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Teaching Mindfulness to Create Effective Counselors

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Over the last decade a number of researchers have proposed that therapeutic presence can be fostered through training in mindfulness practices. Most counseling training programs focus on teaching students a set of skills, although the common or contextual factors movement contends that the quality of the therapeutic relationship and the personal characteristics of the therapist are the key determinants of positive therapy outcomes. For the past 10 years we have been teaching mindfulness practices to counseling students in a CACREP-accredited program. Our research suggests that training in practices like mindfulness meditation, yoga, qigong, and body-awareness can help counselors to realize and embody the personal characteristics that foster therapeutic presence. This article provides a detailed description of our mindfulness-based course, proposes recommendations for counseling coursework in mindfulness, and discusses the impact of the course on the ability to cultivate therapeutic presence.

Writers from a variety of perspectives and theoretical orientations have suggested that therapeutic presence—defined by Geller, Greenberg, and Watson (2010) as "bringing one's whole self into the encounter with clients by being completely in the moment on multiple levels: physically, emotionally, cognitively, and spiritually"—may be central to successful psychotherapy (p. 599). The common or contextual factors movement, for instance, counters the push toward manualized therapy and empirically supported treatments (ESTs) by drawing on data which suggest that the quality of the therapeutic relationship and the personal characteristics of the therapist are key determinants of positive therapy outcomes (Duncan, Miller, Wampold, & Hubble, 2010; Elkins, 2007; Fauth, Gates, Vinca, Boles, & Hayes, 2007; Frank, 1973; Wampold, 2001; Westen, Novotny, & Thompson-Brenner, 2004). Wampold (2010) described the common factors as elements present in all forms of psychotherapy. Although different working models have conceptualized the common factors, it is difficult to list specific factors because they are so intertwined. Nonetheless, one factor often mentioned is the working alliance between therapist and client (Wampold, 2010).

Besides investigating which treatments might work well with specific

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client issues, many researchers have looked at how the quality of the therapeutic relationship can lead to effective outcomes. For example, Westen et al. (2004) critiqued what they saw as faulty assumptions underlying some research validating ESTs; they suggested that variance in outcomes is due in part to the therapeutic relationship. Hauser and Hays (2010) emphasized common factors, the therapeutic alliance, and counselor attributes as elements leading to effective outcomes. And within psychoanalysis, relational, intersubjective, and attachment-oriented approaches have all stressed the importance of presence in the therapy relationship (Mitchell & Aron, 1999; Rubin, 1996; Safran, 2003; Stolorow, Atwood, & Orange, 2002; Wallin, 2007). If the quality of the therapeutic relationship is indeed a common factor in psychotherapy, what is it about the relationship that influences therapy outcomes?

Carl Rogers (1957) spoke of this quality of presence when he identified the necessary and sufficient conditions of therapeutic change, among them unconditional positive regard, empathetic understanding, and congruence. Rogers considered congruence most important, saying

> The third condition is that the therapist should be, within the confines of this relationship, a congruent, genuine, integrated person. It means that within the relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly (Rogers, 1957, p. 97).

Klein, Kolden, Michels, and Chisholm-Stockard (2001) described congruence as therapists being in touch with how they experience their clients and being willing to use this information in the therapeutic process. They explained that "genuine responses require mindful attention and self-reflection" (p. 398). Learning self-reflection includes becoming aware of one's feelings and knowing when to communicate them to the client. Another dimension of congruence is learning when there is no genuineness, or when the relationship lacks attunement (Klein et al., 2001).

Like Rogers, others believe therapeutic presence deeply affects the quality of the therapeutic relationship (see Geller & Greenberg, 2011). Geller and Greenberg (2002) attempted to capture the essence of therapeutic presence by pointing to three components: "*availability and openness* to all aspects of the client's experience, *openness to one's own experience* in being with the client, and the *capacity to respond* to the client from this experience" (p. 72). Gehart and McCollum (2008) described presence as "an attitude or stance toward present experience that the therapist brings to the moment-to-moment therapeutic encounter" (p. 178). They considered therapeutic presence to be a state more of *being* than of *doing*. Yet most training programs focus on teaching students skills, which might be thought of as doing rather than being. While we believe learning fundamental counseling skills is still essential, graduate training programs in counseling seem to be lacking in more implicit aspects of the

therapeutic relationship.

This problem is underscored by research that indicates that therapists tend to not adhere to new or advanced therapy methods once training has ended: Fauth et al. (2007) suggested that psychotherapy training should concentrate on teaching a few "big ideas" through training in meta-cognitive skills, such as pattern recognition and mindfulness. While theory and research emphasize the importance of therapeutic presence, there have been few studies of how a counselor can cultivate therapeutic presence and integrate it into the therapeutic relationship (Hauser & Hays, 2010). Our research suggests that mindfulness might be useful.

MINDFULNESS

In recent years a number of researchers and clinicians have proposed that therapeutic presence might be fostered through training in mindfulness practices (Bruce, Manber, Shapiro, & Constantino, 2010; Christopher & Maris, 2010; Fauth et al., 2007; Fulton, 2005; Gehart & McCollum, 2008; Gökhan, Meehan, & Peters, 2010; Grepmair et al., 2007; Shapiro, Brown, & Biegel, 2007). Mindfulness refers to a state of being aware, with acceptance, of thoughts, emotions, and sensations as they arise.

Mindfulness has been found to influence how therapists and other health care practitioners relate to their emotional life. For instance, Shapiro, Schwartz, and Bonner (1998) found that medical and premedical students participating in Mindfulness-Based Stress Reduction (MBSR) training were able to both reduce their anxiety and depression and increase their empathy. Compared to a cohort control group, counseling students participating in another MBSR program reported significant decreases in stress, negative affect, rumination, and state and trait anxiety, and significant increases in positive affect and self-compassion (Shapiro, Brown, & Biegel, 2007). After reviewing research on therapists who meditate and on outcomes for clients of therapists who meditate, Davis and Hayes (2011) reported, "Mindfulness helps therapists: develop their ability to experience and communicate a felt sense of clients' inner experiences [and] be more present to clients' suffering; and helps clients express their body sensations and feelings." A study of brief mindfulness training for doctoral students found significant increases in participants' reports of mindfulness abilities, in their ability to observe internal phenomena, and in their ratings of self-kindness (Moore, 2008). Mindfulness practices also seem to foster compassion for self and empathy for others. Greason and Cashwell (2009) found that for counseling students mindfulness was a predictor of self-efficacy and empathy and was related to the ability to direct attention. These findings are aligned with our own, as we will discuss.

If mindfulness can increase empathy and response flexibility and decrease

reactivity, it is likely to promote therapeutic presence. McCollum and Gehart (2010) found that beginning therapists could cultivate therapeutic presence by practicing mindfulness meditation; study participants reported such positive effects relating to presence as being able to attend to both their own and the client's experience in the same moment-by-moment awareness. Mindfulness practices seem to help counselors-in-training to relate to themselves and others with more genuineness, acceptance, and empathy.

In previous studies we examined how mindfulness training affects counseling students, especially in learning self-care practices that could help prevent burnout, vicarious traumatization, and compassion fatigue (Chrisman, Christopher, & Lichtenstein, 2009; Christopher et al., 2011; Christopher, Christopher, Dunnagan, & Schure, 2006; Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008). While self-care is a notable benefit, the beneficial influence of mindfulness does not seem to be restricted to the therapist; the benefits extend to all participants in the therapeutic relationship. A dramatic example comes from Grepmair et al. (2007), who found that the patients of meditating psychotherapists-in-training scored higher than those of nonmeditating trainees on almost every measure they were administered, including global functioning, a symptom checklist, and subjective experience.

These studies imply that teaching mindfulness strategies is an effective way to improve the therapeutic relationship. In what follows we fully describe a mindfulness-based course, propose recommendations for counselor educators offering courses in mindfulness, and discuss the impact of our course as expressed in qualitative studies from 2006 through 2011.

THE MINDFULNESS COURSE

The second author 13 years ago designed a course based loosely on the MBSR program (Kabat-Zinn, 1990) for master's-level counselors-in-training, entitled Mind-Body Medicine and the Art of Self-Care. The course was designed to (a) give students practical tools for self-care while in graduate school and beyond, and (b) familiarize them with mindfulness and contemplative practices and their relevance in counseling, psychotherapy, and behavioral medicine. The course is a three-credit, 15-week elective meeting twice a week for two and a half hours. The first 75–90 minutes consist of learning and practicing meditation, yoga, the body scan, and qigong (an ancient Chinese mind-body practice of which tai chi is a martial arts form). The session typically begins with the eight brocades of qigong (gentle stretching movements similar to tai chi) followed by a mindfulness yoga routine. Mindfulness yoga, a relatively gentle practice, emphasizes becoming aware of the body and learning to hold poses with equanimity and a minimum of effort; it is similar to much

hatha yoga currently taught in the United States (an example of the qigong and mindfulness yoga routines practiced in class can be downloaded at http://www.montana.edu/wwwcc/docs/selfhelp.html).

Meditation based on the Vipassana or insight approach is introduced in the third week. It begins with development of concentration practice through a focus on the breath. Over time awareness of sounds, physical sensations, feelings, and thoughts as a focus of meditation are slowly introduced. By the end of the semester the practice emphasizes *choiceless awareness*—a form of meditation where the contents of awareness are allowed to come and go and the student learns increasingly to identify with awareness itself. The class also occasionally introduces other practices for self-care or increasing awareness to alter the normal routine, among them the tai chi practice of "push hands," which cultivates the art of yielding and a sensitivity toward others; tennis ball self-massage, where we spend up to an hour finding trigger points in the body and working with them from a mindful perspective; and a "slapping massage" in which groups of three students take turns using a firm slapping with loose wrists across the body of a fourth to generate massage. This practice helps students to dwell in their body and instill the idea that anyone can give and receive massages.

The second half of each session involves didactic instruction and discussion. Course readings include materials from health psychology, psychological and medical anthropology, behavioral medicine, cultural psychology, and religious studies as well as introductions to various mindfulness traditions (including both those indigenous to specific traditions and contemporary Western interpreters), applications to counseling and behavioral medicine, and current research. Throughout the semester audiovisual materials educate and inspire students (see the appendix for a list of books and audiovisual materials).

The most important assignment is for students to practice some form of mindfulness outside of class for at least 45 minutes 4 times a week. Students are also expected to meet once a week in pairs to process their practice activity. Other assignments are a 50-page journal to encourage both intellectual and experiential reflection, and brief presentations on empirical research related to mind-body medicine. The course is led by the second author, a certified yoga teacher who has practiced yoga and meditation for 30 years.

IMPLEMENTATION OF MINDFULNESS TRAINING

Although we believe that counselor education should incorporate mindfulness training, as counseling programs increasingly begin to integrate this approach, we believe it is important to offer perspective on the challenges.

The first consideration is whether program faculty have a sufficient background. Like Jon Kabat-Zinn (2006), who warned, "Don't turn mindfulness

into a commodity," we take a conservative stance in teaching mindfulness practices. While many naturally are excited about this approach and want to "get on the bandwagon," teaching mindfulness practices requires a dedicated personal practice. For Kabat-Zinn, having a personal practice means daily meditation and another body-centered practice and attendance at several 7- to 10-day silent meditation retreats. Other approaches give less emphasis to this type of personal commitment, such as those based on Acceptance and Commitment Therapy and Dialectical Behavior Therapy. From Kabat-Zinn's perspective, however, mindfulness needs to become a way of life, not just a skill, an intervention, or an outlook.

We believe teaching mindfulness effectively requires deep knowledge of oneself, acquired through years of personal practice, and that counselor educators interested in teaching mindfulness should therefore move slowly into what needs to be a life-long commitment. This sort of teaching cannot be done from a manual. In a sense instructors must be able to drop into deep contact with themselves, a kind of altered state, where in putting words to what is occurring in the present moment they find opportunities to teach mindfulness principles. It is a kind of *teaching from within*. We recommend that faculty interested in bringing mindfulness into counseling training who do not yet have years of personal experience try to find meditation teachers with whom to co-teach. Yoga teachers might also be a possibility, although much yoga currently taught in the United States is so focused on "power" or "flow" that, while beneficial in many respects, it can keep participants from being able to deeply notice what is transpiring in their bodies moment-by-moment.

From our experience, learning how to instruct in mindfulness practice (e.g., leading a meditation or yoga session) is relatively easy. The real art in teaching mindfulness is to help students to apply the practices to their own lives by, e.g., helping them to discover that the practices have implications for how they relate to their bodies and physical sensations, to emotions, and to the contents of their minds. When teaching we invite students to notice their experience before and after they do specific practices; this allows them to draw their own conclusions about the effect of each practice. The task of the instructor is to help students learn to be aware of their experience and accept it. This involves pointing out obstacles, pitfalls, and other challenges that could occur for students beginning practice and helping them surmount these. Instructors need to be prepared for how deeply mindfulness practices can impact students—and clients. Many counseling students go through radical changes that can call into question their sense of identity, leave them uncertain about how they previously managed difficult emotions, and disrupt their interpersonal relationships. Mindfulness training intensifies such changes.

While mindfulness practices may induce states of relaxation, that is not the point. The point is that they can profoundly alter our relationship to our-

selves and our minds. As Ray (2008) said, "The conscious mind, which previously was the engineer of our human existence, moves increasingly into the role of listener and helper" (p. 215).

It is critical to make space within the class to process these changes. Instructors need to be sensitive to group "moods" and use their intuition to sense when a class is feeling overwhelmed or disoriented by the changes they are making. This entails keeping any class agenda or timetable flexible and creating discussions with both small groups and the whole class to explore their experiences and the changes they are making. Many internal changes manifest themselves in ways that are hard to articulate. Through hearing another person's account, students can better connect with their own experiences and understand the dynamics of these internal changes.

These discussions also help to motivate students. The impact of mindfulness practice tends to be dose-related; through continual processing of experiences, those whose practice is less regular hear from those who are more committed. These discussions are also essential to creating a climate of safety, a kind of holding environment that can contain students as they undertake what can often be a painful and difficult journey (see, e.g., Maris, 2009). Instructors need to be prepared with group facilitation skills to ensure that the course group dynamics support a climate of safety.

Instructors should also be aware of the kinds of experiences meditation can engender, both positive and negative, and be able to recognize and differentiate what have been termed "spiritual emergencies" from psychopathology as generally conceived (Grof & Grof, 1989). Students may have different motivations for taking a mindfulness course. Some may want to learn how to integrate disavowed aspects of their experience; others might use the practices as a form of "spiritual bypass" allowing them to linger in peaceful or blissful states to avoid dealing with painful emotions, the "shadow," or unresolved issues (Rubin, 1996; Welwood, 2000).

While it is crucial that the class environment be supportive, other supports are necessary to integrate ideas generated by the readings and practices. It is especially important that students being trained in mindfulness practices also be in therapy themselves so that they have a context to process and integrate changes that our research has shown impact every domain of their life. Classmates often serve as a support system for learning to integrate mindfulness practices into a busy schedule. Being asked to practice four times per week for 45 minutes can feel like a lot of time to students with many other things going on in their lives, but practicing mindfulness as homework is an important element of the course. Students often support each other in practice outside of class, thus building a routine of mindfulness practice into their schedules.

Another challenge is finding room in the curriculum for mindfulness training; we have yet to find an optimal space. And, of course, there is consid-

erable pressure to not offer or to eliminate courses not seen as meeting (enough of) the accreditation standards. In these lean times, it can be challenging to make the case that mindfulness training is essential. It is helpful if other faculty are supportive of the aims of the course so that students receive reinforcement in multiple settings with the changes that they are making personally and in integrating mindfulness into how they conceptualize their clinical work (Maris, 2009). Naturally, the insights and changes that come with studying and practicing mindfulness carry over into student work with clients. It is helpful for supervisors to understand these changes so that they can apply concepts and move learning forward in skills courses, practicums, and internships.

DISCUSSION

For the past seven years with colleagues and former students we have conducted qualitative studies of the impact of the Mind-Body Medicine and the Art of Self-Care course.

The results can be reviewed in detail elsewhere (Chrisman, Christopher, & Lichtenstein, 2009; Christopher et al., 2011; Christopher, Christopher, Dunnagan, & Schure, 2006; Maris, 2009; Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008). We used qualitative inquiry because in a new field it is important to understand peoples' experience in their own terms, before the topics of interest have been predetermined by research measures and theories. We then used inductive content analysis to identify themes in the data (Patton, 2002; Strauss & Corbin, 1994). Students were informed that their voluntary involvement in the studies in no way affected their grade. Information was collected after the semester was over, and student information was kept confidential.

Two themes recurred throughout these studies: increased awareness of self and others, and increased acceptance of self and others. Many mindfulness students reported becoming more aware, patient, mentally focused, empathetic, compassionate, attentive, responsive, and able to handle strong emotions; they also described being less defensive, reactive, and judgmental. These findings are consistent with other studies of counseling students who practiced mindfulness (Greason & Cashwell, 2009; Moore, 2008; Shapiro, Brown, & Beigel, 2007). This suggests that mindfulness practices are useful for increasing attention and empathy, two elements related to therapeutic presence. Moreover, mindfulness training apparently endures. One of our studies showed that influences from mindfulness training continued to impact a counselor up to six years later (Christopher et al., 2011). This is consistent with the finding that MBSR is associated with high compliance rates even three years later (Miller, Fletcher, & Kabat-Zinn, 1995).

Through our research we consistently found that psychotherapists and

counselors, both in graduate school and already practicing, described a variety of ways in which mindfulness practices helped them to foster presence. Geller and Greenberg (2011) proposed that a therapist's ability to be present with clients enhances the therapeutic relationship and promotes healing. This type of presence seems to entail a variety of dimensions, among them enhanced awareness of their own inner experience and the experience of the client, and acceptance of both themselves and the client. In turn, awareness and acceptance seem related to becoming less reactive. Consistent with work on mentalizing and the reflective function (Fonagy, Gergely, Jurist, & Target, 2002), many of our participants described being better able to nonreactively witness their own thoughts and emotions: They learned to take their minds "less seriously" and not feel that they have to "do something" when they become anxious, and were then less reactive to their clients' experiences. For instance, they could maintain a therapeutic connection with a struggling client rather than being caught in their own sense of inadequacy or need to be in control. These students thus felt more free to respond in the moment, without judgment or distraction by other thoughts. In approaching therapy more calmly, slowing the mind, the participants were able to stay connected to their clients and themselves rather than trying to "fix" clients or distract the clients and themselves from painful experiences (see Maris, 2009). These student reports seem consistent with Siegel's claim (2007) that mindfulness facilitates a self-attunement that increases capacity to attune to others.

Our students also described being better able to notice their own countertransference reactions. Rather than being unaware, they could be observers, just noticing what was happening in the present moment, without judgment, and without trying to suppress their reactions or act them out. Thus, rather than responding reactively, they had more freedom to intentionally choose how to respond to a certain feeling aroused through countertransference. This seemed to be connected to a new ability to tolerate silence and wait through it confidently, allowing new experiences to emerge spontaneously. This helped move therapy from mere dialogue to a level where genuine encounters occurred and clients could begin to experience someone being present in the midst of their own vulnerability.

A number of students indicated that they were able to use themselves, especially their bodily reactions, to gain more insight into their clients' experience. Perhaps the ability to observe and be comfortable with silence was learned through experience with meditation, or exposure to mindfulness concepts such as being in the present moment rather than dwelling on the past or worrying about the future. Students seemed to move from "doing," simply acting out their counseling skills, to "being" with a client in the experience. Both aspects of therapy are important, but we consider therapeutic presence to be in the "being" category. Many participants described having greater empathy with

and compassion not only for their clients but also for themselves as beginning therapists. The kind of presence that mindfulness practices seem to cultivate is thus consistent with writings that emphasize how psychotherapy can help clients by creating new forms of attachment (Beebe & Lachmann, 2002; Fonagy et al., 2002; Siegel, 1999; Stern, 2004; Wallin, 2007).

The common-factors literature suggests that the two main contributors to therapeutic outcome are the person of the therapist and the therapeutic alliance (Duncan et al., 2010). Rogers' core conditions (1957) of acceptance, genuineness, and empathy are still the benchmark for conceptualizing the therapist's contribution to successful outcomes (Duncan et al., 2010). Yet, as Rogers stressed, these are not techniques but ways of being in the world, and although most graduate counseling programs emphasize these core conditions, we have been at somewhat of a loss about how to cultivate them in students. In our studies many students reported that bringing awareness and acceptance more consciously into their lives through mindfulness training improved their relationship with themselves, increased their capacity for true dialog with others, and enhanced their therapeutic work. Thus mindfulness training may not only foster the core conditions but could also help moderate the instrumentalism of modern society (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985) and the managed care mentality (Cushman & Gilford, 2000). Our findings suggest that for therapists-in-training mindfulness training can increase therapeutic responsiveness, empathy, and attentiveness while decreasing reactivity and defensiveness. All of these qualities affect the ability of a therapist to be present with their clients, and thus affect the therapeutic relationship and therapy outcomes. As Grepmair et al. (2007) suggested, "The promotion of mindfulness in psychotherapists-in-training positively affects the course of therapy and the treatment results in their patients" (p. 337).

Although the results support the idea that training in mindfulness practices can improve therapeutic presence, our research does have limitations. As with all qualitative research, our studies are limited by their reliance on the perceptions of our participants. Furthermore, at the time the research was conducted, the course in mindfulness was an elective. Thus, there may have been a self-selecting bias if students who were more open to the benefits of mindfulness chose to take the class. Also, we had no control over practice homework, and a few of the students had an established yoga or meditation practice before the class began. One last limitation concerns the generalizability of the results across different ethnic backgrounds and genders. At our rural Western university, most study participants were women of European-American descent. Despite these limitations, however, our findings are generally consistent with previous research on using mindfulness with therapists-in-training.

There is clearly considerable room for more research on mindfulness training, especially quantitative studies to explore how much change occurred

and in what proportion of the participants or of their clients. We decided it was imperative to introduce students to mindfulness practices in order to cultivate the concept of presence because, as the existential analyst Medard Boss (1965) concluded after an extensive period in India,

> What our psychotherapy needs above all is a change in the psychotherapists. If our science of mental health is to become more effective, psychotherapists will have to balance their knowledge of psychological concepts and techniques with a contemplative awareness. This will have to be an awareness that exercises itself day after day in quiet openness (p. 191).

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APPENDIX

Readings and Audiovisual Materials used in Mindfulness-Based Course

Readings:

Epstein, M. (1995). *Thoughts without a thinker.* New York, NY: Basic Books.

Epstein, M. (1998). *Going to pieces without falling apart.* New York, NY: Broadway Books.

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

Selections from:

Cohen, K. S. (1997). *The way of qigong: The art and science of Chinese energy healing.* New York, NY: Ballantine.

Desikachar, T. K. V. (1995). *The heart of yoga.* Rochester, VT: Inner Traditions International.

Greenspan, M. (2003). *Healing through the dark emotions: The wisdom of grief, fear, and despair.* Boston, MA: Shambhala Publications.

Gunaratana, H. (1992). *Mindfulness in plain English.* Boston, MA: Wisdom.

Ornish, D. (1998). *Love & survival.* New York, NY: Harper.

Rama, S., Ballentine, R., & Ajaya, S. (1976). *Yoga and psychotherapy: The evolution of consciousness.* Glenview, IL: Himalayan Institute.

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Siegel, D. J. (2010). *Mindsight: The new science of personal transformation.* New York, NY: Bantam Books.

Tigunait, P. R. (1983). *Seven systems of Indian philosophy.* Honesdale, PA: The Himalayan Institute.

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Audiovisual Materials:

Ariel, E., & Menahemmi, A. (Directors). (1997). *Doing time, doing Vipassana* [video recording]. India: Karuna Films.

Benson, H. (Author), & Massachusetts General Hospital, & Benson-Henry Institute for Mind/Body Medicine (Producers). (2008). *Advanced Tibetan Buddhist meditation: The investigations of Herbert Benson, M.D.* [video recording]. USA.

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Goldman, L. (Author), & National Geographic (Publisher). (2008). *Stress: Portrait of a killer* [video recording]. USA.

Grubin, D. (Producer). (1993). *Bill Moyers: Healing and the mind: Healing from within* [video recording]. New York, NY: Ambrose Video.

Kukura, A., Philips, J., & Stein, A. M. (Directors). (2008). *The dhamma brothers* [video recording]. USA: Northern Light Productions.

Markowitz, A., & Grubin, D. (Producers), & Grubin, D. (Director). (1993). *Bill Moyers: Healing and the mind. Volume 1, The mystery of chi* [video recording]. New York, NY: Ambrose Video.