

Clinical Considerations for Mindful Awareness for Youth

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Key Points

- Differentiate between traditional and contemporary conceptualizations of MA.
- Critically evaluate how adaptations to MA have both expanded accessibility and potentially limited the scope of mindful practices.
- Identify proposed mechanisms through which MA operates.
- Evaluate current empirical evidence for MA interventions across clinical youth populations; recognizing both promising findings and significant methodological limitations.
- Evaluate current empirical evidence for MA interventions across general youth populations.
- Identify options for clinical applications and modifications of MA techniques per developmental stage.

Abstract

Mindful awareness (MA) is generally viewed as the present, non-judgmental awareness and acceptance of momentary experiences. However, Western psychology has yet to differentiate MA from mindfulness or mindfulness-based interventions. Fraught with critiques from MA traditionalists, modern MA developed as a secular, medically minded intervention aimed at mending inter- and intrarelationshps. While current research offers some theories about the mechanisms of change underlying MA interventions (e.g., exposure and response prevention), research on the factors that contribute to the success of MA interventions is underdeveloped. Mindful awareness is considered to be a flexible transdiagnostic approach for pediatric anxiety, depression, inattention, learning, and mood (Beauchemin et al., 2008; Kallapiran et al., 2015). Though promising, many methodological limitations exist and limit the generalizability of and confidence in the impacts of MA. This article reviews the background of MA, as well as related mechanisms of change, impacts for youth populations, youth-centered adaptations, and implementation considerations for youth populations.

Keywords

Meditation; Mindful; Mindfulness; Mindful awareness; Mindfulness-based cognitive therapy; Mindfulness-based intervention; Mindfulness-based practice; Mindfulness-based stress reduction; Mindfulness training; Youth

Introduction

From both a definitional and clinical perspective, mindful awareness (MA) has proven difficult to standardize. Current literature fails to clearly differentiate the state of mindful awareness from the intentionality of mindfulness or mindfulness-based practice (MBP) and typically synonymizes these three terms. For that reason, the following article will also use these terms interchangeably while providing an overview of the origins, mechanisms, impacts, adaptations, and modern applications of MBPs.

Mindful awareness has been defined in current research as, "... contain[ing] attention focusing and includ[ing] behaviors such as intense looking at objects or scenes, careful examining, fingering and inspecting them with interest for details (Nieminen and Sajaniemi, 2016, p. 2). Similarly, mindfulness is described as the ability to, "... (1) act with awareness; (2) be less reactive; (3) be non-judgmental; (4) develop the ability to label and describe with words the internal world and (5) self-observe" (Siegel, 2009, p. 152). Similarities are seen within the action-oriented wording of both definitions, as well as within the shared goals of MA and mindfulness, as both processes target improvements in attention management, emotional regulation, and social-emotional resiliency (Nieminen and Sajaniemi, 2016).

Traditional versus Contemporary Mindfulness

Using the conceptualization of Monteiro and colleagues (Monteiro et al., 2014), this article will refer to both "traditional" and "contemporary" forms of mindfulness, with the latter being those not explicitly grounded in the Buddhist practices in which mindfulness originated some 2600 years ago. This traditional, or "spiritual", form of mindfulness emerged in the Axial Age (800–200 B C E.) from the belief that liberation from suffering was an integral process of life. It was also recognized as one "limb" of the Eightfold Path. More generally, the Eightfold Path represents the fourth of the Buddha's four noble truths, with each "limb" representing different categories such as wisdom, mental/meditative development, and engaged action in the world. Within each domain, one can seemingly engage in "right" (*sammā*), skillful, or wholesome (*kusala*) action—or behavior that leads to cessation of suffering—or "wrong" (*micchā*), unskillful, or unwholesome action—behavior that does not alleviate suffering. Each "limb" is believed to be interdependent on the others, and suffering is thought to not be truly diminished until skillful conduct has been developed in all categories (Monteiro et al., 2014).

Per these beliefs, one then practices "right mindfulness" via incorporating MA within these other practices that, ultimately and collectively, cultivate wisdom, understanding, ethics and concentration. For example, Bodhi (1984) describes the Buddha's original teachings on how to exercise "right mindfulness" and his efforts to extend mindful practice beyond that of simply focusing on one's breath. One such extension is an exercise termed "mindfulness and clear comprehension" in which any and all actions (e.g., looking, bending, speaking, drinking) are performed with full awareness. To achieve "clear comprehension" in pursuit of "right mindfulness", one must: (1) explicitly understand the reason said action is being performed (i.e., identify the goal and ensure that the action aligns with Buddhist principles); (2) understand the suitability of the action (i.e., know the most efficient manner for achieving the action's goal); (3) keep one's mind in a constant state of meditation while performing the action; and (4) understand that the action is an impersonal process contributing toward a collective good or goal (Bodhi, 1984).

Contrastingly, "wrong mindfulness" (*micchā sati*), in accordance with traditional Buddhist teachings, is assumed when mindfulness is taught/used only as a meditative strategy without engagement in other aspects of the Path (e.g., ethics). Traditionalists therefore critique contemporary mindfulness practices as tools used solely for meditative purposes rather than to achieve holistic liberation from suffering or unbounded absorption into ethical functioning. Modern mindfulness is also criticized for its primary emphases on the cultivation of attention and concentration, as traditional philosophers noted these functions as necessary but not sufficient for "right mindfulness" to develop (Monteiro et al., 2014).

With an initial attempt to adapt traditional mindfulness to that of a Western nature, the following definition of mindfulness was first noted in contemporary psychology approximately 35 years ago: (1) "... the ability to view both objects and situations from multiple perspectives and (2) the ability to shift perspectives depending upon context" (Grossman, 2015, p. 17). Within academic psychology, spiritually based concepts were adapted to secular and clinical models of well-being that translated the mindful process into a therapeutic technique with the goal of improving emotion regulation (Scharf, 2013).

Scharf (2013) further elaborates that contemporary understandings of mindfulness (e.g., present-focused attention) emerged from a 20th century revival of the Theravāda—a conservative branch of Buddhism that adheres to Pali sources for discussions of non-judgmental, present awareness. This adaptation seemingly encouraged the ability of "laypersons" to gain insight without strict adherence to the principles of traditional Buddhism (Baer et al., 2006; Scharf, 2013). However, traditional teachers and philosophers caution against using mindfulness in these ways that contradict Buddhist principles (e.g., offering mindfulness programs to profit-driven corporations) due to the belief that it constitutes "wrong mindfulness" (Monteiro et al., 2014).

While both traditional and contemporary forms of mindfulness share the goal of alleviating suffering, contemporary versions have developed according to medical, clinical and secular models concerned with mending intra- and interrelationships (Monteiro

et al., 2014). Though MA stands at the core of popular mindfulness-based interventions (MBIs) such as Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), there is still disagreement among Western scholars regarding its definition (Grossman and Van Dam, 2011). Buddhist traditionalists, in an even starker contrast, deny that the process of mindfulness should be operationalized at all, and posit that mindfulness is more of a *process* rather than a state to be achieved (Christopher and Gilbert, 2007; Grossman and Van Dam, 2011).

Despite discrepancies in its definition and practice, mindfulness has maintained popularity in current research and clinical settings, and has yielded important, yet limited, research findings. While a critical evaluation of this body of research is presented later in this article, discussion moves forward to assess psychological mechanisms of change.

Mechanisms of Mindful Awareness

Meditation

Despite the surge in popularity of MBIs over the last decade, knowledge of related mechanisms of change remains underdeveloped (Young et al., 2018), though some academics have proposed theories. Bodhi (1984) posits that mindfulness has both the goal and outcome of honing attention while eliminating distraction, and is more an act of *undoing* (e.g., *not* thinking) than of *doing*. Viewing “doings” as interference with the mindful process, mindfulness is said to *undo* pre-established conceptual and interpretive frameworks via “noting”—i.e., “it does nothing but note, watching each occasion of experience as it arises, stands, and passes away” (Bodhi, 1984, p. 82). Mindful practice is then believed to alter one’s sense of self by releasing prior learning and judgments so that the individual can view their inner and outer worlds with novelty and fresh perspective (Siegel, 2009).

The ability to direct one’s attention in such a detached way is theoretically developed via meditation, or the intentional regulation of concentration (Baer, 2003). Traditional meditation practices such as extended periods of motionless sitting, body scan meditation, and task-based mediation (e.g., mindful walking) are regularly incorporated into MBIs such as MBSR—the most frequently cited mindfulness training program in academic psychology (Baer, 2003; Kabat-Zinn, 1982).

Sharing the principle of non-judgmental acceptance—or the lack of evaluation of cognitions, emotions and sensations—most meditation exercises train attention to internal (e.g., bodily sensations, thoughts) and/or external (e.g., sight, sounds) experiences without the requirement to change the experience in any way (Baer, 2003). This is similar to the original Buddhist teachings of “mindfulness breathing”, in which the Buddha promotes acceptance of a long or short inhalation as it occurs, and then of a long or short exhalation as it occurs. Without forcing or intentionally altering the breath in any way, one simply observes the breath moving in and out (Bodhi, 1984). Due to the continuous accessibility of the breath, as well as its ability to influence functions of other vital organs—e.g., heart—and respond to emotional, cognitive and behavioral changes, it is a common anchor in most meditations (Grossman and Van Dam, 2011). Due to MA’s emphasis on the ability to recognize internal and external experiences while letting them pass without alteration, a primary consequence of mindful meditations is the realization that most thoughts, emotions and sensations are transient (Baer, 2003).

Exposure and Cognitive Change

Kabat-Zinn et al. (1992) proposed that this ability to view cognitive, affective and physiological states as temporary improves emotion regulation and lessens emotional reactivity via principles of exposure and response prevention (E/RP). During a given mindful exercise, individuals may be exposed to things such as pain (e.g., from prolonged motionless sitting) and/or the occurrence of task-irrelevant, anxious or depressive cognitions. As mindfulness promotes acceptance of, and not distraction from, these thoughts and sensations, the participant does not have the opportunity to escape these experiences. Therefore, one’s tolerance of related thoughts, emotions, and sensations may increase following prolonged exposure to them.

Additionally, individuals often believe that disastrous consequences often accompany or follow states of distress (e.g., “If I think about something bad, then something bad will happen”). When faced with such thoughts during meditation, they will ultimately experience the absence of these feared consequences, thus aiding desensitization to these thoughts, feelings and physiological experiences (e.g., “I thought about something bad, and nothing bad happened”; “Just because I feel uncomfortable does not mean that something awful is coming”). Cognitive change may then follow this habituation as participants learn to accept various internal events without fearing them or regarding distressing thoughts as facts (Baer, 2003; Kabat-Zinn, 1982; Kabat-Zinn et al., 1992).

Examples of fostering acceptance toward, while restraining reactivity to, cognitive and emotional experiences are commonly found in MBCT—an eight-week group intervention program developed to prevent relapse of major depressive episodes. More formally incorporating meditation with aspects of cognitive therapy, MBCT promotes a defused, or detached, view of one’s thoughts via rehearsal of statements such as, “I am not my thoughts”, and, “thoughts are not facts”. In this way, ruminative cognitive patterns are disrupted as individuals are taught to view their thoughts as temporary mental events rather than aspects of themselves or of reality (Baer, 2003).

Self-Management

As mindful meditation trains awareness to the unfolding of cognitive, emotional and physiological states, academics argue that this more readily enables individuals to engage in coping (Baer, 2003; Kabat-Zinn, 1982). Teasdale et al. (1995) notes that, since

mindfulness brings awareness to all internal events, this would alert an individual to early signs of a potential depressive relapse (such as noticing an increase in depressive thoughts), for example, or the urge to binge or engage in addictive conduct. This recognition may then activate behavior change such as reducing impulsivity or applying a skill previously learned in a treatment program (Linehan, 1993). Improved self-management, or self-observation, is therefore proposed as an additional mechanism enhancing the positive effects of mindfulness (Baer, 2003; Kabat-Zinn, 1982; Linehan, 1993).

Rehearsal

Integral to the processes of meditation, exposure, and mastery of MA, generally, is repetition. Repeated rehearsal of mindful activities (e.g., body scan meditation) and the repeated exposure to distressing cognitive and affective states without contingent disaster are suggested to alter neural activity and create healthier cognitive habits (Greenberg and Harris, 2012). Grossman (2015) remarked that mindfulness is less about being *more* attentive to momentary experiences than it is about repeatedly cultivating and experiencing mindful moments. Similar remarks from Daubenmier et al. (2013) suggested that this repetitive process improves the ability to regulate attention, differentiate between thinking about and actually experiencing physical sensations, and to observe transient thoughts and emotions more clearly.

The criticality of repetition is commonly seen within standardized MA protocols. For example, traditional MBSR requires participants to meet weekly for approximately two-and-a-half hours to receive instruction and rehearsal in mindfulness meditation skills. Individuals also participate in an eight-hour intensive mindfulness session midway through the program, and complete homework assignments to enhance learning, mastery and generalization of skills to daily routines (Baer, 2003; Kabat-Zinn, 1982).

Impacts of Mindful Awareness on Clinical Youth Populations

... this is not only the outcome of mindfulness—this list is a very clear description of living mindfully ... body regulation, attuned communication, emotional balance, fear extinction/modulation, flexibility, insight, empathy, morality, intuition ... (Siegel, 2009, p. 139).

Application of Mindful Awareness

Mindful awareness has become increasingly integrated into psychotherapeutic practice and, from a primarily scholarly perspective, this article will briefly discuss research on the impact(s) of MBIs for clinical youth populations below. It is important to note that this is not an exhaustive review, however, and more explicit clinical applications and adaptations will be discussed more in-depth later in this article.

While this section provides a general scholarly discussion, it is still important for individual clinicians to consider the unique client and their context before introducing MA in therapy. That is, while the principles of MA described earlier may seem deceptively simple (e.g., be present-oriented and non-judgmental; observe but do not try to change thoughts, emotions, or sensations), youths may have internal and/or external challenges that may make integration of MA more difficult.

For example, MBIs commonly target aspects of executive functioning such as working memory (e.g., holding information within immediate awareness) and cognitive flexibility (e.g., shifting and redirecting attention). Since executive functioning is still developing for children and adolescents, performing and mastering these mindful tools may be more difficult for them compared to adults (Tang et al., 2015). Interestingly, while it is important to consider these limitations when introducing MA, such difficulties may actually and additionally underscore MA as a needed treatment component for these youth. Therefore, the ways MA is introduced, taught and rehearsed are critical considerations so that youth can still benefit from mindful interventions despite pre-existing challenges.

Internalizing Disorders: Depression and Anxiety

Anxiety is the most prevalent diagnosable condition among adolescents, with approximately 30% of teens experiencing an anxiety-related disorder (Bitsko et al., 2022). Depression is also seen in high rates among this age group, with current estimates indicating a 19.2% prevalence rate among youth aged 12–19 years-old (Bitsko et al., 2022; Brener et al., 2023). Among children under 10 years-old, prevalence rates are lower with approximately 11% of children aged three to 17 years-old having an anxiety disorder and 4% being diagnosed with depression (CDC, 2023). Encouragingly, however, the most recent survey from the Centers for Disease Control (CDC; 2023) found that 55% of adolescents in the United States reported discussing their mental and emotional health with a health care professional. Because it seems that youths are actively seeking mental health support, it is of the utmost importance to understand the extent to which MA can reduce anxiety and depression symptoms so that such techniques can be incorporated into treatment, if needed.

In their meta-analytic review of 33 randomized control trials, Dunning et al. (2019) found that MBIs produced significant reductions (small to moderate effect sizes) in depression and anxiety symptoms among youth. Clinically, these MBIs reportedly helped youth recognize catastrophic and ruminative thinking patterns characteristic of anxiety and depressive disorders, respectively (Dunning et al., 2019). Such results may provide clinicians with better insight regarding the cognitive processes to target, and create distance from, when using MBIs with youth.

Results of this review are consistent with other context driven interventions. For example, [Raes et al. \(2014\)](#) demonstrated a reduction in depressive symptoms in adolescents who participated in a school-based mindfulness program, with effects mediated by reductions in ruminative thinking. Similarly, in their work with adolescent psychiatric outpatient populations, [Biegel et al. \(2009\)](#) found that significant decreases in anxiety, depression, and somatic complaints were shown among participants who participated in an MBI compared to treatment-as-usual (TAU) controls. More specifically, the practice of observing, but not reacting to, anxious thoughts reportedly interrupted the worry-avoidance cycle that often maintains anxiety disorders. Understanding the effectiveness of MA is important for the treatment of internalizing disorders, but, more specifically, uncovering the neurological and confirming the clinical underpinnings of MA is a needed next step in related research.

Externalizing Disorders: Attention-Deficit/Hyperactivity Disorder (ADHD)

As noted earlier, the application of MA to clinical presentations with executive functioning weaknesses, such as ADHD, is potentially fraught with challenges from both developmental (e.g., incomplete development of executive functioning skills) and clinical perspectives. Youth with ADHDs have inherent neurobiological difficulties in sustaining attention, and this may be a reason why research on the effectiveness of MA for youth with ADHD is mixed.

Some reviews report significant improvements in executive functioning and ADHD symptoms following an MBI ([Cairncross and Miller, 2020](#))—proposing that mindfulness may serve as a form of attention training. Whereas other reviews ([Evans et al., 2018](#)) were critical of the methodological quality of pediatric MBI research and did not think it appropriate to offer any definitive conclusions for its application in youth ADHD populations. While Zhang and colleagues ([Zhang et al., 2023](#)) reported positive but small effects of MBI on inattention, they also argued for additional research evidence. Small positive effects of MBIs were also shown in a work by [Vekety et al. \(2020\)](#), but, notably and interestingly, this effect was only significant when children's behaviors were rated by teachers.

The summary of research targeting the use of MA with youth with ADHD is characterized by caution. Until studies are designed to directly address core symptoms of ADHD, clinicians may consider using alternate evidence-based practices with MA as an adjunctive component. Prevalence rates do indicate that approximately 40% of children with ADHD have comorbid anxiety disorders and about 19% have depressive symptoms ([Danielson et al., 2024](#)). Therefore, clinicians may consider using MA to improve functioning in these collateral areas.

Externalizing Disorders: Conduct Disorder (CD) and Behavioral Dysregulation

Regulating emotional reactivity and impulse control are considered central to mindful practice and are also areas where youth with conduct disorders and oppositional behaviors often have most difficulty ([APA, 2016](#)). Some early research from [Singh et al. \(2007\)](#) showed promise as three adolescents with conduct disorder successfully learned and applied mindfulness techniques, with resulting reductions in aggressive behaviors and improvements in self-control.

There has been preliminary support showing reductions in anger and aggression, hallmark symptoms of conduct disorder, in students that participated in school-based MA interventions compared to control groups ([Fix et al., 2022](#)). However, there is concern about methodological rigor and generalizability of related studies ([O'Dean et al., 2025](#)), as well as a general lack of studies differentiating the impact of mindfulness interventions from established evidence-based psycho-social treatments for conduct problems ([Masi et al., 2023](#)). Youths who experience significant behavior dysregulation often receive a myriad of supports and it may be difficult to differentiate effects of MA alone.

Similar to ADHD research, further research is needed to determine the potential benefits of mindfulness with these behavioral populations, as well as the mechanisms of change. Methodological challenges seen in MA research for youth with ADHD are also seen within prevention studies of MA use for CD ([Caldwell et al., 2021](#)).

Neurodevelopmental Disorders: Autism Spectrum Disorder (ASD)

Integrating MA into clinical work with youth with ASD warrants careful consideration of youth factors such as: (a) developmental level, (b) unique diagnostic characteristics, and (c) level of awareness of internal states (i.e., affective, cognitive, and physiological). Consistent with work on ADHD, it is important that clinicians determine which symptoms would empirically benefit from MA. Of note, no research studies have demonstrated a positive impact of MA interventions on the core symptoms of ASD (e.g., cognitive rigidity). Rather, some preliminary research ([de Bruin et al., 2015](#)) has reported that, following an MBI, autistic adolescents disclosed an improvement in quality of life and a decrease in rumination, and that parents reported improved social responsiveness on behalf of their child(ren). However, no changes in worry or MA were concluded, of which were the targets of the intervention.

Ridderinkhof and colleagues ([Ridderinkhof et al., 2018](#)) did report that mindfulness training improved emotional and behavioral functioning in adolescents with ASD, with effects maintained at follow-up. They proposed that the structured, predictable nature of mindfulness practice in the absence of social demands created a low-pressure learning environment that helped participants acquire and eventually apply these skills. Overall, before clinicians begin integrating MA in their clinical practice with youth with ASD, it is important that they evaluate the current status of the ever-evolving research in this area and then consider the target client, as well as any adaptations that would likely optimize clinical outcomes.

Neurodevelopmental Disorders: Learning Disorders

When reviewing research on the application of MA for youth with learning disorders, it is important to note that: (1) *learning disorders* is a broad category and symptoms can look different for each child; and (2) youth with learning disorders often have

a comorbid diagnosis/es (e.g., ADHD, anxiety) and experience secondary emotional difficulties such as academic performance anxiety and/or low self-confidence and efficacy. These symptoms may exacerbate learning challenges, themselves.

As discussed, MA can address the cognitive, behavioral and emotional sequelae which are relevant to and impact learning. Using a multiple-baseline design to study four elementary school students with ADHD, [Carboni et al. \(2013\)](#) found that a brief mindfulness training, in which students were taught to return wandering attention to a focal point, improved on-task behavior. This finding holds promise as the continuous need to catch and redirect focus may mirror attentional demands of academic tasks.

While students may be attending more, however, that does not necessarily mean they are learning better. Future research may consider targeting the ability of MA to enhance acceptance of academic challenges for youth with learning disorders, as these students are commonly disgruntled by these difficulties and avoid challenging academic tasks—further compounding learning challenges. In their five-week mindfulness meditation program for 34 adolescents with learning disorders, [Beauchemin et al. \(2008\)](#) found improvements in social skills, anxiety regulation, and academic performance compared to controls. Similarly, [Schonert-Reichl and Lawlor \(2010\)](#) presented an MA curriculum, inclusive of 10 lessons and three daily meditation sessions, to six elementary school classrooms. Findings demonstrated that, compared to the six control groups, students who received mindfulness training showed considerable improvements in social-emotional competence. Though these results are promising, more research is needed in this area before fully integrating MA into school-based curriculum. Understanding not only *if* it works but *how* it works will be essential to guide future clinical practice.

Adaptations to MA for Clinical Youth Populations

Also critical to understand are needed modifications to MA interventions for children and adolescents in-and-out of school settings. While many mindfulness exercises described in youth research emerged from adult programs, the cognitive, behavioral and emotional differences between adults and youths are noteworthy and likely impact interventions. For example, executive functioning skills, including memory and concentration, are less developed for youths compared to adults. Therefore, it may be more developmentally appropriate to require pediatric MA practice with shorter durations and higher levels of repetition. Due to weaker cognitive skills—e.g., abstract reasoning, metacognition—in youths compared to adults, MBIs for youths may also need to more frequently incorporate games and stories, as well as more action-oriented meditation to enhance understanding and engagement (e.g., mindful drawing; [Tan, 2015](#)).

In multiple studies of elementary school children, researchers provided vague suggestions regarding the inclusion of age-appropriate mindfulness exercises and games ([Nieminen and Sajaniemi, 2016](#)). Specific proposals such as incorporating music, yoga, written and visual prompts, and choreographing shorter moments of silence came from two studies yielding decreases in disruptive behaviors and improvements in self-control and concentration following school-based MA interventions like Move-Into-Learning and Mindful Schools ([Black and Fernando, 2014](#); [Klatt et al., 2013](#)). Similarly, [Ames et al. \(2014\)](#) reported that an eight-week, modified MBCT program yielded decreases in worry and rumination and improvements in quality of life for six depressive adolescents. Aside from a lack of specificity regarding said modifications, this study had several methodological limitations such as a lack of control groups, only short-term follow-up, and reliance on self-report measures. Further research is needed and will be critical in determining evidence-based adaptations for youth populations.

Mindful Awareness for General Youth Well-Being

While the prior section discussed MA practices within clinical populations, below is a brief and general review regarding effects of MA on attentional control and emotion and behavior regulation in non-clinical youth populations.

Attention and Academic Performance

When studying the impact of MA among youth, some of the most common dependent variables are attention and concentration (and, by extension, academic performance). School-based mindfulness programs have been shown to have a positive yet modest effect on cognitive performance via improvements in sustained attention and concentration ([Zenner et al., 2014](#)). Some of these attentional improvements have been shown to influence improved organizational skills, as well as increased rates of homework completion, classroom participation, and reading and math achievement ([Bakosh et al., 2016](#); [Schonert-Reichl and Lawlor, 2010](#)). A similar challenge as that seen when studying clinical samples is the needed differentiation between progress effected from MA versus other interventions or other components of the MBI.

Social Skills and Peer Relationships

With social development and related challenges being a common source of strife among youth, it would seem worthwhile to understand the impact(s) of MA on social anxiety, peer conflict, and quality of social relationships. Since MA may help increase emotional awareness and regulation, this may collaterally help youth make better social decisions via the improved ability to access rational decision-making processes. There is some research to support the implementation of a mindfulness-based program

among youth for social difficulties, with much of this work happening in school settings. Facilitating such programs provides students with an opportunity to practice MA in real-time and within settings that social stress most commonly arises. Improvements in prosocial behavior, empathy, perspective-taking, conflict resolution and emotional control, as well as reductions in aggressive behavior and social anxiety, have been demonstrated (Raes et al., 2014; Schonert-Reichl et al., 2015; Thierry et al., 2016). Greater analysis as to what components of these MBIs led to these changes is warranted.

Emotion Regulation and Mood

Managing strong emotions and the behaviors that accompany them are a common challenge among clinical and subclinical youth populations. Since MA seemingly promotes awareness of thoughts, feelings, and physiological sensations, it would be logical to infer that MA would be a promising approach for mood regulation difficulties. Moderate decreases in negative emotions and improvements in overall psychological well-being following MBIs were reported in a systematic review by Kallapiran et al. (2015). Similar to theories mentioned previously, the authors proposed that the awareness and observation of emotions without becoming overwhelmed by or immediately responding to them may, in fact, be the mechanism of change.

Implementation of Mindful Awareness

Below are examples of ways to implement MA in clinical youth practice in both individual and group formats. It should be noted that many of these skills are from broader, evidence-based treatment programs and manuals, and are not designed to stand alone. Importantly, they may also be adapted and incorporated into other treatment protocols a clinician is currently employing. For instance, mindful awareness techniques can often be integrated into an existing manualized approach to treating anxiety. The citation for each skill is provided and readers are encouraged to review the actual manual and scripts themselves, rather than depend on the edited versions below.

Techniques: Mindful Breathing

There are many approaches for teaching mindful, or focused, breathing to improve anxiety, stress, and anger regulation. The language used and need for modifications like visual aids will vary based on the developmental age of the child. Semple and Lee (2011) offer a manualized approach to mindful breathing that utilizes the concept of “anchor breathing” to promote anxiety management. Clinicians introduce the concept of belly breathing with the help of visual aids (e.g. the rising and falling of breath on the belly of a stuffed animal) and, with the child, practice the technique together for up to 5 min. Daily rehearsal is then assigned as homework. Increasing awareness of the physical signs of anxiety allows the youth to use breathing as an “emergency brake”, preventing the escalation of stressful situations. Self-monitoring is used to track progress and, as the skill becomes more natural, clinician support fades.

Semple and Lee (2011). *Mindfulness-based cognitive therapy for anxious children: A manual for treating childhood anxiety*. New Harbinger Publications.

Techniques: Body Scan

The body scan technique was one of the original tools within MBSR (Kabat-Zinn et al., 1992). It has been used across many populations and adapted for youth to help them become aware of the physical manifestations of emotions. Goodman and Greenland, 2009 provide a progressive body scan protocol for children and adolescents where the clinician provides guidance in noticing sensations in different parts of the body. The youth is then reminded to become aware of such sensations without making efforts to change them. Authors estimate that the process takes approximately 10–15 minutes to complete, and, throughout the sessions, youth learn where they physically “hold” different emotions (e.g., sadness in their stomach, stress in their shoulders). This increased awareness may serve as an early warning system for possible emotional escalation.

Goodman, T. A., & Greenland, S. K. (2009). Mindfulness with children: Working with difficult emotions. In *Clinical handbook of mindfulness* (pp. 417–429). New York, NY: Springer New York.

Teaching MA in a Group Format

Below are several empirical school-based programs that teach MA in a group format. Advantages of these programs are that: (a) school-based staff with minimal mindfulness training can deliver these interventions via written scripts; (b) practices can be integrated within other social-emotional learning curricula; and (c) students can practice together, share their experience in learning these skills, and support one another with real-time skill application. Clinicians are encouraged to look at the content of such programs and consider the research evidence, exercises involved, time commitment, and required training when selecting a group-based program. Below are programs that may warrant consideration:

Broderick, P. C., & Metz, S. (2009). Learning to BREATHE: A pilot trial of a mindfulness curriculum for adolescents. *Advances in school mental health promotion*, 2(1), 35–46. <https://learning2breathe.org/>

Maloney, J. E., Lawlor, M. S., Schonert-Reichl, K. A., & Whitehead, J. (2016). A mindfulness based social and emotional learning curriculum for school-aged children: The MindUP program. In *Handbook of mindfulness in education: Integrating theory and research into practice* (pp. 313–334). New York, NY: Springer New York. <https://www.mindup.org/>

Mortlock, J. T. (2019). Audio-guided Mindful-Based Social Emotional Learning (MBSEL) training in school classrooms: The inner explorer program. In *Handbook of Mindfulness-Based Programmes* (pp. 251–263). Routledge. <https://innerexplorer.com/>

Summary

Originating approximately 2600 years ago, MA has and continues to evolve within academic and clinical practices (Monteiro et al., 2014). Offering promise with its demonstrated impact on attention and emotion regulation, MA seems an approach potentially powerful for various youth presentations and developmental stages. While MA demonstrates promise as a transdiagnostic intervention, the evidence base is still developing. Weare (2013) noted common methodological limitations in MA-related studies such as small sample sizes, samples of those who volunteered rather than being chosen, limited use of control groups, randomized groups, and mixed method designs, a lack of standardized measures and measures assessing long-term skill maintenance, and an overreliance on self-reporting.

In agreement, Rempel (2012) remarked on the importance of developing MA assessment measures validated specifically for youth populations, as the only measure currently normed for youths is the Child and Adolescent Mindfulness Measure (Nieminen and Sajaniemi, 2016). Modern academics also suggest that teachers of MBIs have a routine mindfulness practice to be better equipped to answer questions from and offer guidance to youth, though current research does not consistently note if these practices existed for trainers (Rempel, 2012).

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