

THESIS

THE RELATIONSHIP BETWEEN THERAPIST IN-SESSION MINDFULNESS AND THE
WORKING ALLIANCE

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ABSTRACT

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Therapists' levels of mindfulness are empirically supported as an influential factor in psychotherapy. The current study developed a questionnaire with which to measure the impact of therapists' levels of in-session mindfulness (ISM) on clients' ratings of the working alliance, symptom change, and therapist presence. Forty-one therapist and client participants completed questionnaires addressing these variables, and results showed that higher levels of therapist ISM were related to higher levels of alliance and client symptom improvement. The relationship between therapist ISM and therapist presence was not found to be significant. Exploratory factor analysis of the new measure demonstrated support for a five-factor solution matching the structure of the measure on which it was based. Finally, discussion is offered around uses for the new measure and areas of future research surrounding therapist ISM and related topics.

TABLE OF CONTENTS

ABSTRACT.....	ii
Introduction.....	1
Therapy Works.....	1
The Working Alliance.....	2
Different Perspectives on the Alliance	2
Therapist Contributions.	3
Therapist presence	3
Therapists In Training	5
Mindfulness	6
Mindfulness in Relationships	8
Mindfulness in Therapy.....	8
Mindfulness and the working alliance.....	10
Measuring Mindfulness	11
The Current Study.	12
Hypotheses.	13
Method	14
Participants.....	14
Inclusion and exclusion criteria.....	14
Procedure.....	15
Development of a new measure.....	15
Measures.....	17
Therapist In-Session Mindfulness	17
Therapist Trait Mindfulness.	17
Working Alliance from the Client’s Perspective.....	18
Therapist Presence from the Client’s Perspective.	18
Client Symptomology.....	19
Therapist’s Dissociative Tendancies	19
Results.....	21
Discussion.....	23
Development of a Measure	23
Therapist In-Session Mindfulness and the Alliance.....	24
Therapist In-Session Mindfulness and Client Symptom Improvement	25

Therapist In-Session Mindfulness and Therapist Presence	25
Limitations	26
Implications and Future Directions	27
Tables	29
References	32

Introduction

The ways in which psychotherapists contribute to interactions with their clients can dramatically impact the effectiveness of therapy (Flückiger, Del Re, Wampold, & Horvath, 2018). The Working Alliance, which describes the relationship between client and therapist, accounts for significant variability in client outcomes and is a prime example of the contributions therapists make to their client's growth (Wampold, 2010). Several therapist qualities have been identified as likely contributing to higher levels of alliance; these include being non-judgmental and the ability to attune to client's verbal and non-verbal communication (Hick & Bien, 2008), both of which are positively correlated with therapist's levels of mindfulness (Grepmaier et al., 2007). While it is possible that many therapists could benefit from higher levels of mindfulness and the associated increased levels of alliance, therapists in training are particularly likely to benefit due to their inexperience performing the complex tasks associated with their role (Grepmaier et al., 2007; McCollum & Gehart, 2010). While measures exist that assess how mindful therapists are on average, there is currently no tool available to measure therapist's level of mindfulness *in session*. In alignment with Bishop and colleagues' (2004) theory that levels of mindfulness change based on context, the authors assert that therapists' *in-session* mindfulness (ISM) must be measured, and thus a new measure must be created to do so.

Therapy Works

An impressive 80% of clients who take part in psychotherapy have more favorable outcomes than those from waitlist control groups (Dragioti, Karathanos, Gerdle, & Evangelou, 2017). This finding generalizes across a wide range of theoretical orientations and over 80 evidence-based treatments (American Psychological Association) which are used in individual,

couple, and family therapy to address dozens of diagnoses. Within this long list of empirically supported treatments, there are surprisingly few consistent therapeutic mechanisms responsible for change (Wampold, 2010). Research on client symptom improvement points to the strong influence of common factors, or the ingredients consistently associated with positive outcomes no matter the specific form of therapy. These include client motivation, therapist techniques, and the Working Alliance, among others (Wampold, 2010).

The Working Alliance

The concept of the alliance has been divided into three distinct features: Agreement between therapist and client on the *goals* of treatment, client and therapist perception of agreement on *tasks* which will lead to the achievement of the goals, and the quality and depth of the *bond* between therapist and client (Bordin, 1979). Meta-analyses have shown a positive correlation between alliance and treatment outcomes across therapeutic approaches, types of alliance measures, time of assessment, and rating perspective (client, therapist, observation; Flückiger, Del Re, Wampold, & Horvath, 2018).

Several studies have found that common factors such as the alliance explain more variance than theory-specific techniques in contributing to positive outcomes (Hick & Bien, 2008). This means that the relationship between client and therapist is more influential on client outcomes than specific techniques like cognitive restructuring. In short, the literature now confirms what psychotherapy clients, if asked, would probably report as being common sense: a deep and authentic connection between client and therapist and agreement on goals and tasks utilized to achieve those goals are critical aspects of successful therapy.

Different Perspectives on the Alliance

The alliance can be assessed from both the perspectives of the therapist and the client—perceptions which may be quite similar or may differ drastically (Geller et al., 2010). Meaning, a therapist may perceive a very strong alliance with their client and rate it as such, while that client may feel the therapist does not understand them or their goals for therapy and therefore would provide a low rating of the alliance. That said, the literature strongly suggests that it is the client's assessment of the alliance that is more strongly correlated with session outcomes than the therapist's perception (Geller et al., 2010).

Therapist Contributions

Although clients' *perceptions* of the alliance are more strongly correlated with treatment outcomes than therapists', a meta-analysis has found that therapists' *contributions* are significantly more influential in impacting ratings of the alliance than clients' contributions (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012). A variety of therapists' interpersonal qualities consistently predict higher levels of alliance; these include expressing acceptance, empathy, and warmth, and rarely demonstrating negative behaviors such as blaming, ignoring, or rejecting (Hick & Bien, 2008; Zuroff, Kelley, Leybman, Blatt, & Wampold, 2010). Additionally, therapist's ability to maintain full attention on the client while suspending judgments about the self or about what the client shares are essential to an effective alliance (Ryan et al. 2012). The combination of these interpersonal and intrapersonal characteristics has been referred to in the literature as *therapist presence*.

Therapist presence. Therapist presence points to qualities of a therapist's ways of *being*, more so than the techniques used in *doing* their job, as Hick and Bien (2008) have described it. Presence has been conceptualized by examining three facets of a therapist's way of being, including “an 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'' (Geller & Greenberg, 2002, p. 72). It has been consistently shown that a high level of therapist presence is related to higher ratings of the alliance and better treatment outcomes (Geller & Borges, 2014). When therapists have high levels of presence they are more likely to be attuned to the multifaceted world of their clients, picking up on the various verbal and non-verbal cues clients offer. An important qualification here is that the client must *feel* their therapist's presence for it to be impactful—meaning that client's *sense* of therapist's presence is what matters versus a therapist's self-report. Clients who experience a warm and open reception from their therapist report being more felt, connected, and supported (Bruce, Manber, Shapiro, & Constantino, 2010) often due to neurological shifts that set the stage for emotional connection (Geller & Porges, 2014).

Therapists' ability to attune to themselves is essential for effective attunement to clients. Therapists' physical and emotional sensing of their own experience is a primary tool used to facilitate attunement to the client (Geller, Greenberg, & Watson, 2010). Attunement to their experience and that of their client's allows therapists to be proficient at combining therapeutic techniques with intuition to provide an effective therapeutic experience (Geller et al., 2010). A therapist who is skilled at picking up cues from clients but obtuse to their own emotionally-based reactions will invite unnoticed countertransference into the equation, potentially sabotaging the therapeutic process.

Although the aforementioned qualities are known to be important, many therapists report having difficulty remaining fully attuned to their clients in an empathetic and non-judgmental manner (Ryan et al., 2012). Similarly, data collected on variance in therapy outcomes suggests that some therapists lack high levels of presence (Swift et al., 2017) and are ineffective at

positively contributing to the alliance (Del Re et al., 2012), dynamics that likely lead to therapy falling short of its full potential to create change.

Therapists vary in their abilities to be present in session due to a range of factors (Geller et al., 2010). For example, therapists who are more self-critical may distance themselves from the room and the process with the client by engaging in inner dialogues of self-critique or self-evaluation. In addition, some therapists may be highly absorbed in evaluations of the effectiveness of particular interventions and be distracted as they focus on those relative successes or failures. Other therapists may be highly reliant on planning the session, intervention by intervention, trying to stay on a pre-planned “track”. As the session aligns with or veers from those plans, a therapist may be less present in the room with the client as they are focused on how the plan is working. All these dynamics vary between therapists, however, one group who may be particularly at risk for the outlined preoccupations are new therapists who are in training (McCollum & Gehart, 2010).

Therapists in Training

Therapists in training are a population who are at particularly high risk of having low levels of session presence and ineffectively contributing to the alliance due to the complex and anxiety-provoking experience of learning to conduct therapy (Grepmaier et al., 2007; McCollum & Gehart, 2010). Therapists in training must learn to simultaneously manage a wide variety of high-consequence factors to effectively perform their role. They need to track session timing, provide effective interventions, maintain a nurturing relationship, and be aware of a myriad of verbal and non-verbal cues from clients (McCollum & Gehart, 2010). Additionally, they must remain aware of their own biases and judgments that arise throughout sessions, being sure they do not interfere with the quality of treatment. Anxiety can also increase from the pressure of

being evaluated by a supervisor who reviews notes, videotape, and/or transcripts from sessions. These circumstances provide the perfect breeding ground for self-critical thoughts and feelings of self-doubt—all of which can lead to being less present.

To prepare new therapists to succeed through these challenges, clinical programs aim to impart the necessary skills to their students by providing lectures, demonstrations, opportunities for practice, and ample feedback (McCollum & Gehart, 2010). That said, many programs produce trainees who can perform therapeutic skills (validation, reflection, open-ended questions, etc.) with competence, but who struggle to generalize those skills into forming strong alliances with clients and helpful ways of being in session (Hick & Bien, 2008). It has been suggested that mindfulness practice be utilized in clinical training curricula due to its ability to increase presence and attentional abilities and help reduce judgmental attitudes toward self and others (Bruce et al., 2010; Geller & Greenberg, 2012; Hick & Bien, 2008; McCollum & Gehart, 2010; Ryan et al., 2012; Swift et al., 2017). There are numerous examples of mindfulness being successfully utilized to help train new therapists (Baker, 2016; Grepmaier et al., 2007; McCollum & Gehart, 2010; Shapiro, Brown, & Biegel, 2007; Srichannil & Prior, 2014; Swift et al., 2017), possibly by way of reducing self-judgment and increasing present-centered attention.

Mindfulness

Mindfulness has been defined as a “nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is” (Bishop et al., 2004, p. 232). Put differently, when individuals are mindful, they intentionally *notice* the quality of their thoughts, emotions, and bodily sensations, accepting their presence without deciding if they are good or bad.

It is important to note that mindfulness can be present both because of intentional practices and as a product of one's natural tendency to be more or less present-centered or judgmental (Bostov, Ohlrogge, Britz, Hautzinger, & Kotchoubey, 2018). In addition to natural variation between people, mindfulness varies within individuals from moment to moment as situations differ in emotional and attentional intensity (Bishop et al., 2004). For example, it can be easier for therapists to be mindful in a session they find interesting and engaging and harder when with a client they find boring or who triggers personal memories.

There are many ways to intentionally practice mindfulness, with one of the most common being through meditation. Mindful meditation often involves maintaining awareness of breathing and the physical sensations associated with the breath, redirecting the attention to those sensations whenever the mind becomes distracted by other stimuli (Vollestad, Neilson, & Nielson, 2012). In addition to being practiced through formal meditation, mindfulness can be incorporated into intentional movement, active listening exercises, feeling bodily sensations, and exploring emotions.

When one notices the various aspects of their internal experience with greater awareness, one can then more freely choose to *respond* to life's challenges more often than jumping to automatic, unskillful *reactions* (Ryan et al., 2012). On a behavioral level, mindfulness practice provides training in moving toward discomfort while avoiding the habits of negative mental chatter, ultimately leading to desensitization to and greater acceptance of uncomfortable situations (Barnes, 2007).

Mindfulness has been linked to wellbeing due to practitioner's increases in self-compassion (Baer, Lykins, & Peters, 2012), emotion regulation, self-awareness, and immune functioning (among others), and decreases in psychological distress related to anxiety and

depression (Davis & Hayes, 2011; Vollestad, Nielson, & Nielson, 2012). Researchers have suggested that mindfulness decreases the likelihood of becoming emotionally overwhelmed by inoculating practitioners to the negative effects of stressful events. This hypothesis was confirmed by a study that found more mindful people experienced lower levels of stress and negative emotions when in conflict than non-mindful people who experienced the same challenging events (Barnes, 2007).

Mindfulness and Relationships

Although its applications for nurturing connection have been well established and appear to have significant utility in numerous applications, most of the research on mindfulness has focused on benefits to individual practitioners with less emphasis on relationships—romantic or otherwise (Gambrel & Keeling, 2010). That said, studies have concluded that increasing attunement to one’s own emotional experience through being mindful results in an improved ability to connect with others (Gambrel & Keeling, 2010; Jones, Welton, Oliver, & Thoburn, 2011). Examples of this phenomenon have been found in the positive correlation between levels of mindfulness and couple’s relationship satisfaction, attention to partner stress, and level of empathy (Gambrel & Keeling, 2010). Studies have also found that mindfulness enhances parent-child relationships by decreasing ineffective, automatic responses to stressors and helping parents and children connect more deeply (Gambrel & Keeling, 2010). Additionally, mindfulness is positively correlated with secure attachment and negatively correlated with both anxious and avoidant attachment (Gambrel & Keeling, 2010). Just as being mindful leads to a *self*-accepting mindset, it often leads to more acceptance of others—a tendency that facilitates the development of authentic, lasting connections (Ryan et al., 2012).

Mindfulness in Therapy

Mindfulness has become increasingly common in psychological treatment settings for individuals, couples, and families, with measurable benefits to both therapists and clients (Atkinson, 2013). Examples of treatment approaches that are either mindfulness-based (introducing mindfulness practices) or mindfulness-informed (theoretically based on mindfulness without explicitly teaching it) include Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2018), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2011), and Dialectical Behavior Therapy (Linehan et al., 2006).

Meta-analyses have concluded that mindfulness-based treatments have demonstrated similar effectiveness to other well-validated psychological and psychiatric modalities for a wide variety of diagnoses (Goldberg et al., 2018; Khoury et al. 2013) and that participants in mindfulness-based treatment have lower attrition rates than those participating in alternative therapies (Atkinson, 2013). In an analysis of nearly 150 non-overlapping studies with over 12,000 participants, mindfulness-based treatment proved to be most useful in treating depression and was comparable to rigorously tested treatment strategies for pain management, disordered eating, anxiety, and smoking cessation (Goldberg et al., 2018).

Therapists' experience with mindfulness training has also been linked to various treatment outcomes. In one study, clients of therapists who practiced meditation before their sessions had significantly better symptom reduction, faster rates of change, and higher self-reported wellbeing than clients of non-meditating therapists (Grepmaier et al. 2007). The same study also found that clients of meditating therapists gave higher ratings to their therapy experience. This study highlights that beyond specific mindfulness-based or mindfulness-informed therapy approaches, therapist's variability resulting from personal meditation practice

or formal meditation training has significant implications. This variation may manifest as more or less attunement to the present moment versus being in one's head planning the next intervention, or the tendency to engage in harsh judgment about performance versus engaging in more mindful self-compassion. Unfortunately, we do not yet have a way of specifically measuring therapist's natural or intentional levels of *in session* mindfulness versus dispositional mindfulness resulting from meditation training. This gap in the measurement literature limits our ability to make specific claims about the impact of therapist's level of in-session mindfulness on session processes and outcomes.

Mindfulness and the working alliance. The evidence presented in this article points to the notion that therapists who engage in more mindful practices in session will be more effective at contributing to positive ratings of the alliance than their less-mindful counterparts. More mindful therapists may benefit from greater ease executing some of the complex tasks associated with their role—namely, self-regulating and producing appropriate responses and interventions while effectively attuning to client's verbal and non-verbal communication (Grepmaier et al., 2007). Furthermore, non-judgmental and self-accepting attitudes—both of which are developed through mindfulness—may help therapists productively move on from errors made in session by decreasing the presence of unproductive mental chatter (Elvins & Green, 2008). More mindful therapists may develop greater capacities for empathy, acceptance of client's point of view, and ability to help clients feel seen and heard, all of which are essential to an effective alliance (Hick & Bien, 2008). Mindful therapists' practice of attuning to their own experience may provide a heightened ability to attune to clients' needs (Gambrel & Keeling, 2010). Other advantages are due to biological differences in mindful therapists' brains, such that they have a heightened capacity to regulate attention, develop social connections, employ an empathetic mindset, and

regulate physiological and emotional arousal (Allen et al., 2012; Atkinson, 2013). Additional evidence suggests that mindful therapists will cultivate effective alliances due to heightened self-awareness, decreased countertransference risks, and increased attunement to clients' verbal and non-verbal communication (Grepmaier et al., 2007). Furthermore, multiple calls for research have been made for exploring the impact of mindfulness on process variables such as the working alliance (Davis & Hayes, 2011; Swift et al., 2017). The ability to measure new therapists' levels of mindfulness in session may allow for training programs to assess which trainees would benefit from mindfulness training—the end goal being to support new therapists in being optimally effective at contributing to the alliance.

Measuring Mindfulness

The various definitions of mindfulness make it inherently challenging to measure and report on. Mindfulness has been described in the literature as a temporary state, an enduring trait or way of being, a meditation practice, and a clinical intervention (Vago & Silberstein, 2012). For the sake of this study, the dichotomy between *trait* and a *state* is most relevant.

Conceptualizing mindfulness as a trait equates to viewing mindfulness in terms of a person's average level across their life. There are approximately ten measures of trait mindfulness, with two of the most commonly used being the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) and the Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Both scales provide prompts to which respondents rate how often they experience the thoughts or situations described or how much they agree with statements provided. The MAAS presents prompts such as *I find it difficult to stay focused on what's happening in the present*, while the FFMQ presents prompts such as *I perceive my feelings and emotions without having to react to them*.

In contrast, conceptualizing mindfulness as a state leads to measuring levels of mindfulness during specific, narrow periods, thus highlighting fluctuations above or below one's trait (or average) level. There are three state mindfulness measures, with the most commonly used being the Toronto Mindfulness Scale (TMS; Lau et al., 2006). The TMS presents prompts such as *I was curious about my reactions to things*, to which respondents rate how much they agree or disagree. The other state mindfulness measures are the State-Mindful Attention Awareness Scale (State-MAAS; Brown & Ryan, 2003), which has five items and is based on the trait MAAS, and the State Mindfulness Scale (SMS; Tanay & Bernstein, 2013) which examines respondent's experience of bodily sensations, emotions, and thoughts. Both the State-MAAS and the SMS present prompts to which respondents rate how much they agree or disagree. Examples from the State-MAAS and SMS include *I was doing something without paying attention*, and *I noticed pleasant and unpleasant emotions*, respectively. Ultimately, the trait and state measures mentioned seek to assess the degree of mindfulness a person possesses regardless of context or setting.

The measures of state mindfulness described above have significant limitations regarding their ability to effectively measure therapist's ISM. The TMS lacks generalizability to the context in question because it was created specifically for the measurement of mindfulness occurring during meditation. The State-MAAS has insufficient content validity because it ignores aspects of physical and mental experience that are key in gaining a comprehensive understanding of therapists' mindfulness (Tanay & Bernstein, 2013). While the SMS provides more generalizable results than the TMS and seems to achieve greater content validity than the State-MAAS, it lacks the specificity in verbiage needed to isolate therapist's ISM experience.

The Current Study

This study is interested not in influencing mindfulness, but in measuring new therapists' levels of mindfulness in the context of therapy and the correlation with their client's ratings of the alliance, levels of symptom change, and ratings of therapists' presence. In alignment with Bishop and colleagues' (2004) theory, the authors assert that therapist mindfulness is most useful when measured as a *state* which can be evoked with intention rather than a *trait* that is maintained as a dispositional quality. Past research has measured therapist's trait mindfulness, thus overlooking the contextual variance that exists in levels of mindfulness *in-session*. Given the significant implications on the quality of practice that can come from being more mindful in session and the inherent challenges of working as a new therapist that lead to being *less* mindful (Grepmaier et al., 2007; McCollum & Gehart, 2010), new therapists' in-session state mindfulness must be measured. As part of the current study, the authors developed and tested a measure to address this need.

Hypotheses

The authors propose the following hypotheses: that an exploratory factor analysis will demonstrate that items on the MIST (the measure created in this study) reflect five distinct facets, which when combined represent the construct of *therapist in-session mindfulness* (hypothesis 1). Next, that higher ratings of therapist ISM (rated by the therapist) will be positively associated with client-rated alliance scores (hypothesis 2). Next, it is hypothesized that higher ratings of therapist ISM (rated by the therapist) will be positively associated with client-rated perceptions of therapist presence (hypothesis 3). Lastly, it is hypothesized that higher ratings of therapist ISM (rated by the therapist) will be positively associated with clients' symptom improvement (hypothesis 4).

Method

Participants

Participants for this study were recruited using convenience sampling. Participants included clients and therapists from a training clinic at a large Western United States University. Standard procedure at the clinic includes clients being informed about the potential of taking part in research upon beginning therapy. Clients indicated whether their data can be used for research on the informed consent form that they filled out at the start of treatment. Therapists were provided with informed consent forms before participation in the study. All therapists and clients engaged in the study voluntarily. Therapists did not have access to their clients' data. 51 participants agreed to take part in the study, 10 of whom either opted out before officially providing consent or did not end up providing data after consenting, resulting in a final sample of 41 clients.

Inclusion and exclusion criteria. All therapists who worked in the training clinic were eligible for participation in the study. Clients were eligible to participate if they were 18 years of age or older and able to read English at an eighth-grade level. Clients involved in individual, couple, and family therapy were eligible for participation unless someone attending therapy with them was under 18 years old. To clarify, if a family was in therapy with parents who were over 18 years old and a child who was under 18 years old, the presence of the child disqualified the whole family from participation.

Procedure

This study took place at a large, western United States university training-clinic. The study utilized a cross-sectional, non-experimental design to find associations between the various

independent variables and the dependent variable in question. The current study was a pilot study that aimed to develop and test a new measure and draw preliminary conclusions about the relationships between variables.

Researchers gave therapist and client participants questionnaires to complete on iPads directly after the conclusion of a therapy session. Data was collected at a single time point, and analyses controlled for the number of sessions that therapists and clients had completed together. The questionnaire used allowed clients to indicate how many sessions had been completed, with options ranging from “one” to “ten or more”. The minimum number of sessions completed was one, the maximum was ten or more, the average was seven, and the standard deviation was 3.33. Client participants filled out the surveys in the clinic waiting room and therapist participants filled out the surveys in their office. After completion of the survey participants gave their iPads to research assistants. Therapists did not have access to any of the data provided by the client participants.

Development of a new measure. Due to the limitations described in the review of the literature, the authors developed a new measure called the Mindfulness In-Session- Therapist (MIST) questionnaire with items adapted from the FFMQ (Baer et al., 2006) to measure therapists’ levels of ISM. The FFMQ was chosen for adaptation because of the broad range of constructs assessed by the scale, strong reliability and validity, and alignment with Bishop and colleagues’ (2004) conceptualization of mindfulness. Additionally, the FFMQ provides the ability to analyze the various facets of mindfulness independently and effectively understand their unique relationships with other variables.

The five facets of the FFMQ are observing, describing, acting with awareness, nonjudging of inner experience, and nonreactivity to inner experience. *Observing* involves

noticing internal and external experiences such as thoughts, emotions, sights, and smells, and is most strongly correlated with the related construct of *openness to experience* (Baer et al., 2006). The ability to observe allows therapists to notice what is occurring in and around them, providing a foundation from which to mindfully respond. *Describing* refers to the ability to put one's internal experience into words and is strongly correlated with *emotional intelligence*. Describing helps therapists manage the various emotions that arise for them in adaptive ways by accurately acknowledging and working with the specific feelings that are present. *Acting with awareness* refers to remaining in the present moment and is negatively correlated with *dissociation* and *absent-mindedness*. When therapists act with awareness they are staying cognitively and emotionally present with the experiences their clients are having in session. *Nonjudging of inner experience* refers to an openness to the whole spectrum of internal experiences that one may have and has a strong negative correlation with *difficulties with emotion regulation*. Therapists who are non-judgmental of their inner experiences can process the emotions that arise for them in session and facilitate therapy from a balanced place. *Nonreactivity to inner experience* points to the ability to let whatever arises in the attentional field to pass without preoccupation and is strongly correlated with *self-compassion*. Therapists who are nonreactive to their inner experiences can acknowledge and work with whatever comes up for them in session without getting swept up in their internal experience. Together, nonreactivity and nonjudgment of inner experiences have been described as effectively operationalizing the construct of *acceptance* (Baer et al., 2006). Items from all five facets of the FFMQ were adapted for use in the MIST.

The MIST differs from the FFMQ in that it asks for responses to reflect the therapy session that just concluded, and wording of statements within the items always references being “in session”. The MIST is a 26-item measure that asks respondents to indicate on a five-point

Likert-type scale (1 indicating *never or very rarely true* to 5 indicating *often or always true*) how much the statements describe the therapist's experience in the therapy session that they just concluded. An example of FFMQ item modification for use on the MIST is as follows: An *observing* item from the FFMQ which is worded *When I'm walking, I deliberately notice the sensations of my body moving* will be modified to *In this session, I deliberately noticed sensations in my body* for the MIST.

Measures

Therapist In-Session Mindfulness (Mindfulness in Session – Therapist, MIST; developed for this study). To measure therapist's level of in-session, 26 statements were presented to which therapists indicated on a five-point scale how much the statements describe the therapist's experience in the therapy session that just concluded. 12 items on this scale were reverse-coded. An example item from this measure was *In session, I deliberately noticed sensations in my body*. Cronbach alphas for the current study were .79 (Observing subscale), .72 (Describing subscale), .81 (Act with Awareness subscale), .87 (Nonjudgmental subscale), and .76 (Non-reacting subscale). The minimum was 1, and the maximum was 5.

Therapist Trait Mindfulness (Five Facet Mindfulness Questionnaire, FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). To assess therapist's levels of trait mindfulness, 39 statements were presented to which therapists responded on a five-point scale indicating how much they agreed. 19 items on this scale were reverse-coded. An example of an item from this scale was *I deliberately notice the sensations of my body moving*. Baer and colleagues (2006) found alphas ranging from .72 to .92 for the five facets. Cronbach's alpha for the current study was .82, the minimum was 1, and the maximum was 5.

Working Alliance from the Client's Perspective (Working Alliance Inventory- Short Form Revised, WAI-SR; Paap & Dijkstra, 2017). To assess the working alliance, twelve statements or questions about experiences that clients might have with their therapist were used, to which clients responded on a scale from one to five with one indicating *seldom* and five indicating *always*. Examples of items included *I believe ____ likes me* and *____ and I respect each other*. Clients were asked to mentally insert the name of their therapist into the blanks in each question or statement on the measure. Higher scores on this measure indicated a better Working Alliance, with all responses on the measure being positively coded. Paap and Dijkstra (2017) found cronbach's alphas ranging from .81 to .90 on the subsections of the measure (goals, tasks, and bond sections), and a total alpha of .91. Cronbach's alpha for the current study was .91, the minimum was 2.25, and the maximum was 5.

Therapist Presence from the Client's Perspective (Therapist Presence Inventory- Client Version, TPI-C; Geller et al., 2010). To assess therapist presence, three items were used, one of which was reverse-coded. An example item from this measure included *My therapist was fully in the moment with me*, to which clients rated their predominant experience from the session that just occurred on a seven-point scale. Geller and colleagues (2010) found a cronbach's alpha of .82. Cronbach's alpha was .48 for the current study. Two of the three items in the TPI assess therapists' ways of *being* in session, and one item addresses specific remarks made by the therapist in session, which the authors interpreted as being out of line with the theoretical aim of the measure. The authors removed the item that addressed statements made by the therapists and found an alpha of .71 and used this version of the measure for their analyses. The minimum was 6, and the maximum was 7.

Client Symptomology (Outcome Questionnaire, OQ; Mueller, Lambert, & Burlingame, 1998). To assess the severity of client's mental health challenges, 45 statements were presented to which clients responded on a five-point scale to indicate how much they agreed. Example items included *I get along well with others* and *I find my work/school satisfying*. Higher scores on this measure indicated worse symptomology. Mueller and colleagues (1998) found a cronbach's alpha of .93. Cronbach's alpha for the current study was .83, the minimum was 1.6, and the maximum was 3.18.

Therapist's Dissociative Tendencies (Dissociative Experience Scale, DES; Bernstein & Putnam, 1986). A 28-item scale was used to measure therapist's perception of how often they demonstrated dissociative behaviors. Therapists responded on a ten-point scale ranging from 0% to 100%, indicating what percentage of the time the statement reflected their experience. The authors then converted those percentages into numbers ranging from 1 to 10. Example items were *Some people have the experience of finding themselves in a place and having no idea how they got there*, and *Some people find that they have no memory for some important events in their lives*. De Beradis and colleagues (2009) used the DES with a non-clinical sample and found a cronbach's alpha of 0.94. Cronbach's alpha was .81 for the current study, the minimum was 1, and the maximum was 10.

Analytic Approach

The proposed study included clients who were nested within therapists. This means that the data holds some interdependence as clients who see one therapist may share some variability that is different from clients who are seeing a different therapist. However, given the occurrence of an unexpected national health crisis (COVID-19, 2020) the authors were unable to gather enough data to allow for nested data analyses. Therefore, a linear regression was conducted, as

well as an exploratory factor analysis on the newly created measure. Researchers also ran separate regressions for each outcome variable. The final sample of 41 participants were used in each analysis. The current study utilized the total score on the MIST for analyses, as opposed to scores from the sub-scales, to draw preliminary conclusions about the relationship between ISM and outcomes variables.

Results

An exploratory factor analysis was conducted on the therapist in-session mindfulness measure. Results revealed support for a five-factor solution, matching the factor structure of the FFMQ as anticipated. Eigenvalues were 3.1 (factor 1), 2.4 (factor 2), 1.9 (factor 3), 1.7 (factor 4) and 1.5 (factor 5) (see table 1 for loadings). The maximum likelihood method (canonical) was used to extract the factors and this was followed by a promax (oblique) rotation. Inspection of the scree plot, the residual correlation matrix, the proportion of variance accounted for, and the interpretability of the factors was examined to determine the number of factors to retain for each sub-sample (Loehlin, 1998; Tabachnik & Fidell, 2001). In interpreting the factor pattern, an item was considered to load sufficiently on a given factor if the factor loading was .35 or greater on that factor and less than .35 on the other factors. These criteria resulted in the removal of four items that did not clearly load on one single factor. This resulted in a final set of 22 items, loading on 5 factors: observe, describe, act with awareness, nonjudgment of inner experience, and nonreactivity to inner Experience (thus, supporting hypothesis 1).

First, we conducted bivariate correlations among the variables (see Table 2). Correlations revealed further support for the therapist ISM measure developed here (MIST). Specifically, a significant positive correlation was observed between the MIST and the measure of trait mindfulness, indicating evidence for convergent validity of the MIST. Furthermore, there was a significant negative correlation between the MIST and the dissociative tendencies scale, indicating evidence of divergent validity.

Given the limitations mentioned in the analytic approach section, we were unable to gather enough data to utilize a statistical approach that would account for the nested nature of

this data. This is an unfortunate limitation to the interpretation of the following results. Utilizing a linear multiple regression, the number of sessions was first added as a control variable, therapist ISM was added as the dependent variable, and client-rated alliance, client-rated therapist presence, and client-rated symptomology were added as independent variables. The overall regression model was significant, $F(3, 138) = 10.78, p < .001$ (see Table 3). Results were the same when individual regressions were run with after separating the various outcome variables.

Results revealed that therapist ISM was significantly negatively related to client symptoms, $\beta = -.36, t = 4.03, p < .001$, meaning that higher ratings of therapist ISM was associated with lower ratings of symptomology (thus supporting hypothesis 2). In addition, higher ratings of therapist ISM were associated with higher ratings of the alliance as rated by the client, $\beta = .43, t = 3.01, p < .001$ thus, supporting hypothesis 4. Interestingly, therapist ISM was not significantly associated with client-rated therapist presence, $\beta = .16, t = 2.03, p = .09$. (thus, not supporting hypothesis 3).

Discussion

Development of a Measure

The current study sought to address the gap in the literature regarding the association between therapist ISM and session processes and outcomes. Unfortunately, the existing measures of mindfulness either lack generalizability to the context of therapy (in the case of the TMS), ignore important aspects of therapists' experience with clients (in the case of the State-MAAS), or have been created to assess trait, rather than state mindfulness. The need to fill this gap in the literature appears to be quite significant when considering Bishop and colleagues' (2004) theory that mindfulness changes based on context, along with the abundance of literature suggesting that higher levels of therapist mindfulness will lead to better therapy (Baker, 2016; Ryan et al., 2012; Srichannil & Prior, 2014; Swift et al., 2017).

Given the lack of availability of a measure with which to analyze therapists' ISM, the authors developed the Mindfulness In-Session- Therapist (MIST) questionnaire by altering the FFMQ, a widely used trait mindfulness measure. Modifications to the FFMQ included altering item language to address the context of therapy and eliminating items that appeared obsolete in the new application. The authors used exploratory factor analysis to find that 22 of the original 26 of items on the MIST held together to represent a single construct: therapist in-session mindfulness. The MIST addresses five facets of therapists' in-session experience: their ability to *observe* the states of their bodies and minds; demonstrate emotional intelligence by being able to *describe* that experience; remain focused on the session by *acting with awareness*; remain open to their emotions by being *nonjudgmental of their inner experience*; and to avoid preoccupation with distractions by being *nonreactive to their inner experience*.

The current study found evidence to support the convergent and divergent validity of the MIST. As expected, there was a significant positive correlation between therapists' levels of ISM and their trait mindfulness (as measured with the FFMQ). This means that therapists who are generally more mindful are also more mindful in session. That said, the correlation was not overly strong, suggesting that the MIST and the FFMQ are tapping distinct constructs. Also as predicted, there was a strong negative correlation between therapists' levels of ISM and their dissociative behaviors such as acting without awareness and lacking perception of inner experience. This means that therapists who are more mindful in session generally demonstrate lower levels of dissociative tendencies. This finding was in line with past research suggesting the divergent nature of dissociative behaviors and mindfulness. That study found a negative correlation between dissociation and mindfulness, as measured by six commonly used mindfulness measures (Baer et. al, 2006).

Therapist In-Session Mindfulness and the Alliance

In addition to validating the new measure, this study sought to understand the relationship between therapists' levels of ISM and the alliance with their clients. As predicted, results showed that higher levels of therapist ISM had a strong, positive association with levels of alliance. These findings are consistent with previous literature suggesting that higher levels of therapist state mindfulness are associated with better relationships with clients (Grepmaier et al., 2007) and that better relationships lead to better treatment outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018). Simply, the findings suggest that therapists who are non-reactive toward their internal experience may be able to hold back knee-jerk responses and more effectively build relationships with their clients. For example, a therapist who is triggered by a client may have the strong urge to push a client in a direction that will soothe the *therapist's* emotional struggle, and

in doing so, stray from the goals that brought the client into therapy. Conversely, when that therapist can notice and *not* react to the urge to stray from the client's goals, the relationship with the client is improved.

Therapist In-Session Mindfulness and Client Symptom Improvement

Results of the current study also showed, as predicted, a strong, positive correlation between therapists' levels of ISM and levels of client symptom improvement. This finding is in line with past research that suggested that higher levels of therapist mindfulness would be associated with client symptom improvement (Bruce et al., 2010). Furthermore, these findings support the idea that therapists who are present and self-aware develop a connection with their clients that may act to reduce clients' symptom levels (Ryan et al., 2012). Finding such as these are reminiscent of the common factors research that has demonstrated the strong influence that the working alliance has on treatment outcomes (Wampold, 2010). Finally, these results may suggest that therapists' in-session mindfulness acts as a mechanism of connection through which clients' symptom improvement occurs.

Therapist In-Session Mindfulness and Therapist Presence

The authors were initially surprised upon discovering a lack of significance in the relationship between therapists' levels of ISM and presence, but later established a logical explanation; comparing Bishop and colleagues' (2004) definition of mindfulness with Geller and colleagues' (2010) definition of presence highlights the distinct nature of the constructs. Bishop and colleagues' (2004) definition of mindfulness stresses the importance of *nonjudgmental* attention to thoughts and feelings, whereas Geller and colleagues' (2010) definition of presence only stipulates being completely in the moment, which one can argue can be done in a judgmental manner. For example, consider a client who is in session deliberating about their

struggles with compulsive drinking and the impact it had on their life, and all the while the therapist is internally appalled by the selfishness of the client for the resulting harm to the client's family. It could be said that the therapist is indeed *present* in the moment with their judgments of the client, but the existence of those judgments would suggest a low level of mindfulness. This example highlights one clear possibility as to the lack of a significant correlation between therapists' levels of ISM and presence.

Alternatively, the lack of significance between therapists' ISM and presence could be attributed to the constructs being measured from client perspectives versus therapist perspectives. Logically, these differing perspectives could lead to quite different interpretations of how the therapist showed up in the room. For example, a therapist could easily conclude a session feeling self-critical of how distracted they were or of how an intervention went differently than intended (Zuroff et al., 2010), and rate themselves as having low ISM. A client coming out of that same session could have had a great experience (and rated their therapist as having a high level of presence) given the client's lack of attachment to the therapist's goals and the fondness they feel toward their therapist. This example demonstrates the different types of goals that therapists and clients might have; therapists are thinking about executing interventions and building the alliance, while clients want to feel seen, validated, and supported. It is completely plausible that a client could achieve their goal of feeling seen and supported by their therapist even though the therapist felt completely distracted and disconnected from their client (Geller et al., 2010).

Limitations

Although the findings of the current study revealed important information about the relationship between therapist ISM and levels of the alliance and client symptom change, several limitations should also be considered. Given the occurrence of an unexpected national health

crisis (COVID-19, 2020), the authors were unable to gather enough data to allow for nested data analyses and instead utilized a multiple regression. The ideal sample size would have been 125 or above (five or more participants for each item in the newly developed measure). That said, it is striking that the EFA yielded such clean results with the small sample. Another possible limitation of the current study was the use of self-report from the participants; further research is needed to explore objective measures of mindfulness and clients' experiences of therapy. Lastly, demographic information was not collected, resulting in the researchers' inability to conclude which groups of clients and therapists (by age, ethnic background, etc.) tended to score differently than other groups.

Implications and Future Directions

Past research has shown that therapists' levels of mindfulness have significant implications on their relationships with clients and the benefits clients receive from taking part in therapy (Swift et al., 2017). That said, until now, there has been no available measure with which to specifically analyze therapists' levels of *in-session* mindfulness. In alignment with Bishop and colleagues' (2004) theory that mindfulness changes based on context, the authors developed and validated the MIST to assess this variable with greater efficacy.

With the MIST at their disposal, therapist training programs can now assess which trainees could benefit from increased levels of ISM and offer strategies to support those improvements. This development represents an opportunity for training programs to offer targeted, individualized feedback and education to their students. With an understanding of which therapists are specifically working on improving ISM, clinical supervisors can focus their support of the trainee on topics relevant to that growth. For instance, if the MIST identified that a

therapist had low levels of the *Observe* factor, supervisors could coach trainees on pausing throughout sessions to notice their own emotions or to deliberately feel sensations in the body.

In addition to its utility in training settings, the authors assert that the results of the current study may also suggest there be merit in using the MIST for post-graduate level therapists. Past research has concluded that higher levels of therapist mindfulness have been associated with numerous benefits; some of those include an improved ability to attune to clients (Gambrel & Keeling, 2010), develop social connections, and regulate emotions (Allen et al., 2012; Atkinson, 2013). That being said, none of the aforementioned findings utilized an instrument that specifically targeted therapists' *in-session* mindfulness, so further research is needed in these areas. Given the evidence showing that therapists are at high risk for burnout (Lim et al., 2010) and the reduction in burnout and increased job satisfaction that are associated with higher levels of mindfulness (Luken & Sammons, 2016), the authors suggest utilizing the MIST to achieve a more nuanced understanding of the relationship between therapist mindfulness and job satisfaction and burnout.

Acknowledging the significant associations found in this study between therapist ISM and levels of alliance and clients' symptom improvement, the authors suggest that future research include a confirmatory factor analysis to confirm a final set of items for the MIST. Finally, the authors suggest a variety of future research parameters in which to test the MIST to see how the measure performs: Those include utilizing larger sample sizes, testing of post-graduate therapists, and inclusion of clients who differ demographically from the current sample and who have higher levels of clinical distress.

Tables

Table 1

MIST Items and Corresponding Factor Loadings

Item	Factor Pattern				
	1	2	3	4	5
In session I pay attention to how my emotions affect my thoughts and behavior.	.88				
In session I notice visual elements in my surroundings, such as colors, shapes, textures, or patterns of light and shadow.	.71				
In session I notice how conversations affect my thoughts, bodily sensations, and emotions	.71				
In session I notice the smells and aromas of things.	.61				
In this session I deliberately notice the sensations of my body.	.69				
In session I tell myself that I shouldn't be thinking the way I'm thinking.		-.81			
In session I make judgments about whether my thoughts are good or bad.		-.78			
When I have distressing thoughts or images in session, I judge myself as good or bad, depending what the thought/image is about.		-.71			
In session I disapprove of myself when I have irrational ideas.		-.78			
In session I criticize myself for having irrational or inappropriate emotions.		-.67			
In session I perceive my feelings and emotions without having to react to them.			.88		
During challenging situations in session, I can pause without immediately reacting.			.71		
When I have distressing thoughts or images in session I am able just to notice them without reacting.			.69		
When I have distressing thoughts or images in session, I feel calm soon after.			.66		

When I have distressing thoughts or images in session, I “step back” and am aware of the thought or image without getting taken over by it.	.78					
In session my mind wanders off and I’m easily distracted.	-.88					
In session I rush through activities without being attentive to them.	-.81					
In session I find myself doing things without paying attention.	.61					
In session I can easily put my beliefs, opinions, and expectations into words.	.70					
In session I can usually describe how I feel at the moment in considerable detail.	-.76					
In session I have trouble thinking of the right words to express how I feel about things	-.61					
Even when I’m feeling terribly upset in session, I can find a way to put it into words.	.75					
Eigen Values	3.1	2.4	1.9	1.7	1.5	

Note. Factor 1 = Observe; Factor 2 = Describe; Factor 3 = Act with Awareness; Factor

4 = Nonjudgment of Inner Experience; Factor 5 = Nonreactivity to Inner Experience

Table 2

Correlations, Means, and SDs

	1	2	3	4	5	6
1. FFMQ	1.00					
2. MIST	.74**	1.00				
3. DES	-.46**	-.33**	1.00			
4. Presence	.37**	.17*	-.26*	1.00		
5. Symptoms	-.25*	-.26*	.15	-.13	1.00	
6. Alliance	.39**	.21*	-.36**	.24**	.59**	1.00
Mean (SD)	4.1 (.92)	3.9 (.61)	3 (2.1)	6.87 (.29)	2.22 (.31)	4.44 (.58)
Possible Range	1-5	1-5	1-10	1-7	1-5	1-5

* $p < .05$, ** $p < .01$

Table 3

Summary of Multiple Regression Analysis for Therapist In-Session Mindfulness

Predictor	β	t	p
Alliance	.43	3.01	.001***
Client Symptoms	-.36	4.03	.001***
Therapist presence	.16	2.03	.09

Note. *** $p < .001$

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