Mindfulness, a meditative practice associated with reduced anxiety and depression (Khoury et al., 2013), and more effective emotional regulation (Davis & Hayes, 2011), has become increasingly popular, both in popular culture and the health-care world. A strong theoretical case has been made that mindfulness has a place within occupational therapy (Reid, 2011; Elliot, 2011) and that occupational therapists are in a unique position to connect the “being” that mindfulness honours with the “doing” of people’s occupations (McCorquodale, 2013). There is, however, a degree of abstraction in the discussion of the theory of mindfulness. How can practitioners actually implement it in practice? A number of challenges are posed to its real-world application. I will address two in this paper: the challenge of integrating mindfulness in a uniquely occupational way and the difficulty of helping clients adhere to a mindfulness routine. I am an occupational therapist who has practiced mindfulness in my personal life for seven years, and I have reflected on my experience within the occupational therapy context to generate the suggestions I share here.

Mindful occupation
The first challenge to consider is how mindfulness can be integrated into practice in an occupational way. Some have argued that mindfulness is important to occupation. Reid (2008) suggests mindfulness can lead to occupational presence, a state of consciousness of being aware of oneself, “engaged in occupation in place” (p. 43), and that this can influence well-being. McCorquodale (2013) highlights the benefits of a mindfulness practice by occupational therapists when used as a way to access intuitive knowledge about their clients. Elliot (2011) notes that mindfulness is itself an occupation. But, what might mindfulness look like in practical terms for a practitioner?

Mindfulness has been defined in many ways in the fields of psychology and occupational science, as well as by Buddhist writers in popular literature. Brown and colleagues (2007) describe it as a mental state of “present-oriented consciousness” (p. 214). The Buddhist teacher Thich Nhat Hanh describes it as “the capacity to shine the light of awareness onto what’s going on here and now” (2011, p. 20). I describe mindfulness simply as the practice of presence, where presence is an awareness of the events in our stream of consciousness, whether they be emerging thoughts, sensing our physical environment, or feelings such as happiness, tiredness or boredom. When we are present, we notice these events of consciousness with awareness, rather than being ‘caught up’ in them.

As a student of occupational therapy, I have found that occupations can be carried out with varying degrees of presence. Consider two different ways of driving. One driver, after a busy day at work, puts her brain on “autopilot,” turns on the radio and “zones out” as she drives her familiar route home from work. She arrives home with no problems. A second driver decides to turn off his radio and spend the 20-minute drive paying attention to the fine details of the car bumping over gravel on the road, the sound of the engine gearing up and the complex events of the road. The second driver has been engaged in mindful driving. McCorquodale (2013) notes that mindfulness is the opposite of mindlessness. Similarly, mindful driving can be experienced as the opposite of mindless driving. Rather than zoning out, the mindful driver has “zoned in” to the occupation. He has spent 20 minutes building on his capacity to relax and respond effectively to stressful events (Davis & Hayes, 2011), and his experience of the occupation is likely enhanced because he has been focussed wholly on it.

Forming a mindfulness habit
The benefits of mindfulness accrue with practice (Kabat-Zinn, 1990). We may want to introduce clients to such sitting meditations in order to build a foundation for the practice. As occupational therapists, however, we can go beyond this and incorporate mindfulness training into occupational therapy. Making breakfast, washing dishes, eating a meal or going for a walk can all be done more or less mindfully (Nhat Hanh, 2011). I suggest that our profession’s niche in mindfulness should be built around helping clients to identify occupations during which they would benefit from greater presence and which they can use as formal meditation practices.

Formal mindfulness meditation usually begins with sitting quietly and paying attention to one’s breath (Kabat-Zinn, 1990). We may want to introduce clients to such sitting meditations in order to build a foundation for the practice. As occupational therapists, however, we can go beyond this and incorporate mindfulness training into future practice. Making breakfast, washing dishes, eating a meal or going for a walk can all be done more or less mindfully (Nhat Hanh, 2011). I suggest that our profession’s niche in mindfulness should be built around helping clients to identify occupations during which they would benefit from greater presence and which they can use as formal meditation practices.
and messy. It is our responsibility to understand clients’ deeper motivations; we can harness our understanding of those motivations to promote an effective mindfulness habit in clients.

Occupational therapists can help people to identify reasons for meditating. People generally form habits when they can connect their behaviours to a tangible payoff (Duhigg, 2012). We can help clients identify ways they could benefit from continuing to meditate long after our intervention sessions are finished. Such benefits can include an increased sense of peace in the world, improved ability to manage pain (Kabat-Zinn, 1982) and enriched self-awareness during activities (Reid, 2008). We draw directly on our client-centred practice philosophy when we customize the education we offer to the unique needs of the individual.

Occupational therapists can also help clients to find the mindfulness practice that is right for them. I believe that the best way to ensure the continuity of a practice is to fit the practice to the lifestyle, rather than the other way around. As practitioners, we can assist clients to find a practice that they will actually want to commit to. For example, some people simply don’t like sitting still. For such individuals, more kinetic meditations, such as walking meditations, may be a better option. Some people may not be interested in mindful eating, but may be willing to spend ten minutes washing dishes mindfully following a meal.

Occupational therapists can help clients develop a mindfulness plan that is practical and realistic. Research about habit formation of health behaviours suggests that a common obstacle to developing habits is unrealistic plans (Aarts et al., 1997). Many mindfulness practitioners recommend meditating for at least 20 minutes each day, and a client may even agree to this. However, if he or she doesn’t realistically have the time or motivation to do it regularly, the practice will not be sustained. During busy periods, I have managed to maintain a mindfulness routine in my life by meditating for as little as five minutes each morning. While shorter than the ideal amount of time (Kabat-Zinn, 1990), this has maintained the continuity of my habit. We can encourage clients to use similar strategies. In order to best position clients to maintain a mindfulness habit, we can let go of ideals and focus on the pragmatic factors that will allow clients to maintain that habit. This way, we can ensure that practicing mindfulness is something clients look forward to doing.

Finally, occupational therapists can encourage clients to be non-judgemental with themselves in relation to their mindfulness practice. Clients might be inclined to drop mindfulness when they believe they are not “good” at meditating, that they can’t “stop their thoughts.” But this is unnecessary. In my experience, I have found I was able to stick to mindfulness because I didn’t worry about being good at it. Human minds are uncooperative and race automatically through their own inner monologues. Even as an experienced meditator, I frequently get lost in thought. Each time I remember my intention to meditate and reorient myself to the present moment, I consider this to be the act of participating in meditation. This is the practice of gaining awareness of the wanderings of our minds and recapturing focus. No matter how many times clients realize they are lost in thought, rather than berating themselves for this, they can congratulate themselves for finding focus again.

Conclusion
With the widespread appeal and growing recognition of the benefits of mindfulness today, it is appropriate that many health professionals are introducing the practice to clients. Occupational therapists can claim our own niche in this area by focusing on bringing mindfulness into occupations and helping our clients to develop the habit of mindfulness. In this way, we can draw on the fundamental client-centred values of our profession as we extend mindfulness into our practice.

References

About the author
Randy McVeigh, OT, is an occupational therapist in community rehabilitation and return to work in Vancouver, BC. He graduated with his MScOT in 2014 from Western University, where he developed the connections between his mindfulness practice and occupational therapy principles during a mindfulness course led by Dr. Elizabeth Anne Kinsella. He can be reached at: randy.mcveigh@gmail.com