impact of an ACT workshop to the same workshop plus six sessions of phone consultation that focused on experiential and emotional elements aimed to increase participants' psychological flexibility. The 20 participants were attending a convention; 10 of them only attended the workshop while the remaining 10 received six 30-minute phone sessions during the course of three months that used brief meditation, visualizations, or metaphors to increase participants' psychological flexibility. Results showed the therapists who received the workshop experienced a reliable increase in ACT knowledge; further, phone consultation was a feasible addition to the workshop condition and helped improve therapist psychological flexibility over time. Luoma and Vilardaga (2013) cited the usefulness of ACT's experiential training elements in their study, but added that there has been little research beyond this into the effects of this practice-what–you-preach approach.

Summary. While limited research reflects the benefits of using ACT as a framework for counselor training, there is evidence reported in this section as to how the approach can benefit trainees in the helping profession. This vein of research also shows ACT training includes experiential elements that improve therapist psychological flexibility, a prerequisite for therapists to be able to effectively use ACT techniques so they can model and reinforce for their clients (Luoma & Viladarga, 2013). This inclusion of ACT constructs in counselor training (Pakenham & Stafford-Brown, 2012; p. 63) suggests ACT is already set up as a framework for aiding CITs

in professional development, and the research shows the main mechanism for doing this might be enhancing psychological flexibility.

In summary, the research outlined in this chapter describes the needs of CITs in their process of professional identity development. These include interventions that address, in both their personal and professional lives, the increased levels of anxiety they experience as they constantly face novel tasks in their clinical training. Additionally, CITs must aim to become self-aware through the exposure to their own and others' intense emotions, thus increasing their emotional intelligence. In general, mindfulness helps the practitioner learn to sit with emotions and thoughts – both positive and negative – and learn how not to avoid them and instead accept them nonjudgmentally. Some of the literature explored how mindfulness can help CITs manage stress, be less reactive, and heighten self-awareness. However, there is still the question of how to teach mindfulness to CITs. ACT provides a simple model of implementing mindfulness into everyday practice (as opposed to formalized meditation regimen) and perhaps, as this study purports to explore, provide a theory-driven guide for counselor educators. The premise for this study, supported by the literature presented here, was to investigate how using ACT language centered on present moment awareness, cognitive defusion, and emotional regulation can help CITs with professional development.

Chapter 3: Method

The purpose of this chapter is to describe the following: specific research questions, population, instrument, procedures, and data analysis used in this study. This study aimed to provide empirical support for mindfulness as a tool for counselor development, specifically exploring how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility. A quantitative method explored these elements of ACT, which this study posited could be helpful in advancing CIT training because evidence exists in the literature for these elements being crucial to professional identity development.

Research Questions

Three research questions guided this study in a clear and purposeful manner and present the researcher's main points of inquiry. The three research questions that steered this study are included below, as are the proposed hypotheses for each question:

1. What are the levels of awareness, defusion, acceptance, and psychological flexibility in CITs?
    a. Are there differences in these constructs between those who practice mindfulness and those who do not?
    b. Are there differences in ACT constructs on those who practice mindfulness on a weekly basis versus less frequently? For less than six months versus six months or more?

H_a: There is a statistically significant difference between those who practice mindfulness and those who do not on levels of cognitive fusion, emotional regulation, and psychological

flexibility. Those who practice mindfulness more often will rate themselves higher on ACT constructs.

2. What is the relationship between the constructs of awareness, defusion, and acceptance in CITs?

H_a: There are statistically significant, positive correlations between mindfulness, defusion, and emotional regulation

3. Do levels of awareness, defusion, and acceptance predict levels of psychological flexibility in CITs?
    a. Are there differences in predictive levels in these based on whether or not they practice mindfulness, frequency, and/or duration of mindfulness practice?

H_a: Since the variables are correlated, at least one of them will belong in the regression model and explain some of the variance of scores on psychological flexibility, thus providing evidence for ACT constructs at work with CITs. Practice of mindfulness and frequency of that practice will add predictive power to the model.

Participants

Participants for this study included students in CACREP-accredited master's degree programs in clinical mental health or school counseling. The participants were currently enrolled in or recent graduates of their respective programs. All participants must have been currently in or completed a practicum or internship course to ensure they were receiving exposure to the professional practice element delineated by CACREP (2016). CACREP states professional practice experiences provide CITs with the opportunity to apply theory and develop counseling skills under supervision as well as work with clients who represent diverse backgrounds.

A priori power analyses via G*Power (Faul, Erdfelder, Lang, & Buchner, 2007) were conducted to determine the appropriate number of participants for this quantitative study. For the bivariate correlations, power analysis conducted with alpha set at .01, power set at .80, and effect size at .30, indicated the need for a sample of 107 participants or more. Power analysis for the stepwise regression conducted with alpha set at .05, power set at .80, and effect size at .15, indicated the need for a sample of 92 participants or more. Therefore, the recruitment goal was set at a minimum of 110 participants for this study; the final count of participants was 138.

Participants were recruited through several different methods; first, an email (see Appendix A) was sent through CESNET-L, a professional counseling listserv, COUNSGRAD, a master's level counseling student listserv, and other specific listservs to which I determine CITs who practice mindfulness might belong (i.e., DiverseGrads, Association for Creativity in Counseling, neuroscience network). The survey was posted to the aforementioned listserv three to four times over the span of seven weeks. Also, I sent an email to my colleagues and alumni one time during this same time period. I posted the link to the Qualtrics survey on the ACA Connect "Call for Participants" discussion board twice. Additionally, I posted the link to the survey on Facebook and Twitter accounts that relate to relevant counseling associations, including Association for Creativity in Counseling, regional sections of the Association for Counselor Education and Supervision, and state-level counseling associations. The final recruitment effort included sending e-mails to directors and coordinators of master's programs in clinical mental health and school counseling, using a list of CACREP-accredited programs as a guide. These efforts resulted in more than 250 e-mails during the span of seven weeks.

Potential participants were offered the chance to enter a drawing for one of two gift cards worth $30 each. Participants did not need to complete the surveys to enter into the drawing. Any

person who opened the link could decline or accept the invitation to participate and could enter their e-mail address into their drawing, regardless of participation decision.

Procedure

This study was quantitative and data collection occurred electronically via Qualtrics, which allowed me to build an online survey using its HIPAA-compliant platform. An e-mail meant to solicit participants (see Appendix A) was sent through pre-determined listservs as well as to colleagues and alumni from my home institution. The survey was posted to the listserv four times over the span of four weeks and I e-mailed my colleagues and alumni twice during this same time period. Additionally, I posted the link to the survey on Facebook and Twitter accounts that relate to relevant counseling associations, including Association for Creativity in Counseling, regional sections of the Association for Counselor Education and Supervision, and state-level counseling associations. The final recruitment effort included sending e-mails to directors and coordinators of master's programs in clinical mental health and school counseling, using a list of CACREP-accredited programs as a guide. The recruitment e-mail included a link to the consent form (see Appendix A) which directed participants to select "Yes" or "No" to agree to complete the survey and give their permission to analyze and report on their data in aggregate form. The consent form did not require any identifying information from the participants.

After participants consented, they were directed to the survey (see Appendix B). If participants declined consent, the website redirected them to a different page that thanked them for their consideration and offered the opportunity to enter into the random drawing. Participants then completed the series of online measures in the following order: 1) Five-Facet Mindfulness Questionnaire (FFMQ), 2) Cognitive Fusion Questionnaire (CFQ), 3) Emotion Regulation Questionnaire (ERQ), 4) Acceptance and Action Questionnaire-II (AAQ-II), and 5)

Demographic Questionnaire. The survey included 87 items total and required about 15 to 20 minutes to complete. Survey data was stored in the secure, encrypted, password protected Qualtrics survey platform until all requisite data was collected. Then I downloaded the data in a .CSV Excel file and saved it as a password protected Excel database on my personal computer, which was also password protected.

After five weeks of data collection, most people who showed interest in participation could not complete the survey because they did not meet the original inclusion criteria, which stated participants had to be currently enrolled in their program's internship class. Thus, inclusion criteria were changed after five weeks of data collection to include master's students who were enrolled in practicum and graduates of counseling programs that had less than one year of professional experience.

Instrumentation

A total of four assessments were used to collect data for this study in addition to informed consent and demographics. They are detailed in this section; where necessary, authors granted permission to use all scales (Appendix D).

Five-Facet Mindfulness Questionnaire (FFMQ). The FFMQ is a 39-item self-report assessment developed by Baer, Smith, Hopkins, Krietemeyer, and Toney (2006). The instrument measures participant responses on a 5-point Likert scale: 1 equals "Never or very rarely true," 3 equals "Sometimes true," and 5 equals "Very often or always true" (Baer et al., 2006). There are five facets of mindfulness measured by the FFMQ: Acting with Awareness, Describe, Nonjudge, Nonreact, and Observe. Questions on the FFMQ include, "I'm good at finding words to describe my feelings," "I am easily distracted," and "I make judgments about whether my thoughts are good or bad." While many researchers use the five facets of the measure individually, Baer et al. (2006) stated the Total FFMQ can be divided by 39 to get an average score. In line with the

precedence set by Van Fam, Earleywine, and Danoff-Burg (2009) and Baer, Same, and Lykins (2011), this study will use the FFMQ as an overall measurement of participants' present moment awareness.

Baer et al. (2006) integrated items from various other mindfulness assessments, including the Mindful Attention Awareness Scale, Kentucky Inventory of Mindfulness, Freiburg Mindfulness Inventory, Cognitive and Affective Mindfulness Scale-Revised, and the Southampton Mindfulness Questionnaire, using a factor analytic approach. The literature hails the FFMQ as one of the most promising measures of mindfulness because of its inclusion of these mindfulness measures, which allowed Baer et al. (2006) to access all the factors that each measure tapped. These facets of mindfulness explored in the FFMQ line up with the subcategories mentioned above and include observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience (Baer et al., 2006).

Baer et al. (2008) found the alpha coefficients for all five facets measured by the FFMQ to range from .72 to .92 among regular meditators, nonmeditators, general community members, and students, which means the internal consistency ranges from adequate to good for a variety of populations. Christopher, Neuser, Michael, and Baitmangalkar (2012) reported Cronbach's alpha coefficients ranging from .86 to .93 for the five facets of mindfulness. Internal reliability was established by Baer et al. (2006) and again by Neuser (2010), both of whom found all the factors of the FFMQ to be positively correlated with each other among a sample of meditators and non-meditators. The FFMQ has shown convergent validity with psychological well-being (Baer et al., 2008) and life satisfaction (Christopher et al., 2012). The FFMQ showed divergent validity with depression (Christopher et al., 2012) as well as responsiveness to various forms of mindfulness

training (Goldberg et al., 2013). The coefficient alpha for the FFMQ in the current study was .91, indicating excellent evidence of reliability.

Cognitive Fusion Questionnaire (CFQ). The CFQ is a 13-item questionnaire designed to assess cognitive fusion, or the idea of people overidentifying with their thoughts (Dempster, 2009). The assessment is scored on a 7-point Likert scale where 1 means "never true," 4 means "sometimes true," and 7 means "always true." The CFQ includes items such as, "I tend to react very strongly to my thoughts," and "My thoughts cause me distress or emotional pain." Four of the items on the CFQ are reverse scored in an effort to reduce response bias (Dempster, 2009). Demptser (2009) stated high scores on the CFG denote higher levels of cognitive fusion and reported internal consistency of .88. Dempster (2009) initially proposed 44 questions to encompass cognitive fusion and allowed ACT clinicians and researchers to rate these items; through exploratory factor analyses, the number of items was reduced to 13.

Gillanders et al. (2014) also studied the psychometric properties and determined the CFQ had good test-retest reliability (r=.80, p<.001). Dempster (2009) found the CFQ correlated with the Southampton Mindfulness Questionnaire and advised the measure could be measured in relation to other measures of mindfulness due to the idea that there was a strong relationship between defusion and mindfulness. The CFQ also strongly correlated with a measure of life satisfaction due to cognitive fusion's posited role in development of mental health problems, specifically depression and anxiety (Dempster, 2009). Additionally, Gillanders et al. (2014) investigated the construct validity of the CFQ and determined the assessment correlated highly in predicted directions with psychological flexibility, mindfulness, rumination, distress, burnout, and frequency of automatic thoughts. The coefficient alpha for the CFQ in the current study was .88, indicating good evidence of reliability.

Emotion Regulation Questionnaire (ERQ). The ERQ is a 10-item scale designed to measure respondents' tendency to regulate their emotions in two different ways; the first, Cognitive Reappraisal, and the second is Expressive Suppression (Gross & John, 2003). The reappraisal strategy is considered positive while the suppression strategy is said to be harmful (Gross & John, 2003). The items are rated on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Six items make up the Cognitive Reappraisal facet and four items make up the Expressive Suppression facet. Some of the questions include, "When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm," and "I keep my emotions to myself." Each individual receives two scores, one from each subscale; higher scores indicate greater use of that respective emotion regulation technique.

Since its development, Ioannidis and Siegling (2015) cited its wide use and good psychometric history. Specifically, the ERQ has demonstrated adequate to good internal consistency and temporal stability (Gross & John, 2003; Sala et al., 2012; Batistoni et al., 2013), as well as sound convergent and discriminant validity (Gross & John, 2003; Balzarotti et al., 2010; Cabello, Salguero, Fernandez-Berrocal, & Gross, 2012).

Enebrink, Bjornsdotter, and Ghaderi (2013) sampled 1,433 Swedish parents of children aged 10-13 years; the internal consistencies of the two subscales were found to be adequate, with Cronbach's alphas being .81 for cognitive appraisal and .73 for expressive suppression. Enebrink et al. (2013) reported the ERQ correlated positively with marital adjustment and negatively with harsh discipline. Ioannidis and Siegling (2015) also investigated validity of the ERQ among a university student sample; the authors established criterion validity for cognitive reappraisal, reporting it accurately predicted high positive and low negative affect in addition to negative worry, while emotion suppression accurately predicted negative association with positive affect

and was positively related to social anxiety. The coefficient alpha for the ERQ in the current study was .63, indicating fair evidence of reliability.

Acceptance and Action Questionnaire (AAQ-II). This assessment, developed by Bond and Bunce (2003), purports to measure a person's experiential avoidance and psychological flexibility. Building on cognitive theory, new approaches such as ACT posit mental health is influenced by how people relate to their thoughts and feelings rather than the form (e.g., whether they are negative or positive). The items on the AAQ-II are rated on a 7-point Likert scale from 1 (never true) to 7 (always true). When used to measure psychological flexibility, high scores on the measure mean the individual engages in less experiential avoidance and immobility and higher scores indicates greater acceptance and action.

Bond et al. (2011) published the psychometric properties of the AAQ-II; the mean alpha coefficient is .85; the rest-retest reliability for 12-months is .79. The researchers stated they ran the assessment with several diverse samples and it showed no significant bias toward age, gender, or race (Bond et al., 2011). Fledderus, Bohlmeiher, Pieterse, and Schreurs (2012) investigated the psychometric properties of the AAQ-II with a sample of adults with mild to moderate anxiety and depression (N = 376). Their analyses suggested the measure is reliable for measuring experiential avoidance in individuals that fall within their population. The coefficient alpha for the AAQ-II in the current study was .87, indicating good evidence of reliability.

Demographics Questionnaire. Participants includes questions about demographic data for descriptive purposes (see Appendix E). They were asked to report age, gender, field of study, race/ethnicity, geographic location, level of exposure to mindfulness, whether or not they practiced mindfulness, and if so, in what way, how long, and how often they engaged in this practice.

Data Analysis

Research Question 1: What are the levels of awareness, defusion, acceptance, and psychological flexibility in CITs? (a) Are there differences in these constructs between those who practice mindfulness and those who do not? (b) Are there differences in ACT constructs on those who have been practicing mindfulness on a weekly basis versus less frequently?

To answer this question, I completed descriptive statistics on the demographic data and study variables, including frequency statistics and measures of central tendency. To answer questions 1a, I conducted a t-test in order to determine differences among individuals who endorsed practicing mindfulness and those who did not; this analysis looked at differences between these two groups on measures of present moment awareness, cognitive defusion, acceptance, and psychological flexibility. I also ran a t-test to look at question 1b, which was interested to see if the duration and frequency of mindfulness practice makes a difference in how participants report use of ACT constructs. Additionally, differences by program type (clinical mental health versus school) were also examined via t-test.

Research Question 2. What is the relationship between the constructs of awareness, defusion, and acceptance in CITs?

Correlational analyses examined the relationships between the constructs of awareness, defusion, and acceptance. Both the nature and strength of the relationship were determined.

Research Question 3. Do levels of awareness, defusion, and acceptance predict levels of psychological flexibility in CITs? (a) Are there differences in predictive levels in these based on whether or not they practice mindfulness and/or frequency of mindfulness practice?

To answer this question, I conducted a standard multiple regression to evaluate what outcome variables predicted greater psychological flexibility. Initially, I specifically tested whether or not scores on measures of mindfulness, cognitive defusion, and emotional regulation

contribute to the model that predicts psychological flexibility. Then, I added a step to create a hierarchical regression model to determine whether how long (less than six months or greater than six months) or how often the participants practice mindfulness (i.e., on a weekly basis, less frequent than once a week) was predictive of psychological flexibility. The predictor variables in this question were present moment awareness, cognitive defusion, acceptance, whether mindfulness is practiced, and frequency of mindfulness practice.

Chapter 4: Results

I conducted this study to explore empirical support for mindfulness as a tool for counselor development, engaging in a theory-driven guide to implementing mindfulness into counselor training. Specifically, this quantitative study assessed how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility, which has been associated with lower levels of anxiety and increased emotional acceptance. This study used mean comparison, correlational analysis, and multiple regressions. The results are described in the following paragraphs and tables.

Participants

A priori power analyses via G*Power (Faul et al., 2007) were conducted to determine the appropriate number of participants for this quantitative study. For the bivariate correlations, power analysis conducted with alpha set at .01, power set at .80, and effect size at .30, indicated the need for a sample of 107 participants or more. Power analysis for the multiple regression conducted with alpha set at .05, power set at .80, and effect size at .15, indicated the need for a sample of 92 participants or more.

Data was collected during a seven-week period; during that time, 251 people visited the Qualtrics survey through the link provided. Initially, only students in a CACREP-accredited master's program in clinical mental health or school counseling who were enrolled in their internship class could participate. After five weeks of data collection, a total of 110 individuals had visited the Qualtrics survey but only about 40 people were eligible to participate due to enrollment restrictions.

As previously mentioned, after five weeks, the inclusion criteria was expanded to include students in practicum class or recent graduates who had less than one year of professional, post-

master's experience. After two more weeks of data collection with the new inclusion criteria, a total of 251 individuals visited the survey over the course of seven weeks. Of these, a total of six people declined participation after reading the informed consent. Forty-one participants agreed to participate but did not complete the entire survey. Of the remaining participants, 63 of them either completed the survey before inclusion criteria was expanded or were not currently or previously enrolled in a CACREP-accredited master's in counseling program. This left 138 participants who completed the survey and provided responses that were eligible for inclusion in analysis. Response rate cannot be determined because the sampling method relied on referrals from initial contact people and listservs.

Ages of the 138 participants ranged from 21 to 59 years old. Of the participants, 85% (n=117) identified as female, 13% (n=18) as male, and about 2% identified as transgender (n=3). Three participants chose not to identify their gender. The predominant race/ethnicity of participants was Caucasian/European American at 75% (n=104), followed by Hispanic/Latin American at 7% (n=10), African American at 6.5% (n=9), Multiracial/multiethnic at 4% (n=6), and the remaining 8% (n= 10) dispersed across North African-Middle Eastern, Hispanic/Latin American and Asian/Asian American (n=9). Most participants were from the Southern region of the United States (44%, n=60), while 24% of the participants came from North Central (n=33), 17% came from the North Atlantic (n=24), and 10% came from the Western region of the country (n=14). About 2.5% of participants hailed from the Rocky Mountain region (n=4) and the remaining 2.5% of participants identified living elsewhere (n=3).

All participants included in analysis were enrolled in CACREP accredited programs either at the time of completing the survey or previously. About 80% of participants (n=111) were currently enrolled in a CACREP-accredited master's program; of these, 68 individuals were

currently Clinical Mental Health students (50%), 26 participants were in a school counseling program (19%), and 17 respondents were in programs with different titles (12%). Of the 111 currently in their programs, a total of 90 respondents were currently enrolled in their respective master's program internship course while 15 participants were enrolled in the practicum course. The remaining six respondents were enrolled in master's programs and working in the field (but for less than one year).

About 20 % of all participants were not currently enrolled in a CACREP-accredited master's program (n=27) and all of these individuals identified being previously enrolled in a CACREP program. About 12% of all respondents were currently working as a counselor (n=16) and 7% of them were not currently working as a counselor (n=11).

Descriptive Results

Descriptive results are presented in the following section. Descriptive analysis was assessed on the total scores from assessments that measured mindfulness, cognitive fusion, emotional regulation, and psychological flexibility. Furthermore, differences were examined along the lines of field of study, region of the country, whether or not person had established mindfulness practice, and frequency/duration of that practice. Differences in other categories were not examined because there were not enough participants in each category.

Mindfulness

Of the 138 participants, 75% (n=103) endorsed practicing mindfulness and 25% said they did not practice any form of mindfulness (n=35). Most people endorsed using more than one type of mindfulness (68%, n=71) while 31% (n=32) of those who practice mindfulness use only one type of meditation. Table 4.1 outlines the specific methods of the 103 participants who reported practicing mindfulness. Individuals who identified meditation as one way they practiced

mindfulness (n=56) were asked to provide a description. These included: Bible study and prayer, deep breathing, loving kindness meditation, Vajrayana (life) meditation, sitting practice, Zen practice, and guided meditation.

Table 4.2 describes the frequency and duration of the mindfulness practice of the 89 people who reported having a routine practice. Additionally, only 16 participants (12%) from the whole sample reported their program of study offered a workshop or class in mindfulness, suggesting that the other participants who practiced mindfulness learned about these methods outside of their counseling programs.

Mindfulness (FFMQ)

The FFMQ composite score assessed the overall attribute of mindfulness (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). The score range for this scale is 7-195, where higher scores indicate higher levels of overall mindfulness. Participant scores for this study ranged from 83 to 172, with the mean score on this scale being 136.43 (SD = 16.47), suggesting that participants demonstrated a slightly above average level of mindfulness. The FFMQ is typically divided into five different subscales; see Table 4.3 for average scores on each one. For all other aspects of the analyses, the composite score on the FFMQ was used. To provide more context about mindfulness in this study, the subscales are presented as well as any significant differences between mindfulness practitioners and non-practitioners. As seen in Table 4.3, there was a significant difference between practitioners and non-practitioners on the subscales of Observe, Describe, and Act with Awareness facets of mindfulness, but not the Nonjudgment and Nonreaction subscales.

There was a significant statistical difference between those who reported having a mindfulness practice and those who did not, $t(133) = -10.03$, $p=.002$. The mean score on the

FFMQ for those who practiced mindfulness was 139.00 (SD = 15.65) while the mean for those who did not practice mindfulness was 128.97 (16.75). Additionally, there was a statistically significant differences among mental health and school counseling students on the overall score on the FFMQ, t (87) = 8.78, p=.039, with Clinical Mental Health students (M = 138.67, SD = 17.21) demonstrating higher levels of mindfulness than School Counseling students (M = 129.88, SD = 17.92). Ultimately, scores were indicative of participants overall reporting higher than average overall mindfulness with Clinical Mental Health counselors scoring higher than School counselors.

Cognitive Fusion (CFQ)

The CFQ assessed participants' tendency to overidentify with their thoughts (Dempster, 2009). The score range for this scale is 13-91, where higher scores indicate more cognitive fusion. Scores ranged from 21 to 72, with the mean score on this scale being 41.59 (SD = 10.25), suggesting that participants demonstrated a slight tendency toward overidentifying with thoughts.

There was no significant statistical difference between those who reported having a mindfulness practice (M = 41.11, SD = 9.92) and those who do not (M = 43.08, SD = 11.25) on the CFQ, t (132) = 1.95, p=.344. Additionally, there was not a statistically significant difference among mental health and school counseling students on the overall score on the CFQ, t (89) = -2.40, p=.305, with Clinical Mental Health students (M = 41.14, SD = 10.21) scoring only slightly lower than School Counseling students (M = 43.54, SD = 9.57). Ultimately, scores were indicative of participants overall reporting higher than average scores on the measure of fusion with thoughts. However, there were no significant differences between any groups identified.

Emotion Regulation (ERQ)

The ERQ assesses participants' emotion regulation through two subscales: emotion reappraisal and emotion suppression. Reappraisal means a person is able to reframe an emotional response while suppression involves inhibiting one's response to events that elicit emotions (Dubert et al., 2016). When analyzing scores on the ERQ, mean scores ranged from 1 to 7 on both subscales, and a higher mean scores indicate greater use of that specific emotion regulation tactic. The mean score on the reappraisal scale was 5.13 (SD = 1.12) and the mean score on the suppression scale was 2.88 (SD = 1.29), meaning that the sample in general was more likely to use the reappraisal technique when regulating emotions than suppression of emotions.

On the reappraisal subscale, there was no significant statistical difference between those who reported having a mindfulness practice (M = 5.20, SD = 1.11) and those who do not (M = 4.92, SD = 1.16), t (57) = -.29, p=.207 (equal variances not assumed since Levene's test of equality was statistically significant). Additionally, there was no difference on the suppression scale between mindfulness practitioners (M = 2.84, SD = 1.26) and non-practitioners (M = 3.00, SD = 1.37), t (135) = .17, p=.500.

There was not a statistically significant difference among mental health and school counselors on the reappraisal subscale, t (91) = .01, p=.962, with Clinical Mental Health students (M = 5.11, SD = 1.22) scoring nearly identical to School Counseling students (M = 5.10, SD – 1.14). Additionally, there was no difference between CMH students (M = 2.83, SD = 1.29) and School Counseling students (M = 3.31, SD = 1.40), t(91)= -.48, p=.120, on the suppression scale. Ultimately, scores were indicative of participants overall using the reappraisal technique when regulating emotions rather than emotion suppression. However, there were no significant differences between any groups identified.

Psychological Flexibility (AAQII)

The AAQ-II assessed participants' psychological flexibility (Bond & Bunce, 2003). The score range for this scale is 7-70, where higher scores indicate higher levels of psychological flexibility. Scores ranged from 28 to 70, with the mean score on this scale being 53.69 (SD = 9.16), suggesting that participants demonstrated slightly above average levels of psychological flexibility.

There was no significant statistical difference between those who reported having a mindfulness practice (M = 53.45, SD = 8.53) and those who do not (M = 54.40, SD = 10.91) on the AAQ-II, t (135) = .95, p=.599. Additionally, there was not a statistically significant difference among mental health and school counselors on the overall score of the AAQ-II, t (91) = .82, p=.703, with Clinical Mental Health students (M = 53.48, SD = 9.00) scoring lower than School Counseling students (M = 52.56, SD = 9.72). Ultimately, scores were indicative of participants reporting higher than average scores on the measure of psychological flexibility. However, there were no significant differences between any groups identified.

Research Question 1

What are the levels of awareness, defusion, acceptance, and psychological flexibility in CITs? (a) Are there differences in these constructs between those who practice mindfulness and those who do not? (b) Are there differences in ACT constructs on those who have been practicing mindfulness for a longer period of time and on a weekly basis versus less frequently?

H_a: There is a statistically significant difference between those who practice mindfulness and those who do not on levels of cognitive fusion, emotional regulation, and psychological flexibility. Those who practice mindfulness more often will rate themselves higher on ACT constructs.

For the most part, the hypothesis for this research question – that there would be a difference on all the constructs in the study between mindfulness practitioners and non-practitioners – was unfounded. The only significant difference, as shown in Table 4.4, was between the participants who practiced mindfulness and those who did not on the FFMQ, which again measures overall level of mindfulness. However, as Table 4.4 shows, there were no other statistically significant differences on scores on the CFQ, the two ERQ subscales, and AAQ-II between these two groups.

Additionally, the second hypothesis that individuals who practice mindfulness more often would rate higher on ACT constructs was also, for the most part, false. Again, only on the FFMQ was there a significant difference, $t(93.15) = -9.02$, $p=.003$ (equal variance not assumed), with those practicing more than one time per week scoring significantly higher ($M = 142.47$, $SD = 16.91$) than those who practice less frequently ($M = 133.46$, $SD = 11.62$). There was also a significant difference between those who had been practicing for six months or less ($M = 132.88$, $SD = 17.12$) and those who had been practicing longer ($M = 141.15$, $SD = 14.63$), $t(94) = -8.27$, $p=.022$, with participants who had been practicing longer scoring significantly higher on the FFMQ.

As demonstrated in Table 4.5, there were no statistically significant differences on the measures of the other the main constructs when it came to duration (six months or more versus less than six months or frequency of practice (once per week versus less often). In order to determine if there were significant main or interaction effects, an Analysis of Variance was performed on a 2 x 2 univariate design, with frequency of mindfulness practice (at least once per week, less than one time per week) and duration of mindfulness practice (zero to six months,

more than six months). The analysis revealed no statistically significant differences and thus no interaction effect of frequency and duration.

Research Question 2

What is the relationship between the constructs of awareness, defusion, and acceptance in CITs?

H_a: There are statistically significant correlations in the expected directions between mindfulness, defusion, and emotional regulation

All of the relationships between the five constructs investigated in this study are detailed in Table 4.6. The hypothesis for this research question was confirmed, as there were statistically significant relationships between all five constructs. In addition, all relationships between constructs were confirmed in the intended direction, with positive constructs positively correlated with positive constructs and negative constructs negatively correlated with positive constructs. In Table 4.6, all correlations shown are in the expected direction.

Psychological Flexibility. Since psychological flexibility is the end goal of ACT, this section explores the relationships between the AAQ-II as a measure of this construct and the other constructs (i.e., mindfulness, cognitive fusion, emotional reappraisal, and emotion suppression). For these participants (n=128), the relationships between a measure of overall mindfulness (FFMQ composite score) and psychological flexibility among participants (AAQII) were assessed using Pearson Correlation coefficients. There was a strong, positive relationship between the FFMQ (M =136.43, SD=16.47) and AAQII (M = 53.69, SD = 9.16), $r(128)$=+.54, $p<.001$, indicating higher levels of mindfulness were associated with higher levels of psychological flexibility. Mindfulness accounted for a moderate proportion of the variance (r^2 = .29).

For the participants (n=133), the relationships between cognitive fusion (CFQ) and psychological flexibility among participants (AAQII) was assessed using Pearson Correlation coefficients. There was a very strong, negative relationship between the CFQ (*M* =41.59, *SD*=10.25) and AAQII (*M* = 53.69, *SD* = 9.16), *r*(133)=-.75, p<.001, indicating higher levels of cognitive fusion were associated with lower levels of psychological flexibility. Cognitive fusion accounted for a large proportion of the variance (r^2 = .56) in psychological flexibility.

In this study (n=136), the relationship between a measure of emotional regulation through suppression (ERQ-suppression) and psychological flexibility among participants (AAQII) was assessed using Pearson Correlation coefficients. There was a significant negative relationship between the ERQ-suppression (*M* =2.88, *SD*=1.29) and AAQII (*M* = 53.69, *SD* = 9.16), *r*(133)=-.37, p<.001, indicating higher levels of suppressing emotions were associated with lower levels of psychological flexibility. Suppression of emotions accounted for a small proportion of the variance (r^2 = .14).

The relationships between a measure of emotional regulation through reappraisal (ERQ-reappraisal) and psychological flexibility among participants (AAQII) were assessed using Pearson Correlation coefficients. There was a significant positive relationship between the ERQ-reappraisal (*M* =5.13, *SD*=1.12) and AAQII (*M* = 53.69, *SD* = 9.16), *r*(136)=+.44, p<.001, indicating higher levels of reappraisal of emotions were associated with higher levels of psychological flexibility. Reappraisal accounted for a small proportion of the variance (r^2 = .20).

In the same sample, the relationships between the CFQ and both facets of the ERQ were assessed using a partial correlation controlling for participants' mindfulness score on the FFMQ (*M* =136.43, *SD*=16.47). This analysis was completed in order to demonstrate relation to psychological flexibility (AAQ) beyond the one that mindfulness provides, signifying that

cognitive fusion and emotion regulation are separate yet significant constructs to psychological flexibility. There was a significant relationship between psychological flexibility as measured by the AAQ-II and cognitive fusion (*M* =41.59, *SD*=10.25), *r*(123)=-.59, p<.001, ERQ-suppression (*M* =2.88, *SD*=1.29), *r*(123)=-.19, p=.04, and ERQ-reappraisal (*M* =5.13, *SD*=1.12), *r*(123)=+..28, p=.002. When controlled for mindfulness, cognitive fusion accounted for a small proportion of the variance while emotion suppression accounted for a moderate proportion of the variance (r^2 = .35) and emotional reappraisal accounts for a small proportion (r^2 = .20) of the variance in psychological flexibility.

Research Question 3

Do levels of awareness, defusion, and acceptance predict levels of psychological flexibility in CITs? (a) Are there differences in predictive levels in these based on whether or not they practice mindfulness and/or frequency of mindfulness practice?

H_a: Since the variables are correlated, at least one of them will belong in the regression model and explain some of the variance of scores on psychological flexibility, thus providing evidence for ACT constructs at work with CITs. Practice of mindfulness and frequency of that practice will add predictive power to the model.

The four constructs, mindfulness, cognitive fusion, emotion suppression, and emotion reappraisal, were used to predict the participants' scores on psychological flexibility. The four constructs were entered together in a standard multiple regression. The overall model was significant F(4, 121) = 14.83, p<.001, R = .76, thus confirming the hypothesis that scores on the measures of ACT constructs would predict scores if psychological flexibility. The model accounted for 59% of the variance, which is a large effect size, but the typical error in predicting

psychological flexibility was relatively high (+/- 12.04) for the 95% confidence level on a 70-point scale.

An examination of the contributions of the constructs to the predictions indicated the following were statistically significant (see Table 4.6): cognitive fusion (b = -.605, sr =.072), t(121) = -7.68, p<.001; emotion suppression (b = -.138, sr =.443), t(121) = -2.18, p<.05; and emotion reappraisal (b = .139, sr =.575), t(121) = 1.99, p<.05. However, mindfulness as measured by the FFMQ did not contribute significantly to the model (b = .041, sr =.047), t(121) = .50, p=.62. These results are laid out in Table 4.7.

Notably, scores on the FFMQ were the only non-significant predictor for scores on the AAQ-II in the previously mentioned multiple regression. A simple linear regression was used to determine whether FFMQ composite scores could predict psychological flexibility. The correlation between the two variables was moderate, r(128) = .54, r2 = .29, and the regression coefficient for FFMQ (b = .299) was significant, t(126) = 7.23, p<.001. The regression constant was 12.63, and the SEE was 7.68. One can predict with 95 percent confidence any individual's psychological flexibility score as measured by the AAQ-II based on FFMQ composite score within +/-15.36 points (on a scale of 7-195). Thus, psychological flexibility can be reliably predicted from scores on the FFMQ, but the degree of accuracy, as indicated by the SEE, suggests a low level of precision.

For this sample, according to analysis, a person's self-report on all four of the ACT constructs accounted for 59%, or a large amount of the variance in psychological flexibility. Here, cognitive fusion, emotion reappraisal, and emotion suppression could be the most informative when predicting psychological flexibility. Referring back to the correlations explained in RQ2, there was a strong relationship, r = -.75, between psychological flexibility and

cognitive fusion, meaning as a person's self-rating of cognitive fusion decreases, their psychological flexibility increases. Additionally, in this sample, r = -.37 for emotional suppression, suggesting that individuals who are likely to suppress their emotions are also likely to have lower scores on psychological flexibility. Lastly, r = +.44 for emotion reappraisal, implying that as participants are more able to reframe their emotions, their scores on psychological flexibility increase. All of these results are consistent with the theoretical premise of ACT.

As a final step, a hierarchical approach was used to determine if, in addition to the ACT constructs, the frequency and duration of mindfulness practice would increase the ability to predict psychological flexibility. There was no statistically significant result when the frequency and duration were added to the regression model, signifying that neither of these variables help predict psychological flexibility among CITs.

Summary

The results of the analysis conclude that mindfulness, cognitive fusion, and emotion regulation do relate significantly to psychological flexibility of CITs. Levels of cognitive fusion and emotion regulation contributed to a model that enables us to predict greater levels of flexibility in this population. While mindfulness did not contribute significantly to the predictive model, it did have predictive value in determining psychological flexibility on its own. Results suggested that frequency and duration of mindfulness had no predictive value on levels of psychological flexibility. Chapter 5 will provide more detail and discussion about the implications of these results.

Chapter 5: Discussion

A primary purpose of this study was to ascertain if ACT would work to describe CITs in order to possibly provide a language for addressing levels of psychological flexibility in CITs since we understand that psychological flexibility is related to coping with anxiety and developing emotional awareness. The ACT constructs explored here, which focus on opening up the individual– being present, defusion, and emotional acceptance – are posited to be helpful in progressing CIT development. This study also was conducted under the assumption that mindfulness is a positive intervention in treatment and counselor education. Baer (2003), Goldberg et al. (2013), and Ryan et al. (2012) are just some of the researchers that establish the positive outcomes associated with either an established practice or high score on a mindfulness scale. Thus, this study worked to go one step further and establish ACT – as a therapy modality that uses mindfulness and acceptance as its main mechanisms – as a useful tool for both counseling and training of helping professionals (Dalrymple & Herbert, 2007; Dehlin et al., 2013; Eifert et al., 2009; Ost, 2014).

With this in mind, this study explored whether there was empirical support for psychological flexibility as a benchmark for counselor development, engaging in a theory-driven guide to implementing mindfulness into counselor training. Specifically, this quantitative study assessed how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility, which has been associated with positive outcomes in things that might help the professional development of counselors, including lower levels of anxiety and increased self-awareness through greater emotional regulation. The discussion that follows will start looking more in depth in the practical significance of the study

results, discuss what they mean in the context of professional development of CITs, and then explore implications and future directions.

Major Findings

The results of this study showed there were slight differences between mindfulness practitioners and non-practitioners on overall level of mindfulness, but not on cognitive fusion, emotion regulation, and psychological flexibility. While there was no differences between self-reported practitioners and non-practitioners of mindfulness, all of the constructs in this study were significantly related in the predicted directions. Ultimately, the combined model of scores on mindfulness, cognitive fusion, and emotion regulation measures was a strong predictor of levels of psychological flexibility. These findings suggest ACT principles are at play within the context of counselor education; a more detailed discussion of these results can be found below.

Mindfulness

Kabat-Zinn (2013) defined mindfulness as the practice of paying attention on purpose and nonjudgmentally to the present moment. Previous studies found mindfulness associated with a multitude of positive outcomes, including stress, pain, illness, brain functioning, and emotional processing (Kabat-Zinn, 2003). In CITs, mindfulness has led to stress response management, better lifestyle choices, and greater well-being for themselves (Rocco et al., 2012). Additionally, CITs who practiced mindfulness historically report better handling of difficult moments and avoiding automatic reactions to clinical situations (Vega et al., 2014). This study tried to establish whether or not mindfulness practice made a difference in CITs' level of cognitive fusion, emotion regulation, and, ultimately, psychological flexibility.

There was no intervention provided; instead, I surveyed CITs who either did or did not have an established mindfulness practice. Most participants in this study reported having a

mindfulness practice and, indeed, the mean score on the FFMQ for all participants was moderately high. It is likely that individuals who are drawn to counseling as a profession might also value the benefits that a practice of mindfulness might provide. Baer, Samuel, and Lykins (2011) admitted, while recruiting regular meditators for a number of studies using the FFMQ, most of their samples had higher than average levels of education and were commonly in the mental health profession. Indeed, Felton et al. (2015) found CITs who practiced mindfulness reported better self-care and reduced anxiety. Rothaupt and Morgan (2007) provided further insight into why so many CITs (75% of them in this sample) might be drawn to mindfulness: greater body awareness, increased patience, and positive outcomes such as gratitude, feelings of connectedness, and intentionality. Additionally, the recruitment e-mail used for this study, while emphasizing participants did not need to be practitioners, did mention mindfulness by name and thus might have attracted individuals who were interested in the construct.

While most participants reported practicing mindfulness, it was still possible to establish that individuals who reported a mindfulness practice tended to behave in more mindful ways, as defined by the FFMQ, thereby connecting the practice of mindfulness with mindful behaviors in daily life. These findings are consistent with those of Van Dam, Earleywine, and Danoff-Burg (2009) and de Bruin et al. (2012), who reported that experienced meditators received significantly higher composite scores on the FFMQ than non-meditators, citing greater familiarity with mindfulness might increase its value to the individual and thus its practice. Specifically in this study, practitioners had significant differences on Observing, Describing, and Acting with Awareness subscales. This differs from de Bruin et al. (2012), who found a significant difference between meditators and non-meditators on all the scales; however, it is important to note the sample size in this study was much larger.

Although the differences between those who did and did not practice mindfulness were slight, and all participants demonstrated slightly above average mindful behaviors, this study reinforced the idea that practice of mindfulness does tend to increase the mindful behavior of CITs. Felton et al. (2013) and Schure et al. (2008) both provided a course in MBSR for CITs; Schure et al. (2008) found students had positive outcomes in physical, emotional, mental, spiritual, and interpersonal domains of their lives. Notably, Schure et al. (2008) reported students demonstrated an increased ability and capacity to deal with negative emotions. This current study does show that mindfulness is related to emotion regulation, with increased mindfulness enabling CITs to engage in positive emotion regulation (reappraisal) and decreased levels of maladaptive regulation (emotion suppression). This study did not address the impact of mindfulness on anxiety, but various studies found mindfulness leads to lower anxiety (Speca et al., 2000; Teasdale et al., 2000) and, specifically, Schure et al. (2008) observed this result among CITs. It is important to note that only 12%of the participants in this study reported their counselor education program formally incorporated mindfulness. Thus, unlike Felton et al. (2013) and Schure et al. (2008), most of our participants' mindfulness practices were self-initiated and maintained.

Other ACT Constructs

While there was a significant difference between mindfulness practitioners and non-practitioners on a measure of overall mindfulness, there was no difference between the two groups on other major ACT constructs, such as cognitive fusion, emotion regulation, and psychological flexibility. Again, all of the participants in the study demonstrated slightly above average levels of mindful behavior, even though there were slight differences based on

mindfulness practices. The possible reasons for and meanings of that are discussed in the following sections.

Cognitive Fusion. Overall, CITs reported a slight tendency to overidentify with their own thoughts. While there are no previous studies that explored fusion among CITs, the students in this study possibly reported more cognitive fusion because they were being exposed to a lot of new information, skills, and experiences. We know that CITs constantly face the reality of being evaluated, the high stakes of working with distressed individuals, and the ambiguity inherent in the act of counseling (McAuliffe & Eriksen, 2011). Cognitive fusion has been known to fuel anxiety (Herzberg et al. 2012), which might explain why CITs, who are known to experience higher levels of anxiety, reported higher levels of fusion in this study.

Levels of cognitive fusion among non-clinical samples vary in the literature; Gillanders et al. (2014) reported a sample of attendees at a training for a psychological intervention scored lower on this measure, indicating less cognitive fusion. However, Batink and de Mey (2011) found a student sample and general population sample – both non-clinical – scored above average on the CFQ, meaning they overidentified with their thoughts. Gillanders et al. (2014) found higher levels of cognitive fusion was correlated to clinical depression and ruminative response style. Nolen-Hoeksema and Jackson (2001) explained this to be a passive focus on distress and possible causes and effects that result from it.

There was a significant negative relationship between scores on the FFMQ and the CFQ, meaning as people report higher levels of mindfulness, they also report lower levels of cognitive fusion. This finding echoes the ACT model and Gillanders et al. (2014), who found mindfulness and cognitive fusion to be negatively correlated. However, there was no significant difference between levels of cognitive fusion between self-reported mindfulness practitioners and non-

practitioners. This might be due to the fact that the two groups were delineated by self-report on a dichotomous variable (Do you practice mindfulness? Yes or No?). Also, the levels of mindful behavior, although statistically different, were not that varied between the two groups, so they tended to be more similar than different in general. The FFMQ, however, is an assessment with stable reliability and validity in measuring overall mindfulness as well as different aspects of the construct. This study did not examine cognitive fusion (or any other constructs) as it relates to mindfulness based on scores on the FFMQ, which might have given us more nuanced information about mindfulness and its relationship to fusion.

Gillanders et al. (2014) pointed out there might be an overlap between the constructs of mindfulness and cognitive fusion, since ACT states that present-moment awareness is used as a part of the process of defusing from cognitions. This might account for the significant relationship between the FFMQ and CFQ. Relatedly, as Gillanders et al. (2014) noted, ACT maintains that additional processes other than mindfulness need to occur as part of the overall model, and this could begin to explain why there was not a significant difference in levels of cognitive fusion depending on whether a person reported practicing mindfulness or not. Indeed, Scott, Daly, and Yu (2017) found even after an ACT intervention with chronic pain patients, cognitive fusion improved the least out of all the outcome variables. Scott et al. (2017) posited the issue might be in the measurement of cognitive fusion, which has been less often assessed and less well studied compared to other processes in the model, continuing to say cognitive fusion seems more difficult to achieve than other parts of the ACT model, hence assessment of this process has been fraught with difficulty.

Furthermore, Bach and Moran (2008) suggested the construct of suppression might indirectly tap into cognitive defusion because it "assesses an individual's inclination to squelch

aversive cognitive content" (p. 59). However, Peterson, Eifert, Feingold, and Davidson (2009) stated the process of defusion is different because instead of simply suppressing the thought, the person is accepting it. The literature is still trying to determine the mechanisms at play that enable a person to achieve cognitive defusion. This suggests that, while mindfulness is certainly correlated with cognitive defusion, it likely is not – as the non-practitioners in this sample show – the only way to accomplish it.

Emotion Regulation. CITs were more likely to use the reappraisal technique when regulating emotions than suppression, meaning they reportedly used a positive emotion regulation technique more frequently than a negative one. Participants in this study were in a master's program, meaning they had more education than the general population. Wiltlink et al. (2011) found that individuals with more years of education scored similarly to the CITs here on the ERQ on suppression, with higher education levels relating to less suppression. In community members as well as students (Gross & John, 2003; Wiltink et al., 2011), previous results show that higher reported rates of emotion suppression were positively associated with depression, anxiety, and stress. On the other hand, these same studies showed that reappraisal was negatively correlated with these outcomes. This hints at the idea that CITs might be able to combat against negative affective outcomes (i.e., anxiety) due to the fact they are more likely, according to results here, to use reappraisal rather than suppression.

There was no significant difference between CITs who practiced mindfulness and those who did not on either of the ERQ subscales, reappraisal or suppression. This failure to link mindfulness to better emotion regulation was surprising given the literature. Most of the previous studies found mindfulness practitioners more effective in regulating emotions (Alda et al., 2016; Doll et al., 2016), and specifically being better at emotion reappraisal and less likely to suppress

emotions (Dubert et al., 2016). One possible explanation for this is the overall mindfulness level for this sample – even among non-practitioners – was moderately high; Hoge et al. (2013) found mindfulness can be used as an emotional regulation strategy in which distressing feelings are not avoided but instead faced with compassion and attempt of understanding.

This supposition was supported, since there was a strong, significant correlation between FFMQ scores and scores on the ERQ-Reappraisal, considered a good coping skill, and a significant negative relationship between scores on the FFMQ and the ERQ-Suppression, which is considered a negative emotion regulation technique. These findings align with previous literature, which states mindfulness works, in part, by encouraging exposure to physical and negative sensations which then leads to desensitization and lower levels of experiential avoidance (Baer, 2001). Indeed, both Harned et al., (2013) and Neacsiu et al. (2014) found that mindfulness helps individuals who tend to avoid negative emotions.

Psychological Flexibility. CITs reported slightly above average levels of psychological flexibility, regardless of mindfulness practice. Wei et al. (2014) found that CITs with higher levels of psychological flexibility reported less experiences of hindering self-awareness, which in turn was positively associated with counseling self-efficacy. CITs in this study scored similarly on psychological flexibility to counselors who had received ACT training (Varra et al., 2008), suggesting that counselors might be a group that generally reports high levels of psychological flexibility, although in Varra et al. (2008), there was a significant difference in pre-intervention and post-intervention scores for counselors in psychological flexibility. This suggests that even though CITs might score higher on psychological flexibility than average, there might still be room for improvement after learning more about ACT.

Theoretically, psychological flexibility is established through the six key ACT processes. Included in these are acceptance, represented here by the ERQ; cognitive defusion, as measured by the CFQ; and being present, assessed in this study by the FFMQ. Consistent with ACT theory, the three major ACT constructs had significant, strong relationships with psychological flexibility: FFMQ and ERQ-reappraisal scores were positively correlated with AAQ-II scores while CFQ and ERQ-suppression scores were negatively correlated with AAQ-II scores. The direction of these relationships lined up with predictions. Consistent with these findings, Gillanders et al. (2014) found that the CFQ and AAQ-II were highly correlated and theorized it might be due to the fact that, within the ACT model, cognitive fusion is a component of psychological inflexibility. While the ERQ and FFMQ have been used in studies alongside the AAQ-II (Bohlmeijer et al., 2011; Dick et al., 2014; Woodruff et al., 2014), I could not find precedence where the investigators looked at their correlation.

Finally, scores on the measures of mindfulness, cognitive fusion, and emotion regulation served as strong predictors for psychological flexibility in this study. This provides support for the idea that ACT works the way it is theorized in this sample of CITs. Again, while AAQ-II scores have been used to predict a number of outcomes, such as post-traumatic stress, dropout from treatment (Bond et al., 2011; Lewis & Naugle, 2017), studies where it was the outcome variable were not readily available. Luoma and Vilardaga (2013) did conduct a pilot study and found that brief ACT training did, in fact, increase the psychological flexibility of therapists, but the authors themselves noted this was only a small step into exploring the effectiveness of the ACT process with helping professionally.

However, while scores on cognitive fusion and emotion regulation contributed significantly to the model, it was surprising that mindfulness scores on the FFMQ did not

contribute significantly to predicting scores on psychological flexibility. When investigated separately, it was clear that overall level of mindfulness did predict scores on the AAQ-II, with higher mindfulness scores leading to greater psychological flexibility, as expected. One reason why mindfulness might not have contributed significantly within the model is due to the fact that mindfulness is already involved as the mechanism of the other constructs. For example, Desrosiers, Vine, Klemanski, and Nolen-Hoeksema (2013) found that mindfulness and emotion reappraisal were significantly, positively correlated and this contributed to a larger picture in their study that emotion regulation skills mediated the relationship between mindfulness and mental health outcomes. Also, as previously mentioned, Gillanders et al. (2014) highlighted the possible overlap between mindfulness and cognitive fusion.

The findings outlined in this chapter so far answer the research questions posed by this study; however, as I have started to discuss and due to the exploratory nature of this investigation, the results leave many more questions unanswered. I will explore some of these future directions after explaining some of this study's limitations.

Limitations

Most of the limitations with this study had to do with the methodology. First, the participants consisted of CITs or recent graduates who were self-reporting on the measures of ACT constructs. Thus, caution that is usually advised when all data is self-report in nature needs to be heeded, such as impression management, relying on memory, and cultural limitations. (Paulhus & Vazire, 2009). For example, there are a significant variety of definitions and conceptualizations of mindfulness. When analyzing the results based on a dichotomous answer of whether a person practices mindfulness or not, self-report might create a group of people who seem alike but are actually more heterogeneous that I would be able to detect.

A second limitation relates to recruitment strategies. I specifically sought out CITs who were likely to practice mindfulness either personally and/or professionally. This likely would account for the majority of the participants (75%) identifying as mindfulness practitioners. Even though statistical tests deemed it appropriate to compare practitioners and non-practitioners, the non-practitioners of mindfulness might have demonstrated selection bias in that, despite not practicing, they chose to participate in a study investigating mindfulness. This surely was exacerbated by the fact that I chose to target specific listservs to which I determine CITs who practice mindfulness might belong (e.g., Association for Creativity in Counseling, neuroscience network).

In the measurement of mindfulness, I was aware of the difficulty in examining mindfulness-based approaches (MBAs), since the ideas behind the approach evolved long before Western scientific method (Baer, 2011). There are a number of mindfulness measures available and in choosing the FFMQ, I limit myself to one definition of the construct. Additionally, I chose to use the composite score on the FFMQ, which made comparison to some of the literature using the measure impossible since researchers often use the five facets of mindfulness separately instead of computing an overall score.

Additionally, this study recruited participants enrolled in or recently graduated from a CACREP accredited program. While CACREP is currently the accreditation body for over 730 master's programs, not all counseling programs nationwide ascribe to its standards, and thus in using CACREP as inclusion criteria, this study did not attempt to access all CITs. A specific limitation of this study's procedure emerged as data collection continued; there were not enough willing participants who met the original inclusion criteria of being currently enrolled in internship class. To meet the targeted sample goal, inclusion criteria changed to include students

enrolled in practicum and recent graduates of master's programs with less than one year of professional experience.

Another type of bias might have come into play in recruitment; since I reached out to CACREP-accredited master's program coordinators and directors, it was up to these individuals to forward my recruitment e-mail to their students or not. Thus, nonresponse bias might have limited access to students at particular programs, lack of access to students who do not regularly check their e-mail, or treat forwarded or en mass e-mails as spam.

Implications

Since most empirical work on ACT explores outcomes with clients, counselor educators have been adapting ACT as a framework to guide counselor training based on research for client populations – not based on any empirical work on the specific CIT population. In this study, I wanted to take a step back and build a stronger case for the use of ACT principles in counselor education; since these results show that a model of scores on mindfulness, cognitive fusion, and emotion regulation measures are able to predict CITs' psychological flexibility, perhaps there is stronger evidence to justify using ACT language in counselor training settings.

Future Research

This study is only the first step in addressing the use of ACT in counselor education. The next step in research is to establish a connection between psychological flexibility and decreased anxiety and increased self-awareness in CITs. This would contribute to empirical support and strengthen the rationale for using ACT as a way to accomplish these professional development tasks.

I also chose to only focus on the ACT principles of present moment awareness, cognitive defusion, and acceptance, and how they contribute specifically to psychological flexibility; these concepts make up the ACT Triflex (see Figure 1.1) and describe the process of separating from

thoughts and feelings, evaluating them, and then being able to work with them instead of trying to avoid them. However, there are three other constructs in ACT – self-as-context, committed action, and values – that also might contribute to CIT training. Future research could look at how these processes play out among CITs and within counselor education.

Also, investigators could try and find out more about the relationship between the ACT constructs themselves. When conducting this study and interpreting its results, I had difficulty finding precedence for my findings due to the fact that many researchers use ACT constructs, such as mindfulness, cognitive fusion, etc., to predict mental health, physiological, or well-being outcomes. The interconnections of the constructs are not fully understood and, until they are, researchers might be faced with such puzzling findings as I encountered when mindfulness was not a significant predictor in the regression model.

Lastly, more can be learned from implementing mindfulness and ACT-informed techniques and interventions with CITs. In doing so, researchers can investigate the processes of ACT and find specific ways it can be useful in the counselor education and training setting. One specific research project that is needed is a qualitative inquiry into the ACT clipboard exercise, which is a metaphor used by ACT therapists to describe the six core processes and the goal of psychological flexibility. In the final few sections, I will explore how this study and its findings can contribute to different aspects of the field, including professional development among CITs and counselor education and supervision.

CIT Professional Development

CACREP (2016) mandates counselor educators provide strategies for self-evaluation, both on a personal and professional level, and this study helps move the literature forward in a few ways. First, it suggests the fact that ACT constructs are inherently present in the CIT

population and provides support for the ACT processes in this population. Since mindfulness-based approaches enhanced positive therapist characteristics (Wilson, 2009), previous investigators hypothesized ACT – which incorporates mindfulness – has a similar effect. Although there were no differences in the ACT constructs measured here based on whether a person practices mindfulness or not, the findings do firmly show that as mindfulness and emotion reappraisal increase, and emotion suppression and cognitive fusion decrease, CITs are likely to have increased psychological flexibility. Since psychological flexibility has been linked to enhanced therapeutic characteristics (Luoma & Vilardaga, 2013; Marshall & Brockman, 2016), this supports the idea that ACT might provide useful training language and techniques for CITs.

As established in the literature, CITs face unique challenges on the path to professional development, most specifically increased levels of anxiety and the demanding task of self-awareness. The literature claims new counselors need more structure because of the strong presence of anxiety within CITs (McAuliffe and Eriksen, 2011; Rønnestad & Skovholt, 2003). The reality of being evaluated, the high stakes of working with distressed individuals, and the ambiguity inherent in the act of counseling come together to fuel this anxiety (McAuliffe & Eriksen, 2011). This study did not directly investigate whether or not mindfulness, cognitive fusion, emotion regulation, and psychological flexibility decrease anxiety. However, higher levels of mindfulness and emotional reappraisal, in addition to lower levels of cognitive fusion and emotion suppression, were found to lead to psychological flexibility. As mentioned previously, psychological flexibility has been associated with lower levels of anxiety (Kashdan & Rottenberg, 2010; Masuda & Tulley, 2012). Mindfulness is a construct, theory, practice, and

technique that counselor educators can provide to CITs in an effort to help them manage the anxiety associated with the counselor professional development process.

Another specific task of CIT professional development is self-awareness, especially of one's own emotions; researchers established a strong correlation between emotional intelligence and counseling efficacy (Easton et al., 2008; Sackett et al., 2012); specifically, CITs with high counselor self-efficacy also rated themselves as highly emotionally intelligent. Part of this emotional intelligence, Easton et al. (2008) explained, is the ability to recognize and manage emotions. In this study, CITs with higher scores on overall mindfulness demonstrated greater ability to use emotion reappraisal, thought of as a helpful regulation skill, and engaged less in emotion suppression, or avoiding negative emotion. This suggests that mindfulness might be helpful in helping CITs learn to manage their emotions. Indeed, Kabat-Zinn (1982) found mindful practice encourages prolonged exposure to emotional sensations (e.g., anxiety, panic), which leads to desensitization and an ability to experience these sensations without emotion suppression. Baer (2003) continued that this exposure leads to acceptance, which has been associated with positive outcomes (McCracken & Gutiérrez-Martínez, 2011). Again, teaching CITs mindfulness would equip them with a way to monitor and adjust their self-awareness, particularly when it comes to emotion regulation.

Prosek and Hurt (2014) held that a combination of training and personal dispositions lead to professional identity, and if counselor educators use ACT in a training context, that means CITs will be abiding by the "practice what you preach" approach the method requires. Not only will CITs be learning about a theory that seems to be naturally occurring in the population, but they will be enacting techniques -- mindfulness, cognitive defusion, emotion regulation -- that

leads to psychological flexibility, a construct that targets some of the unique challenges they face in their training.

CITs can use principles from ACT to guide their development as counseling professionals; for example, CITs should acknowledge any anxious thoughts they might have as they learn and practice new skills, such as "I am doing this wrong" or "I don't know what to say next." ACT posits that it is normal human experience to feel an increase in anxiety as we encounter new challenges and are outside our comfort zones. ACT would suggest the CIT start to defuse from these anxious thoughts by admitting any negative private experiences he or she might be experiencing. Harris (2009) suggests this gives CITs "permission to be imperfect" and, in addition, helps the counselor model openness and acceptance for clients.

Another way CITs can use ACT during their training is to find metaphors that might help them relate any of their experience. One such metaphor is titled, "Wade through the swamp" (Hayes et al., 2009), and demonstrates the reward we can receive if we make room for our negative private experiences (e.g., anxiety, fear, depression). A paraphrased script from Hayes et al. (2009) can be found below:

> *Suppose you are passionate about mountain climbing. You go to climb this mountain you have heard great things about but it is surrounded by a swamp. To get the chance to climb the mountain, you must wade through the swamp. What do you do? You do not just wallow in it indefinitely. You put one foot in front of the other and get to the foot of that mountain because climbing it matters to you.*

The swamp, in CITs' case, might be the anxiety they experience as they have to participate in roleplays when learning theory, working with their first client at their internship, or having to assess a crisis situation for the first time. The mountain is likened to their career in the field, and

if they can wade through the negative internal experiences they experience during training then they will feel more psychologically flexible as they continue on their path of professional development.

Counselor Educators and Supervisors

There are several implications for counselor educators and supervisors made in this study, specifically around incorporating mindfulness into education and training. First and foremost, as Stella (2016) suggested, counselor educators could incorporate mindfulness training in order to maximize the benefits and should consider teaching it in the context of ACT. Numerous studies report positive outcomes as a result of mindfulness and ACT in counselor education context (Greason & Cashwell, 2009; Rothaupt & Morgan, 2007; Rocco et al., 2012; Vega et al., 2014). The findings here suggest a large proportion of CITs might already be participating in mindfulness practice; thus, counselor educators would simply be incorporating an element already present in most students' lives into training. In doing so, counselor educators would be encouraging CITs to not only utilize the practice with clients, but also for their own self-care and well-being (Rothaupt & Morgan, 2007).

Although questions exist on how best to teach mindfulness to CITs, this study offers a theory-driven method to incorporate mindfulness and additional, acceptance-based concepts into counselor education. Findings from this study fall in line with the theory behind ACT, meaning the processes of mindfulness, cognitive fusion, and emotion regulation are already playing out as expected among CITs. Formally incorporating ACT into counselor education settings would simply give CITs a common language in which to speak.

Walser and Westrup (2006) provide some guidance for implementing ACT into counselor education, stating the most effective way they found is to have CITs go through an

ACT workshop. After formal training in ACT, Walser and Westrup (2006) suggested counselor educators and supervisors focus on acceptance of emotions and thoughts, as it relates to the CITs' personal and professional lives, and have the trainee investigate the cost of avoidance in relation to personal values. Another way to incorporate these discussions into counselor training is through a supervision group – led by a supervisor or peer – that uses ACT language as a guide for discussion cases, clients, and challenges.

Whether or not counselor educators formally or informally use ACT in their work, the language in the theory can offer some unique ways to work with CITs. One specific word that counselor educators could adapt is *workability*. In ACT, this concept is used as an intervention to help the individual defuse from the thoughts they are having. When a CIT is experiencing anxiety about whether the reflection they gave or not is the "right" one, the counselor educator/supervisor might ask them if focusing on finding the "right" things to say is a *workable* thought process. Ideally, the CIT would admit it is not and be open to stepping away from finding reflections that fit into the "right" or "wrong" categories and instead focus on being present with the client.

Through this process, we see how defusing with the idea that the CIT has to be "right" in his or her work with a client can help them have more space and energy to pursue other things in the clinical context. This is a practical example of how defusion can support psychological flexibility. Harris (2009) suggested a three-step process for defusing from thoughts, outlined in Table 5.1, along with language the counselor educator/supervisor could use to encourage each step.

Specifically, supervisors can work with CITs on mindfulness, defusion, and acceptance during their sessions together. For example, supervisors can emphasize the utility of language

and how all people, not just clients, can fall prey to cognitive fusion. Through supervision, CITs can discuss their anxiety around making mistakes in both personal and professional realms. Supervisors can teach supervisees to sit with the idea of "getting it wrong" and regulate their anxiety relating to this. Supervisees can help CITs fight their urge, emphasized by society, to fix clients. Then, through parallel process, CITs can work to help clients to sit with and manage their emotions in a more mindful way. To further this, supervisors can provide modeling by sharing their own journey with anxiety around clinical practice, encouraging supervisees to do the same for their clients.

Harris (2009) discusses the metaphor of the "struggle switch" (p. 149), or a dimmer switch in the back of our mind that, when turned on, enables us to struggle against any pain we might be experiencing. The work in a supervision session would be to work to dim this switch so the supervisee does not struggle with their emotions, for example, anxiety around saying the wrong thing during a session with the client. The supervisor asks the CIT – who rated their anxiety at a nine – to tune into their body and thoughts. Together through mindfulness exercises, the supervisor works with the CIT to dim the intensity of the anxiety and discusses how the supervisee can accomplish this during a session if they start to feel the anxiety rising.

In addition to this, counselor educators/supervisors can use also use the ACT technique of metaphor with CITs to encourage defusion. One popular metaphor ACT therapists use is the "Leaves on a Stream" exercise where the supervisee is asked, in the context of a mindfulness exercise, to close his/her eyes and watch his/her thoughts, placing each of them on a leaf and watching those leaves float down a stream (Hayes et al., 1999, p. 159). This is another way of helping CITs notice their thoughts and whether they are fused with them or not; the act of putting

the thought on the leaf alludes to the process of gaining distance (i.e., defusing) from the thought in the hopes of gaining flexibility around that thought.

Flexibility can also be achieved through emotional acceptance; in this same example with the CIT, the counselor educator can work to expose the pursuit of the "right" thing to say with a client as *avoidance* of a variety of possible negative emotional experiences (e.g., failure, disappointment). If the CIT stops letting their avoidance of negative experiences guide their behaviors, they might have the freedom to be more present with the client. Harris (2009) offered language counselor educators/supervisors could adopt in their work with CITs to encourage acceptance: "Allow it to be there;" "Open up and make room for it;" "Give it permission to be where it already is," "Stop wasting your energy on pushing it away," etc. (p. 135).

The Association for Contextual Behavior Science is the international organization that projects the voice of the ACT community; their website is full of free information, useful activities and worksheets, and access to experts in ACT. Counselor educators could reference these materials at https://contextualscience.org/ for additional guidance in how to implement ACT language into their work.

Conclusion

There is increasing evidence that using pathology and symptom reduction to guide counseling is not the only -- let alone best -- way to work with clients, patients, or students. Instead, mindfulness and acceptance-based approaches are gaining ground in a quest for better, long-lasting, and more universally applicable treatment methods. Hayes, Pistorello, and Levin (2012) explain acceptance is a method of increasing psychological freedom of the individual, "regardless of the experiential echoes of his or her own history" (p. 982). ACT is not the only method to use these concepts; DBT teaches its practitioners mindfulness and "radical

acceptance" as integral processes toward achieving the positive outcomes associated with that specific modality. As we continue to explore theories like ACT and DBT in all contexts, including counselor education, we can only stand to gain knowledge about how to advance the counseling field.

The purpose of this quantitative study was to provide empirical support for mindfulness as a tool for counselor development, engaging in a theory-driven guide to implementing mindfulness into counselor training. Specifically, I explored how the ACT principles of present moment awareness, cognitive defusion, and acceptance contribute to psychological flexibility, which has been associated with lower levels of anxiety and increased emotional acceptance. The results of the analysis concluded that mindfulness, cognitive fusion, and emotion regulation do enable us to predict greater levels of psychological flexibility in this population.

Ultimately, these findings demonstrate that, among CITs, ACT operates the way it is proposed to work. This suggests that CITs could benefit as much from learning and enacting the theory as clients who have already benefited (Öst, 2014). More specifically, ACT might be able to address some unique challenges that CITs face during their education and training, such as increased anxiety and the utility of emotional intelligence. Indeed, as the waves of cognitive behavioral theory continue to roll and acceptance gains ground as a desired outcome of treatment, further research into ACT constructs, acceptance, and mindfulness in the counselor education context needs to be conducted in an effort to understand truly how these ideas can improve our work.

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Appendices

Appendix A

Dear colleagues,

You are invited to participate in a dissertation study examining if mindfulness helps counselors become more self-aware and emotionally intelligent. The overall objective of this research study is to explore three core processes of Acceptance and Commitment Therapy (commonly known as ACT) – present moment awareness, cognitive defusion, and emotional acceptance – and how these might be enhanced to aid counselors-in-training in their professional identity development. The study is conducted under the advisement of Dr. Melinda Gibbons and has been approved by the Institutional Review Board at the University of Tennessee, which is a group of people who review research to protect the rights and welfare of research of participants.

I am seeking participants who are or have been master's students in CACREP-accredited programs in clinical mental health or school counseling. Participants interested will be entered into a drawing for one of two available $30 Visa gift cards. **You do not need to practice mindfulness to be eligible to participate**.

Participants will be deemed **eligible** if they:

- You are enrolled or were previously enrolled in a CACREP-accredited master's program AND
- You are currently enrolled in practicum or internship course **OR** a recent graduate with less than one year of post-master's experience

The anonymous survey will take approximately 15-20 minutes to complete and all information will be kept confidential. Findings from this study will help inform counselor educators about the benefits of implementing mindfulness into their course curriculum.

To participate in this study, please click the link below. Please forward this request to any other students eligible to participate in this study.

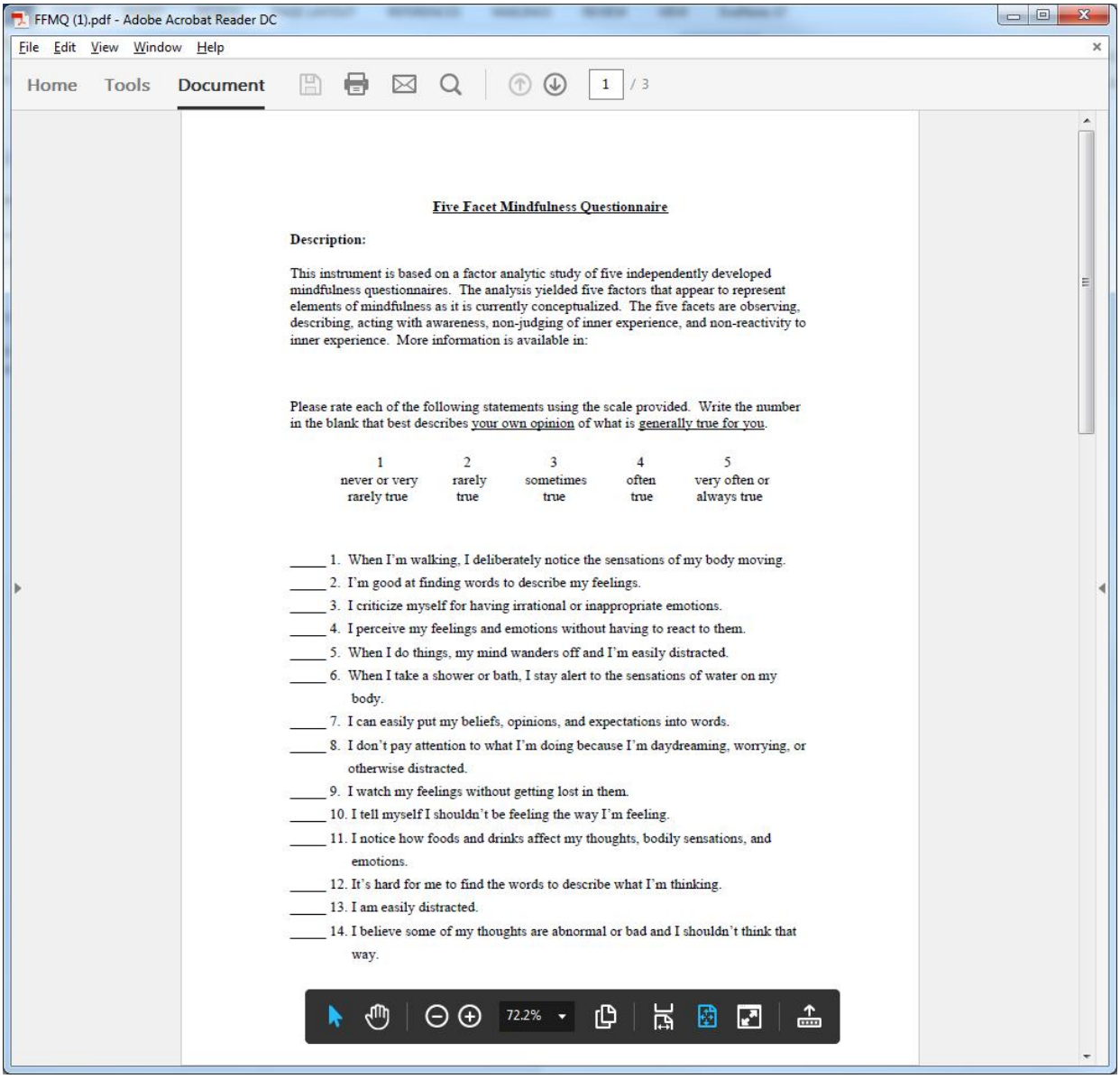
https://utk.co1.qualtrics.com/jfe/form/SV_aWaYzMnBeLE5Q9f

Thank you for considering this request!

Emma C. Burgin, M.A.
Doctoral Candidate, Counselor Education
Department of Educational Psychology & Counseling
University of Tennessee, Knoxville
eburgin@vols.utk.edu

Appendix B

Five Facet Mindfulness Questionnaire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Five Facet Mindfulness Questionnaire

Description:

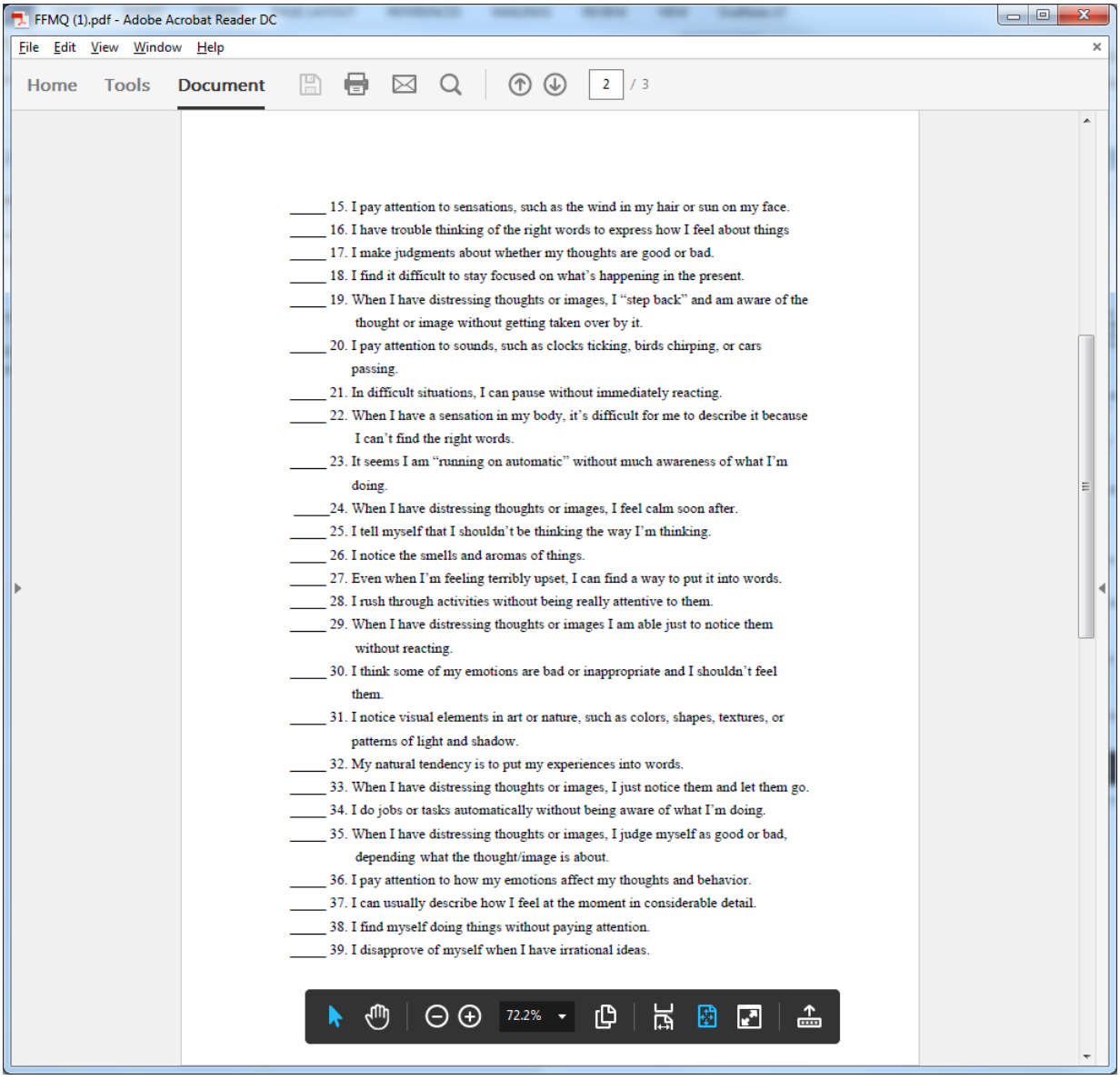
This instrument is based on a factor analytic study of five independently developed mindfulness questionnaires. The analysis yielded five factors that appear to represent elements of mindfulness as it is currently conceptualized. The five facets are observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. More information is available in:

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
never or very rarely true	rarely true	sometimes true	often true	very often or always true

_____ 1. When I'm walking, I deliberately notice the sensations of my body moving.
_____ 2. I'm good at finding words to describe my feelings.
_____ 3. I criticize myself for having irrational or inappropriate emotions.
_____ 4. I perceive my feelings and emotions without having to react to them.
_____ 5. When I do things, my mind wanders off and I'm easily distracted.
_____ 6. When I take a shower or bath, I stay alert to the sensations of water on my body.
_____ 7. I can easily put my beliefs, opinions, and expectations into words.
_____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
_____ 9. I watch my feelings without getting lost in them.
_____ 10. I tell myself I shouldn't be feeling the way I'm feeling.
_____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
_____ 12. It's hard for me to find the words to describe what I'm thinking.
_____ 13. I am easily distracted.
_____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.

72.2%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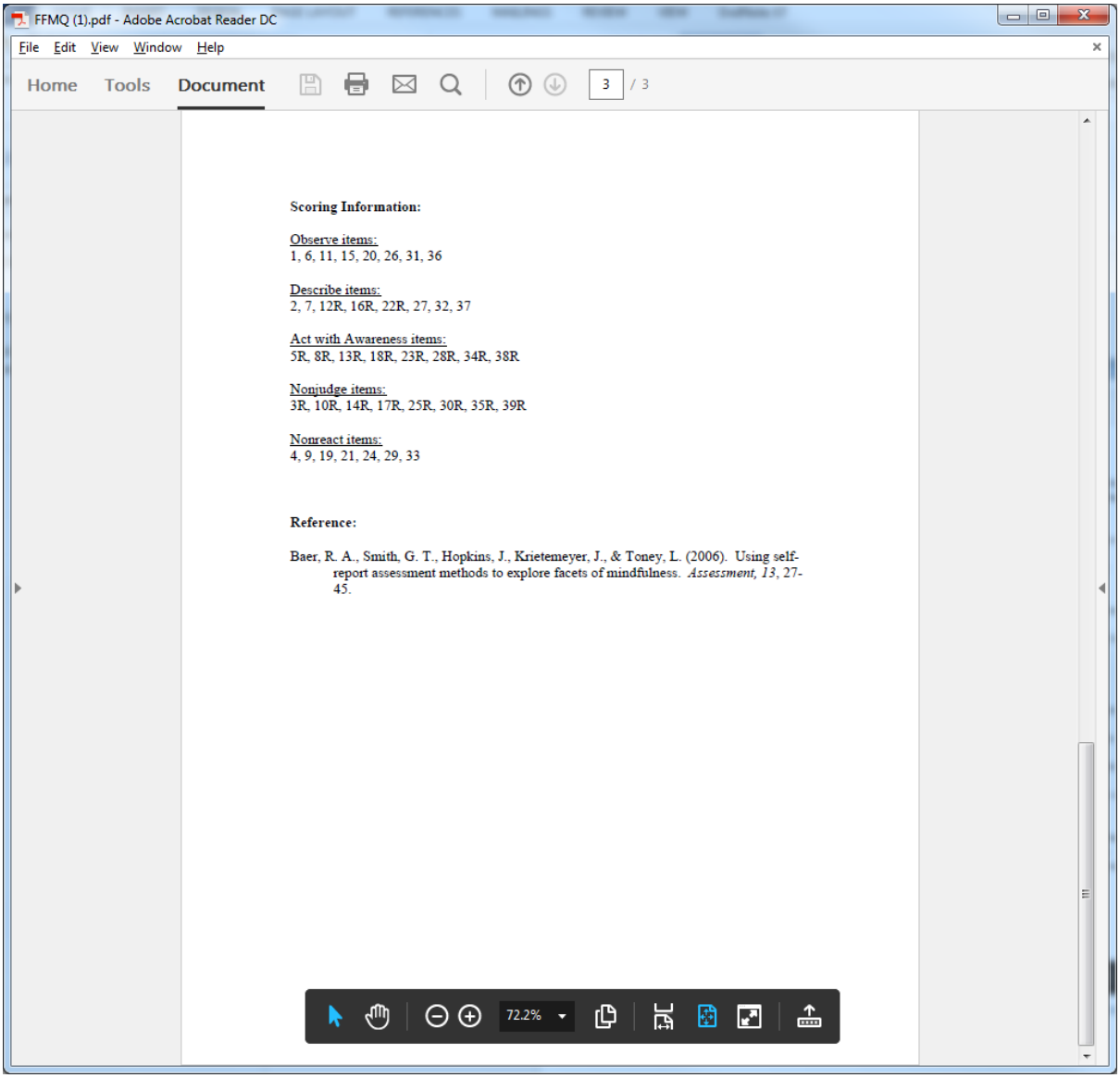
2 / 3
_____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
_____ 16. I have trouble thinking of the right words to express how I feel about things
_____ 17. I make judgments about whether my thoughts are good or bad.
_____ 18. I find it difficult to stay focused on what's happening in the present.
_____ 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
_____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
_____ 21. In difficult situations, I can pause without immediately reacting.
_____ 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
_____ 23. It seems I am "running on automatic" without much awareness of what I'm doing.
_____ 24. When I have distressing thoughts or images, I feel calm soon after.
_____ 25. I tell myself that I shouldn't be thinking the way I'm thinking.
_____ 26. I notice the smells and aromas of things.
_____ 27. Even when I'm feeling terribly upset, I can find a way to put it into words.
_____ 28. I rush through activities without being really attentive to them.
_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.
_____ 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
_____ 32. My natural tendency is to put my experiences into words.
_____ 33. When I have distressing thoughts or images, I just notice them and let them go.
_____ 34. I do jobs or tasks automatically without being aware of what I'm doing.
_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.
_____ 36. I pay attention to how my emotions affect my thoughts and behavior.
_____ 37. I can usually describe how I feel at the moment in considerable detail.
_____ 38. I find myself doing things without paying attention.
_____ 39. I disapprove of myself when I have irrational ideas.
72.2%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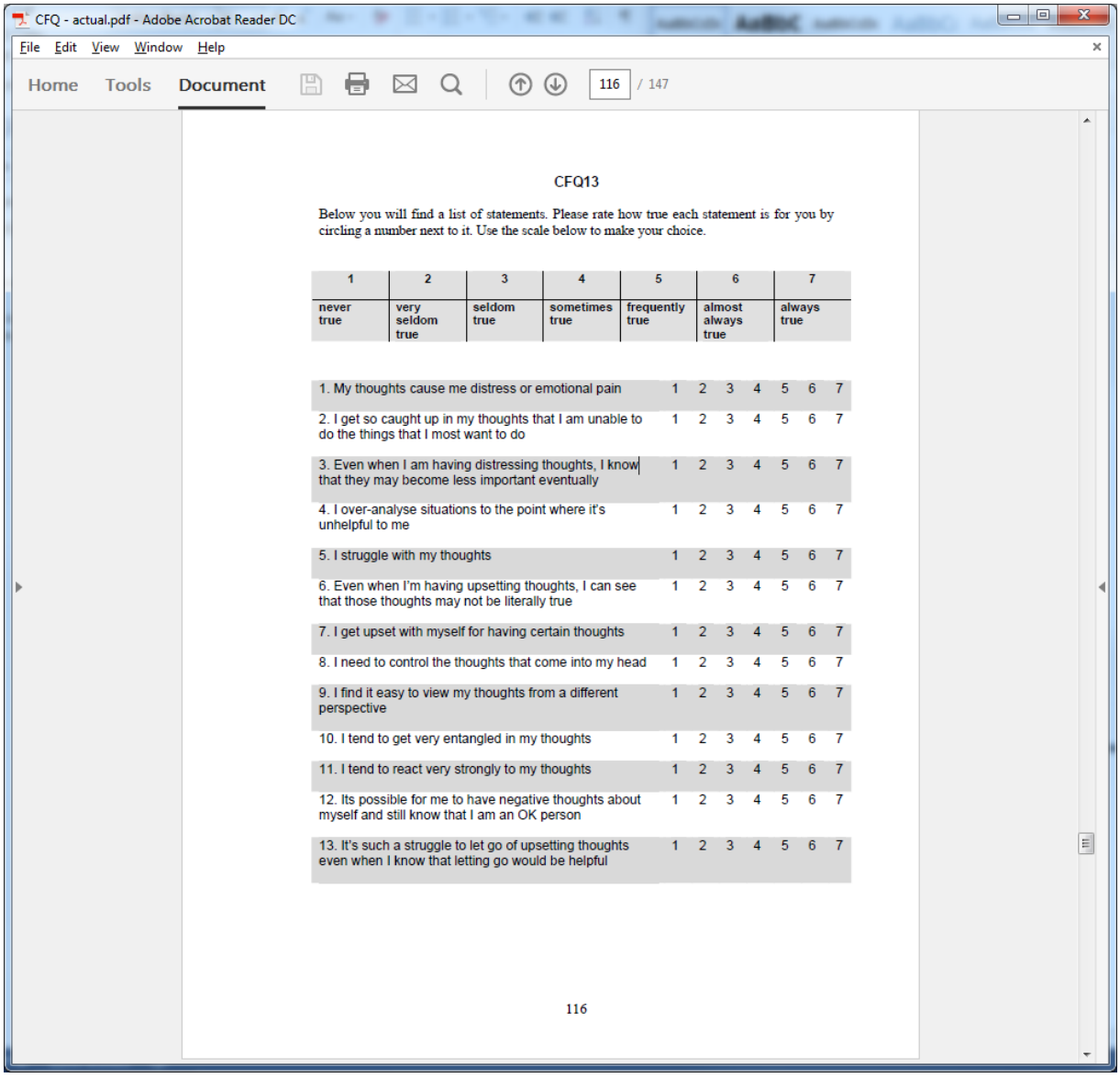
Scoring Information:
Observe items:
1, 6, 11, 15, 20, 26, 31, 36
Describe items:
2, 7, 12R, 16R, 22R, 27, 32, 37
Act with Awareness items:
5R, 8R, 13R, 18R, 23R, 28R, 34R, 38R
Nonjudge items:
3R, 10R, 14R, 17R, 25R, 30R, 35R, 39R
Nonreact items:
4, 9, 19, 21, 24, 29, 33
Reference:
Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. Assessment, 13, 27-45.
72.2%

Appendix C

Cognitive Fusion Questionnaire



CFQ13

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

1. My thoughts cause me distress or emotional pain	1	2	3	4	5	6	7
2. I get so caught up in my thoughts that I am unable to do the things that I most want to do	1	2	3	4	5	6	7
3. Even when I am having distressing thoughts, I know that they may become less important eventually	1	2	3	4	5	6	7
4. I over-analyse situations to the point where it's unhelpful to me	1	2	3	4	5	6	7
5. I struggle with my thoughts	1	2	3	4	5	6	7
6. Even when I'm having upsetting thoughts, I can see that those thoughts may not be literally true	1	2	3	4	5	6	7
7. I get upset with myself for having certain thoughts	1	2	3	4	5	6	7
8. I need to control the thoughts that come into my head	1	2	3	4	5	6	7
9. I find it easy to view my thoughts from a different perspective	1	2	3	4	5	6	7
10. I tend to get very entangled in my thoughts	1	2	3	4	5	6	7
11. I tend to react very strongly to my thoughts	1	2	3	4	5	6	7
12. Its possible for me to have negative thoughts about myself and still know that I am an OK person	1	2	3	4	5	6	7
13. It's such a struggle to let go of upsetting thoughts even when I know that letting go would be helpful	1	2	3	4	5	6	7

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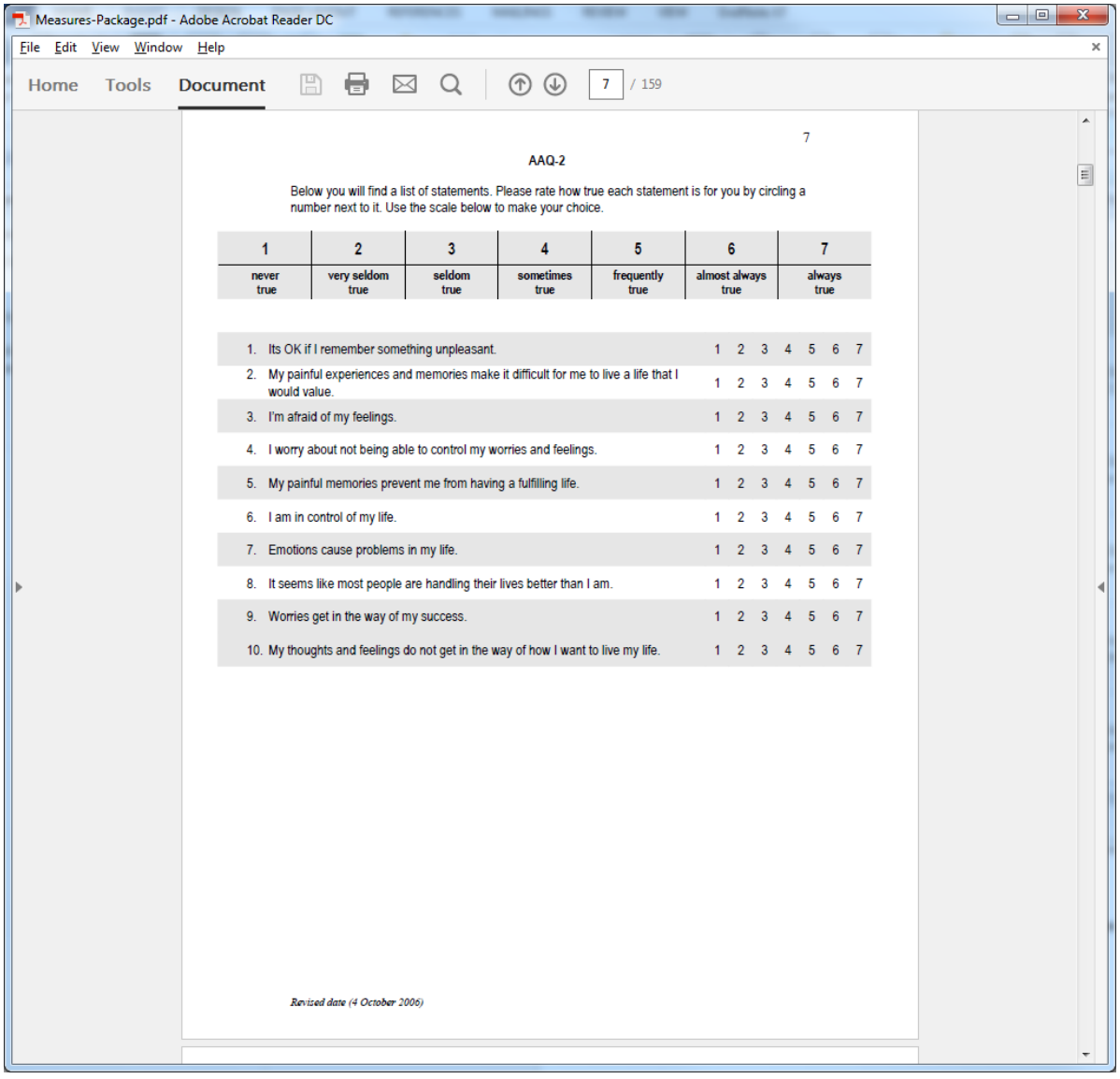
Appendix D

Acceptance and Action Questionnaire-II



7

AAQ-2

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

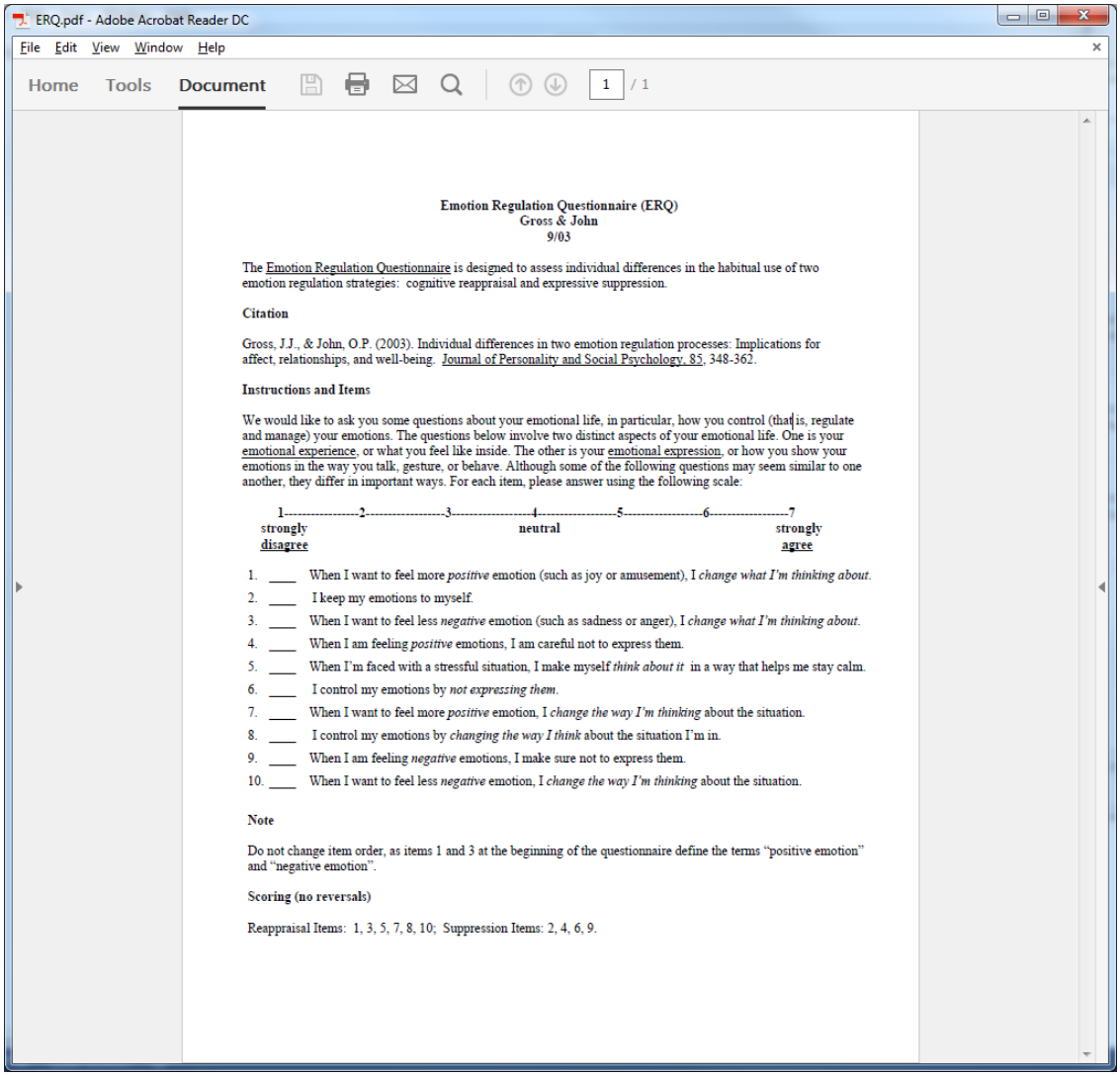
1	2	3	4	5	6	7
never true	very seldom true	seldom true	sometimes true	frequently true	almost always true	always true

1.	Its OK if I remember something unpleasant.	1	2	3	4	5	6	7
2.	My painful experiences and memories make it difficult for me to live a life that I would value.	1	2	3	4	5	6	7
3.	I'm afraid of my feelings.	1	2	3	4	5	6	7
4.	I worry about not being able to control my worries and feelings.	1	2	3	4	5	6	7
5.	My painful memories prevent me from having a fulfilling life.	1	2	3	4	5	6	7
6.	I am in control of my life.	1	2	3	4	5	6	7
7.	Emotions cause problems in my life.	1	2	3	4	5	6	7
8.	It seems like most people are handling their lives better than I am.	1	2	3	4	5	6	7
9.	Worries get in the way of my success.	1	2	3	4	5	6	7
10.	My thoughts and feelings do not get in the way of how I want to live my life.	1	2	3	4	5	6	7

Revised date (4 October 2006)

Appendix E

Emotion Regulation Questionnaire


ERQ.pdf - Adobe Acrobat Reader DC

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Emotion Regulation Questionnaire (ERQ)
Gross & John
9/03

The Emotion Regulation Questionnaire is designed to assess individual differences in the habitual use of two emotion regulation strategies: cognitive reappraisal and expressive suppression.

Citation

Gross, J.J., & John, O.P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. Journal of Personality and Social Psychology, 85, 348-362.

Instructions and Items

We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

1----------2----------3----------4----------5----------6----------7
strongly disagree **neutral** **strongly agree**

1. ____ When I want to feel more *positive* emotion (such as joy or amusement), I *change what I'm thinking about.*
2. ____ I keep my emotions to myself.
3. ____ When I want to feel less *negative* emotion (such as sadness or anger), I *change what I'm thinking about.*
4. ____ When I am feeling *positive* emotions, I am careful not to express them.
5. ____ When I'm faced with a stressful situation, I make myself *think about it* in a way that helps me stay calm.
6. ____ I control my emotions by *not expressing them.*
7. ____ When I want to feel more *positive* emotion, I *change the way I'm thinking* about the situation.
8. ____ I control my emotions by *changing the way I think* about the situation I'm in.
9. ____ When I am feeling *negative* emotions, I make sure not to express them.
10. ____ When I want to feel less *negative* emotion, I *change the way I'm thinking* about the situation.

Note

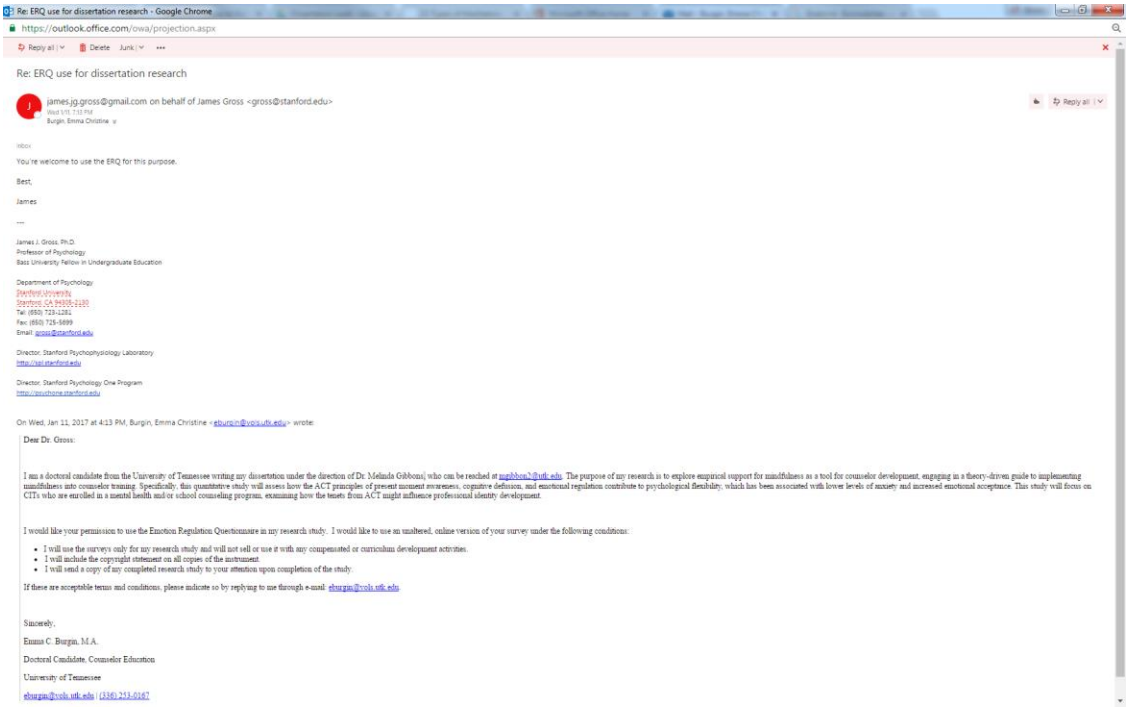
Do not change item order, as items 1 and 3 at the beginning of the questionnaire define the terms "positive emotion" and "negative emotion".

Scoring (no reversals)

Reappraisal Items: 1, 3, 5, 7, 8, 10; Suppression Items: 2, 4, 6, 9.

Appendix F

Permission to use ERQ



Re: ERQ use for dissertation research - Google Chrome

https://outlook.office.com/owa/projection.aspx

Reply all | Delete Junk | •••

Re: ERQ use for dissertation research

james.jg.gross@gmail.com on behalf of James Gross <gross@stanford.edu>

Wed 1/11, 7:53 PM

Burgin, Emma Christine

Inbox

You're welcome to use the ERQ for this purpose.

Best,

James

James J. Gross, Ph.D.
Professor of Psychology
Bass University Fellow in Undergraduate Education

Department of Psychology
Stanford University
Stanford, CA 94305-2130
Tel: (650) 723-1281
Fax: (650) 725-5699
Email: gross@stanford.edu

Director, Stanford Psychophysiology Laboratory
http://spl.stanford.edu

Director, Stanford Psychology One Program
http://psychone.stanford.edu

On Wed, Jan 11, 2017 at 4:13 PM, Burgin, Emma Christine <eburgin@vols.utk.edu> wrote:

Dear Dr. Gross:

I am a doctoral candidate from the University of Tennessee writing my dissertation under the direction of Dr. Melinda Gibbons, who can be reached at mgibbon2@utk.edu. The purpose of my research is to explore empirical support for mindfulness as a tool for counselor development, engaging in a theory-driven guide to implementing mindfulness into counselor training. Specifically, this quantitative study will assess how the ACT principles of present moment awareness, cognitive defusion, and emotional regulation contribute to psychological flexibility, which has been associated with lower levels of anxiety and increased emotional acceptance. This study will focus on CITs who are enrolled in a mental health and/or school counseling program, examining how the tenets from ACT might influence professional identity development.

I would like your permission to use the Emotion Regulation Questionnaire in my research study. I would like to use an unaltered, online version of your survey under the following conditions:

- I will use the surveys only for my research study and will not sell or use it with any compensated or curriculum development activities.
- I will include the copyright statement on all copies of the instrument.
- I will send a copy of my completed research study to your attention upon completion of the study.

If these are acceptable terms and conditions, please indicate so by replying to me through e-mail. eburgin@vols.utk.edu.

Sincerely,

Emma C. Burgin, M.A.

Doctoral Candidate, Counselor Education

University of Tennessee

eburgin@vols.utk.edu | (336) 253-0167

*No other assessment used in this study requires permission from the author(s).

Appendix G

Demographics Questionnaire

1. Are you currently enrolled in a CACREP accredited program?

   Yes

   No
2. Please indicate your field of study:

   Mental Health Counseling

   School Counseling

   Other
3. Are you currently enrolled in the Internship course required by your program of study?

   Yes

   No
4. Age _____
5. Gender:

   Male

   Female

   Transgender

   Other
6. Please indicate the race/ethnicity category that best describes you:

   African/African American

   Alaskan Native

   American Indian

   Asian/Asian American

   Native Hawaiian/Pacific Islander

   Caucasian/European American

   Hispanic/Latin American

   North African-Middle Eastern/Arab American

   Multiracial/Multiethnic

   Other
7. Please identify what your current geographical region is:

North Atlantic (CT, MA, ME, NH, NJ, NY, PA, RI, VT, PR)

North Central (IL, IN, IA, KS, MI, MS, MO, NE, ND, OH, OK, SD, WI)

Rocky Mountain (ID, MT, UT, CO, WY, NM)

Southern (AL, AK, FL, GA, KY, LA, MA, MS, NC, SC, TX, VA, WV)

Western (AL, AZ, CA, HI, NV, OR, WA, Pacific Rim)

Other

8. Do you practice mindfulness?

   Yes

   No

9. If yes, what type(s) (Check all that apply):

   Meditation

      Option to specify type of meditation (e.g., Metta, Vipassana, etc.)

   Body scan

   Progressive Muscle Relaxation

   Guided Imagery

   Yoga

   Qigong

   Tai Chi

   Other (please describe):

10. How often do you practice mindfulness?

    Daily

    2-3 times/week

    Less than 1 time/week

    Monthly

    Never

11. How long have you been practicing mindfulness?

    Less than 3 months

    3-6 months

    6-12 months

    More than 1 year

12. Does your program of study require a course, workshop, etc., in mindfulness?

Yes

No

Appendix H – Figures

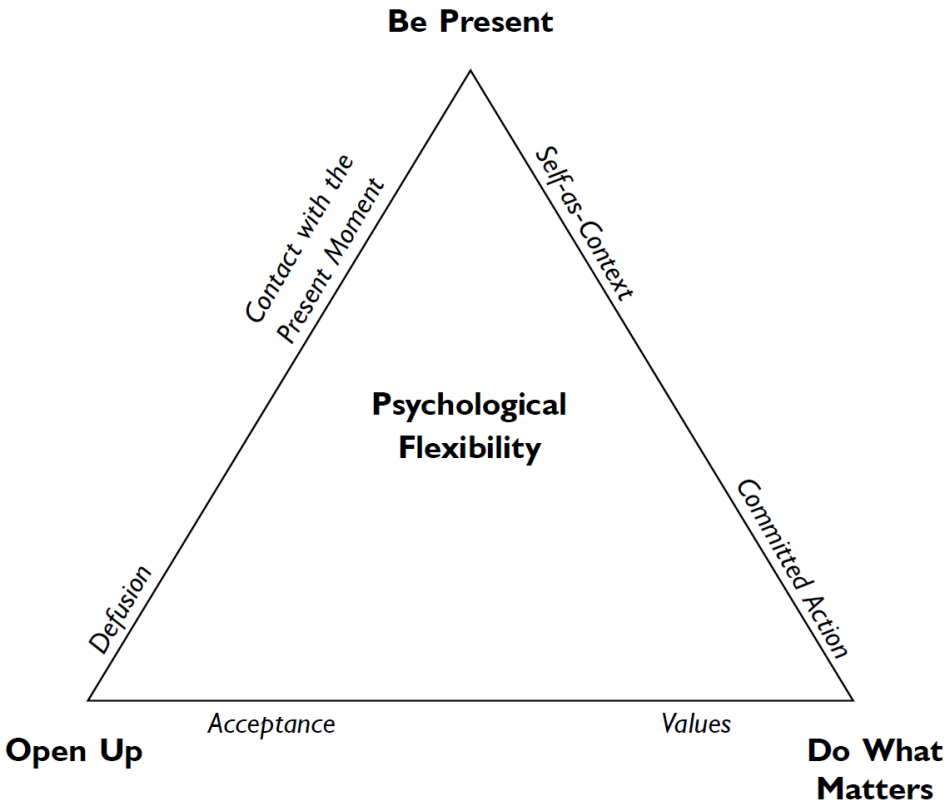


Figure 1.1 The ACT Triflex (Harris, 2009).

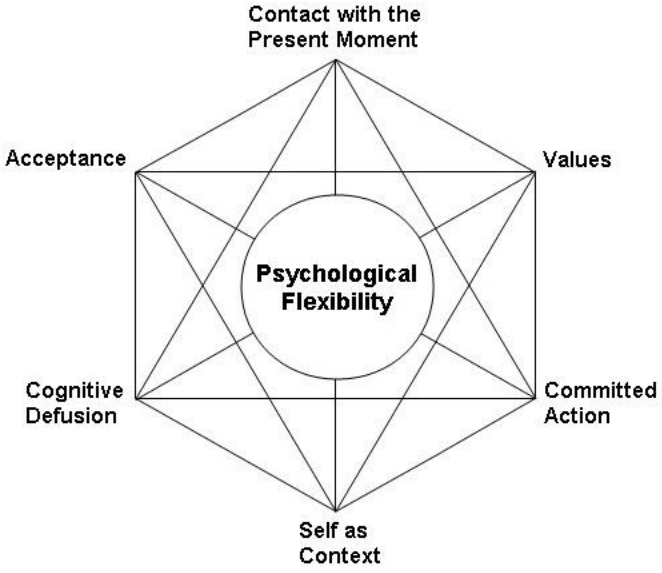


Figure 1.2 The ACT Hexaflex (Harris, 2009).

Appendix I - Tables

Table 1.1

Acceptance and Commitment Therapy's Six Core Processes (Harris, 2009)

Term	Definition
Contact with the present moment	Being psychologically present; connecting consciously with whatever is happening in the moment
Acceptance	Making room for unpleasant feelings and thoughts
Cognitive defusion	Learning to step back and detach from thoughts, memories, images, etc.
Self-as-context	Also known as the observing self, the part of us that is aware of what we are thinking and/or doing in any given moment
Committed Action	Taking effective action guided by our values
Values	Desired qualities of ongoing action

Table 4.1

Types of Mindfulness Practiced Among Participants

Type of Mindfulness	# of participants who practice	% of total who practice mindfulness
Meditation	56	54%
Body scan	48	46%
Progressive muscle relaxation	43	42%
Guided imagery	35	34%
Yoga	49	48%
Qigong	1	<1%
Tai Chi	2	<1%
Other	14	14%

Note. The sample for this table (n=103) is comprised of participants in the study who identified practicing mindfulness. Participants were able to report more than one practice.

Table 4.2

Frequency and Duration of Mindfulness Practice

	Frequency of Practice	
	# of participants	% of total who practice
Daily	13	15%
2-3 times per week	43	48%
Less than 1 time per week	21	24%
Monthly	12	13%
Total	89	100%
	Duration of Practice	
	# of participants	% of total who practice
Less than 3 months	8	9%
3-6 months	15	17%
6-12 months	17	19%
More than 1 year	49	55%
Total	89	100%

Note. The number of participants represented in this table is n=103, the number of participants out of the full sample of 138 that reported practicing mindfulness.

Table 4.3

Scores on FFMQ Subscales, ANOVA between Mindfulness Practitioners and Non-practitioners

Subscale	Mean and SD		Total score possible on subscale	P value
	Mindfulness Practice			
	Yes	No		
Observe	27.94, 5.25 (N=101)	25.77, 5.87 (N=35)	40	.043*
Describe	30.56, 4.67 (N=100)	28.65, 5.08 (N=34)	40	.046*
Act w/ Awareness	27.06, 4.53 (N=101)	25.54, 4.92 (N=35)	40	.026*
Nonjudgement	29.48, 4.99 (N=99)	27.71, 6.14 (N=34)	40	.094
Nonreaction	27.90, 3.58 (N=100)	21.57, 4.35 (N=35)	35	.076

Note: * indicates statistically significant difference at $p<.05$

Table 4.4

Difference in Means between Mindfulness Practitioners and Non-practitioners

Scale	Mean score for Mindfulness Practitioners	Mean score for Non-Practitioners	Mean Difference (t)	Sig. (2-tailed)
FFMQ	139.00	128.97	-10.03	.002**
CFQ	41.11	43.06	1.95	.344
ERQ-reappraisal	5.21	4.92	-.29	.207
ERQ-suppression	2.84	3.01	.17	.500
AAQ-II	53.45	54.40	.95	.599*

Note: * signifies a t-test where Levene's Test for Equality of Variances was statistically significant and thus equal variances were not assumed; ** signifies statistical significance set at 95% confidence interval ($p<.05$).

Table 4.5

Differences between Long- vs. Short-term and Frequent vs. Infrequent Mindfulness Practice

	Means by Duration		Mean difference	p	Means by Frequency		Mean difference	p
	Less than 6 months	6 months or more			At least 1x/week	Less than 1x/week		
CFQ	40.52	41.30	-.78	.692	40.17	42.73	2.56	.213
ERQ-R	5.08	5.25	-.17	.495	5.33	2.74	.50	.079
ERQ-S	3.21	2.71	.50	.079	2.89	2.74	-.15	.580
AAQ-II	53.31	53.50	-.19	.922	53.75	52.94	-.80	.648

Table 4.6

Correlation Matrix of Major Constructs

	1	2	3	4	5
1. FFMQ	1.00				
2. CFQ	-.65**	1.00			
3. ERQ-S	-.35**	.28**	1.00		
4. ERQ-R	.51**	-.47**	-.22**	1.00	
5. AAQ-II	.54**	-.75**	-.37**	.44**	1.00

Note: **Correlation is significant at the p<.001 level

Table 4.7

Multiple Regression of Predictors toward Psychological Flexibility

	B	*SE*	*β*	*F*	R^2
FFMQ	.02	.05	.04	.59	.620
CFQ	-.55	.07	-.61	-7.58	.000**
ERQ-R	1.14	.58	.14	1.99	.049*
ERQ-S	-.97	.44	-.14	-2.18	.031*

Note: *Results significant at p<.05; **Results significant at p<.001

Table 5.1

Getting to Cognitive Defusion (Harris, 2009)

Goal	Language to encourage CIT toward goal
1. Notice thoughts (e.g., "There is a right thing to say to the client")	"So your mind is telling you there is right, correct thing to say to clients in session."
2. Look at the workability of those thoughts	"Is the idea that there is a right and wrong thing to say to clients a workable thought? If you hold tightly to it, does it help you do your job better as a counselor?"
3. Notice when they are fused or defused with thoughts	"At this moment, how caught up are you in that thought? Rate on 1 to 10, with 10 meaning you 100% believe it, how much you believe there is right thing to say to clients."

Vita

Emma C. Burgin is a North Carolina native, growing up in Greensboro, attending undergraduate school at the University of North Carolina at Chapel Hill, and receiving another bachelor's and master's degrees at the University of North Carolina at Charlotte. Her undergraduate degree from UNC-CH was in Dramatic Arts with a second major in Communications Studies. She worked after that as a newspaper reporter for a few years until realizing her true passion. She received her third bachelor's degree in Psychology from UNC-Charlotte, where she continued on to earn her master's in Clinical and Community Psychology. While at UNC-Charlotte, she worked with disenfranchised youth in the community, providing support groups, photography clubs, and participatory action research for the most impoverished communities. She also collaborated with several local organizations to develop her skills and expertise in program evaluation. She rounded out her professional life in Charlotte by working as a psychologist at Daymark Recovery Services, a community mental health agency.

Burgin left her home of North Carolina to pursue her doctorate in Counselor Education and Supervision from the University of Tennessee (but her blood to this day has kept its Carolina blue hue). In Knoxville, she worked with the UT FUTURE program, serving students with intellectual and developmental disabilities (IDD) who often were on the Autism spectrum. Here, she taught work readiness classes and coordinated the internship program. Through FUTURE and other opportunities at UT, Burgin published four peer-reviewed articles and presented at countless local, regional, national, and international conferences during her tenure as a doctoral student. Her research interests expanded to include mindfulness and acceptance-based counseling, severe mental illness populations, grief and trauma, secondary education programs for IDD, and creativity in counseling and counselor education. Additionally, she found a work home at Peninsula Behavioral Hospital in Louisville, Tennessee, where she still works as a Therapist. Here, she still hones her craft as a counselor working with severe mental illness and its impact on children, adults, and families. She received training and certification in Therapeutic Communication Intervention and Applied Suicide Intervention Skills Training (ASIST).