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**MINDFULNESS AND PSYCHOTHERAPY:  
A MIXED METHODS INVESTIGATION**

A Dissertation in

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by

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## ABSTRACT

Psychotherapy research could benefit from attention focusing on the qualities of the therapist that are beneficial to therapy as well as how to cultivate these qualities (Norcross, 2002). Empathy and the ability to quell one's anxiety with clients are known to impact therapy in positive ways. Presence, being grounded in oneself and one's experiences while maintaining attunement to another person, is a relatively uninvestigated therapist quality, but there is preliminary evidence that suggests its importance (Geller & Greenberg, 2002). While mindfulness, a nonjudgmental moment-to-moment awareness of one's experience (Kabat-Zinn, 1997), has been shown to have a range of benefits to individuals, it has not been investigated with respect to psychotherapists. This study was an in-depth mixed methods case design investigating the relationships between therapist mindfulness and presence with empathy, anxiety and session progress from the point of view of the therapist and the client. Quantitative findings show that therapist mindfulness and presence were related to the criterion variables in the expected directions. The qualitative data suggest a number of ways in which therapists might cultivate presence, empathy and reduce their anxiety during sessions with clients. The emerging theory from the quantitative and qualitative data is that by being aware of one's experience in a nonjudgmental way, the therapist is more effective in his/her relationship with the client. Because therapist training involves a strong emphasis on outward attention to the client, these findings will hopefully shed light on the necessity for a balance between outwardly and inwardly attending.

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## **Chapter 1**

### **Introduction**

Mindfulness, a moment-to-moment awareness of one's present experience without judgment, is relatively new to the field of mental health in the Western world (Kabat-Zinn, 1990). While Easterners, especially Buddhists, might be aware of the benefits of practicing mindfulness in their daily lives, Westerners are likely to find the concept and practice of mindfulness to be markedly different from how daily life is usually lived. Mindfulness involves focused attention on oneself and on anything that might arise in one's field of awareness at any given moment (Morgan & Morgan, 2005). The West is popularly known for its fast-paced, action-oriented, "doing-laden" way of life. Mindfulness introduces a space between the body's actions, the mind's thoughts, the heart's emotions, and the self that experiences it. The practice of mindfulness has been shown to alleviate a number of physical ailments and psychological symptoms, while increasing one's quality of life (Grossman, Niemann, Schmidt, & Walach 2003; Kabat-Zinn, 1990). Most pertinent to this study, mindfulness has been shown to decrease anxiety across various populations (Reibel, Greeson, Brainard, & Rosenzweig, 2001; Rosenzweig, Reibel, Greeson, & Brainard, 2003; Shapiro, Schwartz, & Bonner, 1998). There is also some preliminary evidence that mindfulness improves empathy (Lesh, 1970; Pearl & Carlozzi, 1994; Shapiro, Schwartz, & Bonner, 1998; Stile, Lerner, Rhatigan, Plumb, & Orsillo, 2003; Sweet & Johnson, 1990). In fact the empirical literature on mindfulness and its effects across populations, most notably hospital patients and psychotherapy clients, is rather extensive. What has yet to be investigated, however is how mindfulness might impact psychotherapists and their work with clients.



The primary focus of most psychotherapy research is on aspects of therapy that lie outside of the person of the therapist. Recently, empirically supported treatment (EST) research has been at the forefront of psychotherapy research due to instigation from insurance companies as well as from pressure to compete with the medical profession (Soldz & McCullough, 2000). Typically this research involves rigorously testing various theoretical interventions with the goal of developing treatment manuals for psychotherapists to use with particular populations. The field has benefited greatly from this research, but not without costs. In EST research, the person of the psychotherapist, as an integral part of the change process, is ignored (Norcross, 2002). Lambert and Okiishi (1997) argue that the therapist is a central change agent in therapeutic process. Through his extensive research, reviews, and meta-analyses, Wampold (2001) found that there is overwhelming evidence that supports the fact that there are clear therapist effects on client outcome and these effects are greater than effects due to specific techniques. While the most ardent proponents of ESTs have attempted to turn clinicians into technicians who adhere closely to manualized treatment protocols (Waehler, Kalodner, Wampold, & Lichtenberg, 2000), they do so at a cost as therapist adherence to protocols is not shown to positively relate to outcome, and may even have a negative impact on outcome (Wampold, 2001). We know that the qualities of the therapist matter in therapy and yet training is mainly devoted to helping trainees develop theoretical orientations and technical proficiency rather than the qualities that relate more strongly to outcome (Vakoch & Strupp, 2000).

There is no shortage of evidence that the person of the therapist has an impact on the therapy process and client outcome (Crits-Christoph, 1991; Hayes, 2004; Wampold,

2001). Furthermore we know some of the therapist qualities that impact therapy, but what we know about these qualities varies. Although there is always some dissension about the importance of particular constructs, there exists extensive evidence to support the claim that the therapist's ability to empathize, to experience the client's world as if it were his/her own, (Rogers, 1961), as well as to experience what is just beyond the client's awareness (Berger, 1987; Freud, 1912/1958) is almost unanimously agreed upon as important, if not essential despite the type of client, treatment, or therapist (Bohart, Elliott, Greenberg, & Watson, 2002). In addition, the accurate and sensitive communication to the client of this empathy is necessary (Gurman, 1977; Rogers, 1957). Lambert and Barley (2002) summarize empathy's effect on outcome by stating that across studies, it seems to account for 7-10% of therapy outcome. It is assumed that therapists naturally have or will develop the ability to empathize well with and for their clients, but for such an important and, arguably, difficult ability to possess and use well, it is necessary to gain a deeper understanding of how to train therapists how to develop and use empathy (Morgan & Morgan, 2005). Again, there is preliminary evidence that mindfulness enhances one's ability to empathize (Lesh, 1970; Shapiro, Schwartz, & Bonner, 1998). Deepening our understanding of whether and how mindfulness enhances therapist empathy may assist in the cultivation of this important therapist ability.

Therapist anxiety is another aspect of the therapist that affects the therapeutic process, and client outcome (Bowman & Roberts, 1979; Bowman, Roberts, & Griesen, 1978; Friedlander, Keller, Peca-Baker, & Olk, 1986). It is known that therapist anxiety in session and the ability to effectively manage anxiety are important components of countertransference (Gelso & Hayes, 2007). Early on in therapist training, anxiety during

session is one of the most noticeable aspects of therapist that negatively impacts clinical work (Al-Darmaki, 2004; Hayes & Gelso, 1991). Al-Darmaki found that therapist anxiety is significantly higher in the early part of training and subsides after the therapist gains more experience and comfort in his/her role as a therapist. Anxiety is also known to affect more experienced therapists dealing with clients across a range of situations. For instance, experienced therapists report feeling an increase in anxiety when a client is violent, suicidal, or homicidal. Additionally, therapists experience anxiety when a client is in crisis, when they challenge the therapist, and when the therapist's unresolved issues are provoked (Hayes et al., 1998; Menninger, 1990). Whereas there is a plethora of literature on treating clients' anxiety disorders, very little empirical work has been done to understand the ways in which therapists quell their anxiety and how to particularly address the anxiety so common in therapist trainees (Robert & Bowman, 1978). Because of the abundance of evidence supporting mindfulness as a way to decrease anxiety, it seems that research may be helpful in advancing the field's understanding of ways to alleviate anxiety in therapists.

In addition, it is likely that there are other aspects of the therapist that affect the therapy process and client outcome, but remain virtually unknown, at least empirically. One such construct is therapist presence. Rich descriptions of the construct and hypotheses about the importance of therapist presence have been developed (Baldwin, 2000; Buber, 1958; Bugental, 1989; Thorne, 1992). For instance, Carl Rogers highlighted the importance of therapeutic presence towards the end of his career and felt he had underemphasized its importance in earlier writings (Baldwin, 2000). Thorne (1992) insists that had Rogers lived longer and developed the centrality of presence in person-

centered therapy as what underlies the necessary and sufficient conditions, person-centered therapy would have undergone a major shift from the trajectory it was on and from where it is today.

There exists scant empirical knowledge about the importance of the therapist's presence in individual psychotherapy (Geller & Greenberg, 2002). Through a qualitative investigation on the construct, Geller and Greenberg found that therapist presence involves multiple dimensions of the therapist's life. According to the therapists interviewed for their study, the different dimensions of presence can be organized using different stages. The first, "preparing the ground for therapeutic presence," involves readying oneself to enter into the therapeutic relationship with an attitude of openness, acceptance, and non-judgment. This preparation stage also involves practices such as daily meditation and practicing being present to oneself as well as others throughout daily living. The second aspect of presence involves being present while in contact with clients. Therapists described this aspect of presence as listening with a third ear and being attuned to the whole of the client's experience including feelings, thoughts, and bodily sensations. They also described entering into a sacred space where consciousness was expanded during a state of deep presence with a client. Third, therapist presence involves the "experience of presence." Briefly, this involves fully immersing oneself into the client's experience, having the intention of healing the client, while being grounded in him/herself. It involves being mutually aware of one's own experience and the client's experience on a deep, felt sense level.

Beyond learning about and deepening our understanding of therapist qualities that impact therapy, it is necessary to begin to investigate ways that therapists can cultivate

these qualities, which is noticeably absent from the psychotherapeutic literature (Morgan & Morgan, 2005). One hypothesis of this research is that therapist mindfulness could be a way in which therapist empathy and presence are enhanced, while anxiety is quelled. Because this area of empirical questioning is rather new, it was decided to employ a mixed-method design to test hypothesized relationships quantitatively as well as develop theories and questions as they arise from qualitative data. The relationships among therapist mindfulness, presence, empathy, anxiety, and client outcome will be investigated using quantitative methods in a single case study of a therapist-client pair throughout the duration of therapy. In addition, the researcher will use observational and interview data and a grounded theory approach to learn more about aspects of the therapist as they relate to psychotherapy.

## Chapter 2

### Literature Review

#### *Defining and Describing Mindfulness*

While not a new concept and rather an ancient practice for many Easterners and Buddhists worldwide, mindfulness is relatively new to the field of mental health in the Western world. Mindfulness is the conscious moment-to-moment awareness of one's experience without judgment cultivated by systematically paying attention on purpose (Kabat-Zinn, 1990). It originated in Buddhism but is not merely a religious concept (Grossman, Niemann, Schmidt, & Walach, 2003). According to Grossman et al., there are three underlying assumptions to this concept. First, humans are normally unaware of their moment-to-moment experience but are capable of developing an ability to sustain attention to present experience. Second, the development of this ability is gradual. Finally, practicing mindfulness will engender experiencing life's moments as more vivid and will lead to a greater sense of control in one's life.

In addition, the key to mindfulness is not simply paying attention; "the attention must embody compassion, impartiality, and acceptance of self and others" (Shapiro, Schwartz, & Bonner, 1998). Through practicing these qualities, one can cultivate present moment attention in a non-judging and accepting way. This leads to an ability to be open to whatever enters one's field of awareness (Shapiro et al., 1998). Mindfulness is often described in conjunction with meditation, or more specifically, Vipassana (mindfulness meditation) (Kabat-Zinn, 1990). While mindfulness meditation is a way in which the ability to be mindful is thought to improve, it is unclear if other spiritual and non-spiritual activities and practices enhance one's mindfulness.

Much of the literature on mindfulness involves the mindfulness-based stress reduction (MBSR) program founded by Kabat-Zinn in 1979. MBSR has been adapted from the Buddhist meditation practice known as Vipassana (Kabat-Zinn, 1990). This program generally involves 8 weeks of daily mindfulness meditation practice, sitting in silence for 20 minutes, focusing on one's breath and attending to one's inner and outer experiences without judgment or reactivity (Reibel, Greeson, Brainard, & Rosenzweig, 2001). The program also includes weekly meetings for 2.5 hours where participants learn how to do and practice mindfulness meditation. In addition, MBSR programs generally consist of large and small group discussions where participants discuss their experiences, difficulties, and successes with mindfulness meditation along with other life issues they might be facing (e.g., chronic illness).

Research indicates that participating in MBSR programs decreases medical symptoms that accompany illnesses such as cancer and fibromyalgia (Chang, Palesh, Caldwell, Glasgow, Abramson, & Luskin, 2004; Reibel, Greeson, Brainard, & Rosenzweig, 2001). Studies also show significant improvements in relief for chronic pain patients (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn, Lipworth, Burney, & Sellers, 1987; Randolph, Caldera, Tacone, & Greak, 1999). Further, Massion, Teas, Hebert, Wertheimer, and Kabat-Zinn (1995) found improvements in immune function for women who were trained in MBSR.

In terms of mental health benefits, it is empirically well-documented that participating in MBSR programs increases positive mood states (Chang, et al., 2004; Galantino, Baime, Maguire, Szapary, & Farrar, 2005; Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003), mindfulness self-efficacy (Chang et al., 2004), spiritual

experiences (Shapiro, Schwartz, & Bonner, 1998), and social functioning, quality of life, and overall well-being (Reibel et al., 2001). In addition, research indicates that participating in MBSR programs decreases individuals' perceived stress (Chang et al., 2004; Shapiro, Astin, Bishop, & Cardova, 2005), state and trait anxiety (Shapiro et al., 1998), depression and anxiety (Reibel et al., 2001; Rosenzweig et al. 2003; Shapiro et al., 1998; Weiss, Nordlie, & Siegel, 2005), and job burnout (Galantino et al., 2005; Shapiro et al., 2005).

While the physical and psychological benefits of mindfulness are clear and supported through a number of empirical studies, these findings are limited to particular populations, most notably hospital and psychotherapy patients. In line with the findings of current research on mindfulness, it seems likely that these positive benefits relate to other populations as well, including psychotherapists. Beyond the need for research to be conducted illustrating the benefits of mindfulness in psychotherapists, there is also the question: how might these benefits affect the functioning and effectiveness of the therapist and the therapy process?

We know that the work of a therapist involves aspects of a therapist's self that have an impact on the therapy process and outcome (Hayes, 2004; Wampold, 2001). In fact, "multiple and converging sources of evidence indicate that the *person* of the psychotherapist is inextricably intertwined with the outcome of psychotherapy" (Norcross, 2002, p. 4, italics in original). More specifically, Crits-Christoph's (1991) meta-analysis of therapist effects on client outcome showed that therapist effects account for up to 9% of the variance in client outcome. Wampold found that there is a "preponderance of evidence" indicating that there are large therapist effects and these



“greatly exceed treatment effects” (p. 200). We also know that some therapists have better outcomes than others and some therapists have better outcomes with certain clients than others (Lambert & Barley, 2002). What are the therapist attributes and qualities that lead to better outcome and how can therapists cultivate these outcome-related qualities? This is at the crux of this investigation.

Three therapist variables as they are related to therapist mindfulness will be investigated in this study: presence, empathy, and anxiety. Client outcome as it is related to therapist mindfulness will also be investigated. What we empirically know about these therapist variables differs, but we know far more about their importance to therapy than what is known about how to cultivate empathy and presence and quell anxiety.

While mindfulness has been shown to improve individuals’ ability to empathize in other populations (Shapiro, Schwartz, & Bonner, 1998), investigating its effects on psychotherapists and the therapy process seems like a logical next step. Conversely, psychotherapists’ anxiety inhibits the effectiveness of various aspects of the therapeutic relationship and process (Bowman & Roberts, 1979; Bowman, Roberts, & Griesen, 1978; Friedlander, Keller, Peca-Baker, & Olk, 1986). Mindfulness has been shown to decrease anxiety across numerous and diverse populations (Astin, 1997; Miller, Fletcher, Kabat-Zinn, 1995; Reibel, Greeson, Brainard, & Rosenzweig, 2001; Shapiro, Schwartz, & Bonner, 1998). Mindfulness may be an avenue by which therapists can improve their capacity to be present to and empathize with their clients. It may also lead to a reduction in therapists’ anxiety leading to more effective therapy for clients.

## Presence

### *Therapeutic Presence: Definition and Theoretical Links to Mindfulness*

Out of the various constructs to be investigated in this study, therapeutic presence most closely relates to the construct of mindfulness. In fact, because of the way in which mindfulness and presence are defined, it is often difficult to tell where one ends and the other begins. Towards the end of Carl Rogers' career, he began touching on the importance of the therapist's presence in psychotherapy. In an interview, Rogers states:

I am inclined to think that in my writing I have stressed too much the three basic conditions (congruence, unconditional positive regard, and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy – when my self is very clearly, obviously present” (Baldwin, 2000, p. 30).

Some believe that if Rogers had lived longer, he would have further stressed the importance of presence and client-centered therapy would have undergone major changes (Thorne, 1992).

Therapeutic presence is defined as bringing one's whole self to the engagement with the client and being fully in the moment with and for the client with little self-centered purpose or goal in mind (Craig, 1986; Webster, 1998 as cited in Geller and Greenberg, 2003). It is aptly described by Geller and Greenberg (2002) as “*being* with the client rather than *doing* to the client” (italics in original, p. 85). Buber (1958) describes its importance in stating that healing emerges from individuals being fully present to one another. Bugental (1989) defined presence by describing its three components. The first component overlaps entirely with mindfulness and is described as openness to one's own experience in being with the client. The second and third components are an availability and openness to all aspects of the client's experience and the capacity to respond to the

client from this experience (Bugental, 1989). These two latter components involve balancing the therapist's own experience with being in contact with the client's experience.

### *Therapeutic Presence and Psychotherapy*

To date, there has been little empirical investigation into the importance of presence to the therapeutic relationship, therapy process, and outcome. This may be due to the amorphous, almost ethereal, nature of the construct. There exists rich discussion about the importance of therapeutic presence in psychotherapy, but virtually no empirical investigation of the construct (Baldwin, 2000; Bugental, 1989; Geller & Greenberg, 2003).

To illustrate its importance, it may be useful to imagine a therapist without presence. For example, consider a therapist who rushes into session with a client, is easily distracted by his/her own thoughts, emotions, day dreams, the client's mannerisms, the details of the room, the temperature and so on. The therapist approaches the time with the client as merely another obligation in the day and checks the clock every five or so minutes during the session. Might the client pick up on the therapist's lack of presence? Might the client feel invalidated, not heard (all-too reminiscent of the client's experience in his/her family), and devalued? What effects may this have on the relationship, process, and outcome of therapy? The greatest known predictor of outcome, the working alliance (Horvath & Bedi, 2002), might be sacrificed. The therapist might not notice that the quality of the relational bond is weak or that there is disagreement between the client's view and his/her own view of the tasks and goals of therapy. Empathy, another known contributor to outcome might not be felt by the therapist or communicated to the client,

two essential aspects of being empathic (Gurman, 1977; Rogers, 1980). At its worst, the client might abandon therapy altogether resolving that his/her original fear, that he/she was ultimately alone in misery and that no one really cares or could really understand, has come true.

It could be argued that therapist presence is a necessary precondition in effectively empathizing with the client, forming an alliance, implementing specific techniques or interventions at a particular time, and other known important aspects of good therapy. Clients typically begin the process of psychotherapy because they are in distress. Often times the therapist is the only individual who is privileged enough to be allowed into the client's private world (Yalom, 1989). The level of deep sharing on the client's part seems to require an equally deep level of reception and engagement (not necessarily verbal engagement) on the part of the therapist. It seems that this deep reception and engagement on the part of the therapist engenders stronger relational connectedness and the client's sense of trust in the therapist. Given relational connectedness and trust in the therapist, healing takes place in the process of therapy (Rogers, 1957). The importance of a healing environment and client trust in the therapist and therapy process are two essential components of the contextual model (Frank & Frank, 1991). Therapist presence is virtually an untapped variable that may have far-reaching potential.

Geller and Greenberg (2002) conducted a qualitative study on therapeutic presence by interviewing seven experienced therapists (at least 10 years experience), four of whom identified as having a humanistic orientation, one as cognitive-behavioral and was an experienced meditator, one as transpersonal, one as Eriksonian, and one as

Adlerian. After being given a brief description of presence, therapists were asked to reflect upon their own experience of presence over their next few sessions with clients. At least one week later, the therapists were interviewed by the researchers. Through the information gathered, a model of therapeutic presence was formed which is best described in three stages.

The first stage is called “preparing the ground for therapeutic presence.” Preparation begins prior to the beginning of session as well as throughout daily life, two sub-categories. Therapists discussed the “intention to bring the whole self” to the therapeutic encounter, “clearing a space” internally from personal concerns and distractions, as well as approaching the client with “an attitude of openness, interest, acceptance, and non-judgment” (Geller et al., 2002, p. 77). In the sub-category of “preparing in life,” therapists discussed having a “philosophical commitment to presence” and practicing it in their lives outside of the therapy context (Geller et al., p. 77). Most of the therapists interviewed emphasized the importance of daily meditation as an integral part of cultivating presence and attending to themselves, their own needs and concerns outside of a session, as a means of increasing their ability to be present.

The second stage is called “the process of therapeutic presence” and reflects what the therapist does in session with a client. This involves three sub-categories. The first, “receptivity,” involves fully taking into one’s being, in a palpable and bodily way the experience of a session. This stage “demands a conscious intention and commitment to remaining open, accepting, and allowing, to all the dimensions and experiences that arise” (Geller et al., p. 78). It involves listening with the third ear. One therapist stated that it is listening with her body to the client’s bodily experience. Therapists also reported

an extrasensory level of communication between themselves and their clients when in a state of deep presence. They described it as sharing sacred space and experiencing an altered and expanded state of consciousness. The second sub-category is “inwardly attending” and involves the therapist using him/herself as an instrument to understand the client, responding more creatively and spontaneously along with being congruent and authentic. Therapists described being attuned to themselves in a state of presence, which allows them to return to the present moment when they are not present. The third sub-category is “extending and contact” which involves making themselves accessible and transparent in their responses to clients.

Finally, the third stage is called the “experience of presence,” which comprises four subcategories. The first is “immersion,” where therapists described being absorbed in the experience of the moment. The second, “expansion,” encompasses a sense of timelessness, energy and flow, spaciousness, enhanced awareness of sensation and perception, and enhanced quality of thinking and emotional experiencing. The third sub-category is “grounding” and involves feeling centered in one’s self and one’s own personal existence while immersing into the client’s pain and experience. The fourth is “being with and for the client” and involves including the intention for the client’s healing, experiencing feelings of awe, wonder, warmth, compassion, and love. There is also an experience of the absence of ego while being with and for the client.

Through their qualitative investigation, Geller and Greenberg (2002) highlight how central therapist presence is to the participants’ work with their clients and in their lives. While caution should be used in generalizing these findings to other therapists, the

depth and richness that emerged from the interviews about presence illustrate a beginning step in further understanding this important therapist construct.

Geller (2003) also developed a measure of presence which, to date, has not been published and has rarely been used. The Therapist Presence Inventory (TPI; Geller, 2003) is a measure using the therapist's perspective of his/her presence in any given therapy session. An alternate version has been developed to measure clients' perceptions of therapist presence during a therapy session (Vinca & Hayes, 2007). We found that therapist ratings of their presence accounted for 5% of the variance in client symptoms reduction from intake to termination. Client ratings of therapist presence accounted for 13% of this variance. Both therapist and client ratings of therapist presence were positively related to therapist empathy and inversely related to therapist anxiety. These results further indicate the possibilities in understanding more about therapist presence and how to cultivate it in therapists.

## Empathy

### *Defining Empathy*

Rogers defined empathy as an “accurate understanding of the client’s world as seen from the inside. To sense the client’s private world as if it were your own, but without ever losing the ‘as if’ quality—that is empathy, and this seems essential to therapy” (Rogers, 1961, p. 284). Rogers (1980) further defined empathy as “being sensitive, moment by moment, to the changing felt meanings which flow in this other person” (p. 142). May (1967, p. 97) noted that empathy is a “learning to relax, mentally and spiritually, as well as physically learning to let one’s self go into the other person with a willingness to be changed in the process” Eagle and Wolitzky (1997) point out the

importance of being right there with the client without over-identifying. There exists an optimal distance whereby the therapist seeks to understand the client without losing an awareness of being outside of the client's perspective. This optimal distance is analogous to Rogers' (1961) "as if" quality of empathy. But is empathy only sharing in a client's conscious experience or does it delve deeper into a client's unconscious? Berger (1987) proposes that empathy can go deeper in that a therapist who is "with" a client may very well be empathizing with what is beneath the conscious. This is aligned with Freud's (1912/1958) famous statement that the therapist must "turn his own unconscious like a receptive organ toward the transmitting unconscious of the patient" (p. 112).

### *Empathy and Psychotherapy*

Empathy is a necessary condition of any successful psychotherapeutic relationship. While each theoretical orientation has its own definition of empathy, it is inarguably an essential component across theoretical orientations (Bohart, Elliott, Greenberg, & Watson, 2002). In addition, it is imperative to the psychotherapeutic relationship that the client perceives the therapist's empathy (Bohart et al., 2002). As Gurman (1977, p. 523) aptly states, "it is clear from the findings presented...*that there exists substantial, if not overwhelming evidence in support of the hypothesized relationship between patient-perceived therapeutic conditions [including empathy] and outcome in individual psychotherapy and counseling*" (as cited in Barrett-Lennard, 1986, italics in original). In a meta-analysis of the relationship of empathy to psychotherapy outcome, Lambert and Barley (2002), found that empathy accounts for 7-10% of the variance in outcome. Lambert and Barley also found that empathy supersedes specific



interventions accounting for outcome variance, illustrating the importance of empathy in the therapeutic relationship.

Empathy has been found to be an integral part of particular dimensions of the therapeutic relationship that contribute to outcome. For instance, the quality of the therapeutic alliance, a collaborative aspect of therapy, contributes more to outcome in therapy than do techniques (Horvath & Luborsky, 1993). The strength of the alliance between client and therapist is mediated by empathy. The therapist-client relationship cannot form without the therapist experiencing empathy for the client and most importantly, this being communicated to and felt by the client (Horvath & Luborsky, 1993). Regarding alliance building, empathy is a necessary condition. Research has shown that there is a “moderate-to-strong correlation between client-perceived empathy and some aspects of the alliance” (Horvath & Luborsky, 1993, p. 562). The therapist’s ability to experience what the client is thinking and feeling and the communication of this experience to the client contributes to the construction of a relationship bond and therapeutic alliance. Because empathy not only correlates with outcome, but also contributes to the therapeutic alliance which also predicts outcome, there is a need to further understand how therapists can experience and communicate accurate empathy.

#### *Empathy and Mindfulness: Theoretical links*

Lesh (1970) argues that “one cannot be empathic with another if he does not even know what his own experience is” (p. 43). Mindfulness is an acceptant look at one’s own experience, which leads to deeper awareness. This self-work is a precondition for assisting and empathizing with others. In Eastern and Buddhist psychology, empathy is said to arise with deepening insight about the nature of the world and with softening of

the illusion of the “self” as separate from the world around us. The illusion dissipates through the practice of mindfulness, leading to an appreciation of one’s affinity with all beings. The depth of this understanding naturally engenders compassion and empathy for oneself and others (Germer, 2005). The ability to pay attention to one’s moment-to-moment experience in a compassionate, non-judgmental way while experiencing acceptance of oneself and others relates to empathy in important ways. First, mindfulness involves being immersed in the present moment, which entails an awareness of one’s thoughts, feelings, and actions. The usual way in which we are enslaved by our thoughts, judgments, past experiences, and future worries are diminished and even absent when in a mindful state. When clients express themselves in verbal and non-verbal, overt and covert, concrete and symbolic ways, mindful therapists are able to take in more of the nuances of these communications without being overly clouded by their own judgments or inner noise. Lazar et al. (2005) found this astute ability in advanced mindfulness practitioners. These individuals were able to detect the most miniscule and fleeting facial microexpressions of emotion in others more than other groups were able to, including CIA agents. Second, mindful therapists learn through being mindful in their own lives how to experience themselves, as well as others, without judgment. This nonjudgmental attitude is translated to clients, who can then experience themselves more fully and with less judgment (Lesh, 1970). Third, the practice and cultivation of mindfulness translates to therapists being more in control of their own thoughts, feelings, and behaviors (Walsh & Shapiro, 2006). This means that mindful therapists are less likely to be at the mercy of distractions while being present to their clients. Therapists have control over what they will allow into their field of awareness. This produces the utmost focus on different

aspects of the therapeutic encounter, including the client, the therapist's own internal reactions, and the process of therapy.

The mindful therapist can fully join the clients in their experience while maintaining the “as if” quality Rogers (1961) deemed to be so important to empathic relating. The therapist's subjectivity is not compromised, but rather utilized for the benefit of the client. The mindful therapist's understanding can be expressed to the client through a lens of acceptance and compassion. This is in direct opposition to how many clients both view themselves and experience others viewing them, which may be harsher and less compassionate. Wallace's (1999) essay on intersubjectivity in Indo-Tibetan Buddhism, where mindfulness is at the heart of its teaching, discusses how mindfulness and empathy are inextricably related. He states that “the central Buddhist insight practice of the four applications of mindfulness is a means for gaining insight into the nature of oneself, others, and the relation between oneself and the rest of the world, which provides a basis for cultivating a deep sense of empathy” (p. 209). The importance of empathy in psychotherapy is clear and yet,

Therapists receive little or no formal training in the cultivation of attention or empathy. We seem to understand their importance as therapeutic skills and perhaps we pick up a few tricks through supervision and trial and error. Beyond this, it is assumed that those skills will naturally manifest in the treatment room.

(Morgan & Morgan, 2005, p. 73)

The concern is that the ability to empathize with clients does not naturally happen for many psychotherapists. In addition to theoretical connections between mindfulness and empathy, there is preliminary empirical evidence as well.

### *Empathy and Mindfulness: Empirical Links*

Research has pointed to the relationship between meditation, mindfulness, and empathy in numerous empirical studies (Lesh, 1970; Pearl & Carlozzi, 1994; Stile, Lerner, Rhatigan, Plumb, & Orsillo, 2003; Sweet & Johnson, 1990). Lesh's seminal research was the first to explore the relationship between meditation and therapist empathy. While his research did not use the term mindfulness, the form of meditation that the therapists took part in is called zazen, which means sitting meditation. This entails sitting motionless and concentrating on one's in and out breath while suspending the flow of ordinary thoughts (Maupin, 1962 as cited in Lesh, 1970), by non-judgmentally noticing the thought and then letting it pass. Zazen is nearly identical to the sitting meditation in the MBSR program. In observing counseling sessions of both inexperienced and experienced counselors, Lesh concluded that "many of the counselors frequently were not relating to the reality of the person in front of them...It seemed they were more interested in their own need to be the 'problem solver' than to accept the feelings the client was pouring out" (p. 43). Because the author concluded that counselors were not as empathic as they needed to be for effective psychotherapy, the author investigated zazen, or sitting meditation, as a possible practice that might improve counselors' empathy, their openness to experience, and their self-actualization.

Participants were masters students taking counseling courses at the University of Oregon during 1968-69 and though attempted, randomization was not possible. The first group consisted of 16 participants who volunteered to participate in the meditation group and did so. Twelve participants volunteered to participate in the meditation group but ended up being a control group. The third group consisted of 11 participants who did not

want to participate in the meditation portion of the study. They served as a second control group. All groups completed questionnaires at pre-intervention and then four weeks later at post-intervention time.

The intervention involved the 16 participants in the experimental condition going to a designated room in the library every weekday for four weeks from 12:30pm to 1pm for their meditation exercise. The experimenter prefaced the study by stating he would interact with students as minimally as possible in order to avoid disrupting the study. The students went to the specified room each day and listened to an audio tape describing what they were to do during the thirty minute meditation (i.e., pay attention to their breath, count the breaths up to ten and then begin again) as well as what they might experience (i.e., they may feel uncomfortable or anxious) and what to do if they experienced discomfort (i.e., accept the feelings and thoughts with indifference). At the end of the instructions, the tape went silent for 30 minutes at which point the participants were to practice zazen and then the experimenter's voice came back on and instructed the participants to record their experiences. The experimenter would then appear and collect the cards on which the participants had recorded their experiences. At the end of the four weeks, all participants filled out the questionnaires that they had completed before the intervention period. These included the Affective Sensitivity Scale (ASS; Kagan, Krathwohl, & Farquhar, 1965), Experience Inquire (Fitzgerald, 1966), and Personal Orientation Inventory (POI; Shostrom, 1966), measuring empathy, openness to experience, and self-actualization, respectively. The hypotheses were confirmed in that the group that practiced zazen for four weeks showed significant increases in empathy, openness to experience, and self-actualization while the control groups did not.

With regards to the increase in empathy finding, these results need to be clarified. The ASS is a test that involves watching a video tape (in this case it was poor in viewing quality) of client-counselor interactions and marking the feelings the participant thinks the client is experiencing. Their responses were then compared to what clients actually said they were experiencing. The results of this test do not necessarily generalize to the ability to correctly perceive the feelings of a person sitting in front of you during a real counseling session. In addition, correctly perceiving the emotions of another person does not translate into accurate communication of these emotions to the person, a necessary aspect of empathic communicating. Another limiting aspect of the results involved the experimental group's baseline empathy which was higher than the other two groups. This could indicate an exceptional group of participants with regards to empathy, though scores on the ASS did increase after the near-daily zazen and did not in the control groups. In addition, the non-randomized design inhibits causal inference and relegates the "control" groups more accurately to "comparison" groups. Despite the flaws that are arguably inherent in pioneering research, Lesh's research on meditation and empathy was an important first step towards opening the field of psychotherapy research to the possible ways in which therapists' practices, such as meditation, may improve the therapeutic self as a tool in therapy.

Shapiro, Schwartz, and Bonner (1998) investigated the short-term effects of an 8-week intervention modeled after Kabat-Zinn's MBSR program. The 78 participants comprised medical and premedical students and were tested during a particularly stressful time of year, during final examinations.. The intervention group, who participated in the mindfulness intervention course, was compared to a wait-list control group and then this

control group went through the 8-week mindfulness intervention course. The intervention mainly consisted of training the students in mindfulness, which involved sitting meditation, body scan, and hatha yoga. In addition, “loving kindness” and “forgiveness” meditation were introduced to the intervention group. There were two additional pieces to this study’s intervention program which involved didactic material on how to cope with stress and “experiential exercises designed to cultivate mindful listening skills and empathy” (Shapiro et al., 1998, p. 586). Participants in the experimental group were broken up into groups to offer support to one another and discuss their experiences with their mindfulness practice.

As hypothesized, there was a significant increase in empathy from baseline to post-intervention as measured by the Empathy Construct Rating Scale (ECRS; La Monica, 1981) for the intervention group, while the control group experienced a decrease in their empathy. The control group then participated in the treatment program and showed similar increases in empathy. In all studies based on Kabat-Zinn’s MBSR program, mindfulness was not measured. This is not to say that mindfulness was not, in fact, what led to the increases in empathy. It is important to note, however, that these programs include a social support aspect as program participants interact with one another on a weekly basis to both learn mindfulness and to discuss various issues in their lives. The group interaction aspect of the program may influence the post-intervention scores across a variety of variables. In this particular study, participants engaged in a didactic piece that specifically targeted improving empathic listening skills. This is an added barrier to interpreting whether variables in addition to participants’ mindfulness may have contributed to the observed increases in empathy.

## *Summary*

Therapist empathy is an essential aspect of therapy as shown through the extensive empirical support in the psychotherapy literature (Lambert & Barley, 2002). While empirically there is little evidence supporting the importance of therapist presence in therapy, it has been consistently discussed in the theoretical literature as being, arguably, more important than or a precondition to other therapist abilities (Baldwin, 2000). Empathy and presence, while important components of the therapist's self as a healing tool, can be impinged by other aspects of the therapist namely, anxiety.

## Anxiety

### *Defining Anxiety*

Germer (2005) states that "Anxiety probably developed through evolution to keep us alive" and distinguishes between fear, which is a "short-term response to imminent danger" and anxiety, which is "apprehension about events that might endanger us in the future" (p. 153), though they are commonly used interchangeably. According to Rachman (1998), anxiety, which is closely related to fear, has two chief features, a state of elevated arousal and negative affect. The American Psychiatric Association (2000) further distinguishes between maladaptive anxiety as being a response to danger that is not real, and an anxiety disorder, which inhibits a person's ability to function.

Spielberger's (1972, 1983) influential research distinguished between state and trait anxiety. State anxiety is the complex emotional reactions evoked in individuals who perceive a situation as threatening where the individual experiences an intense emotional state along with heightened autonomic nervous system activity. According to Spielberger's (1972), trait anxiety is a relatively stable individual characteristic although



there is evidence that trait anxiety is alterable (Al-Darmaki, 2004; Shapiro, Schwartz, & Bonner, 1998). The particular area of interest for this research endeavor involves psychotherapists' state anxiety, how it hinders the process and outcome of psychotherapy, and how mindfulness may decrease therapists' state anxiety.

### *Anxiety in Psychotherapists*

Much of the empirical literature on therapists' anxiety focuses on the training period of counselors and therapists. A number of empirical studies have shown that there exists a negative relationship between trainees' performance and anxiety level (Bowman & Roberts, 1979; Bowman, Roberts, & Griesen, 1978; Friedlander, Keller, Peca-Baker, & Olk, 1986). The abovementioned studies primarily looked at the effects of state anxiety. At the beginning of counseling training, state and trait anxiety are higher than after training (Al-Darmaki, 2004). Al-Darmaki suggests counselor training needs to address the anxiety associated with being a novice. While counselors are acquiring new skills, techniques, and abilities, the implementation of these is hindered if anxiety is not addressed and reduced.

Research suggests that when a therapist feels anxious due to a client expressing tendencies that are threatening to the therapist (e.g., challenging the therapist), the therapist displays unhelpful responses. Some of these include diverting the discussion, making premature interpretations that block the patient's expressions, moving quickly to summarizing the client's statement, and communicating ill-placed reassurances and disapproval (Dollard & Miller, 1950; Eldred, Hamburg, Inwood, Salzman, & Meyersburg, 1954). Bandura (1956) suggests that "Such reactions not only may impede the progress of psychotherapy but may actually produce a negative therapeutic effect by

reinforcing the strength of the patient's anxieties" (p. 333). Another way that therapist anxiety is believed to negatively impact the therapeutic relationship is through countertransference. State anxiety has been shown to be an affective manifestation of countertransference feelings (Cohen, 1952; Gelso & Hayes, 2007) and the ability to regulate anxiety is central to countertransference management. There exists both theoretical and empirical support for the negative relationship between counselor anxiety management and countertransference behaviors (Cohen, 1952; Gelso & Hayes, 2007; Hayes & Gelso, 1991). In developing a measure for countertransference management, Hayes, Gelso, Van Wagoner, and Diemer (1991) found that experts rated anxiety management as central to the management of countertransference. This finding illustrates that whereas all therapists will encounter situations where their personal issues get stirred up by the client, how they manage their anxiety is an important component to countertransference management.

Research suggests that psychotherapists, in training and post-training, experience anxiety in their role as therapists and that this anxiety interferes with the learning and/or demonstration of behaviors related to effective performance (Bandura, 1956; Bergin & Solomon, 1970; Brams, 1961; Kelly, Hall, & Miller, 1989; Menninger, 1990; Pennscott & Brown, 1972). It is important to briefly discuss the seminal research that relates to the present study. Bandura is perhaps the first to examine psychotherapists' anxiety. He did so by examining its relationship with self-insight and psychotherapeutic competence. The participants were all male and included 32 clinical psychologists, 8 psychiatrists, and 2 psychiatric social workers. Settings included a child guidance clinic, a community psychological clinic, a university student counseling center, and a V.A. neuropsychiatric

hospital. The design for this study is particularly interesting as the therapists within each setting rated each other and themselves on perceived level of anxiety. Therapists were ranked from least to most anxious with respect to three central conflict areas: dependency, hostility, and sex. Supervisors ranked therapists from the most to the least competent. Most therapists were ranked by at least two supervisors, while one was ranked by only one supervisor.

Therapists who were rated as low in anxiety by their co-workers and themselves were rated as higher in competence by their supervisors as compared with those who were rated as high in anxiety. The results suggest a link between therapist anxiety and competence. However one could argue the ways in which anxiety and competence were operationalized and measured were inadequate. While competence was defined as “the therapist’s ability to facilitate improvement in the adjustment of patients” (Bandura, 1956, p. 334), one might argue that a supervisor may not be able to adequately assess this as no information was given as to how they view improvement in the adjustment of patients nor is it known how supervisors assessed their supervisees’ work (e.g., watching video of supervisees’ sessions). Moreover, it is quite possible that due to the various settings in which this study was conducted, the methods of supervision varied as did their understanding of competence. In terms of understanding the ways in which anxiety in the psychotherapist can be decreased, this study offers no postulations.

Research on the how to reduce anxiety in psychotherapists is noticeably absent, especially in research conducted beyond the late 1970s. Roberts and Bowman (1978) discussed what was known at the time about methods in reducing therapist anxiety. They found that systematic desensitization as a way of decreasing counselor anxiety was

examined with mixed results (Carter & Pappas, 1975; Fry, 1973; Monke, 1971 as cited in Roberts et al., 1978). Riley (1975) looked at modeling as a method to decrease anxiety in counselor trainees was examined and showed no significant results among three groups. The first group observed client sessions of a more advanced counselor and had a discussion about the session afterwards. The second group observed a session by a more advanced counselor but had no opportunity for discussion afterward. The third group did not observe a counseling session and had no discussion. The trainees anxiety did not decrease in any of the three groups. In Roberts and Bowman's review on counselor anxiety, they conclude that "the literature on treatment to reduce counselor anxiety has yielded no clear cut support for any of the treatment approaches explored" (p. 56). The literature on ways to reduce trainee anxiety is scant since this time and evidence of reliable methods to do so is inconclusive.

While not an empirical study on ways to alleviate anxiety in psychotherapists, Menninger (1990) conducted a survey of 88 psychotherapists and asked them to list the "five most anxiety-provoking experiences in your practice" and the ways in which they cope with their anxiety (p. 232). The most anxiety-provoking experience for two-thirds of therapists was associated with patients' threats, gestures, attempts, or completion of suicide. Second was violence demonstrated by patients' threats of harming the therapist or his/her family, bringing in firearms, and destroying property of the therapist. Third was an encounter with a difficult patient, which could include intrusion on the therapist's personal life. Other anxiety-provoking events included patients challenging the therapists' competence, patients expressing anger, sexual issues involving the patient's feelings toward the therapist or vice versa. Therapists also responded that their anxiety

had much to do with self-doubt, treatment failure, and countertransference feelings of vulnerability.

The researcher categorized psychotherapists' responses of how they coped into three categories. The first included active coping, and this was expressed by taking action in therapy, consulting, and discussing their anxiety with patients. The second category included avoidance behaviors which involved doing little or nothing to reduce their anxiety, focusing on something else such as relaxation skills and breathing, and physical escape which meant taking time to oneself in a variety of ways when not working. The third category involved extraordinary actions which included restraining or hospitalizing the patient, contacting police, terminating treatment, and filing charges or a report. From Menninger's (1990) survey results, it is not possible conclude which coping behaviors worked more effectively and for which situations. Improving our understanding of the ways in which therapists, both during training and post-training, cope with anxiety inherent in the role of the therapist is imperative. Research in this area may also produce a practice that therapists can integrate into their training in order to quell their anxiety, and in turn increase effectiveness. Mindfulness could be a possible alleviating agent.

#### *Anxiety and Mindfulness: Theoretical Links*

Germer (2005) discusses the process of taking a mindfulness-based approach to treat anxiety. By comparing a mindfulness approach to a cognitive-behavioral (CBT) approach, Germer states that instead of becoming more identified with our thoughts, which is more of a CBT aim, a "mindfulness-based approach to treating anxiety involves becoming less identified with our thoughts: simply noticing the event, as it is occurring, with acceptance" (p. 154). In addition, the mindfulness-based approach is similar to

looking at a film reel, frame by frame with scrutiny, and in doing this, it “loses its horrifying impact” because “being aware, moment to moment, dismantles the fear by distinguishing the raw facts of experience from the frightening conclusions we draw shortly thereafter” (p. 155). The whole of the experience is closely examined by looking at its parts and it becomes clearer that the sense of danger lies in the individual’s perception of the whole and this danger dissipates in looking at the individual parts.

Another point to consider is how the body responds automatically when it becomes anxious and senses danger (real or perceived). Symptoms associated with anxiety such as increased heart rate and blood pressure, rapid breathing, and racing thoughts become automatic and habitual in individuals (Rachman, 1998). Mindfulness empowers the practitioner to react consciously rather than automatically by instituting a pause between the initial perception of danger and the anxious response (Reibel, Greeson, Brainard, & Rosenzweig, 2001). While it may be true that human beings are always trapped, in a sense, in our own minds and perceptions, mindfulness allows us to, in a sense, step outside ourselves in order to see what is taking place. This enables us to change the ways in which we habitually respond or react to a given situation. Bishop et al. (2004) further illustrate this point:

“In a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. This dispassionate state of self-observation is thought to introduce a ‘space’ between one’s perception and response. Thus mindfulness is thought to enable one to respond to situations more reflectively (as opposed to reflexively)” (p. 232).

Beginning practitioners of mindfulness might say that they are “seeing” themselves for the first time as they are taken out of their mechanical, habitual ways and observing themselves.

### *Anxiety and Mindfulness: Empirical Links*

There exists much evidence supporting the effectiveness of MBSR programs in reducing anxiety and enhancing overall well-being (Astin, 1997; Miller, Fletcher, Kabat-Zinn, 1995; Reibel et al., 2001; Shapiro, Schwartz, & Bonner, 1998). In addition, a number of empirical studies show the role MBSR plays in reducing a number of negative mental health characteristics associated with anxiety. In a study of health care professionals, an MBSR program produced significant reductions in perceived stress (Shapiro, Astin, Bishop, & Cordova, 2005). When MBSR was incorporated as an adjunct to outpatient psychotherapy, significant decreases in psychological distress were found as compared to those who were in outpatient psychotherapy only.

Rosenzweig, Greeson, Brainard, and Hojat (2003) conducted a study of medical students’ anxiety during a particularly stressful time of year. This study took place over four years with a total of 302 participants; 140 participated in MBSR groups and 162 in control groups. It is important to mention that the post-intervention time was towards the end of the semester when students were known to typically experience more stress due to final assignment due dates and exams approaching. Group assignment was not randomized in this study as participants who volunteered to participate could choose between participating in the MBSR program or nine seminar course electives on alternative and complementary medicine. The seminar course consisted of didactic sessions, demonstrations, and discussions whereas the MBSR program included teaching

participants a variety of meditation practices and giving them audiocassettes for daily meditation practice. Participants were expected to practice 20 minutes of formal meditation 6 days per week for 8 weeks.

Rosenzweig et al. (2003) found that medical students who participated in the MBSR program experienced significantly less anxiety as reported on the Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1992) and its subscale, Tension-Anxiety, than medical students who did not participate in MBSR. Self-selection bias hinders the interpretability of the results because the medical students who were, perhaps, more knowledgeable, experienced, or intrinsically interested in meditative disciplines may have been more likely chose to participate in the MBSR program. In addition, this study employed the use of one instrument, the POMS, and responses were all self-report. In a study mentioned earlier regarding empathy, Shapiro et al. (1998) also found a significant decrease in state and trait anxiety in medical and premedical students who participated in the MBSR program compared to a wait-list control group. The control group participated in MBSR after the experimental group with matched results. There were no significant differences between groups' pretest scores, but there were significant differences at posttest. Compared with the control group, the intervention group reported less state anxiety and less trait anxiety. After the control group participated in the MBSR program, decreases in anxiety were similar to the previous intervention group.

In the abovementioned studies it is not clear as to the long term stability of the observed change. The MBSR program includes various dimensions that may impede the interpretability of the results as being a product of only mindfulness such as weekly socialization with other participants and the trainer. While the latter study included a



control group, all participants voluntarily signed up for the MBSR program and so the results may not be generalizable to medical students who are not intrinsically interested in mindfulness or to other populations.

Because anxiety is closely related to stress and is often used synonymously, it will be useful to look at the effects of mindfulness on stress as well. Chang, Palesh, Caldwell, Glasgow, Abramson, Luskin, et al. (2004) found that after participating in a MBSR program, participants experienced a significant reduction in stress as measured on the Perceived Stress Scale (PSS; Cohen, Kamarch, & Mermelstein, 1983) when compared to baseline measures. Twenty-eight participants completed the pre and post-tests with 15 only completing the pre-test. The authors state that “there were no significant differences between those who completed the surveys and those who did not in terms of age, sex, ethnicity, or any of the measures, including levels of pain and suffering, positive states of mind, perceived stress, or previous experience with meditation” (p. 142). Results indicate that the intervention was successful in reducing perceived stress. It is important to note that characteristics of the population (93% Caucasian, all living in the San Francisco Bay area and enrolled in a private university continuing education course) limit the generalizability to other populations. In addition, the MBSR program included a one hour discussion as a part of the weekly meetings where participants discussed “experiences of meditation and related observations during the previous week” (p. 143). It is unclear to what degree the discussions were supportive and contributed to the decrease in perceived stress. The authors do not specify when the pre and post-measurements were taken, only that they were “before” the intervention and “after” the intervention, respectively (p. 142). While the PSS asks questions regarding perceived levels of stress in the previous

month, it is unclear as to whether the participants took the PSS immediately following the eighth and final intervention meeting. If this is the case, the participants may have felt especially relaxed as they would have just experienced exercises in meditation, yoga, and were a part of a (possibly supportive) discussion. With this in mind, it is possible that their responses to the questionnaires were biased.

### *Chapter Summary*

The person of the therapist is an integral aspect of therapy and significantly contributes to client outcome (Crits-Cristoph et al., 1991; Norcross, 2002; Wampold 2001). Three therapist variables, presence, empathy, and anxiety relate to therapy process and outcome in different ways. Presence, while scantily investigated in the field of psychotherapy research to date, has been shown to be an important contributor in the ways therapists prepare for session, interact with their clients, choose when and what to say when, and use themselves and their experiences with the client in the therapy for the betterment of the client (Geller & Greenberg, 2002). While empathy has been a widely researched and relied upon therapeutic ability, there has been little investigation into the development or ability to manifest this characteristic (Morgan & Morgan, 2005). Anxiety in therapists has been shown to have a negative impact on therapy, but again, there is little investigation into the ways in which therapists, especially novice therapists, can decrease their anxiety (Bowman & Roberts, 1979; Bowman, Roberts, & Griesen, 1978; Friedlander, Keller, Peca-Baker, & Olk, 1986). The purpose of this study is to investigate the relationship that therapist mindfulness might have with these therapist variables and how they impact therapy process and outcome. Specifically, the hypotheses for this study are: 1) there is a direct relationship between therapist mindfulness and therapist presence;

2) there is a direct relationship between therapist mindfulness and therapist empathy; 3) there is an inverse relationship between therapist mindfulness and therapist anxiety; 4) there is an inverse relationship between therapist mindfulness and client symptomatology.

## Chapter 3

### Method

#### *Participants and Recruitment*

*Therapist participant.* First-year and second-year doctoral students (10 total) in the counseling psychology program at Penn State were given a description of the study in their campus mailboxes, asked to read it including what it would entail to be a participant in this study. All potential participants had a master's degree in a counseling related discipline and have had varying levels of experience as a therapist with a minimum of one year conducting individual therapy. Those who agreed to participate were asked to describe their experience with meditation including how frequently they currently meditate. The researcher selected the individual with the median level of experience with meditation so as to reduce the effects that being an expert or inexperienced meditator might have had on the results. This individual was the therapist participant. The therapist was paid \$100 for their time and commitment to this study.

The therapist who was chosen for the study was a 32 year old, heterosexual male in his 2<sup>nd</sup> year of a doctoral program in counseling psychology with a masters degree in clinical psychology. He grew up in New York City and was second generation Lebanese. He described his theoretical orientation mainly as psychodynamic and had seen individual psychotherapy clients for the two years in the doctoral program.

*Client Participant.* Clients seen for psychotherapy at the Cedar Clinic typically are referred by Counseling and Psychological Services' (CAPS) therapists who conduct initial consultations with students interested in therapy. The researcher for this study asked a number of CAPS staff who regularly conduct initial consultations weekly to

recruit a potential client for this study. In order to recruit a client, the therapist used clinical judgment during the initial consultation along with the client's self-report of presenting concerns and symptoms in order to determine that the client was not a minor, did not have a history of psychoses and was not presently psychotic, did not have bipolar 1 or 2 disorder, was not suicidal, homicidal, and did not have a substance abuse disorder or had been sober for at least 12 months. Additionally, the client had to be willing to meet for a minimum of 8 sessions and a maximum of 12 during the summer months. During the initial consultation session when the client met the abovementioned criteria, the therapist described the opportunity to participate in this study as an option for receiving psychotherapy. When the individual expressed interested, the therapist gave the researcher the potential client's contact information and a meeting between the researcher and potential client was arranged. The researcher described the study and provided a written description of what electing to be a participant entailed. The first recruited individual chose to participate, and so the researcher obtained schedules of both the therapist and client participant and arranged for their first therapy session. The client was paid \$25 at the end of the final session for her time in participating in this study.

The client was a 22-year old, heterosexual, European American female in her last semester of college with a 3.0 GPA. The initial consultation therapist reported in her note that diagnostically the client had "Depressive Disorder NOS" and a "Phase of Life problem." She was given a GAF of 60. Her symptoms included "low mood, low energy, increased sleep, and more irritability." The initial consultation therapist also stated that "since [the client] has been in a relationship with her boyfriend, she's lost contact with her friends." The client described her relationship with her boyfriend as "good" and said

that he was her best friend. The client reported that her parents divorced when she was three years old and she saw her father on the weekends until she was 10. At age 10, the client's father remarried and had another child. She said, "once [her] father remarried, [she] did not have much contact with him." She told the initial consultation therapist that she currently talks to her father every two weeks and it is more of a "check in and not a personal relationship." The client also shared that she previously took diet pills during high school and reported that she had been in a verbally abusive relationship in high school with her ex-boyfriend. According to the client, alcohol and drugs are of concern. She drinks alcohol socially and denied and current or past drug or alcohol abuse. Suicidal ideation was assessed and the client shared that she has never been and was not suicidal at the time the initial consultation was conducted.

### *Instruments*

*Mindfulness.* The Toronto Mindfulness Scale (TMS; Lau et al., 2006; Appendix A) was used to measure the therapist's perceptions of his/her mindfulness during each session. This is a 13-item questionnaire where items are rated on a 5-point Likert scale with scores ranging from 0 = "not at all" to 4 = "very much," where higher scores reflect greater mindfulness. The instrument consists of two subscales, Curiosity and Decentering. The Curiosity subscale includes items that reflect awareness of present moment experience with a quality of curiosity. A sample item from the Curiosity subscale is, "I remained curious about the nature of each experience as it arose." The Decentering subscale includes items that emphasize awareness of one's experience with some distance and disidentification rather than being carried away by one's thoughts and

feelings. A sample item for the Decentering subscale is, “I approached each experience by trying to accept it, no matter whether it was pleasant or unpleasant.”

In investigating the psychometric properties of the instrument, the TMS was used in two studies by Lau et al. (2006) and was found to be both reliable and valid. Internal consistencies for the TMS and its subscales, Curiosity and Decentering, were .91, .86, and .87, respectively. Concerning validity, criterion validity of the TMS was supported by demonstrating higher scores on both factors for participants after an 8-week MBSR group and in individuals with greater than one year versus less than one year of mindfulness meditation experience. Decentering showed validity in the prediction of psychological distress. Regarding discriminant validity, the TMS showed distinctness from measures of self-focused attention involving anxious preoccupation and rumination. Conversely, the TMS was positively but modestly correlated with psychological constructs that included assessments of awareness, openness to experience, and curiosity about one’s current experience.

*Therapist Presence.* Therapist presence was measured using the Therapist Presence Inventory (TPI; Geller, 2001; Appendix B). The TPI assesses therapist presence from the point of view of the therapist. The primary investigator for this project also developed an adapted version to measure therapist presence from the point of view of the client. This client perspective measure was referred to as the TPI-C (Appendix C). The TPI is a 21-item questionnaire whose items are rated on a 7-point Likert scale with higher scores reflecting greater presence. A sample item from the TPI is, “I felt fully immersed in my client’s experience.” The TPI-C is an 18-item questionnaire (some items from the TPI had to be dropped because they were not translatable to a client’s point of view)

where items are rated on a 7-point Likert scale with higher scores reflecting greater presence. A reverse scored sample item from the TPI-C is, “My therapist seemed to have difficulty concentrating.” Therapist presence was measured using both the TPI and the TPI-C in order to obtain the therapist and client perspectives.

The TPI and TPI-C were used in a previous study conducted by the primary investigator. With 16 therapists and 33 clients, the alpha coefficients for the TPI and TPI-C were .93 and .87, respectively. Predictive validity was found in that both the TPI and TPI-C were related to client outcome as measured by the Outcome Questionnaire-45 (OQ-45; Lambert et al., 1996). Specifically, the correlations for the TPI and the TPI-C with the OQ-45 from the first session to immediately post-termination with initial OQ-45 scores partialled out were -.23 and -.36, respectively. Although therapist presence was assessed during one session only, the abovementioned correlations suggest a relationship between therapist presence, even from one session, and a decrease in symptomatic distress as evaluated by the client.

*Empathy.* The Barrett-Lennard Relationship Inventory Empathy subscale Form OS or “other toward self” (BLRI-E; Barrett-Lennard, 1986; Appendix D) is a questionnaire in which clients report their experience of therapist empathy. Client assessment of therapist empathy is in accordance with Gurman’s (1977) definition of empathy which necessitates that the therapist must not only feel empathy for the other, but the client must experience the therapist’s empathy. The BLRI-E consists of 10 questions using a Likert scale ranging from -3 (strongly disagree) to +3 (strongly agree) with higher scores indicating greater empathy. A sample item from the BLRI-E is, “My counselor usually understands the whole of what I mean.”



The BLRI-E has exceptionally sound psychometric properties, and this has been demonstrated throughout the high frequency of its use. Gurman (1977) found that, averaged across studies, the mean internal reliability coefficient for the BLRI-E was .84 and the test-retest coefficient was .83. Gurman (1977) reported results for 6 major factor-analytic studies and concluded that the BLRI is tapping dimensions that are consistent with the initial work done by Barrett-Lennard on the instrument. Further, Gelso and Fretz (1992) contend that the BLRI “continues to be the most effective measure of measuring the facilitative conditions in a manner that is true to Rogers’ theory (p. 143). The BLRI-E was used to assess empathy.

*Anxiety.* The State Anxiety Inventory (SAI; Spielberger, Gorsuch, & Lushene, 1970; Appendix E) is a widely used anxiety measure and was used in this study to assess therapist anxiety during sessions with her client. Spielberger (1972) defines state anxiety as the complex emotional reactions that are evoked in individuals who interpret specific situations as personally threatening. State anxiety also involves heightened autonomic nervous system activity. A sample item from the SAI is, “I felt tense” (Spielberger et al., 1970). The participant indicated his agreement with each item on a Likert scale ranging from 1 = “not at all” to 4 = “very much so,” where higher scores indicate higher state anxiety. The 20 items are summed to produce a total score with higher scores indicating more state anxiety. The test-retest coefficients for the SAI ranged from .16 to .62. This low level of stability is expected since responses to the items are expected to change depending on the situational factors of the participant (Spielberger et al., 1970). Spielberger also found that internal consistency for the SAI was .93. Each item of the SAI was selected on the basis of demonstrated construct validity, as reflected in higher

scores in stressful situations and lower scores after relaxation training (Spielberger et al., 1970).

*Session Progress Scale (SPS)*. Session impact was measured with the SPS (Kolden, 1988; 1991; Appendix F & G). This 4-item session progress scale is part of a more comprehensive scale, the Therapist Session Report (TSR; Orlinsky & Howard, 1966; 1986), which is an established measure in psychotherapy process research based on the generic model of psychotherapy and consists of a series of items measuring five dimensions of therapeutic progress without theoretical jargon. The SPS has a client and therapist form. The fourth item on the client form is, “How helpful do you feel your therapist was to you this session?” The matching item on the therapist form is “How helpful do you feel you were to your client this session?” They rate items on a Likert scale ranging from 1 to 6, with lower scores indicating greater session progress. The words corresponding with each number depend on the question asked. For the abovementioned questions, 1 = “Completely helpful” and 6 = “Not at all helpful.” Internal consistency for SPS has been documented at .85 (Kolden, 1991) (range from .68 to .85 in previous studies (Kolden, 1988, 1991; Kolden & Howard, 1992). A test-retest reliability of .75 has also been documented (Kolden, 2005?). The validity of the SPS and the additional TSR subscales has been consistently demonstrated (Kolden, 1988, 1991; Kolden & Howard, 1992). These scales have all been shown to have predictive validity in relationship to termination outcome (Kolden, 1988, 1991; Kolden & Howard, 1992) and treatment duration (Kolden & Howard, 1987). The SPS has been shown to be a significant measure of changes in mental health status and objectively rated termination outcome.

*Outcome.* Client outcome was measured using the Outcome Questionnaire (OQ-45; Appendix H), a 45-item self-report questionnaire aimed at tracking and assessing client outcomes in a therapeutic setting. The OQ-45 is scored using a 5-point scale where scores range from 0 = “never” and 4 = “almost always,” which yields a possible range of scores from 0 to 180. Higher scores on the OQ-45 indicate more distress and as clients improve scores decrease. Although not used in this study, the OQ-45 has three subscales that measure the quality of the interpersonal relations, social role functioning, and symptom distress. The total score, which provides a global assessment of functioning, was used in this study.

The OQ-45 has been validated across a broad range of normal and client populations (Okiishi, Lambert, Nielsen, & Ogles, 2003). Lambert, Gregersen, and Burlingame (2004) reported an internal consistency for the OQ-45 of .93 and a 3-week test-retest value of .84. Concurrent validity estimates were calculated by comparing the OQ-45 total score with total scores from other measures including the Symptom Checklist-90 (SCL-90; Derogatis, 1977), Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), Zung Depression Scale (Zung, 1965), and the State-Trait Anxiety Inventory (STAI; Spielberger, 1983). All of the concurrent validity estimates with the OQ-45 and these instruments were significant at the .01 level with a range of  $r$ 's from .50 to .85 (Lambert et al., 2004). The OQ-45 has also been shown to be sensitive to the effects of interventions on client functioning (Vermeersch, Lambert, & Burlingame, 2000).

*Procedure*

The client and therapist pair engaged in therapy for 8 sessions. Prior to each session, the client filled out the OQ-45. Therapy proceeded in the way that was natural for the client and therapist without intrusion or instruction from the researcher. The therapist received supervision for the case both as a part of their regular supervision provided by a staff member at CAPS. The supervision was not influenced in any way by the researcher and proceeded however the supervisor and supervisee wished.

The researcher observed each session from behind a one-way window. After each session, the client and therapist completed their respective questionnaires about their experience during that session. The therapist filled out the TMS, the TPI, and the SAI. The client filled out the TPI-C and the BLRI-E. The order of the instruments was randomized. Each participant filled out the questionnaires in separate rooms. The primary researcher collected each of the completed questionnaires and this concluded the client's involvement for that session. Filling out the questionnaires did not exceed 15 minutes for either participant. The therapist was then asked a number of questions about his/her experience in session along with aspects of the therapist's life that he/she thinks impacted the session. This discussion did not exceed 30 minutes and was in a semi-structured interview format. The semi-structured format allows the researcher to ask further questions about what the therapist shares. The interviews were audio taped and the researcher transcribed the interviews verbatim into written format. The interviewer first asked the participant: Please describe your thoughts about the session. The following are the questions that were asked to the therapist regarding the therapist's presence: 1) Were there moments when you felt more/especially present in session today? Please describe these moments. 2) Were there moments when you felt distracted/less present in session

today? Please describe these moments. 3) Was there anything that happened before session that helped you to be present? 4) Was there anything that happened during session that helped you to be present? 5) Was there anything that happened before session that interfered with your being present? 6) Was there anything that happened during session that interfered with your being present? The researcher probed times when moment-to-moment awareness was brought up by the therapist. The following are the questions that were asked to the therapist regarding the therapist's empathy: 1) Were there moments when you felt more/especially empathic in session today? Please describe these moments. 2) Were there moments when you felt less empathic or unmoved by your client in session today? Please describe these moments. 3) Was there anything that happened before session that helped you to be empathic? 4) Was there anything that happened during session that helped you to be empathic? 5) Was there anything that happened before session that interfered with your being empathic? 6) Was there anything that happened during session that interfered with your being empathic? The researcher probed times when moment-to-moment awareness was brought up by the therapist. The following are the questions that were asked to the therapist regarding the therapist's anxiety: 1) Were there moments in session today when you especially felt very low or no anxiety? Please describe these moments. 2) Were there moments when you felt anxious in session today? Please describe these moments. 3) Was there anything that happened before session that helped you to be less or non-anxious? 4) Was there anything that happened during session that helped you to be less or non-anxious? 5) Was there anything that happened before session that interfered with your being less or non-anxious? 6) Was there anything that happened during session that interfered with your

being less or non-anxious? The researcher probed times when moment-to-moment awareness was brought up by the therapist. The researcher transcribed the 8 interviews with the therapist-participant. Once in written form, the researcher began combing through the data, sectioning the interviews according to the questions asked. For instance, all response data were combined from the question, “Was there anything that happened before session that helped you to be present?” The extraneous words were taken out and only the meaningful content of the therapist’s phrases were left. Grounded theory methodology was used to determine central categories. Repeated phrases and phrases that the researcher determined had similar meanings to other phrases were grouped together. After combing through the data several times and clusters of words organized into groups, category names were given. Category names aim to represent the central meaning of the phrases that belong to them. After category names were preliminarily chosen, they were discussed with the researcher’s dissertation advisor and the category names were refined further.

### *Statistical Analyses*

*Quantitative Analyses.* Pearson correlation coefficients were computed to determine if there is a relationship between mindfulness and presence (from both the therapist and client perspectives), mindfulness and empathy (from the client perspective), and mindfulness and anxiety (from the therapist perspective). These correlations were between overall scores on the TMS and the TPI, the TMS and the TPI-C, the TMS and the BLRI-E, the TMS and the SAI, and the TMS and the OQ-45.

Following Yin’s (1994) recommendations regarding case study research, inferential statistics were not used to evaluate the relationships between mindfulness and

the other variables of interest. Yin noted that, similar to research using large samples, case studies are designed ultimately to permit generalizations about theory. Unlike research with large samples, however, in case study research one does not first infer from a sample to a population. This statistical generalization, which normally precedes theoretical generalization in research with large samples, is regarded as inappropriate in case study research. In fact, according to Yin, “A fatal flaw in doing case studies is to conceive of statistical generalization as the method of generalizing the results of the case . . . the method of generalization is ‘analytic generalization,’ in which a previously developed theory is used as a template with which to compare the empirical results of the study” (p. 31). In case studies generalizations are made directly from sample data to theory. Further justification for the decision not to utilize inferential statistics stems from Cohen’s (1994) argument that researchers should be more attentive to effect size than to probability-based significance testing. Along these lines, Cohen and Cohen (1983) described correlations from .10 to .29 as representing small effects, from .30 to .49 as medium effects, and greater than .49 as large effects. Yin’s and Cohen’s guidelines in interpreting data were followed with a focus on medium and large effect sizes.

*Qualitative Analyses.* The therapist responses from the semi-structured interview were analyzed using grounded theory approach. Grounded theory’s “ultimate aim is to produce innovative theory that is ‘grounded’ in data which is collected from a participant or participants” (Fassinger, 2005, p. 157). Further, Fassinger states that,

theory is derived inductively through an iterative, concurrent process of data collection, coding, conceptualizing, and theorizing, wherein new data are constantly compared to emerging concepts until no new themes, categories, or

relationships are being discovered, at which point the properties of, and relationships among, constructs are specified in the form of a substantive theory about the social behavior under investigation (p. 157).

This approach was useful in deepening our understanding of the role that mindfulness and other factors play in enhancing and inhibiting therapist presence, empathy, and anxiety during psychotherapy. The grounded theory approach allows the researcher to make use of participant-generated descriptions by investigating concepts, categories, and connections among categories. Grounded theory permits a deep, discovery-oriented approach to an area of research that is relatively new to investigation (Strauss & Corbin, 1990).



## Chapter 4

### Results

#### *Quantitative Results*

*Preliminary Findings.* Means, standard deviations, ranges, and internal consistencies for variables pertaining to the case can be found in Table 1.

Table 1

#### *Descriptive Data for Variables*

Instrument name	<i>M</i>	<i>SD</i>	<i>Possible Range per Item</i>	<i>Possible Total Range</i>	<i>Total Range for Study</i>	<i>Cronbach's alpha</i>
SPS (Client)	2.93	.56	1-7	4-28	9-14	.60
SPS (Therapist)	3.53	.51	1-7	4-28	12-17	.87
TPI (Client)	5.47	.50	1-7	18-126	90-106	.85
TPI (Therapist)	5.40	.55	1-7	21-147	96-127	.92
BLRI-E (Client)	2.14	.47	-3 - +3	-30 - +30	14-26	.73
TMS (Therapist)	1.98	.25	0-4	0-52	20-30	.41
SAI (Therapist)	1.64	.28	1-4	20-80	29-46	.90
OQ-45 (Client)	.92	.17	0-4	0-180	32-51	.87

*Note.* TPI = Therapist Presence Inventory, BLRI-E = Barrett-Lennard Relationship Inventory-Empathy, TMS = Toronto Mindfulness Scale, SPS = Session Progress Scale, SAI = State Anxiety Inventory, OQ-45 = Outcome Questionnaire.

The internal consistency for the TMS is .41 for this study, which is low and not similar to the internal consistency found in the validation studies of the measure. There are a few possible reasons for this low internal consistency. First, internal consistency assumes that there are a larger number of individuals completing the measure at a particular point in time as opposed to a single individual filling out the measure over the course of 8 different times as was the case for this study. Second, the measure was developed using individuals who were both meditators and non-meditators with the instructions immediately preceding completing the measure stating, “For the next 15 minutes, please pay attention to your breathing and anything that might arise during your experience” (Lau et al., 2006, p. 1450). No other instructions were given. Maintaining awareness on the breath and noting sensations, thoughts, and feelings that arise are basic mindfulness meditation techniques. Thus, it was expected that asking experienced meditators to be aware of their breath in this manner would be sufficient to evoke a state of mindfulness. In the present study, the preceding activity for the therapist was a therapy session with a client. There were no instructions that would intentionally evoke a mindfulness state in the therapist. There are a number of factors that may have influenced how mindful the therapist experienced himself to be. Unlike in the development of the measure, there was no time set aside for the therapist in this study to intentionally spend time focusing on his own experience. His mood, the activity that he was engaged in prior to coming to the therapy session, along with other factors may have interfered with his ability to be and experience himself as mindful. Additionally, interacting with a client demands that the therapist not be solely focused on his breathing and arising experiences. His attention must also go towards negotiating the therapy session, monitoring the

relationship with the client along with a number of other tasks. An additional reason internal consistency was so low was the range restriction in scores on the instrument. Restricted ranges of scores suppress correlation coefficients, which Cronbach's alpha essentially is (see Table 1).

Third, there were five questions on the TMS that had negative item-total correlations with the instrument in this study. These were: question 4, "I experienced my thoughts more as events in my mind than as a necessarily accurate reflection of the way things 'really' are"; question 6, "I was curious about each of the thoughts and feelings that I was having"; question 10, "I remained curious about the nature of each experience as it arose"; question 11, "I was aware of my thoughts and feelings without overidentifying with them"; and question 12, "I was curious about my reactions to things." A therapist in the context of relating with a client might not typically have the same degree of attention and energy focused inwardly about his experiences as an individual who has been instructed to sit for 15 minutes by herself focusing on her breathing and any thoughts, feelings, or sensations that might arise. How much capacity does a therapist have to be "curious about the nature of each experience as it arose" within herself while working with a client? One might suspect that many therapists might not endorse this statement if asked about their experience during therapy, but may endorse it if given the instructions to sit quietly, focusing on their breathing and arising experiences for 15 minutes prior to filling out the measure.

The case means, 2.93 and 3.53, for session progress from the point of view of the client and therapist, respectively, show that both the therapist and the client viewed session progress as being relatively high with the client viewing session progress as

generally higher than the therapist. The therapist's mean rating of session progress was almost exactly at the mid-point, which signifies he thought they were typically progressing moderately whereas the client perceived the session progress as generally about .6 points higher than the therapist. The case means, 5.47 and 5.40, for therapist presence from the point of view of the client and the therapist, respectively, indicate that they each rated the therapist's presence as fairly high. The case mean, 2.14, for empathy from the point of view of the client is indicative of the client perceiving the therapist as being highly empathic. The therapist mean rating, 1.98, of how mindful he was during session with a standard deviation of .25 indicates that he rated himself as slightly lower than the mid-point on the scale and not especially mindful during therapy sessions. The therapist's mean rating of his anxiety, 1.64, during session with a standard deviation of .28, indicates that he generally didn't feel anxious with the client. The case mean for the client's symptomatology as measured by the OQ-45 was generally less than 1 signifying that she was generally low in her endorsement of symptoms.

Figures 1 – 7 illustrate the total values for the variables with respect to each session.

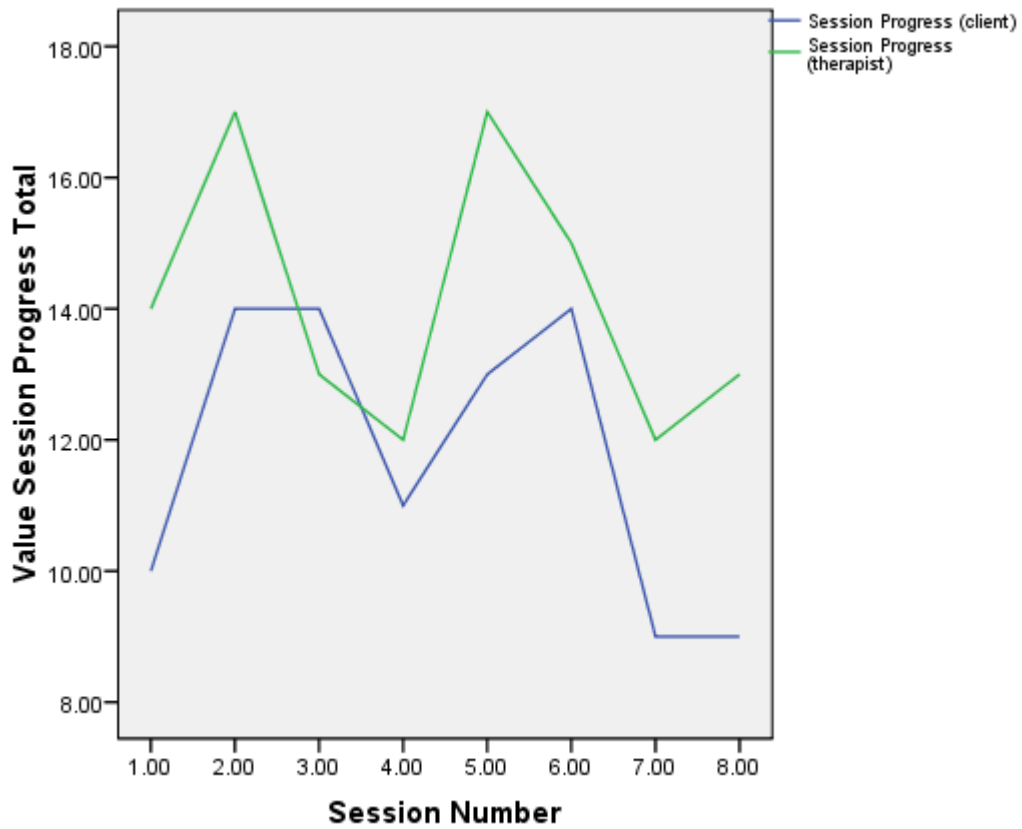
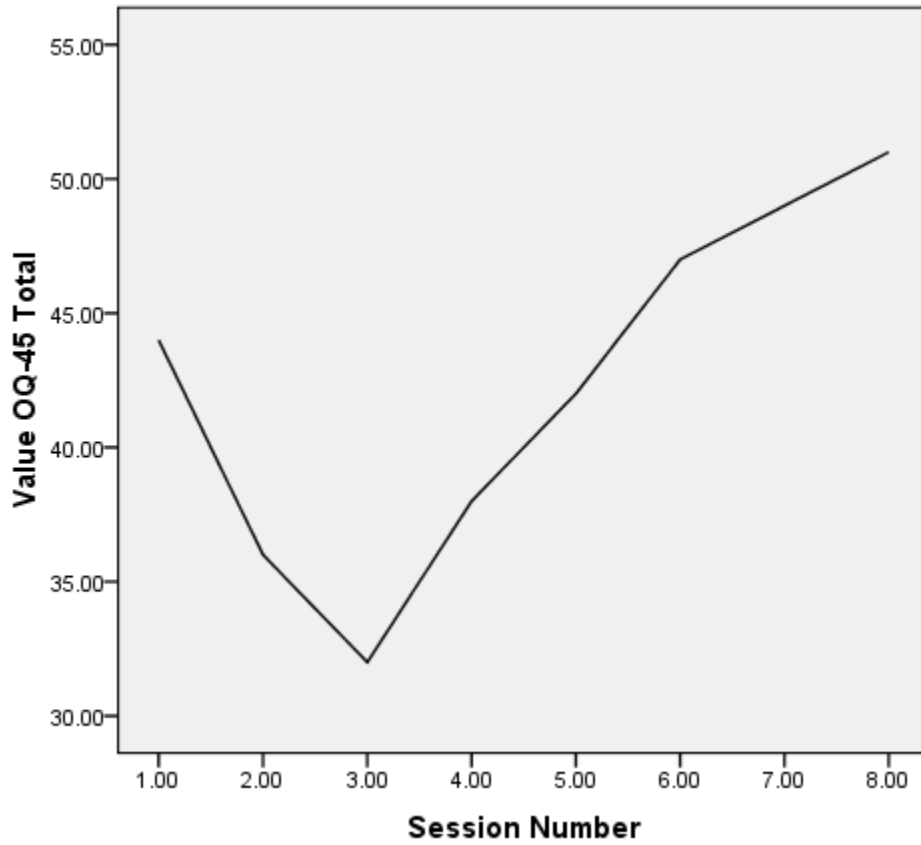
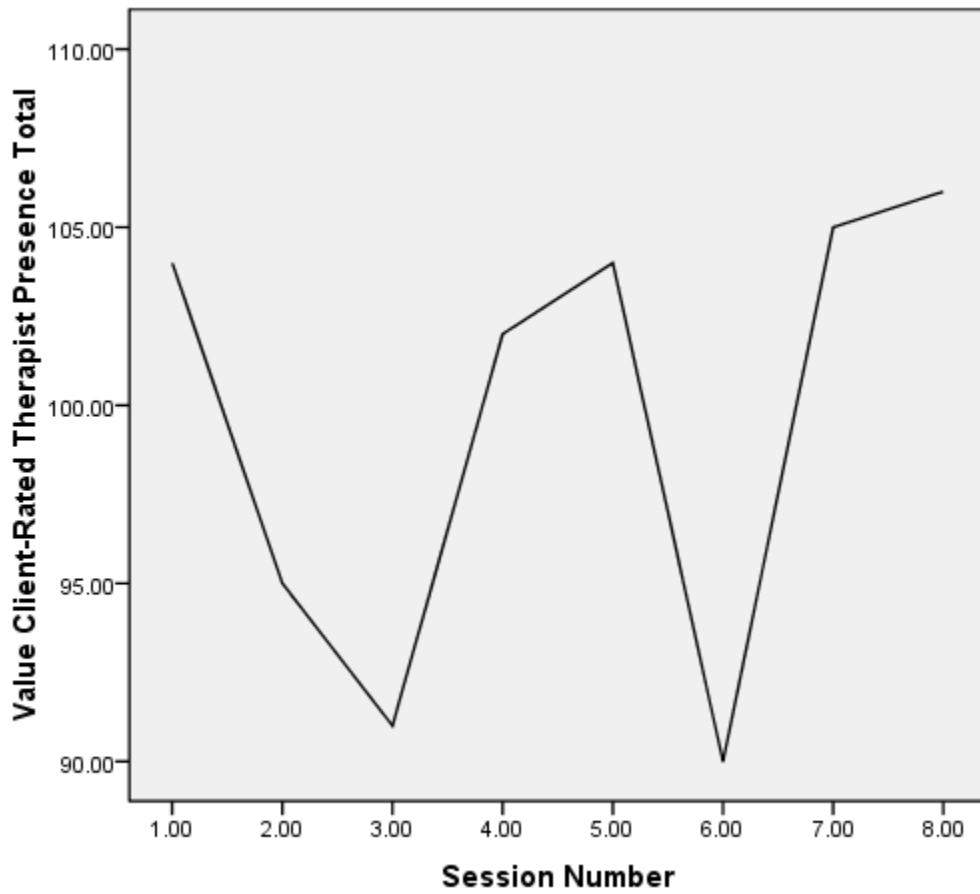


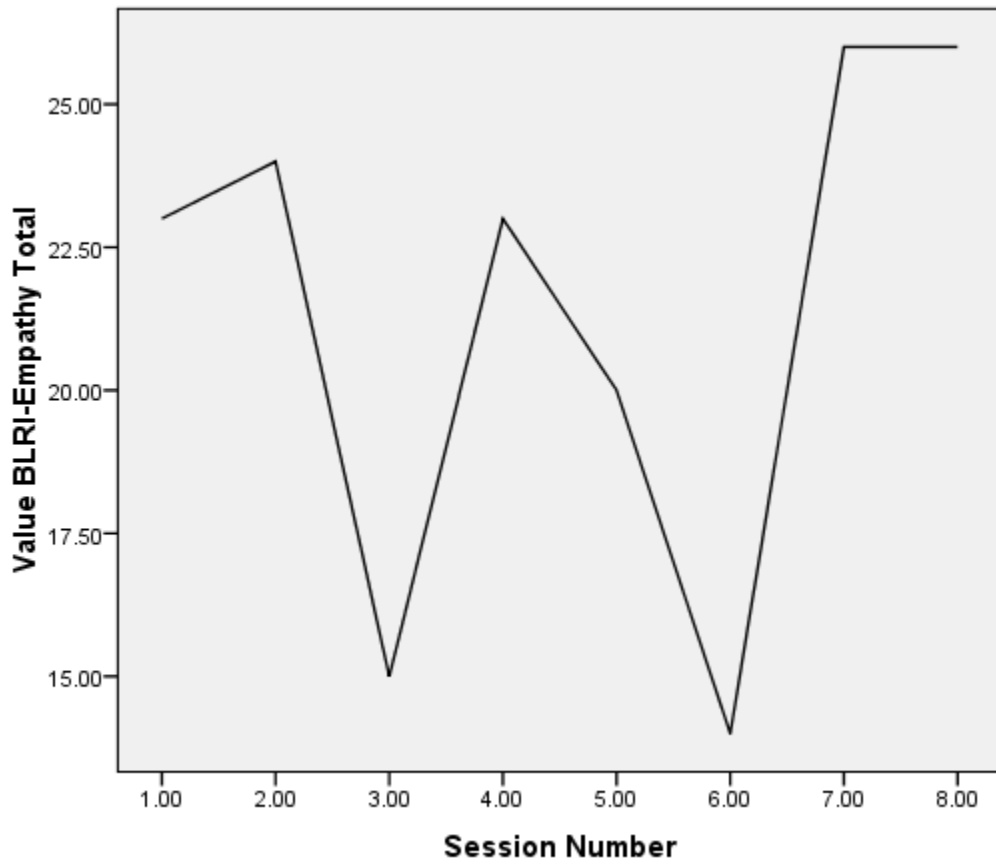
Figure 1. Therapist and client ratings of session progress per session.



*Figure 2.* Client ratings of symptomatology per session.

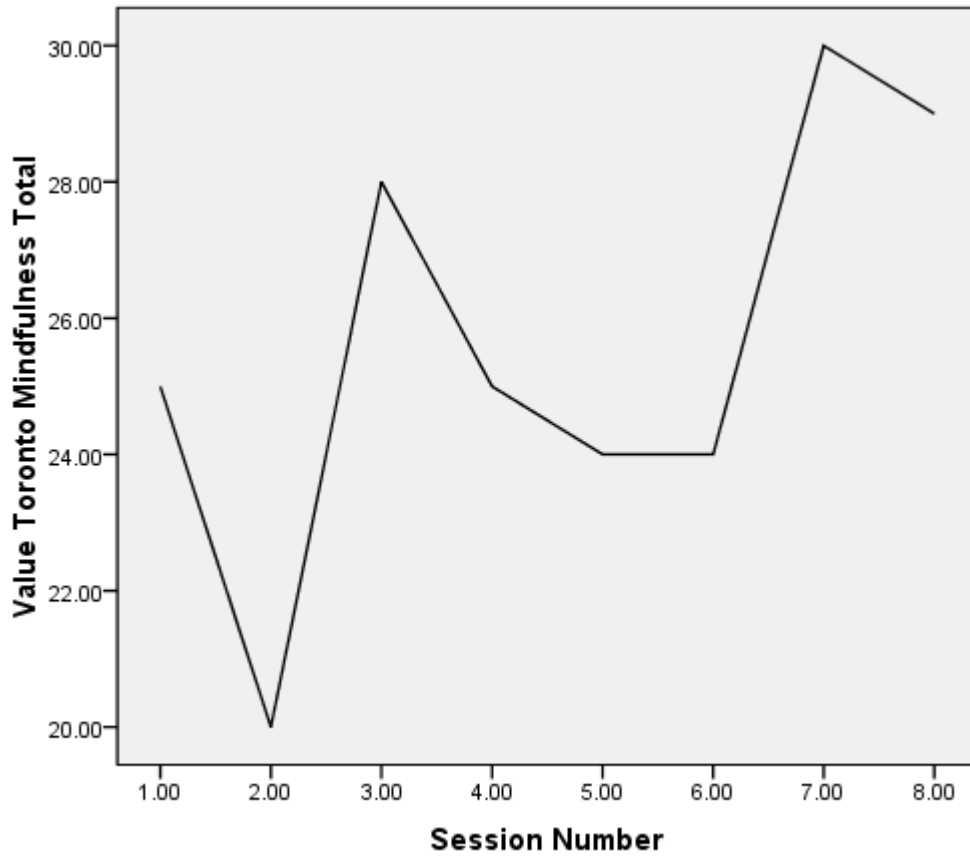


*Figure 3.* Client ratings of therapist presence per session.

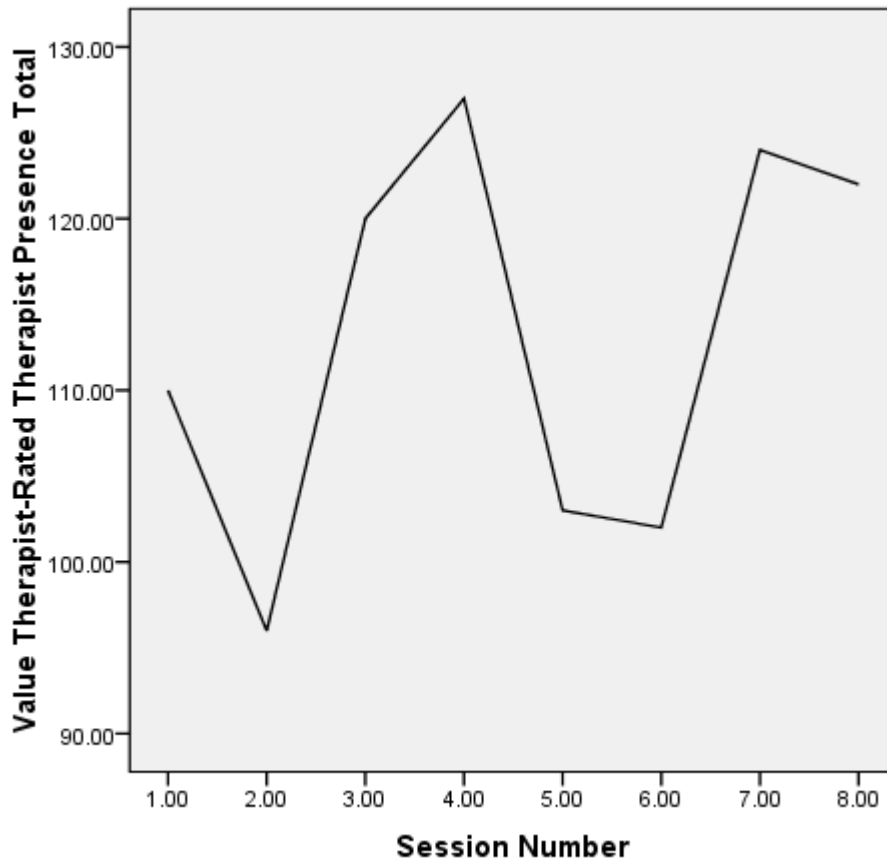


*Figure 4.* Client ratings of empathy per session.

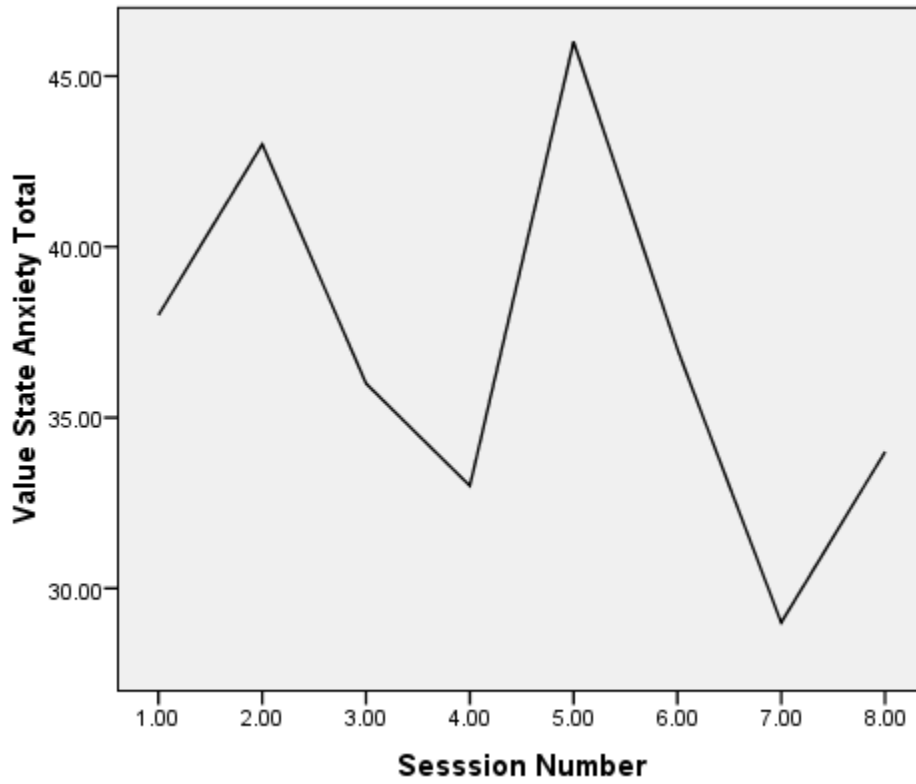




*Figure 5.* Therapist ratings of mindfulness per session.



*Figure 6.* Therapist ratings of presence per session.



*Figure 7.* Therapist ratings of state anxiety per session.

Table 2 illustrates one-tailed significance Pearson correlations among all variables.

Table 2

*Correlations Among Variables*

	TPI (Client)	BLRI- E(Client)	TMS (Therapist)	SPS (Therapist)	TPI (Therapist)	SAI (Therapist)	OQ-45 (Client)
<hr/>							
SPS (Client)							
Correlation	.85	.77	.64	.63	.65	-.63	.66
Sig. 1-tailed	.00	.01	.04	.04	.04	.05	.04
TPI (Client)							
Correlation		.81	.37	.25	.40	-.19	.52
Sig. 1-tailed		.01	.19	.27	.16	.33	.09
BLRI-E(Client)							
Correlation			.17	.22	.30	-.26	.38
Sig. 1-tailed			.34	.30	.23	.27	.18
TMS(Therapist)							
Correlation				.79	.82	-.76	.42
Sig. 1-tailed				.01	.01	.02	.15
SPS (Therapist)							
Correlation					.95	-.94	.19
Sig. 1-tailed					.00	.00	.32
TPI (Therapist)							
Correlation						-.83	.13
Sig. 1-tailed						.01	.38
SAI (Therapist)							
Correlation							-.36
Sig. 1-tailed							.19

*Note.* TPI = Therapist Presence Inventory, BLRI-E = Barrett-Lennard Relationship

Inventory-Empathy, TMS = Toronto Mindfulness Scale, SPS = Session Progress Scale,

SAI = State Anxiety Inventory, OQ-45 = Outcome Questionnaire.

*Primary Findings.* The first research hypothesis was that there would be a direct relationship between therapist mindfulness and therapist presence. The correlation between therapist mindfulness and presence from the client's perspective was .37, which represents a medium effect, according to Cohen and Cohen (1983). This effect size indicates that the more mindful the therapist perceived himself to be, the more present the client perceived the therapist to be. The correlation between therapist mindfulness and therapist self-reported presence was .82, which represents a large effect size indicating that there is a strong relationship between how mindful and how present the therapist perceived himself to be during session.

The second hypothesis of this study was that there would be a direct relationship between therapist self-perceived mindfulness and client ratings of therapist empathy. The correlation between the two was .17, which is a small effect size. The therapist's perceptions of his mindfulness did not vary much in accordance with the client's perception of his empathy. The third hypothesis was that there would be an inverse correlation between therapist mindfulness and therapist anxiety. The correlation for these variables was  $-.76$ , which represents a large effect. This strong inverse correlation and large effect size indicates that the more mindful the therapist rated himself to be, the less anxious he perceived himself to be during session. The fourth hypothesis was that there would be an inverse correlation between therapist mindfulness and client symptomatology. The correlation between therapist mindfulness and client symptomatology was .42, which is a medium effect in the opposite direction to what was hypothesized. After further looking into the measure used for this client symptomatology, it became clearer to the researcher that the OQ-45, which was completed by the client

before each session, would not be related to the therapist's mindfulness during the previous session.

*Additional Findings.* There was generally a modest to strong relationship between session progress and therapist presence from both the perspective of the client and the therapist. As Table 2 shows, the correlation between the client's perception of both session progress and therapist presence was .85, which is a large effect size indicating the more present the client perceived the therapist to be, the more progress the client perceived to make in the session. The correlation between the client's rating of session progress and the therapist's self-rated presence was .65, which is a large effect size. This finding shows that there is a relationship between the client's view of how much progress was made during session and the therapist's perception of his presence. The therapist's perception of session progress was modestly related to the client's perception of therapist presence with a correlation of .25, which is a small effect size. The therapist's perception of session progress was strongly related to his perceptions of his presence; the correlation was .95.

The correlation between the client's rating of session progress and the therapist's rating of session progress was .63, which indicates a large effect size. This finding highlights that there was a high level of agreement between the therapist and client perspectives on session progress.

The correlation for therapist mindfulness and the client's rating of session progress was .64, which is a large effect size. This finding indicates a strong relationship between how mindful the therapist viewed himself to be and how much progress the client perceived to take place during session. The correlations for therapist mindfulness

and session progress, therapist presence, and therapist anxiety all from the point of view of the therapist are .79, .82, and -.76, respectively, which are all large effect sizes. These findings indicate that the more mindful the therapist perceived himself to be, the more session progress he perceived to take place, and the more present and less anxious he perceived himself to be. The client's perceptions of therapist presence and empathy have a large effect size and are correlated at .81 indicating that there is a relationship between presence and empathy from the point of view of the client. There is a .30 correlation between the therapist self-rated presence and the client's rating of empathy, reflecting a medium effect size.

### *Qualitative Results.*

#### *Pre-session Factors Perceived to Facilitate Presence.*

As described in Chapter 3, after each psychotherapy session the therapist was interviewed and was asked, 'Was there anything that happened before session that helped you to be present?' The categories that emerged from the therapist's responses were: Self-Confidence, Intentional Way of Being, Mindfulness, and Planning for Session. Self-Confidence refers to the therapist's belief in himself and his sense of assuredness about his skills as a therapist. Self-confidence contributed to his being more present in the session with the client by giving him the sense that he has been an effective therapist in the past and the belief that this ability would carry over to his therapy with the present client. The therapist engaged in activities such as thinking of positive feedback he had received from previous supervisors about his ability as a therapist. He also engaged in positive self-talk from feelings he had about himself. For example, when asked 'Was there anything that happened before session that helped you to be present?' he once

stated, “thinking about some positive things about myself and other positive things that people told me about me. [He quotes others and himself], ‘You’re good at things you’re warm, you’re kind, you’re intelligent, people like you.’” The therapist described self-confidence as having an impact on presence during the session in that feeling more self-assured contributed to being able to focus more on the client and the relationship process during session because there was a “baseline sense of trust in [him]self” and his abilities as a therapist. Energy and attention could be spent on being “attuned” and “more present” to the client.

Intentional Way of Being refers to the therapist’s attention and action taken towards embodying characteristics he wanted to experience and exude before and during session. He perceived that in intentionally trying to be a certain way before session (e.g. loving, respectful, open, relaxed), it helped him to be more present during session. The therapist believed these characteristics that he brought into session affected his ability to be present with the client or had shared characteristics with being present to the client. Some of his phrases that were grouped under this category were “filled self up with love,” tried to intentionally be “respectful, open, less judgmental towards [the client],” along with “purposeful relaxing.”

Mindfulness refers to the therapist’s practice of being non-judgmentally aware of himself and his experience moment-to-moment. The phrases the therapist used are descriptors of the construct of mindfulness, hence the category name was chosen. His phrases include, “feeling [body] tensions without aversion or attachment,” “noticing tensions in my head and in noticing them, they dissipate; I watch them dissipate,” and “aware of [my] breath.” The therapist’s perception was that in experiencing mindfulness,



“there was a clearer space” for him to orient himself towards his time with the client, which led to being more present to her.

Planning for Session refers to the therapist’s preparation for his time with the client. He described actions he took before session, which he felt contributed to being more present during session with the client. These included, reading the intake, thinking over previous sessions, “played out, thought through anxieties and planned for them to arise” in order that he wouldn’t be caught off guard by them as much. Through his preparation, the therapist felt that he could more readily “sink into session with her” because he felt the strategic part of therapy had been taken care of giving him more “room within [him]self” to attend to the client and his own experience during session.

*In-session Factors Perceived to Facilitate Presence.*

The therapist was then asked ‘Was there anything that happened during session that helped you to be present?’ The categories that emerged from the therapist responses over the eight sessions were: Paying Attention (with two subcategories of To Client and To Self), Intentional Way of Being, Validation that Therapy is Working, and Understanding the Client More. Paying Attention To Client represents the therapists’ focused attention on the client, in which he noticed “the client’s emotion” and “her non-verbals.” The therapist indicated that this close attention to the client helped him to be more present in that attention to her is an “essential ingredient” to being present. Paying Attention To Self represents the ways in which the therapist used his attention towards himself to become more present during session. Some examples of phrases shared are, “watched self and my reactions,” “noticed body tensions,” and “paid attention to by

breathing, my body, my experiences.” He acknowledged the importance of this dual attention towards himself and his client in being as present as he could be.

Intentional Way of Being was mentioned as a category earlier and again indicates the therapist’s attention and action towards the characteristics he wanted to experience and exude before and during session. It is the way in which the therapist tried to be in session with the client. Some phrases used by the therapist to illustrate this were, “trusting myself,” “dissipating tensions and purposeful relaxing myself using the breath,” “moving out of my head and away from too much thinking,” and “having a plan for session.” He acknowledged that “doing this work on [him]self” during session allowed him “more room” for the purity of exchange between himself and the client. In working towards getting himself into a trusting, relaxing, less-attention-on-thinking pose, he experienced himself as being more present with the client.

Validation that Therapy is Working refers to the aspects of therapy the therapist felt were indicators that his work with the client was achieving something purposeful. These phrases included, “client talked and worked in session,” (the client began therapy being less verbal), “client expressed emotion,” and “client expressed she had insight.” Although the therapist did not explicitly say this, experiencing validation that therapy was working seemed to remove the question of, ‘am I doing good work?’ and ‘is the client getting something out of this?’ The absence of these questions gave the therapist more room within himself to be present to the client.

The category, Understanding the Client More, refers to the sense that the therapist was knowing and ‘getting’ the client increasingly throughout the duration of therapy. This category was given to a cluster of phrases that the therapist said illustrating the

progress he was making towards understanding his client more deeply. These included, “feeling like I am understanding her better,” and “I’m getting her more now.” The therapist did not explicitly state the process of how this process helped him to be more present with the client, but it seems that the experience of understanding his client more created a more relaxed environment for him. Over time, he didn’t have to spend energy “trying to figure her out,” which may have given him more opportunity to focus his attention on himself and the client during the process of therapy.

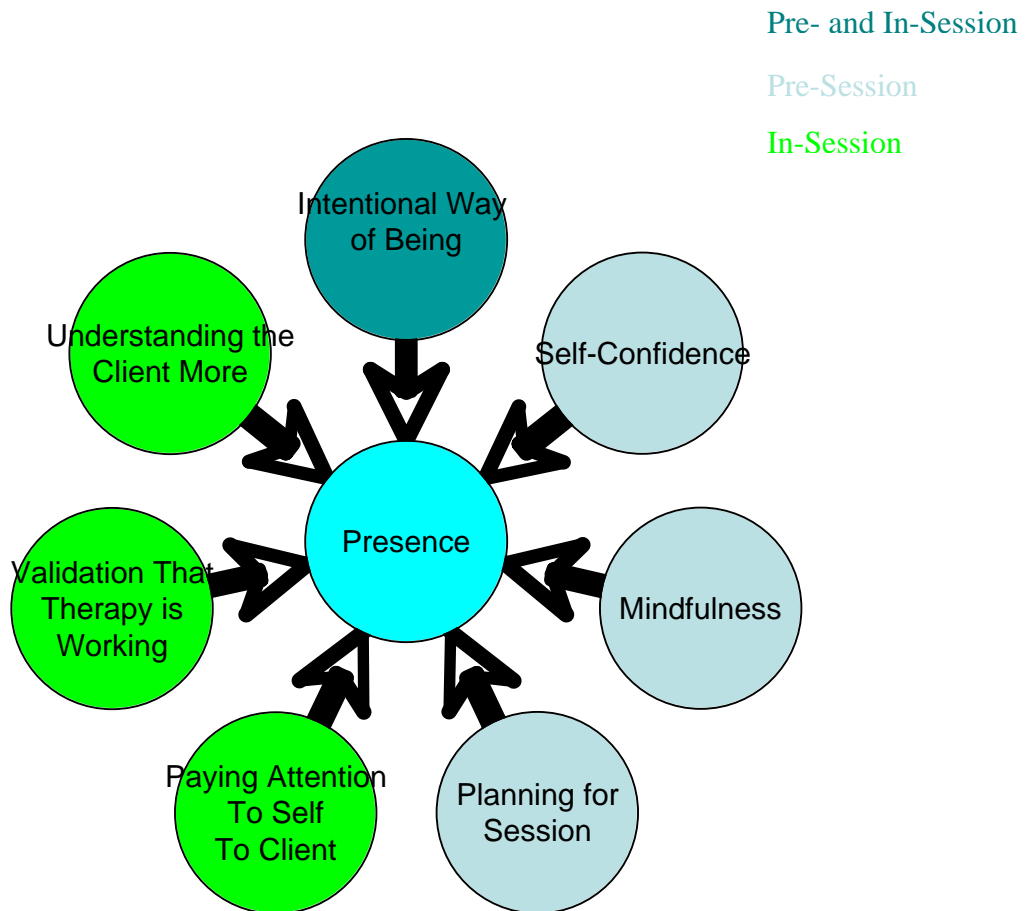


Figure 8. Factors perceived to facilitate presence.

*Pre-session Factors Perceived to Interfere With Presence.*

The therapist was then asked, ‘Was there anything that happened before session that interfered with your being present?’ The categories, Anxiety and Discouraged in Self, emerged. Anxiety referred to the therapist’s worry and tension about a number of things mostly unrelated to the therapy. The category name emerged from phrases he used to describe his experience, some of which included the word anxiety, itself. He stated that he was having “stress and anxiety about other things, especially [the comprehensive examination],” “money problems,” “feeling rushed to get to session because of being late” and “being sweaty.” The therapist’s sense of his anxiety and stress about outside life matters was that they were interfering and “taking up space” inside of him, diminishing his ability to be present to the client.

The category of Discouraged in Self refers to the sense of feeling disheartened about aspects of himself. The category included phrases that indicated ways in which the therapist “failed [his] own expectations.” The experience of being disheartened appeared to interrupt his ability to attend to other aspects of himself and the client because he was spending a significant amount of attention and energy on feeling discouraged in himself. According to the therapist, the heaviness of feeling discouraged in himself took away from his ability to be as present to the client as he could have been during session. The therapist spoke about this as though there is a certain amount of energy and attention he has and when it is spent on issues such as over-identifying with difficult emotions or life stressors and worries, it takes away from the overall allotment of energy and attention that could be spent on the therapy session.

*In-session Factors Perceived to Interfere With Presence.*

The therapist was then asked, ‘Was there anything that happened during session that interfered with your being present to the client?’ The categories that emerged were: Self-Doubt, Session Management, Inhibiting Reactions, and Expectation/Judgment of Client. Self-Doubt refers to the therapist’s feeling that he didn’t know or trust himself. Self-Doubt as a category name was chosen to depict the phrases the therapist used such as, “is this too intense for her?” “I was unclear where to go,” “I was trying to develop and make a coherent theory,” “I was trying to solve the client’s problem,” “I didn’t know how to help her,” and “when she was showing emotion but saying she doesn’t want to talk about it, I wasn’t sure what to do.” In persistently questioning himself and not trusting what he was doing, the therapist indicated that it took attention away from the client and himself in the moment. This process decreased his ability to be as present as he would like to be.

Session Management refers to the therapist’s experience of having to attend to and take care of the parameters of therapy such as time and structure. He reported having to make sure the pace of the session was appropriate and that he’d end the session at an appropriate, natural place at around the 50 minute mark. Session Management as a category illustrates the ways in which the therapist felt the necessity for his focus to intermittently be on managing the structure and time of the session got in the way of his ability to be present to the client. He reported that when he was paying attention to the time and structure of the session, his ability to be present to the client decreased because his attention and energy were being spent elsewhere.

Inhibiting Reactions refers to the aspects of the therapist’s experience where he felt reactions and feelings towards the client that “took up a lot of space” and inhibited

his ability to be present during session. The phrases in this category included, “she’s attractive and I was trying not to focus on her attractiveness,” “she’s in pain and I really can’t stand not being of help to her; I want to help!” “I had feelings that I’m going to have to pull teeth to get her to talk because I was remembering a similar client from before,” “I didn’t want to end our therapy; I wanted to continue with her,” and “I was feeling the impending loss of the relationship with her.” The therapist experienced himself at times as being overly involved in these feelings and reported that this over-involvement took away from his ability to be as present as he would have liked to be at times during the session.

The category of Expectation/Judgment of Client refers to the therapist’s experience of himself as feeling critical towards the client and of not accepting her for who she is and where she is in the process of therapy. It is a title given to describe a cluster of phrases such as “the client wasn’t giving me any material; she should talk more” and “I had an expectation that she should talk.” Over the 8 sessions, the therapist shared that there were ways in which his expectation of the client interrupted his ability to be present to her in that the two oppose each other. When he was more heavily involved in his feelings of non-acceptance and judgment towards the client, he was less able to perceive himself and her without these feelings coloring the experience.

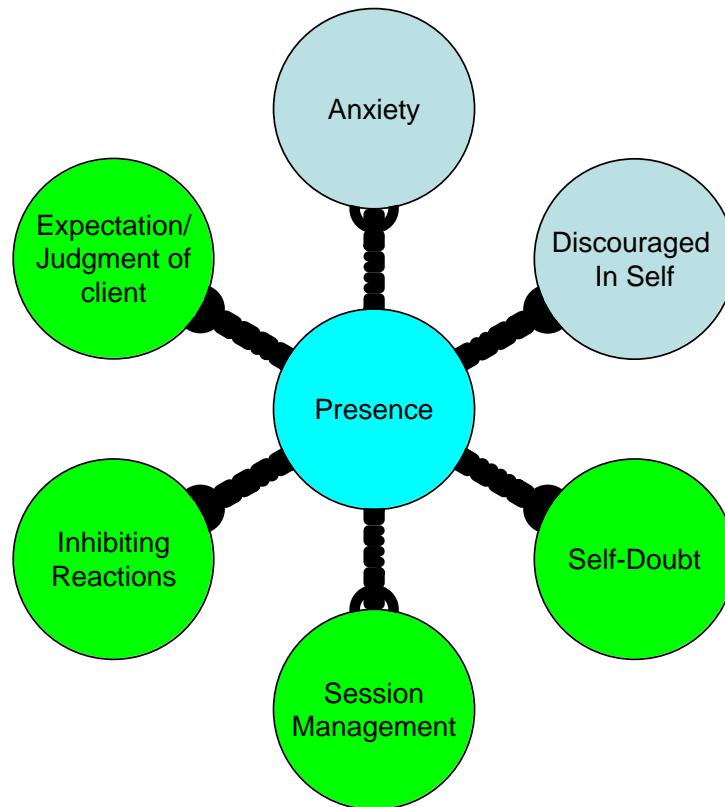


Figure 9. Factors perceived to interfere with presence.

*Pre-session Factors Perceived to Facilitate Empathy.*

The discussion shifted to the therapist's experience of empathy. He was asked, 'Was there anything that happened before session that helped you to be empathic?' The categories that emerged from this discussion over 8 interviews were: Planned for Session, Intentional Way of Being, Self-Confidence, Connections with Others, and Self-Care. The category, Planned for Session, refers to the actions he took to prepare for his time with the client. An example of therapist phrases that represented ways in which he prepared himself for the therapy included, "read her intake" in order to get a sense of why she sought therapy and "thinking over what occurred in previous sessions with her." The

therapist felt that by preparing for session in these ways, he went into the session already being oriented towards her and her struggle. This primed him to be empathic.

Intentional Way of Being was mentioned as a category earlier and again indicates the therapist's attention and action towards the characteristics he wanted to experience and exude before and during session. It is the way in which the therapist tried to be in session with the client. The category included phrases such as "clearing my head, making [internal] space," "releasing tensions and anxieties," "relaxing," "expecting her not to open up right away and accepting this about her," and "calming myself down about other stressors." The therapist felt that by orienting himself towards trying to be relaxed, accepting, and open, empathy could follow naturally.

Self-Confidence refers to the therapist's belief in himself and his sense of assuredness about his skills as a therapist. Self-confidence contributed to his being more present in the session with the client by giving him the sense that he has been an effective therapist in the past and this ability will carry over to his therapy with the present client. The category included the therapist engaging in positive self-talk before session. He experienced feeling more open to share in the client's experience when he felt more self-assured and confident in his ability as a therapist.

The category, Connections with Others, implies the relationships and the sense of affiliation the therapist has with others. This category includes therapist responses such as "thinking of my family and feeling close to them," "having just had a meaningful and close interaction with [friend's name] prior to this session, which primed me to be more sensitive," and "working in my other job with moms and kids where I'm connecting with them regularly." The therapist understood the process of connecting with others outside



the therapy session to be a primer for connecting and being open to the client, which includes being empathic towards her.

The category, Self-Care refers to the activities he engaged in that helped him in other areas of life and unburdened his task list. This category included responses such as “I slept well,” “I ate breakfast,” and “I paid my bills.” The therapist’s experience of this process is that by taking care of himself through sleeping and eating well as well as completing tasks for other areas of life, he had more space within himself to experience along with the client. The category, Understanding the Client More, refers to the sense that the therapist was knowing and ‘getting’ the client increasingly throughout the duration of therapy. This category was given to a cluster of phrases the therapist used illustrating the progress he was making towards understanding his client more deeply. This category included statements such as, “I have been feeling like I’m beginning to understand her better which improves my overall empathy of her.” In knowing the client more deeply in terms of how she relates in the world and her central issues she’s working through, the therapist felt better able to empathize with her. It appears as though the more he knew of the client, the more he felt with and for her.

*In-session Factors Perceived to Facilitate Empathy.*

The therapist was asked, ‘Was there anything that happened during session that helped you to be empathic?’ The categories that emerged were: Client Emotion, Intentional Way of Being, Understanding the Client More/Self-Confidence, and Validation that Therapy is Working. The category of Client Emotion refers to the feelings the client was experiencing and showing during therapy. Some of his responses to the question were, “her strong emotion,” “I was touched by her pain,” “I’ve felt similar

feelings as she is feeling,” and “her tone of voice implied painful emotion.” The client’s expression of emotion or the therapist’s sensing of the client’s emotion acted as a flag for the therapist’s empathic attunement, increasing his experience of empathy for her.

Intentional Way of Being was mentioned as a category in previous sections and again indicates the therapist’s attention and action towards the characteristics he wanted to experience and exude before and during session. It is the way in which the therapist tried to be in session with the client. The category involved statements such as, “paid close attention to her and her non-verbal [behavior] making sure she felt heard,” “deliberately not wanting to have an agenda,” “accepting her and her struggles,” “feeling calm,” “respecting her and what she’s saying,” and “being patient.” The experience of the therapist was that by priming himself towards deliberately trying to be attentive, accepting, and respectful, empathy naturally flowed from this place and he was able to be more empathic to her.

The category, Understanding the Client More/Self-Confidence, refers to the therapist’s experience of increasingly knowing and ‘getting’ the client, which leads to feeling more self-assured in his ability as a therapist working with her. This category involved responses such as, “intellectual understanding of her,” “piecing things together, understanding how different aspects of her life relate,” “knowing her better,” “having more insight about her,” “I understood her hurt,” and “I’m seeing the larger growth movements she’s engaged in.” His sense was that as he began to know her more deeply and conceptualize her history and how it relates to her presenting concerns, he was able to feel more self-confident and these both led to being more empathic towards her.

The category name, Validation that Therapy is Working, refers to the therapist’s sense that the client was making progress during therapy and, as a part of the therapeutic process, he felt affirmed in his abilities as a therapist. Some of the therapist phrases in this category are, “she’s challenging herself,” “she’s letting down her defenses,” “I recognize I have a unique relationship with her,” “she was elaborating and talking more,” and “it felt like a genuine exchange.” Through experiencing therapy as being beneficial to the client and the client making progress, the therapist perceived himself to be more empathic towards her. Perhaps perceiving therapy as working reduced his tension around self-doubt and concern that the client isn’t benefiting, freeing him up to feel more with and for the client during session.

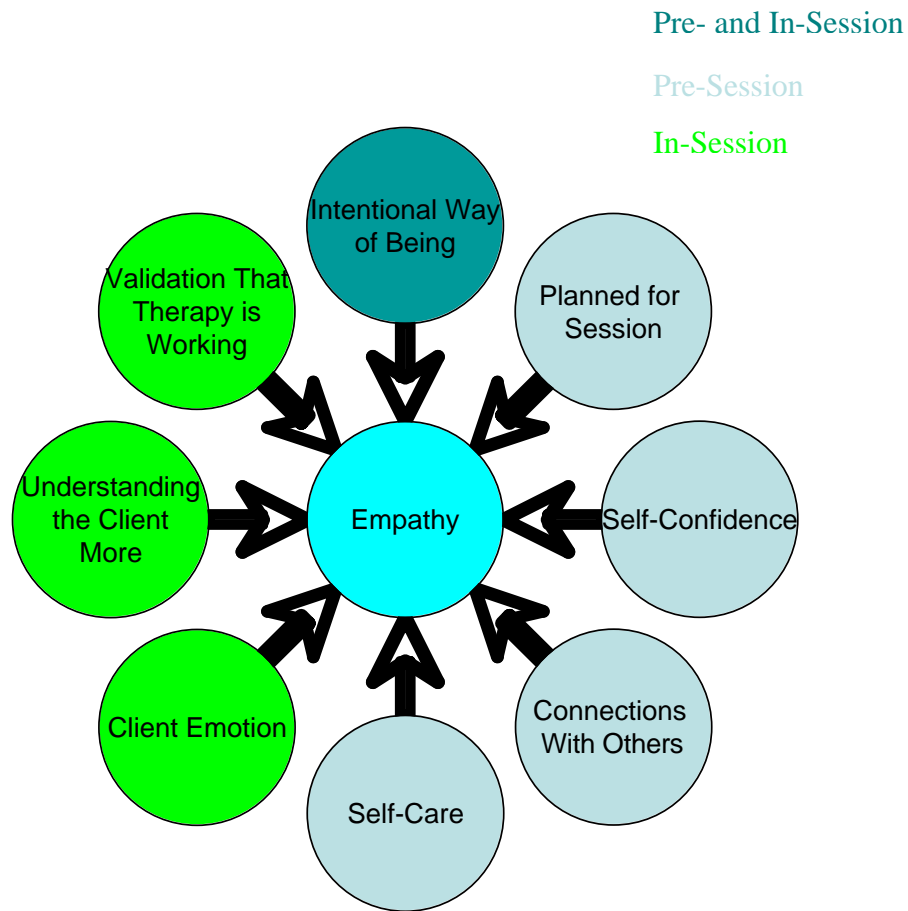


Figure 10. Factors perceived to contribute to empathy.

*Pre-session Factors Perceived to Interfere With Empathy.*

The therapist was then asked, ‘Was there anything that happened before session that interfered with your being empathic?’ The categories that emerged from his responses were Anxiety and Discouraged in Self. Anxiety referred to the therapist’s worry and tension about a number of things mostly unrelated to therapy. The category name emerged from phrases he used to describe his experience and included the therapist’s anxiety about outside stressors such as “comps” as well as “anxiety about the upcoming session,” and “anxiety from running late and being sweaty.” The therapist’s sense of his anxiety and stress about outside life matters was that they were interfering and “taking up space” inside of him, diminishing his ability to be empathic to the client.

The category of Discouraged in Self refers to the sense of feeling disheartened about aspects of himself. It included statements such as, “I was disappointed in myself for [outside stressors],” “I just didn’t feel good about myself,” and “I felt self-absorbed with negative feelings about myself.” The experience of being disheartened appeared to interrupt his ability to empathize with the client because he was spending a significant amount of attention and energy on feeling discouraged in himself. According to the therapist, the heaviness of feeling discouraged in himself took away from his ability to be as empathic to the client as he could have been during session. Again, the therapist spoke about this as though there is a certain amount of energy and attention he has and when it is spent on issues such as over-identifying with difficult emotions or life stressors and

worries, it takes away from the overall allotment of energy and attention that could be spent on the therapy session.

*In-session Factors Perceived to Interfere With Empathy.*

The therapist was asked, ‘Was there anything that happened during session that interfered with your being empathic?’ The categories that emerged from his responses were Confusion, Expectation/Judgment of Client, and Session Management. Confusion refers to the therapist’s sense of not knowing during the therapy session. Some of his responses were, “she confused me,” “I was struggling for what to talk about,” “I’m confused” and “she says something incongruent of how I experience her; I get confused.” In his confusion, the therapist perceived himself to be more involved in “trying to figure her out” and less able to empathize with her.

Expectation/Judgment of Client refers to the therapist’s critical feelings towards the client. Some of his responses were, “she doesn’t go deeper [and I want her to],” “she’s in a good mood—is this mood fake? I can’t empathize with her good mood,” and “she shows emotion but can’t explain it [and should be able to].” The therapist’s judgment and expectation about the client impeded his ability to be empathic to her during session because the critical feelings oppose the experience of feeling with the client. By being overly involved in his own negative reactions to the client, the therapist couldn’t empathize with her experience as much as he would have liked to.

The final category, Session Management refers to the therapist’s experience of having to attend to and take care of the parameters of therapy such as time and structure. This category included the therapist having to “structure the session [time],” “because it’s termination session, I don’t want to go too deep only to end and leave her,” “sometimes

in therapy, [I] shouldn't be empathizing because [I'm] ending session or therapy altogether and [I] don't want to draw her out more," and "I was making an interpretation so I wasn't empathizing with her." Again, if attention and energy are limited and he is allotting a considerable amount of attention and energy to managing the session, it leaves less for him to empathize with the client.

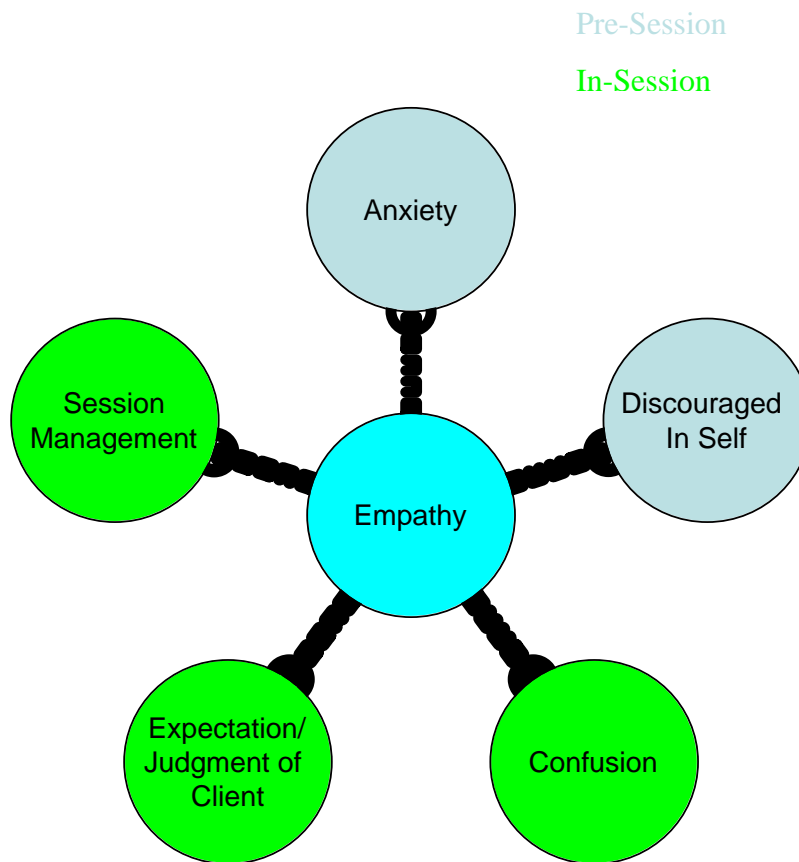


Figure 11. Factors perceived to interfere with empathy.

*Pre-session Factors Perceived to Facilitate Low Anxiety.*

The discussion shifted towards the topic of the therapist's anxiety. The therapist was asked, 'Was there anything that happened before session that helped you to be less anxious or non-anxious?' The categories that emerged were: Self-Care, Self-

Confidence/Feeling Validated, Intentional Way of Being, Planned for Session, and Mindfulness. The category, Self-Care, refers to the activities he engaged in that helped him in other areas of life and unburdened his task list. Some of the therapist responses were, “napping,” “eating well, feeling healthy,” “eating breakfast,” “looking forward to going out with the guys tonight—something fun,” and “[studying for] comps and my finances are going well.” The therapist’s experience of this process is that by taking care of himself through sleeping and eating well along with completing tasks for other areas of life, he entered the therapy session with less overall anxiety and was primed for being less anxious with the client.

The category, Self-Confidence/Feeling Validated, refers to the therapist’s sense of feeling affirmed and effective as a therapist. Some of the therapist statements were, “I’m feeling like I’m helping her,” “I have confidence about my comps [process],” “I’m trusting the positive feedback that I’ve received from others that I do a good job [as a therapist],” and “trusting myself.” Through experiencing therapy as being beneficial to the client and the client making progress, the therapist didn’t have as much to worry about whether or not what he was doing was working. Perhaps perceiving therapy as working reduced his tension around self-doubt and concern that the client isn’t benefiting, freeing him up from anxiety with the client during session.

Intentional Way of Being again indicates the therapist’s attention and action towards the characteristics he wanted to experience and exude before and during session. It is the way in which the therapist tried to be in session with the client. The category, Intentional Way of Being, included therapist statements such as, “consciously wanting to be calm,” “trusting myself and the therapeutic process,” “thinking of positive things in

my life,” “cognitively restructuring so I see the positive in my difficult life situations,” and “accepting I will be anxious and being okay with that.” By priming himself towards deliberately trying to be attentive, accepting, and respectful, he experienced less anxiety in the therapy session.

Planning for Session refers to the therapist’s preparation for session. He described actions he took before session, which he felt contributed to being more present during session with the client. These were, “preparing before session and coming up with a game plan for session,” “thinking ahead to the session and planning for the anxieties that I will have/preparing for what I will do when they arise,” and “bringing anxieties [from my life outside of my role as a therapist] into my awareness and realizing I can’t do anything about them now.” Through his preparation, the therapist felt that he could more readily “sink into session with her” because he felt the strategic part of therapy had been taken care of, which freed him up from anxiety during session.

Mindfulness refers to the therapist’s practice of being non-judgmentally aware of himself and his experience moment-to-moment. The therapist’s statements clustered around the construct definition of mindfulness. These were “breathing, closing my eyes, and focusing on my breath,” “noticing all the things I’m failing and succeeding at,” and “bringing up anxieties and in naming the anxieties, they dissipate.” The therapist’s experience was that in experiencing mindfulness, his anxiety decreased. He noticed that the two oppose each other in that a result of noticing his experience of tensions and anxieties was that they decreased.

*In-session Factors Perceived to Facilitate Low Anxiety.*



The therapist was asked, ‘Was there anything that happened during session that helped you to be less or non-anxious?’ The categories that emerged were: Feeling Validated, Acceptance of Self, Understanding the Client More, and Mindfulness. Feeling Validated refers to the sense of approval and acceptance the therapist experienced in his relationship with the client as well as more generally from other relationships. Some of his responses were, “she responded to my jokes,” “she seemed comfortable with me,” “I was allowed into her experience,” “she gave me an expression of warm joy,” “I felt I understood her,” “conversation was flowing/absence of questions and doubts,” and “remembering the positive feedback I got from my own therapist and supervisor that I’m good.” By experiencing the sense that he is an effective therapist, he noticed he didn’t experience as much worry and anxiety about his performance and his ability to help the client.

The category, Acceptance of Self, represents the therapist’s non-judgmental and compassionate stance towards himself. Some of the phrases from his responses included, “recognizing I can’t fix things in the first session,” “there was an absence of questions and doubt,” and “recognizing I will feel some anxiety and being okay with that.” Through viewing himself with acceptance, the therapist experienced less anxiety even when he viewed himself as anxious because the acceptance of his anxiety led to a decrease in it and an absence of feeling additional anxiety for feeling anxious. He experienced the process of self-acceptance as being a key factor in being less anxious with the client.

As mentioned earlier, Understanding the Client More, refers to the sense that the therapist was knowing and ‘getting’ the client increasingly throughout the duration of therapy. This category was given to a cluster of phrases the therapist said illustrating the

progress he was making towards understanding his client more deeply. Some of the therapist responses included statements such as, “I understand her and what’s going on for her.” Although the therapist did not explicitly state the process of how this process helped him to be more present with the client, it appeared that during the interview the experience of understanding his client more created a more relaxed environment for him and a reduction in anxiety.

As mentioned previously, Mindfulness refers to the therapist’s practice of being non-judgmentally aware of himself and his experience moment-to-moment. The therapist’s statements clustered around the construct definition of mindfulness. Mindfulness encompassed responses such as “being aware of anxiety and this awareness was followed by the dissipation of the anxiety,” “noticing when breathing is more constricted and then relaxing the breathing,” and “focusing on my body and body tensions.” The therapist’s experience was that in experiencing mindfulness, his anxiety decreased. He noticed that the two oppose each other because a result of noticing his experience of tensions and anxieties was that they decreased.

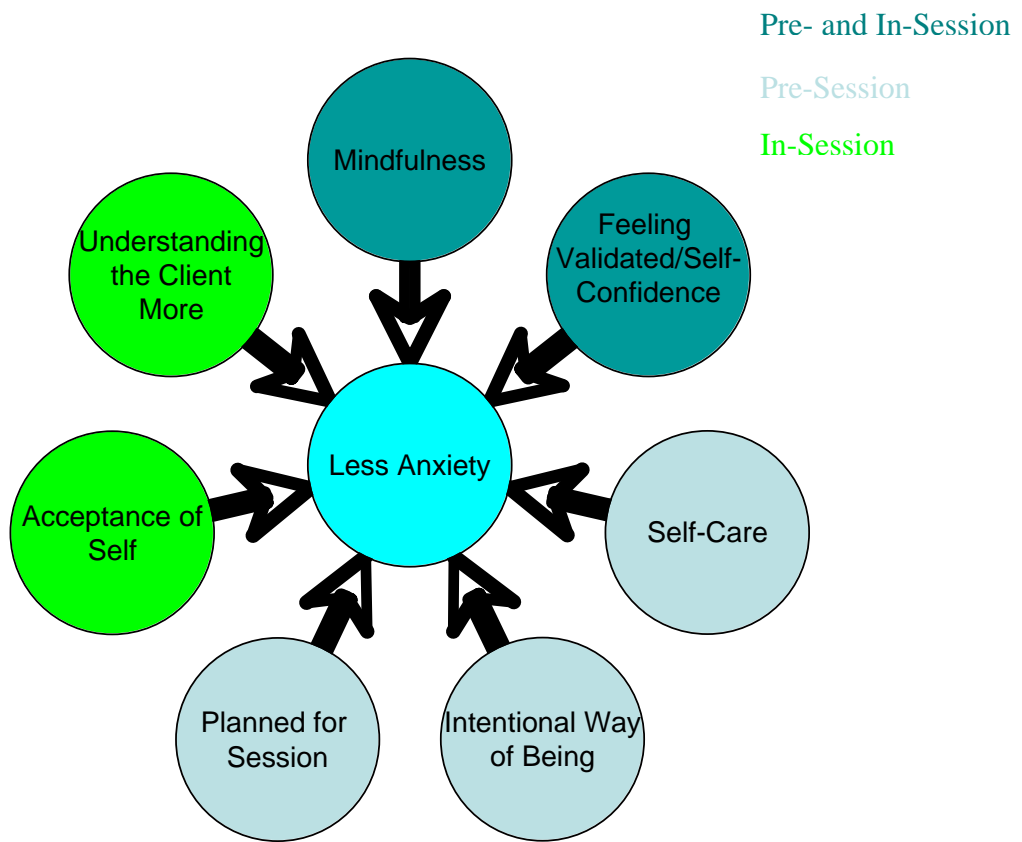


Figure 12. Factors perceived to facilitate low anxiety.

*Pre-session Factors Perceived to Contribute to Anxiety.*

The therapist was asked, ‘Was there anything that happened before session that interfered with your being less or non-anxious?’ The categories that emerged were, Anxiety, Poor Mood, Low Self-Confidence, and State of Wanting. Anxiety refers to the therapist’s sense that his worries and tensions about life matters outside of the therapy session was impeding his ability to be non-anxious during session. This category encompassed statements such as, “I have school-related stress and anxiety,” “I have anxiety about comps,” and “I don’t have enough money.” When the therapist was more

involved in his life stresses and anxieties, he was bringing them into session and this was impeding his ability to be non-anxious with his client.

The category of Poor Mood refers to the therapist's negative frame of mind. The therapist responded with phrases such as, "I forgot my cigarettes, which pissed me off," "I was in an overall poor mood," and "I missed the bus, which pissed me off." He described how being in a negative mind state brought him to a rather low place overall and created more uneasiness during session with the client than he would want to have. He equated this sense of uneasiness with anxious feelings.

The category of Low Self-Confidence refers to the therapist's low self-efficacy and lack of self-assuredness. This is illustrated by therapist statements such as, "I wanted to do a good job and I was feeling low in ability," "I wondered, 'did I do enough and was I helpful/effective?'" "I wanted to come across as a good therapist for this project," and "I wondered if we lost our connection due to having had two weeks go by since our last session." The therapist's experience of feeling low in self-confidence led to him worrying about his performance and ability. According to him, this led to feeling more anxiety during session with the client.

The category, State of Wanting, illustrates the therapist's experience of desiring for himself and for his client. The therapist indicated that his sense of "wanting to help her," "wanting to do a good job," and "wanting to come across as a good therapist for this project" increased his anxiety in session. In his experience of being over-involved in wanting to be something particular for the client, the therapist experienced a sense that he might not be doing enough. This led to feeling more anxious about his performance and his impact on her.

*In-session Factors Perceived to Contribute to Anxiety.*

The therapist was then asked the final question of the interview, ‘Was there anything that happened during session that interfered with your being less or non-anxious?’ The categories that emerged were: Expectation/Judgment of Client, Inhibiting Reactions, Confusion, Perception that Client Has Expectations of Me, State of Wanting, Being Absorbed by Anxieties, and Low Self-Confidence/Judgment of Self.

As previously mentioned, Expectation/Judgment of Client refers to the therapist’s critical feelings towards the client. The category included therapist responses such as, “she wasn’t talking [and should have been],” “I was perceiving that I’m going to have to pull teeth to get her to talk,” “I had the expectation that she’d bring up stuff and when it doesn’t happen, I panic,” and “she says things are good and I don’t know where to go from that statement.” The therapist’s judgment and expectation about the client impeded his ability to be non-anxious during session because the critical feelings created a sense that the client and the progress of therapy ought to be different. He felt anxiety about how much work he’s going to have to do with her and a question about how to achieve this.

Inhibiting Reactions refers to the aspects of the therapist’s experience where he felt reactions and feelings towards the client that inhibited his sense of calm during session. These feelings increased his perception that the work he’d have to do with her would be really difficult and require effort and technique he wasn’t sure he had. This led to a sense of feeling more anxious while connecting to her. The category included therapist statements such as, “I was perceiving that I was going to have to pull teeth and this was my experience with other clients.”

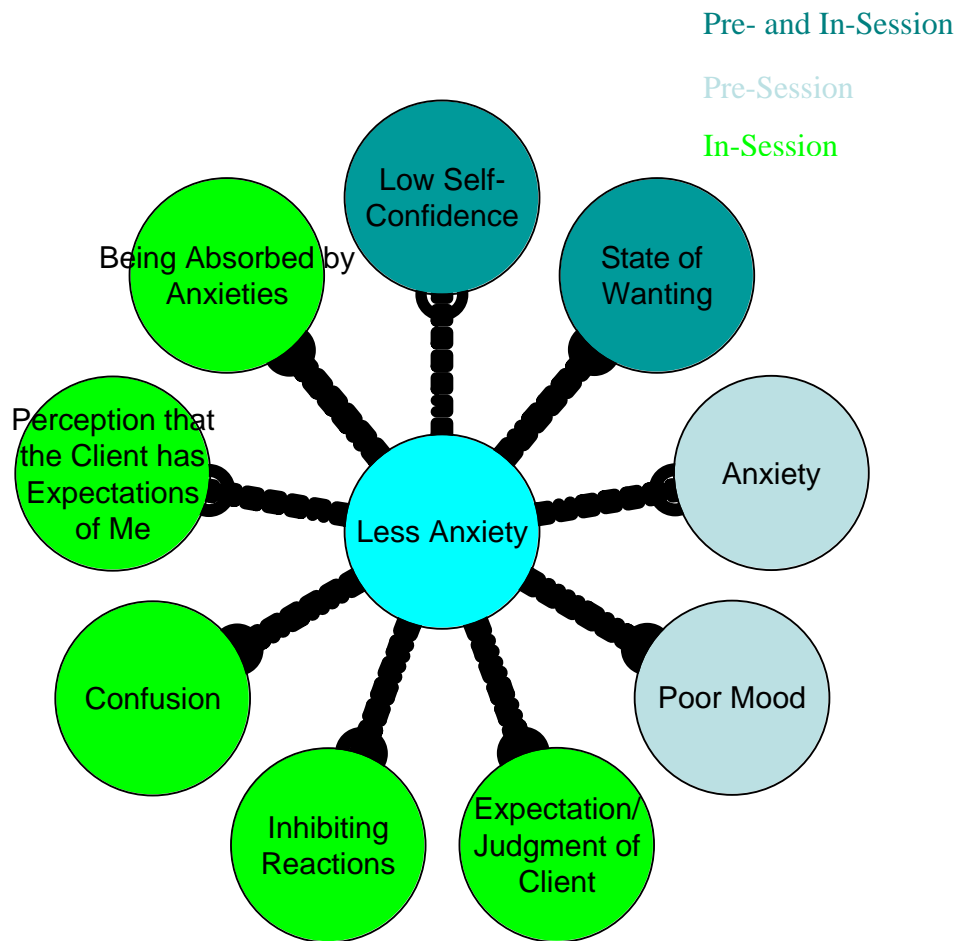
The category of Confusion is where the therapist felt he was unsure about something in therapy and this increased his anxiety level. Examples of statements he said were, “I don’t know her goals and expectations in therapy,” “I was unsure which way to go,” “I was unsure how to take her out of her emotional experience,” “I was unsure how to go deeper,” “I was unsure if I was gentle enough or if the intensity of the session was too much,” “the situation is ambiguous,” “she says things are good and I don’t know what to do with this statement,” “I became solution-focused and I wasn’t in the moment,” and “I was trying to figure her situation out.” The therapist experienced a lack of assuredness and a sense of being unsure how to proceed. He experienced anxiety when he felt confused and unsure of himself, and when he wasn’t sure what the client’s experience was and whether therapy was helping the client, he felt more anxious.

The category of Perception that the Client Has Expectations of Me refers to the therapist’s view that the client wanted him and therapy to look a particular way. He said statements such as, “she said she wanted something to be fixed,” and “I thought she communicated that she wanted results right away.” Perceiving these expectations on him made him worry about his performance and whether or not the client was pleased with the work he was doing. This worrying increased his anxiety during session.

As mentioned previously, the category, State of Wanting, illustrates the therapist’s experience of desiring for himself and for his client. It refers to the therapist’s feelings of “wanting to be gentle” and “wanting to make the session meaningful.” In his experience of being over-involved in wanting to be something particular for the client, the therapist experienced a sense that he might not be doing enough or doing therapy ‘right.’ This led to feeling more anxious about his performance and his impact on her.

The therapist experienced himself as being overly involved with his feelings of worry which led to the category of Being Absorbed by Anxieties. His perception was that during the times when he was more identified with or attached to his anxieties, it led to additional anxiety. This is in contrast to the times when he was able to see his anxiety with more equanimity and space between himself and the experience, which he perceived reduced his anxiety. Some of the statements in this category are, “buying into [the anxieties] and not seeing them for what they really are, which are just anxieties.”

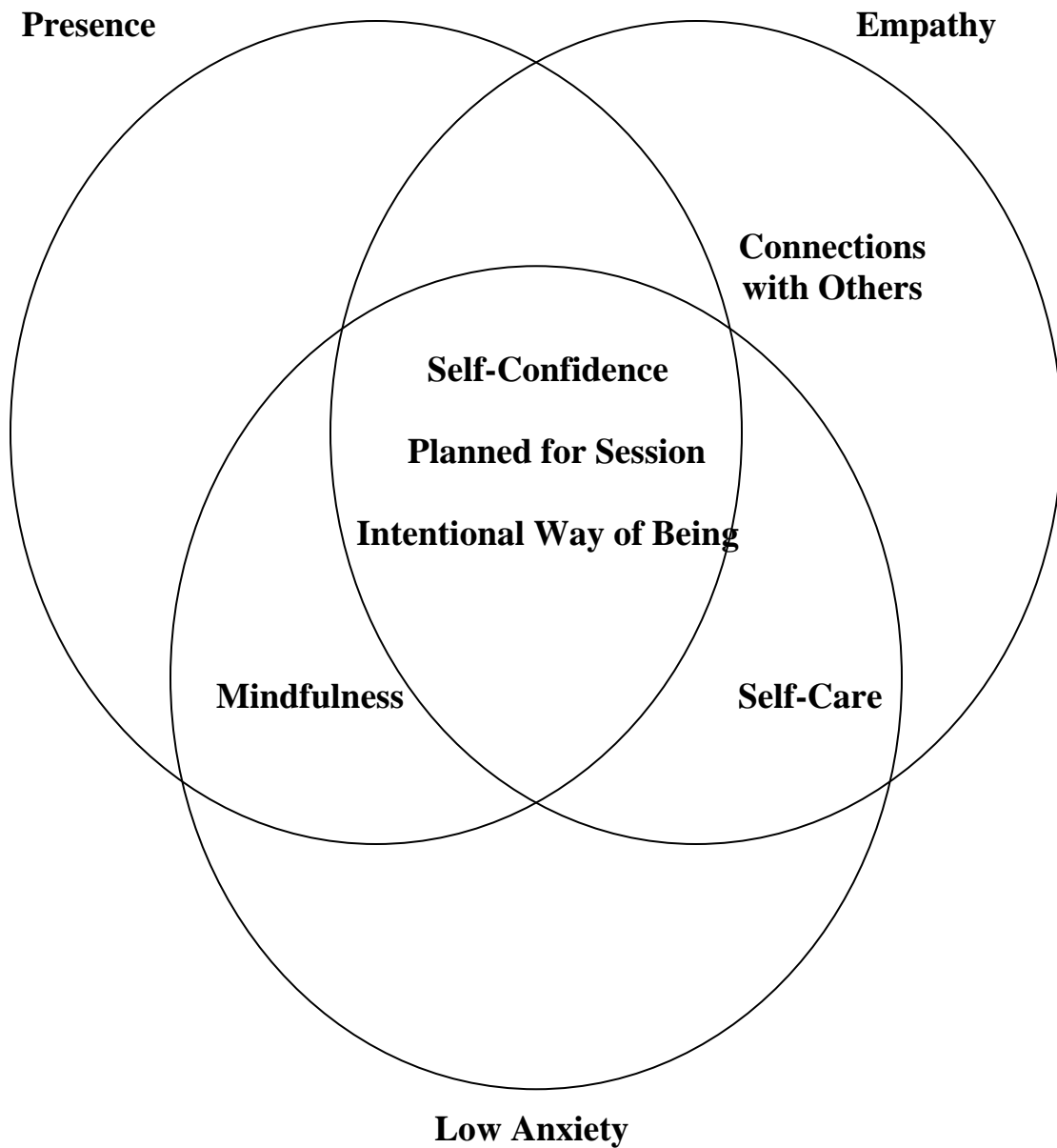
The category of Low Self-Confidence/Expectation and Judgment of Self refers to the therapist being critical and non-accepting towards himself. Statements include the therapist’s experience of “not being forgiving towards myself for goofs” and “not trusting myself.” He felt that during times when he was more judgmental and critical towards himself along with not meeting his own internal criteria for how he should be, he felt anxiety about his performance and his ability to help the client.



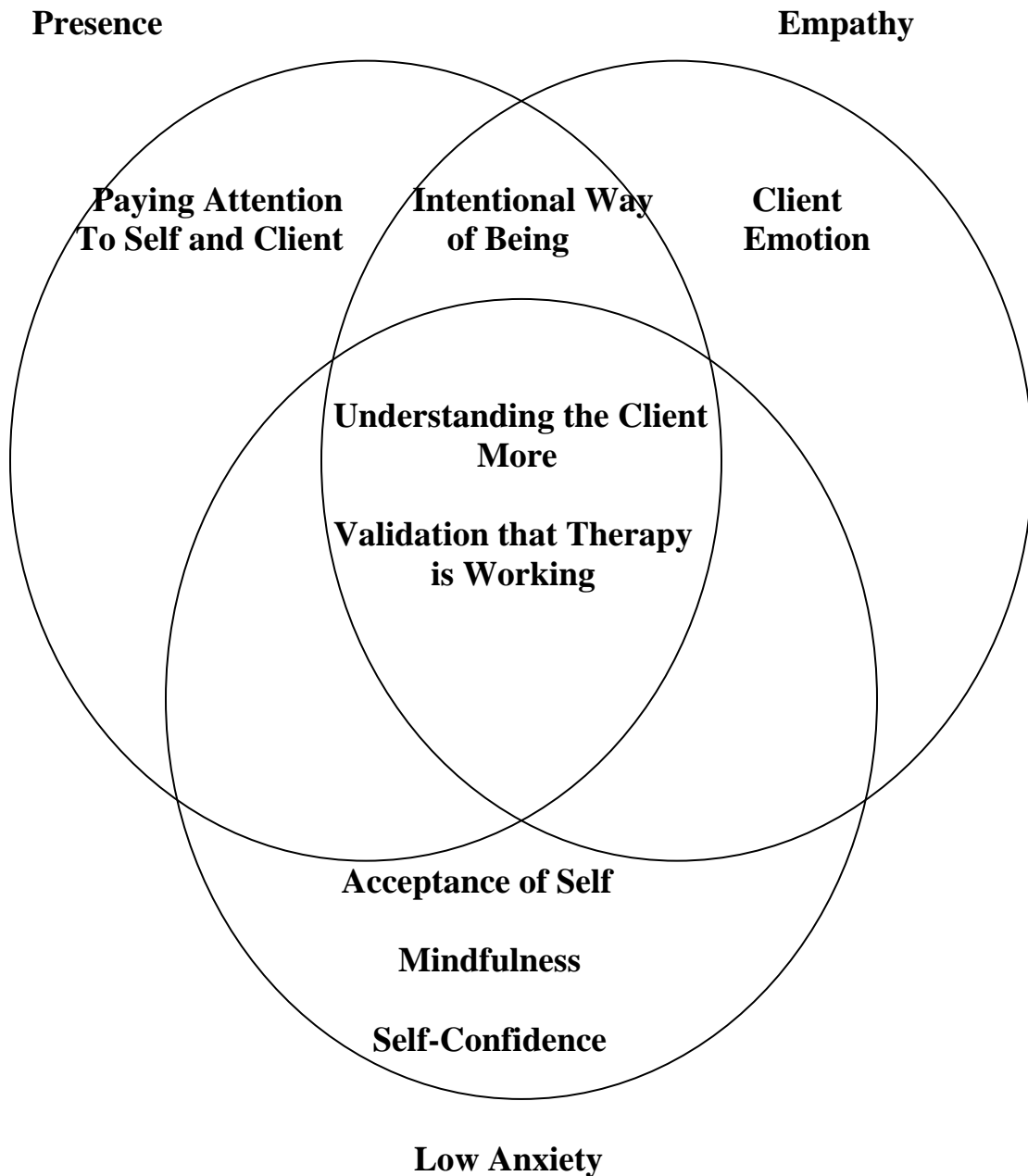
*Figure 13.* Factors perceived to contribute to anxiety.

There are several categories that overlapped among constructs indicating that the therapist experienced certain aspects of preparing for session and being in session as contributing and interfering across variables. The figures below illustrate the pre-session and in-session categories, respectively, and how they overlapped with one another to contribute to or interfere with being present, empathic, and less anxious.

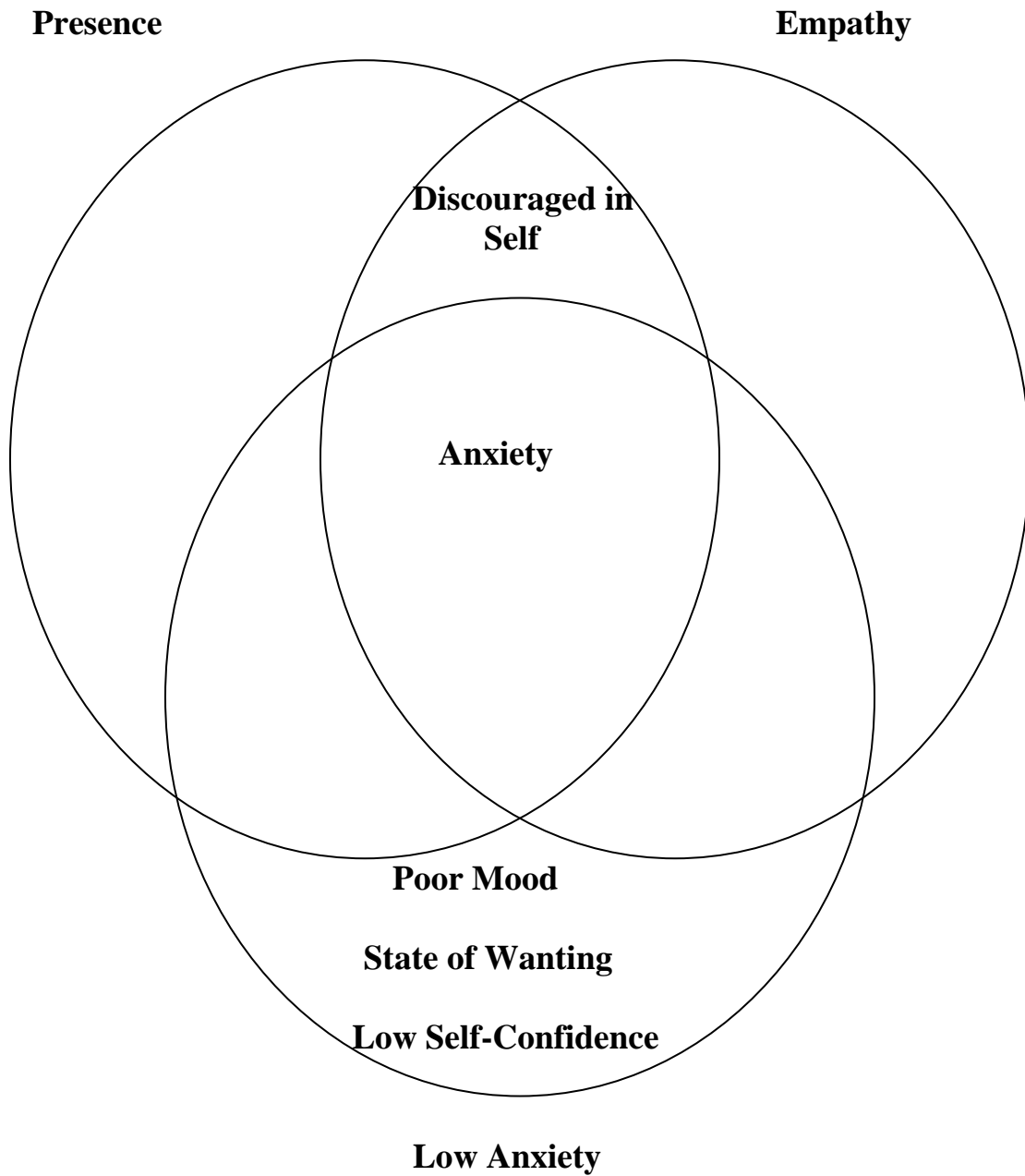




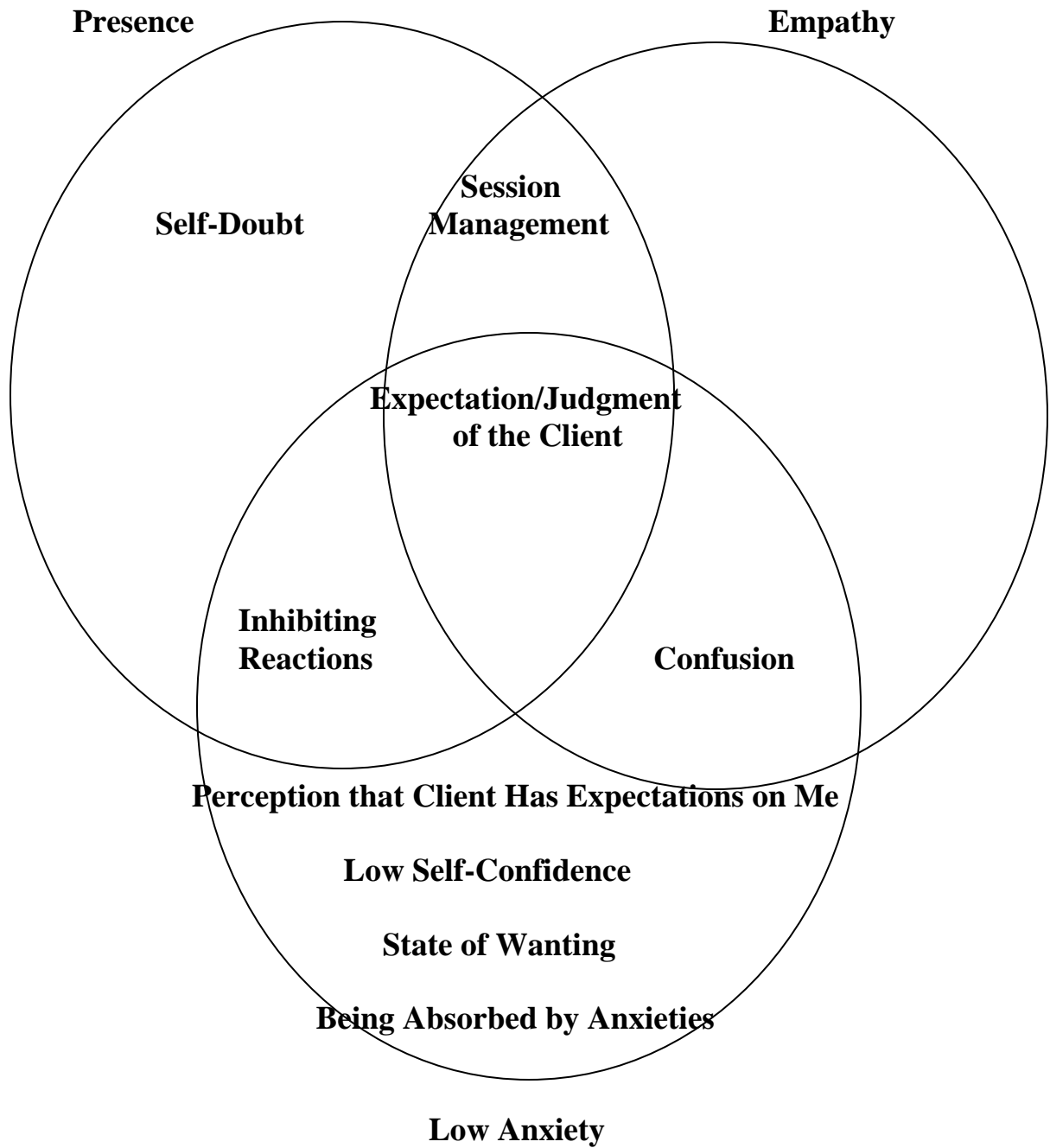
*Figure 14.* Overlapping pre-session categories perceived to contribute to one or more of the variables, presence, empathy, and low anxiety.



*Figure 15.* Overlapping in-session categories perceived to contribute to one or more of the variables, presence, empathy, and low anxiety.



*Figure 16.* Overlapping pre-session categories perceived to interfere with one or more of the variables, presence, empathy, and low anxiety.



*Figure 17.* Overlapping in-session categories perceived to interfere with one or more of the variables, presence, empathy, and low anxiety.

## **Chapter 5**

### **Discussion**

There is no shortage of evidence that the person of the therapist has an impact on the therapy process and client outcome (Crits-Christoph, 1991; Hayes, 2004; Wampold, 2001), even though the primary focus of psychotherapy research has emphasized aspects outside the person of the psychotherapist (e.g., the client, techniques). Furthermore we know some of the therapist qualities that impact therapy, but what we know about these qualities varies. The therapist's anxiety during session, empathic skills, and his/her ability to be present with the client are important aspects of the therapist that have been discussed and, to varying degrees, investigated in the psychotherapy literature. The aim for this case study was to expand and deepen what is known about two aspects of the therapist which are thought to be critical to therapy, anxiety and empathy, along with exploring aspects of the therapist that have not been given much attention in the psychotherapy literature, namely presence and mindfulness. In the current study, both the therapist and client perspectives were considered in each therapy session and the relationships between their respective views were observed. This offered an opportunity to examine the experience of therapy from both sides of the therapy relationship.

Beyond expanding and deepening what we know about these aspects of the therapist, the question of "how" was central to this investigation. For instance, how do therapists orient themselves towards being empathic? What helps and what hinders the therapist's empathic ability? The therapist's experience of himself and what he believed to be contributing and inhibiting factors for him in engaging with his client were of particular interest. Open-ended questions about the therapist's experience led to a mixed-

methods case study design where post-session interviews assisted in exploring aspects of the therapist's experience with himself and the client. The exploration of the therapist's experience before and during session offers a deeper understanding of these relatively unknown internal processes of the therapist.

In the following sections, both quantitative and qualitative findings will be discussed, compared, and integrated as they pertain to the primary criterion variables of interest. Implications for training, practice, future research, and theory will then be presented.

### *Presence*

Descriptions of and hypotheses about the importance of therapist presence have been developed in the clinical and theoretical literature (Baldwin, 2000; Buber, 1958; Bugental, 1989; Thorne, 1992, Geller & Greenberg, 2002). Strupp and Binder (1984), for instance, highlighted the importance therapist presence in writing that, "Frequently underestimated is the degree to which the therapist's presence and empathic listening constitute the most powerful source of help and support one human being can provide to another" (p. 41). The factors that contribute to therapist presence in order to be able to cultivate this ability can add to our understanding of this therapist characteristic.

As predicted, mindfulness and presence were positively related in the quantitative findings of this case study. The stronger relationship existed between the therapist's self-rating of presence and mindfulness (note that these parenthesized statistics throughout the discussion are correlations by denoting  $r = .82$ ), but still a medium effect existed between the client's rating of the therapist's presence and mindfulness ( $r = .37$ ). The finding that therapist mindfulness relates to the therapist's ability to be present with the client makes

conceptual sense and highlights that one way in which presence may be cultivated is through the practice of mindfulness. Mindfulness, a moment-to-moment awareness of one's experience without judgment (Kabat-Zinn, 1990), prepares the ground for presence to another. Presence is conceptually similar to mindfulness in that it is "inwardly attending" along with attending to a being "open, accepting, and receptive" to the other's experience (Geller & Greenberg, 2002, p. 77-78). Arguably, one cannot be present if he/she is not mindful. Mindfulness can be viewed as presence towards oneself. Presence to another involves a balancing of awareness of self and other. For the purposes of therapy, the therapist's awareness of self is as important as the surgeon's scalpel. Where the scalpel is the surgeon's tool, the self is the therapist's tool (Hayes, 2004). The self is the place from which all decisions, reactions, movements, feelings, conceptualizations, and so on occur for the therapist. The surgeon sharpens her scalpel as she readies herself for surgery. The therapist practices mindfulness in order to prepare herself for relational engagement with the client. As Rogers mentioned, presence is the underlying, precondition to the necessary and sufficient conditions (Baldwin, 2000). Mindfulness is a way one readies him/herself and hones his/her ability for being present.

Additionally, the therapist discussed mindfulness as being a contributing pre-session factor in helping him to be present with his client. His responses include, "feeling [body] tensions without aversion or attachment," "noticing tensions in my head and in noticing them, they dissipate; I watch them dissipate," and "aware of [my] breath." The therapist's perception was that in experiencing mindfulness, "there was a clearer space" for him to orient himself towards his time with the client, which led to being more present to her.

Other pre-session contributing factors to being present to the client included self-confidence and planning for session. In-session factors were indicative of the therapist getting more comfortable and confident in himself as therapy progressed. These included feeling validated that therapy was working, knowing the client more for session, and paying close attention to himself and to the client. A contributing factor that emerged as being helpful towards being more present with the client both pre and in-session was intentionally orienting himself towards being a particular way, in this case, relaxed, open, accepting, and calm.

As predicted, anxiety inhibited the therapist from being present to the client and this was found in the quantitative and qualitative results. When the therapist experienced more anxiety, he was less present during session. The larger effect existed between therapist anxiety and the therapist's self-rating of presence (-.83) with a small effect between therapist anxiety and the client's rating of therapist's presence (-.19). The observed relationships, where both the client and therapist experienced the therapist as less present when he was more anxious, offers a clearer indication that anxiety most likely does impact the therapist's ability to be present. Other factors that the therapist believed impeded his ability to be present included inhibiting reactions, feeling discouraged in himself, doubting himself, having judgments of the client, and spending energy and attention on managing the session.

An impressive relationship between presence and session progress emerged in this study. The client and therapist rated both therapist presence and session progress. It is important to look at which rater should be given priority for his/her assessment of the different constructs. It seems likely that the therapist would be the most accurate rater of



his presence since it is a measure of his internal process. For session progress, it seems most appropriate to give more attention to the client's rating of session progress since the client is the recipient of therapy and, ultimately, it is the client's experience of therapy and view of session progress that gives psychotherapy its value. When looking at the relationship between therapist presence and session progress, it is also advantageous to look at the relationship between the therapist's view of presence and the client's view of session progress in order to avoid monosource bias. The relationship for these variables is .65, which indicates a large effect. Although it cannot be determined how the two constructs are related, the relationship between the two indicates the possibility for a strong relationship between how present the therapist experiences himself to be and how much session progress the client was made during session. If this relationship is in the expected direction, the implications for therapists and psychotherapy are far reaching. Some of these implications will be discussed in further detail below.

### *Empathy*

As essential as empathy is to successful therapy across virtually all types of clients, treatments, and therapists (Bohart, Elliott, Greenberg, & Watson, 2002), it is assumed that therapists naturally have or will develop the capacity to empathize well with their clients. For such an important ability to cultivate and use effectively, there is very little information on how to train therapists in developing and using empathy (Morgan & Morgan, 2005). As predicted in the quantitative findings, mindfulness was related to therapist empathy, although with a small effect ( $r = .17$ ), indicating the possibility that therapists who hone their ability to be mindful may also be perceived as slightly more empathic. An additional quantitative finding was that the more present the therapist was,

the more empathic he was perceived to be. As expected, this relationship was strongest when the client rated both presence and empathy ( $r = .81$ ), but there was also a medium effect between client-rated empathy and therapist-rated presence ( $r = .30$ ). These relationships support the notion that therapists who are present are better able to manifest their capacity to be empathic.

Mindfulness introduces the ongoing, moment-to-moment experiences of emotions, thoughts, and bodily sensations, to the individual. It is a way of deepening self-knowledge through observing and experiencing whatever is in the field of awareness at any given moment. By inwardly attending and then extending this attention to the client, the therapist is better able to be attuned to the client and can be more receptive and aware of client non-verbal behaviors, intonation changes, and other subtleties of the client's experience. The therapist's sharpened awareness of self allows for greater sensitivity and receptivity as the client conveys his/her experience in the moment. The therapist pays attention to his/her experience and can more keenly feel the changes in him/herself based on the client's changing experience. This ability to be mindful and present enhances the therapist's ability to experience the client's private world from the vantage point of the client's lived experience. By continuing to attend to oneself along with the client, the therapist is optimally situated within him/herself and able to both experience the client's inner world and respond accordingly.

The qualitative data support these relationships between mindfulness and empathy and presence and empathy. The therapist indicated that through an intentional way of being, that is, by orienting himself and wanting to be open, accepting, relaxed, and non-judgmental, he experienced himself to be more empathic. These descriptors align with

mindfulness and presence as both attributes include an open, relaxed accepting stance. Additionally, the therapist noted that during session, recognizing the client's emotion enhanced his ability to be empathic. The therapist noticed overt emotional cues such as tearing up as well as subtle, changing microexpressions across the client's face. With regards to especially noticing the client's more subtle changing expressions of emotion, the therapist must have been paying close attention to the client during these times and been present enough to sense the shift in the client's behavior and experience.

Additionally, the therapist spoke about how his expectation and judgment of the client inhibited his ability to be empathic. Judging the client is contrary to mindfulness by definition and is contrary to presence due to the degree to which the therapist experienced this reaction and did not allow it to pass on through his field of awareness. In his description, he felt as though he was absorbed in the experience of judging, which clouded his ability to be present to the client.

In addition to therapist presence, other pre-session constructs that seem to enhance empathy were the therapist's planning for session, self-confidence, connections with others, and self-care. During the session, empathy appeared to feed cyclically upon itself as the therapist described that understanding the client more had the effect of further increasing empathy. Another variable potentially related in a circular way to empathy was the therapist's perception that therapy was working. In other words, when therapy was working, the therapist thought this enhanced his empathy. Logically, and by extension, the therapist's enhanced empathy likely promoted the progress of therapy. Indeed, there was a positive relationship between empathy and session progress when

session progress was rated by the client ( $r = .77$ ), a large effect, and the therapist ( $r = .22$ ), a small effect.

On the other hand, the therapist's anxiety and feeling discouraged in himself were pre-session factors inhibiting empathy and feeling confused and managing the session were the additional in-session factors inhibiting empathy. It appears that when he was having negative feelings and emotions before session, he was less able to attend to and feel with his client. Experiencing and perhaps being focused on his negative emotions he was less available to his client. It could be viewed in terms of available space with an individual. How much availability and willingness does one have to attend to another when negative emotions and experiences are taking up space within the individual? The in-session factors of feeling confused and spending energy managing the session again indicate that the therapist may have had less internal, emotional space when he was focusing on other aspects of the session, namely, his own feelings of confusion or time and pacing of the session.

### *Anxiety*

Anxiety during session is one of the most noticeable aspects of therapists that negatively impacts clinical work (Al-Darmaki, 2004; Hayes & Gelso, 1991). Very little empirical work has been done to understand the ways in which therapists quell their anxiety and how to address the anxiety so common in therapist trainees (Robert & Bowman, 1978). As predicted, the quantitative findings showed that mindfulness had a relationship with therapist anxiety in the expected direction. There was a large effect ( $r = -.76$ ), indicating that the more mindful the therapist was, the less anxious he was. As mentioned previously, presence was related to therapist anxiety when both the client

rated therapist presence ( $r = -.19$ ) and the therapist rated himself ( $r = -.83$ ). These findings highlight that mindfulness practice, with one of the effects being that the individual is more present, could be an important avenue through which therapists can increase their ability to be empathic and present while reducing their anxiety.

The practice of mindfulness, of bringing one's attention to whatever is occurring in the moment without judgment, slows the individual down. If one is mindful, anxiety reactions are seen as just that, anxiety reactions. They lose their grip on the person. The intense effect of an emotional and physiological response is decreased when anxiety is observed. The act of observing necessitates a space coming in between the person and the feeling, thought, or sensation. In this space, the individual is given a bit more freedom than one is usually accustomed to in everyday life. There is no attachment or judgment of the experience. It is just there and in noticing it, one sees that he/she is not merely "anxiety." If there is a part of the individual that is observing, the intensity of a single experience decreases. Also, through mindfulness, one can see an experience as it arises and before it snowballs into a slew of experiences that build on one another. One unobserved anxiety reaction can become one hundred anxiety reactions. One observed anxiety reaction can be left as just that one.

The qualitative data support these relationships. Mindfulness emerged as a pre- and in-session category that contributed to the therapist experiencing little or no anxiety. Acceptance of Self emerged as an in-session category, which is a defining characteristic of both mindfulness and presence. Acceptance of the self, however the self is experienced in any given moment, is part of being mindful and present. Other factors which the therapist thought reduced his anxiety were, understanding the client, feeling validated and

experiencing self-confidence, engaging in self-care activities, intentionally trying to be a particular way with the client, and planning for session.

Being absorbed by his anxieties and inhibiting his reactions impeded the therapist's ability to be calm, according to him. These categories relate to mindfulness in that they are qualities that directly oppose mindfulness. When the therapist was being absorbed by his anxieties, he wasn't able to see them without attachment, hence, he was describing himself as not being mindful. In cases where the therapist was inhibiting his reactions, he wasn't allowing himself to experience whatever he was experiencing in the moment. He was forcing his experiences underground. This opposes both presence and mindfulness in that they involve awareness and acceptance of whatever one experiences in any given moment. Other factors that emerged as inhibiting the therapist's ability to be calm and relaxed were, feeling low in self-confidence, being in a state of wanting, experiencing anxiety, a poor mood and confusion, having expectation of the client, perceiving that the client has expectations of him.

### *Session Progress*

The hypothesis that therapist mindfulness would be related to client symptomatology was not adequately investigated given the measure used to assess symptomatology. Mindfulness and presence were related to session progress in that the more mindful and present the therapist was, the more session progress was made. The relationship between mindfulness and the therapist rating of session progress (.79) and between mindfulness and the client rating of session progress (.65) were both large effects. There were medium to large effects between session progress and presence depending on whom was assessing the construct with the most important relationship

existing between therapist rating of presence and client rating of session progress (.65) (see discussion above). According to these findings, a more mindful therapist and a more present therapist could potentially be a starting place and a contributing factor for effective therapy to take place.

### *Training and Clinical Implications*

The relationship between mindfulness and presence along with the relationships these attributes have with the other therapist qualities and aspects of therapy indicate the importance of new foci in the realm of therapist preparation and the practice of psychotherapy. Graduate training for therapists typically includes a conglomeration of developing client conceptualizations and critical thinking skills, skill training in implementing specific and generalized interventions aligned with particular theoretical orientations, as well as research training (Addis, 2000). There is little emphasis on the therapist as a person and the characteristics that can improve his/her ability to work effectively in this highly complex relationship with clients. It is not enough to know that therapists need to be empathic, present, relaxed and make progress in session. How does one be empathic? How does one embody presence? How does one quell his/her own anxiety? How does one help his/her client make progress? The findings raise the possibility that training therapists in mindfulness may play an important role in the cultivation of presence, empathy, improve session progress, while decreasing anxiety. Graduate training programs could enhance their effectiveness by emphasizing the development of the trainee's personhood, not merely their minds. This would require a shift in how we typically view training by moving into the realm of the body, emotions, mind and more importantly the groundspace from which the trainee functions. The

groundspace can be described as the backdrop of our existence. It is the part of the person that is not feelings, thoughts, or sensations. It is the “I” that supercedes the rest. By being more in touch with and attuned to this groundspace through the practice of mindfulness, the therapist can offer clients a purer connection and a clearer space. Additionally, the client interacts with a less reactive, more intentional, and more accepting person, which can be a corrective experience in its own right. Training therapists in mindfulness through exercises such as body scan awareness, mindful walking, eating, and sitting, could improve various aspects of the client’s experience and progress in therapy.

This case study’s evidence suggests preparing for session by incorporating mindfulness techniques helps to be more present and empathic, and less anxious, while contributing to greater progress during session. It is unclear to what degree mindfulness practiced at different times during the therapist’s life is related to these other variables. For instance, if a therapist practiced mindfulness everyday, but not directly before session, would the therapy session be affected?

Intentionally trying to be a particular way enhanced the therapist’s ability to be more empathic, present, and less anxious. This construct highlights the potential importance of the therapist being thoughtful and developing an intention of how he/she wants to be with the client he/she is about to see. Perhaps there is something in the desire to be a certain way and a focused attention on embodying particular characteristics that affect therapy. In this case, he wanted to be relaxed, open, non-judgmental, and attuned. He felt that he was better able to experience and exude these characteristics during session through merely having the intention to do so. “Intentional Way of Being” sheds light on the importance of therapists spending some time and energy before and during



session being aware of how they want to be with the client. Perhaps in bringing these characteristics up in the therapist's awareness, the self leans towards embodying these characteristics even after his/her attention shifts. Again in the qualitative data, the idea of preparing the groundspace of the therapist's self in order to work effectively in the therapeutic relationship emerged.

The therapist's self-confidence and sense of feeling validated emerged as constructs regarding aspects that helped the therapist be more empathic, present, and less anxious. The therapist thought back to others' comments about his effectiveness as a therapist and his overall ability to connect well with others. He also engaged in positive self-talk statements, which he believed helped him when working with his client. These constructs, especially with regards to clinical supervisors, highlight the importance of giving therapist trainees positive feedback and building their self-confidence. Early in training when supervisees are prone to making many mistakes and supervisors might be prone to being especially critical, it is perhaps more important that supervisors increase the therapist's self-confidence by pointing out the effective parts of his/her work with clients. This idea of offering positive reinforcement and support is supported by supervision research (Ronnestad & Skovholt, 1993). For more advanced therapists, it might be useful to spend some time and energy reflecting on the good work he/she has done with clients along with some positive feedback he/she has received. This notion that the therapist's self-confidence and sense of feeling validated is important is further supported by the therapist's description of aspects that inhibited him from being empathic, present, and relaxed. Having low self-confidence and being discouraged in

himself emerged as constructs that inhibited him from being empathic, present, and relaxed.

### *Research Implications*

The primary focus of most psychotherapy research is on aspects of therapy that lie outside of the person of the therapist. Recently, empirically supported treatment (EST) research has been at the forefront of psychotherapy research due to instigation from insurance companies as well as from pressure to compete with the medical profession, among other factors (Soldz & McCullough, 2000). The field has benefited greatly from this research, but not without costs. In EST research, the person of the psychotherapist, as an integral part of the change process, is ignored (Norcross, 2002). Through his extensive research, reviews, and meta-analyses, Wampold (2001) found evidence that supports the fact that there are clear therapist effects on client outcome and these effects are greater than effects due to specific techniques. We know that the qualities of the therapist matter in therapy and yet training is mainly devoted to helping trainees develop theoretical orientations and technical proficiency rather than the qualities that relate more strongly to outcome (Vakoch & Strupp, 2000). Broadly speaking, the findings from this case study further support the notion that the therapist and the therapist's attributes matter. The qualities that the therapist embodies are related to how both the therapist and the client view therapy and the progression of therapy. Research that focuses on the characteristics of the therapist is warranted in that it affects the client's experience of the therapist, of therapy, and the progression of therapy.

More specifically, research that focuses on the therapist's use of mindfulness and its impact on therapy variables is necessary. The findings of this study that the more

mindful the therapist was, the more present, empathic, and calm he was and the more session progress was made, indicates the need for a larger study with more participants to explore the generalizability of these findings. Future researchers in this area might want to consider exploring when therapists practice mindfulness and the effect it has on therapy. Is there a recency effect in practicing it directly before session or does regular mindfulness practice influence therapists' client sessions regardless of the time it's practiced? Additionally, how does mindfulness affect different therapy variables? Is it in the therapist's sharpened awareness of self through practicing mindfulness that leads to a more empathic, present, less anxious therapist? Is it the byproduct of calmness that the practice of mindfulness often has that is related to these other qualities? Is one of the ways mindfulness improves therapy through presence as a mediating variable?

Presence emerged as an important factor as well. We know very little about the effect that balanced attention toward oneself and another has in the context of therapy. The results from this case study indicate mindfulness practices might be one avenue through which the ability to be present improves. Future research might investigate the cultivation of this ability and its relationship to other aspects of the therapist such as attunement and countertransference management. Additionally, future research could investigate the relationship between presence and aspects of therapy, such as the quality of the alliance, and therapy outcomes, such as client symptomatology and interpersonal functioning.

### *Theoretical Implications*

The results from this investigation orient the psychotherapy research community and therapists towards the person of the therapist and towards themselves, respectively,

as an instrument of change for clients. Through therapy training, therapists might have come to know their likes and dislikes, theoretical leanings, the techniques used in a given session, and major countertransference triggers, but it is argued here, that therapists, like most humans, know very little about their physical, emotional, and intellectual states at any given moment. With conviction therapists might believe that they do not have reactions to a particular client's presenting problem. Or at best therapists might have the awareness that the client discussing her strained relationship with her mother activates unresolved issues with their mother. But the more mindful and present therapists become, the more of themselves they are able see and use in relation to others, namely clients (Geller & Greenberg (2002). Therapists might be more aware of the way in which their body shifts slightly when the client expresses anger or that they feel tension in their chests when the client looks as though she might cry. Therapists might more observantly notice how they direct the client in conversation towards areas of her life that are intrinsically more interesting to them. They might be able to catch the experience of judgment as it rises up physically before it's pushed away. They might catch themselves tapping their foot slightly to keep awake during session. Through the practice of mindfulness the opportunity for deeper self-knowledge and self-compassion emerges (Germer, 2005). And in being present, therapists might come to know both their clients and themselves in relation to clients in new ways, which ultimately may improve the client's experience and functioning.

It might be useful to discuss the ways in which mindfulness and presence are related and different. In brief, one can be mindful without being present as when by oneself, whereas one cannot be present without being mindful as well. Mindfulness is an

intrapersonal process of awareness where all one's experiences are observed without judgment or attachment. An individual practicing mindfulness hears the car horn and "sees" herself hearing the car horn where the emphasis of attention is on the car horn and the hearing of the car horn. Presence takes mindfulness and then brings it into the realm of interpersonal relating. The individual now must be aware of herself, while also being aware of and listening to, with all her senses, the other person. The person aims towards being aware of her intrapersonal processes and grounding herself here, while tuning into the other's experience. Presence is intra and interpersonal whereas mindfulness is intrapersonal. Geller's (2001) measure of presence supports this self and other attention in the original subscales of the measure. These are Inwardly Attending, and Grounding for items that involve one's inner attention, and Being With and For the Client and Extending and Contact that involve attention towards the client.

Therapist presence is also reminiscent of Sullivan's (1970) description of the therapist as a participant observer. He writes, "The fact is that we cannot make any sense of, for example, the motor movements of another person except on the basis of behavior that is meaningful to us" (p. 19). He describes the importance that the therapist "listen to all statements with a certain critical interest, asking, 'Could that mean anything except what first occurs to me?'" (p. 20). All data received by one person from another is filtered through the receiver's individual perception colored by everything from her past. This being the case, the therapist in her role as helper, is benefited by a hesitancy to assume she knows what the other means, and her awareness of herself and her inner process as the client is communicating. Sullivan says, "the psychiatrist has an inescapable, inextricable involvement in all that goes on in the interview; and to the extent that he is

unconscious or unwitting of his participation in the interview, to that extent he does not know what is happening” (p. 18). Sullivan encourages the therapist to participate fully while in the therapy encounter with the client, while also observing herself during the encounter. This creates a space that gives the therapist enough space to resist falsely believing she knows what the client means and then relating to the client based on her false understanding. She can resist the trap of thinking she knows. The therapist as participant observer can be aware of herself as she reacts, responds, and makes interventions so that she is not functioning automatically. She can have intentionality and the ability to see more angles than being merely a participant allows. This awareness and attunement of self and other relates to therapist presence.

There is another way in which this case study could shape future theoretical developments in that the therapist’s body is brought into the arena. Mindfulness and presence include a deeper awareness of the therapist’s entire self, including the body. Psychotherapy theories and research that focuses on the therapist commonly exclude the therapist’s body as an avenue of knowing. The therapist’s thought and emotional processes are central, but the body and the experiences and reactions that occur in the therapist’s body are all but completely neglected. Gendlin (1982; 1996) has been the exception in his research and writing, which detail how to use one’s own body as an avenue for self-knowledge, self-healing, and connecting with others. His terms, felt sense and focusing, are examples of his contributions to this field of body awareness and psychotherapy. He explains how much of what a person knows has never been consciously thought and verbalized. Felt sense is the name he gave to the unclear preverbal sense of 'something', as that something is experienced in the body. It is not the

same as an emotion. This bodily felt 'something' may be of a situation or of something that is 'coming' like an idea or the line of a poem. The focusing process makes a felt sense more tangible and easier to work with (Gendlin, 1982).

What emerged in a number of different ways from the quantitative and qualitative data is the importance of the therapist's attention turned inward in preparation for session and a balance between inward and outward attending when with a client. However, it's not merely attention; it's the way the therapist attends that is essential. Attention that is observational in nature and accepting of whatever might pass through the individual's awareness is key. In terms of training, it is proposed that therapists and trainees could enhance the quality of their interactions with clients two ways. The first is through practicing non-judgmental awareness and observation of themselves and their experiences. This can be practiced through mindfulness meditation and/or mindful eating, drinking, walking, and living. Along with increasing their regular use of mindfulness techniques therapists engage in a balanced attention and awareness of themselves and their clients through non-judgmentally observing their changing experience while attending to and listening deeply to the client during session.

### *Limitations*

Measuring therapist mindfulness during a therapy session is a challenge. Mindfulness measurements generally ask respondents to answer questions about how they typically experience themselves along the continuum of mindfulness (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). The few instruments available that measure mindfulness as a state have been used with individuals who have just finished meditating or, for the control group, sitting quietly by themselves. Therapy involves a complex,

intimate encounter with another individual where there is a strong interpersonal component to the activity. In this study, the TMS was used as it appears to be the most easily translatable measure to the context of therapy. Although, it is a measure designed for individuals who have just meditated and was validated in the context of meditators. While the TMS is the nearest fit for a measure in the context of therapists, it might not be ideal. Perhaps a measure of mindfulness particularly designed for therapists is warranted, where validation can occur on the therapist population.

Another consideration involves the measurement of session progress and how this might be influenced by the level of experience the therapist has had doing psychotherapy. In this study, the therapist was in a doctoral training program and it is plausible that his rating of session progress, especially early in therapy, would be different from an experienced therapist's rating of session progress at the same point in time due to the degree of tolerance each has with regards to how much progress is being made in session. By nature, less experienced therapists have less familiarity with the process and pace of psychotherapy, which lead to attempts to "fix" the client quickly. They might experience less patience and tolerance with the sometimes ambiguous and non-linear nature of psychotherapy. Because this may be the case, more credence might be given to the client's perception of session progress.

There are possibly other important differences between more and less experienced therapists with regards to ratings of variables. There might be a difference between how a therapist in training and a more experienced therapist rate themselves on presence and mindfulness with regards to their experience of themselves in a given session. It could be that less experienced therapists have higher expectations of how they should perform as a



therapist and when they fall short of that, they may be more prone to self criticism and judgment. We also know that therapists in training tend to have higher anxiety, (Al-Darmaki, 2004) which, as this study shows, is related to being less mindful and present.

It is possible that the Hawthorne effect influenced the client and therapist and, therefore, the results of this study. Both participants agreed to participate in the study through filling questionnaires out and, for the therapist, by engaging in an interview after each session. The knowledge that they were part of a study may have influenced their positive ratings on the different measures over time. Future studies may avoid this confound by including a control group where by comparing the effects of interviewing and filling out measures to a condition where neither of these conditions was present.

Case study research inherently has low generalizability. The results of this study are first steps towards investigating the role mindfulness plays in therapists' work, particularly during therapists' training. The results of this study also shed new light on the importance of a relatively unknown construct, presence. While presence emerged as playing an important role in therapy for this case, these results are initial steps towards investigating its relationship to other aspects of the therapist and therapy.

An original hypothesis of this study was that therapist mindfulness would be related to client symptomatology. Although the finding was that therapist mindfulness is inversely related to client improvement as measured by the OQ-45, after further consideration, the researcher determined the way in which this hypothesis was tested was flawed due to when both variables were measured. The OQ-45 assessed client symptoms before each session and therapist mindfulness was assessed after each session. In retrospect, it seems tenuous to assume that there would be a relationship between

therapist mindfulness in a session and reduction in client symptoms from that session to the next, typically one week later. The time lag between OQ-45 measurements was probably too great to demonstrate an effect for therapist mindfulness.

Although the relationship between client symptomatology and therapist mindfulness was not addressed in this study, there are likely other methods of investigating the question that could more adequately address the hypothesis. A more adequate method in addressing the possible relationship between therapist mindfulness and client symptomatology would be to measure client symptoms everyday or a day or two after the therapy session. In this case, the OQ-45 could still be used as a measure of client symptomatology. This method of measuring client symptoms daily or closer to the time of the therapy session where the therapist's mindfulness is measured allows for the possibility of a relationship between the two variables to emerge.

When looking at correlations and effect sizes, it is important to take into consideration a monosource bias for some of them. For instance, the therapist's perception of session progress was strongly related to his perception of his presence; the correlation was .95. This extremely high correlation calls into question the distinction the therapist made in rating these two variables. The correlation between therapist self-rating of mindfulness and presence was .82 indicating that he may have been generalizing his assessment of himself among variables.

Similarly, during the qualitative interviews, there was a tendency to have overlapping categories that explained the contributing factors. While it could be that these constructs are related and benefit from similar session preparation and in-session awareness, it may also be that the therapist was generalizing his experience. He may have

been unable to distinguish how what he did helped him differently towards being more empathic, present, and relaxed during his work with the client.

Limitations notwithstanding, this study shows some of the important ways the person of the therapist matters in psychotherapy. Perhaps most importantly, this study shows how mindfulness could enhance therapists' presence and empathy, while reducing their anxiety during sessions with clients and improving the progression of therapy. Through this ancient practice of effortful attention turned inward, therapists may access themselves in newer and deeper ways and in turn be more effective in their highly complex, relational role as psychotherapist.

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**Appendix A**  
**Toronto Mindfulness Scale**

We are interested in what you just experienced. Below is a list of things that people sometimes experience. Please read each statement. Indicate the extent to which you agree with each statement by writing in the number that corresponds to your experience. In other words, how well does the statement describe what you just experienced, just now?

- 0: Not at all
- 1: A little
- 2: Moderately
- 3: Quite a bit
- 4: Very much

- \_\_\_ 1. I experienced myself as separate from my changing thoughts and feelings.
- \_\_\_ 2. I was more concerned with being open to my experiences than controlling or changing them.
- \_\_\_ 3. I was curious about what I might learn about myself by taking notice of how I react to certain thoughts, feelings or sensations.
- \_\_\_ 4. I experienced my thoughts more as events in my mind than as a necessarily accurate reflection of the way things 'really' are.
- \_\_\_ 5. I was curious to see what my mind was up to from moment to moment.
- \_\_\_ 6. I was curious about each of the thoughts and feelings that I was having.
- \_\_\_ 7. I was receptive to observing unpleasant thoughts and feelings without interfering with them.
- \_\_\_ 8. I was more invested in just watching my experiences as they arose, than in figuring out what they could mean.
- \_\_\_ 9. I approached each experience by trying to accept it, no matter whether it was pleasant or unpleasant.
- \_\_\_ 10. I remained curious about the nature of each experience as it arose.
- \_\_\_ 11. I was aware of my thoughts and feelings without overidentifying with them.
- \_\_\_ 12. I was curious about my reactions to things.
- \_\_\_ 13. I was curious about what I might learn about myself by just taking notice of what my attention gets drawn to.



## Appendix B Therapist Presence Inventory

Take a moment to reflect on your experience of today's session and then answer the following questions.

Please rate your **PREDOMINANT** experience during THIS session. Mark each statement in the left margin with the number that corresponds to how true or untrue you feel the statement is about your experience in the previous session.

- 1: Not at all
- 2: Very Little
- 3: A Little
- 4: Moderately
- 5: A Lot
- 6: Quite A Lot
- 7: Completely

- \_\_\_ 1. I was aware of my internal flow of experiencing.
- \_\_\_ 2. I felt tired or bored.
- \_\_\_ 3. I found it difficult to listen to my client.
- \_\_\_ 4. The interaction between my client and me felt flowing and rhythmic.
- \_\_\_ 5. Time seemed to really drag.
- \_\_\_ 6. I found it difficult to concentrate.
- \_\_\_ 7. There were moments when I was so immersed with my client's experience that I lost a sense of space and time.
- \_\_\_ 8. I was able to put aside my own demands and worries to be with my client.
- \_\_\_ 9. I felt distant or disconnected from my client.
- \_\_\_ 10. I felt a sense of deep appreciation and respect for my client as a person.
- \_\_\_ 11. I felt alert and attuned to the nuances and subtleties of my client's experience.
- \_\_\_ 12. I was fully in the moment in this session.
- \_\_\_ 13. I felt impatient or critical.
- \_\_\_ 14. My responses were guided by the feelings, words, images, or intuitions, that

emerged in me from my experience of being with my client.

- 15. I couldn't wait for the session to be over.
- 16. There were moments when my outward response to my client was different from the way I felt inside.
- 17. I felt fully immersed with my experience and yet still centered within myself.
- 18. My thoughts sometimes seemed to drift away from what was happening in the moment.
- 19. I felt a synchronicity with my client in such a way that allowed me to sense what he/she was experiencing.
- 20. I felt genuinely interested in my client's experience.
- 21. I felt a distance or emotional barrier between my client and myself.

## Appendix C Therapist Presence Inventory-Client

Take a moment to reflect on your experience of being with your therapist during today's session and then answer the following questions.

Please rate your **PREDOMINANT** experience during THIS session. Mark each statement in the left margin with the number that corresponds to how true or untrue you feel the statement is about your therapist in the previous session.

- 1: Not at all
- 2: Very Little
- 3: A Little
- 4: Moderately
- 5: A Lot
- 6: Quite A Lot
- 7: Completely

- \_\_\_ 1. My therapist seemed to be aware of his/her internal flow of experiencing.
- \_\_\_ 2. My therapist seemed tired or bored.
- \_\_\_ 3. My therapist seemed to have difficulty listening to me.
- \_\_\_ 4. The interaction between my therapist and me felt flowing and rhythmic.
- \_\_\_ 5. My therapist seemed to have difficulty concentrating.
- \_\_\_ 6. My therapist seemed to be able to put aside his/her own demands and worries to be with me.
- \_\_\_ 7. My therapist seemed to feel distant or disconnected from me.
- \_\_\_ 8. My therapist seemed to feel a sense of deep appreciation and respect for me as a person.
- \_\_\_ 9. My therapist seemed to feel alert and attuned to the nuances and subtleties of my experience.
- \_\_\_ 10. My therapist seemed to be fully in the moment in this session.
- \_\_\_ 11. My therapist seemed to feel impatient or critical.
- \_\_\_ 12. It seemed that my therapist couldn't wait for the session to be over.

- \_\_\_ 13. There were moments when it seemed that my therapist's outward response to me was different from the way he/she felt inside.
- \_\_\_ 14. My therapist seemed to feel fully immersed with my experience and yet still centered within him/herself.
- \_\_\_ 15. My therapist's thoughts seemed to drift away from what was happening in the moment.
- \_\_\_ 16. My therapist seemed to feel a synchronicity with me in such a way that it seemed to allow him/her to sense what I was experiencing.
- \_\_\_ 17. My therapist seemed genuinely interested in my experience.
- \_\_\_ 18. My therapist seemed to feel a distance or emotional barrier between us.

## Appendix D Barrett-Lennard Relationship Inventory

Listed below are a variety of ways that one person may feel or behave in relation to another person. Please consider each statement with reference to your present relationship with your counselor. Mark each statement in the left margin according to how strongly you feel that it is true, or not true, in this relationship. Please mark each item. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

- +3: Yes, I strongly feel that it is true.
- +2: Yes, I feel it is true.
- +1: Yes, I feel that it is probably true, or more true than untrue.
- 1: No, I feel that it is probably untrue, or more untrue than true.
- 2: No, I feel it is not true.
- 3: No, I strongly feel that it is not true.

- \_\_\_ 1. My counselor usually senses or realizes what I am feeling.
- \_\_\_ 2. My counselor reacts to my words but does not see the way I feel.
- \_\_\_ 3. My counselor nearly always sees exactly what I mean.
- \_\_\_ 4. My counselor's own attitude toward things I do or say gets in the way of understanding me.
- \_\_\_ 5. My counselor realizes what I mean even when I have difficulty in saying it.
- \_\_\_ 6. My counselor usually understands the whole of what I mean.
- \_\_\_ 7. My counselor does not understand me.
- \_\_\_ 8. My counselor appreciates exactly how the things I experience feel to me.
- \_\_\_ 9. My counselor's response to me is so fixed and automatic that I don't get through to him/her.
- \_\_\_ 10. My counselor doesn't listen and pick up on what I think and feel.

## Appendix E State Anxiety Inventory

Directions: A number of statements which people have used to describe themselves are given below. Read each statement and then indicate with the appropriate number how you felt while in the previous session with your client. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings best.

- 1: Not at all
- 2: Somewhat
- 3: Moderately so
- 4: Very much so

- \_\_\_ 1. I felt calm.
- \_\_\_ 2. I felt secure.
- \_\_\_ 3. I felt tense.
- \_\_\_ 4. I was regretful.
- \_\_\_ 5. I felt at ease.
- \_\_\_ 6. I felt upset.
- \_\_\_ 7. I was worrying over possible misfortunes.
- \_\_\_ 8. I felt rested.
- \_\_\_ 9. I felt anxious.
- \_\_\_ 10. I felt comfortable.
- \_\_\_ 11. I felt self confident.
- \_\_\_ 12. I felt nervous.
- \_\_\_ 13. I was jittery.
- \_\_\_ 14. I felt "high strung."
- \_\_\_ 15. I was relaxed.
- \_\_\_ 16. I felt content.
- \_\_\_ 17. I was worried.

\_\_\_ 18. I felt over-excited and “rattled.”

\_\_\_ 19. I felt joyful.

\_\_\_ 20. I felt pleasant.

**Appendix F**  
**Session Progress Scale-Client Form**

**1. How do you feel about the session which you have just completed?  
(circle the one answer which best applies.)**

THIS SESSION WAS:

1. Perfect
2. Excellent
3. Very good
4. Pretty good
5. Fair
6. Pretty poor
7. Very poor

**2. How much progress do you feel you made in dealing with your problems this session?**

1. A great deal of progress
2. Considerable progress
3. Moderate progress
4. Some progress
5. Didn't get anywhere this session
6. In some ways my problems seem to have gotten worse this session



**3. How well do you feel that you are getting along, emotionally and psychologically, at this time?**

I AM GETTING ALONG:

1. Very well; much the way I would like to.
2. Quite well; no important complaints
3. Fairly well; have my ups and downs.
4. So-so; manage to keep going with some effort
5. Fairly poor; life gets pretty tough for me at times.
6. Quite poorly; can barely manage to deal with things

**4. How helpful do you feel your therapist was to you this session?**

1. Completely helpful
2. Very helpful
3. Pretty helpful
4. Somewhat helpful
5. Slightly helpful
6. Not at all helpful

**Appendix G**  
**Session Progress Scale-Therapist Form**

**1. How do you feel about the session which you have just completed?  
(circle the one answer which best applies.)**

THIS SESSION WAS:

1. Perfect
2. Excellent
3. Very good
4. Pretty good
5. Fair
6. Pretty poor
7. Very poor

**2. How much progress do you feel your client made in dealing with his/her problems  
this session?**

1. A great deal of progress
2. Considerable progress
3. Moderate progress
4. Some progress
5. Didn't get anywhere this session
6. In some ways his/her problems seem to have gotten worse this session

**3. How well do you feel that your client is getting along, emotionally and psychologically, at this time?**

HE / SHE GETTING ALONG:

1. Very well; much the way he/she would like to.
2. Quite well; no important complaints.
3. Fairly well; he/she has ups and downs.
4. So-so; manages to keep going with some effort
5. Fairly poor; life gets pretty tough for him/her at times.
6. Quite poorly; can barely manage to deal with things

**4. How helpful do you feel you were to your client this session?**

1. Completely helpful
2. Very helpful
3. Pretty helpful
4. Somewhat helpful
5. Slightly helpful
6. Not at all helpful

## Appendix H Outcome Questionnaire-45

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Session # \_\_\_\_\_ Date \_\_\_\_\_

- |  |        |           |            |               |
|--|--------|-----------|------------|---------------|
| 1. I get along well with others.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 2. I tire quickly.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 3. I feel no interest in things.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 4. I feel stressed at work/school.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 5. I blame myself for things.  |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 6. I feel irritated.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 7. I feel unhappy in my marriage/significant relationship.   |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 8. I have thoughts of ending my life.  |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 9. I feel weak.  |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 10. I feel fearful.  |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 11. After heavy drinking, I need a drink the next morning to get going. (if you do not drink, mark "never"). |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |
| 12. I find my work/school satisfying.  |        |           |            |               |
| Never  | Rarely | Sometimes | Frequently | Almost Always |

13. I am a happy person.				
Never	Rarely	Sometimes	Frequently	Almost Always
14. I work/study too much.				
Never	Rarely	Sometimes	Frequently	Almost Always
15. I feel worthless.				
Never	Rarely	Sometimes	Frequently	Almost Always
16. I am concerned about family troubles.				
Never	Rarely	Sometimes	Frequently	Almost Always
17. I have an unfulfilling sex life.				
Never	Rarely	Sometimes	Frequently	Almost Always
18. I feel lonely.				
Never	Rarely	Sometimes	Frequently	Almost Always
19. I have frequent arguments.				
Never	Rarely	Sometimes	Frequently	Almost Always
20. I feel loved and wanted.				
Never	Rarely	Sometimes	Frequently	Almost Always
21. I enjoy my spare time.				
Never	Rarely	Sometimes	Frequently	Almost Always
22. I have difficulty concentrating.				
Never	Rarely	Sometimes	Frequently	Almost Always
23. I feel hopeless about the future.				
Never	Rarely	Sometimes	Frequently	Almost Always
24. I like myself.				
Never	Rarely	Sometimes	Frequently	Almost Always
25. Disturbing thoughts come into my mind that I cannot get rid of.				
Never	Rarely	Sometimes	Frequently	Almost Always
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never").				
Never	Rarely	Sometimes	Frequently	Almost Always
27. I have an upset stomach.				
Never	Rarely	Sometimes	Frequently	Almost Always

28. I am not working/studying as well as I used to.  
Never Rarely Sometimes Frequently Almost Always
29. My heart pounds too much.  
Never Rarely Sometimes Frequently Almost Always
30. I have trouble getting along with friends and close acquaintances.  
Never Rarely Sometimes Frequently Almost Always
31. I am satisfied with my life.  
Never Rarely Sometimes Frequently Almost Always
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never").  
Never Rarely Sometimes Frequently Almost Always
33. I feel that something bad is going to happen.  
Never Rarely Sometimes Frequently Almost Always
34. I have sore muscles.  
Never Rarely Sometimes Frequently Almost Always
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.  
Never Rarely Sometimes Frequently Almost Always
36. I feel nervous.  
Never Rarely Sometimes Frequently Almost Always
37. I feel my love relationships are full and complete.  
Never Rarely Sometimes Frequently Almost Always
38. I feel that I am not doing well at work/school.  
Never Rarely Sometimes Frequently Almost Always
39. I have too many disagreements at work/school.  
Never Rarely Sometimes Frequently Almost Always
40. I feel something is wrong with my mind.  
Never Rarely Sometimes Frequently Almost Always
41. I have trouble falling asleep or staying asleep.  
Never Rarely Sometimes Frequently Almost Always
42. I feel blue.  
Never Rarely Sometimes Frequently Almost Always

43. I am satisfied with my relationships with others.  
Never      Rarely      Sometimes      Frequently      Almost Always

44. I feel angry enough at work/school to do something I Might regret.  
Never      Rarely      Sometimes      Frequently      Almost Always

45. I have headaches.  
Never      Rarely      Sometimes      Frequently      Almost Always

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The University of Pennsylvania, Philadelphia, PA 2003

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The Pennsylvania State University, University Park, PA 2001

#### **PROFESSIONAL POSITIONS**

**Pre-doctoral Intern**, Counseling and Psychological Services (CAPS) 2008-09

The Pennsylvania State University, University Park, PA

- Provide individual, couples, crisis, brief, and group psychotherapy along with initial consultations to undergraduate and graduate students.
- Supervise advanced doctoral students in psychotherapy.
- Participate in outreach and research.
- Conduct psychological assessments.

#### **TRAINING & EXPERIENCES**

##### **Practicum Experiences**

Counseling and Psychological Services (CAPS), Practicum Counselor

The Pennsylvania State University, Fall 2006-Spring 2007

MBNA Career Services, Practicum Counselor

The Pennsylvania State University, Spring 2006

CEDAR Clinic, Practicum Counselor

The Pennsylvania State University, Fall 2005

School Social Work/Counseling Intern

Powell Elementary School

West Philadelphia, PA August 2002-May 2003

Medical Social Work Intern

Department of Liver Transplant at the Hospital of the University of Pennsylvania  
Philadelphia, PA August 2001-May 2002

#### **RELATED POSITIONS**

Co-instructor for undergraduate class on counseling theories and skills (CNPSY 403)

The Pennsylvania State University, Summer 2006/Spring 2007

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#### **AWARDS & HONORS**

University Fellowship, 2005 – 2007

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Dean's Scholarship Award, 2001-2003

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