THE IMPACT OF MINDFULNESS TRAINING ON THERAPEUTIC ALLIANCE, EMPATHY, AND LIVED EXPERIENCE: A MIXED METHODS STUDY WITH COUNSELOR TRAINEES

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Proponents of mindfulness practices suggest that this method provides counselors a means to cultivate therapeutic relationship skills and improve client outcomes. While some research affirms this hypothesis, other investigations report mixed results. To date no studies include a mindfulness training program with counselor trainees that examine therapeutic alliance via quantitative and qualitative outcomes.

The purpose of this study was to explore the impact of a 6 week mindfulness training program with counselor trainees (n = 9) engaged in clinical practice. Examined concepts included (a) counselor and client therapeutic alliance, (b) counselor mindfulness and empathy, and (c) counselor experiences of learning mindfulness practices.

Participants were master's level counseling students enrolled in a CACREP accredited program. The trainees were volunteers registered in practicum or internship courses gaining clinical experience at the counseling program's training clinic.

A mixed methods design was implemented whereby quantitative (multiple baseline and pre-post) data and qualitative (phenomenological) data were collected concurrently, analyzed independently, and compared. Quantitative data were collected to explore changes in counselor and client therapeutic alliance scores over 16 weeks as well as counselor empathy and mindfulness levels pre- and post-training. Qualitative data were gleaned from participants' lived experiences as they learned mindfulness practices.

Quantitative results included statistically significant improvements in counselor trainee mindfulness, empathy, and therapeutic alliance scores. No significant change in client alliance scores was recorded but counselor trainee alliance scores became more aligned with client scores over time. Qualitative findings included participants' reports

that mindfulness effectively enhanced their lives in physical, affective, cognitive, and behavioral domains.

Implications from this study support the notion that mindfulness training is a useful method for counselor education. A mindfulness training program can be utilized to enhance multiple dimensions of counselor trainees' personal and professional lives. With respect to professional development, this research suggests that mindfulness training is an effective method to improve counselor trainees' therapeutic relationship skills and facilitate attunement with clients.

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Chapter 1

Introduction

The relationship between counselor and client is consistently considered a *common factor* in the facilitation of positive client outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Lambert, 1992; Martin, Garske, & Davis, 2000). Operationalized as the therapeutic or working alliance (Horvath & Greenburg, 1989), this relationship is broadly described as the "collaborative and affective bond" between counselor and client (Martin et al., 2000; p. 438). According to several meta-analyses, therapeutic alliance contributes significantly to therapeutic outcome, second only to client factors (Horvath & Barley, 2001; Horvath & Symonds, 1991; Lambert, 1992; Martin et al., 2000). These findings initiated a scientific inquiry into counselor factors or qualities that facilitate the development of the therapeutic alliance (Fulton, 2005; Hick, 2008; Martin, 1997; Shapiro & Carlson, 2008).

In a review of multiple studies, Lambert and Ogles (2004) found that therapeutic relationship factors consistently correlated more highly with client outcome than specific therapy techniques; certain counselor characteristics were associated with a strong working alliance. Effective therapists were consistently identified as more understanding, accepting, empathetic, warm, and supportive. Furthermore, therapists who developed constructive therapeutic relationships were less likely to blame, ignore, neglect, reject, or push a technique-based agenda on resistant clients.

Based on its empirical significance, counselor training programs should consider focusing on the therapeutic alliance (Fulton, 2005). However, traditional training for mental health practitioners involves gaining a knowledge base and a set of techniques

while less focus is placed on fostering an attitude or therapeutic stance that might facilitate the therapeutic relationship and therapeutic outcome (Bien, 2008; Fulton, 2005, Twemlow, 2001a). Typically, students are taught the various components of effective therapy as separate, manageable skills such as: restatements, open-questions, tone of voice, reflection, validation, disclosure, confrontation, etc. (Bien, 2008; Ivey, 1998; Ivey & Ivey, 2010). Assessing visible and measurable techniques is an effective and traditional training practice because it makes the complex process of counseling more amenable to teach as well as learn. Yet, given the importance of the relationship between the counselor and client, it might also be useful to teach the type of personal qualities (Fulton, 2005), attitude (Bien, 2008), and "attributes of mind" (Twemlow, 2001a, p. 1) that facilitate the therapeutic alliance (Horvath et al., 2011; Lambert & Barley, 2001). Mindfulness practices have been proposed to cultivate these counselor qualities that facilitate the therapeutic relationship (Martin, 1997; Hick, 2008; Shapiro & Carlson, 2009)

Mindfulness Interventions in the Helping Professions

Mindfulness instruction for counselors in training (CITs) can be utilized to develop counselor characteristics that enhance the therapeutic relationship (Fulton, 2005; Hick, 2008; Shapiro & Carlson, 2009; Stauffer, 2008; Twemlow, 2001a). Mindfulness can be described as a non-judgmental, present-centered awareness in which each thought, feeling, or sensation that occurs in the current moment is acknowledged and accepted as it is (Kabat-Zinn, 1990; Shapiro, Schwartz, & Bonner, 1998; Segal, Williams, & Teasdale, 2002). Mindfulness has been integrated into psychodynamic (Safran & Reading, 2008), cognitive and behavioral (Hayes, Strosahl, & Wilson, 1999; Roemer &

Orsillo, 2008), humanistic (Andersen, 2005), attachment-based (Wallin, 2007), and positive psychology frameworks (Hamilton, Kitzman, & Guyotte, 2006).

Mindfulness-based counseling interventions have also shown to be effective with specific conditions such as chronic pain (Kabat-Zinn, 1990), stress (Shapiro et al., 1998), anxiety disorders (Kabat-Zinn et al., 1992), depressive relapse (Segal et al., 2002; Teasdale et al., 2000), disordered eating (Kristeller & Hallett, 1999), cancer (Monti et al., 2006; Carlson, Ursuliak, Goodey, Angen, & Speca, 2001), and suicidal behavior (Linehan, Armstrong, Suarez, Allman, & Heard, 1991; Williams, Duggan, Crane, & Fennell, 2006). According to Aggs and Bambling (2010), the mindfulness based approaches most prevalent in the literature seem to be mindfulness based stress reduction (MBSR; Kabat-Zinn, 1982, 1990), mindfulness based cognitive therapy (MBCT; Segal et al., 2002), dialectical behavior therapy (DBT; Linehan, 1993), and acceptance and commitment therapy (ACT; Hayes et al., 1999). MBSR, in particular, has been utilized with over 15,000 patients and there are over 250 MBSR programs in clinics and hospitals internationally (Davidson & Kabat-Zinn, 2004).

In addition to its use as a clinical intervention, mindfulness based approaches have been employed to improve well-being and effective practice of mental health practitioners (May & O'Donovan, 2007). Mindfulness practices have been reported to improve practitioner empathy (Aiken, 2006; Lesh, 1970; Shapiro et al., 1998; Wang, 2007), self-compassion (Shapiro, Astin, Bishop & Cordova, 2005; Shapiro, Brown, & Beigel, 2007), self-efficacy (Bentley Greason & Cashwell, 2009), patience, and intentionality (Rothaupt & Morgan, 2007).

With regard to CITs, mindfulness practices have been shown to help trainees develop skills that impact their effectiveness as therapists. In a recent series of studies, mindfulness training for CITs improved their attentiveness to the therapeutic process, comfort with silence, and attunement (focused attention and clear perception) with themselves and clients (Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008) as well as self-awareness, insight into professional identity (Birnbaum, 2008), presence (McCollum & Gehart, 2010), emotional intelligence (Cohen & Miller, 2008), and overall wellness (Ryback & Russell-Chapin, 1998). These studies illustrate the potential for using mindfulness based approaches with CITs in an effort to enhance therapeutic relationship development and ultimately improve client outcome.

Statement of the Problem

Despite promising findings that mindfulness interventions have a positive effect on facets of the working alliance, CIT mindfulness training to improve the working alliance with clients has not been fully explored. Methods to develop therapeutic alliance aptitude in CITs are warranted (Hick, 2008). Scholars have argued for the benefits of mindfulness meditation that can enhance components of the therapeutic alliance such as the cultivation of attention, compassion, empathy, therapeutic presence, attunement, and a broader perspective of coping with suffering (Chung, 1990; Fulton, 2005; Henley, 1994; Martin, 1997, Thompson, 2000; Twemlow, 2001b; Siegel, 2010). Mindfulness training has shown promise for enhancing therapeutic alliance skills in CIT preparation based on the perception of CITs (Christopher & Maris, 2010; McCollum & Gehart, 2009). The problem under investigation is the lack of research that examines the

therapeutic value of mindfulness training for CITs from the perspective of both the CIT and the client (Hick, 2008; Fulton, 2005; McCollum & Gehart, 2010).

Purpose of the Study

The purpose of this study was to examine the effects of a mindfulness training program (MTP) on the establishment of therapeutic alliance among master's level CITs and their clients. A structured mindfulness intervention was also expected to have an impact on CIT's level of mindfulness and empathy. Existing research on mindfulness interventions with CITs has predominantly focused on a single research methodology (qualitative). This project affords the consideration of combining the benefits of multiple research approaches in an effort to complement previous research. This project was a mixed methods, convergent parallel design (Creswell & Plano Clark, 2011) study whereby quantitative and qualitative data were collected concurrently, analyzed independently, and compared. Including quantitative and qualitative elements within the study allowed the combined results to have an enriching context and depth. The quantitative portion of the study included a time-series and pre- and post-data collection method to evaluate the impact of the mindfulness training on therapeutic alliance, mindfulness, and empathy. Therapeutic alliance scores were collected over 14 weeks in a time-series format while empathy and mindfulness scores were collected pre- and post-training. A qualitative, phenomenological approach (Moustakas, 1994; van Manen, 2001) was used to explore the experiences of CITs as they learned and applied mindfulness practices to their personal and professional lives.

Treatment Protocol

The treatment for this study was the mindfulness training program (MTP) which was taught to CITs in a series of 6 weekly classes. The MTP was implemented by the principal researcher and the faculty advisor for the study.

The MTP consisted of two modules: (1) mindfulness for personal development, and (2) mindfulness for professional development. The curriculum included didactic, experiential, and discussion/reflection formats in each class as well as daily and weekly homework assignments. During the course of the intervention, CITs were asked to keep a daily log of mindfulness practice and a weekly journal about their experiences. Sessions 1 and 4 were 2.5 hour classes and introduced each of the modules. Sessions 2, 3, 5, and 6 were each 1 hour classes.

Module 1 (session 1-3) was built on a foundation of mindfulness concepts and experiential activities designed for personal growth. The context for Module 1 was primarily informed by MBSR (Kabat-Zinn, 1982; 1990; Stahl & Goldstein, 2010) as this method focuses on the development of an individual mindfulness practice and mindset. Having a foundation in mindfulness that begins with a personalized understanding and practice is essential before interpersonal mindfulness can be cultivated (Shapiro & Carlson, 2009; Siegel, 2010).

Module 2 (session 4-6) was based on therapeutic mindfulness literature that included concepts and activities specifically targeted toward practitioners in the helping professions with the intent of cultivating healing relationships (Fulton, 2008; Morgan & Morgan, 2005; Siegel, 2010; Shapiro & Izett, 2008; Surrey, 2005). This portion of the course allowed CITs to utilize their newfound mindfulness skills in a relational manner with others. The intent of this module was to help the participants expand their

awareness of and compassion for self to encompass these same qualities in their personal and professional relationships.

Sample and Setting

Participants (n = 9) were recruited from a master's level counseling training clinic in a university counseling program accredited by the Council for the Accreditation of Counseling and Related Programs (CACREP). The CITs were enrolled in one of three levels of training courses (practicum, internship 1, and advanced internship 2) gaining clinical experience at the program's Counseling and Training Clinic. A control group (n = 8) of CITs were also engaged in clinical training at the program clinic. They were not involved in the MTP yet, as part of their training experience, they and their clients reported therapeutic alliance data. This control group was used as a comparison group. The client sample (n = 50) included adult volunteers who were engaged in therapy with the CITs during the course of the study. University appointed practicum and internship teaching faculty (n = 5) were also recruited to participate. Faculty evaluated therapist-client session tapes and then provided their ratings of therapeutic alliance. The faculty also responded to an overall evaluation survey regarding the developmental level of their CIT with respect to counselor competencies.

Instrumentation

Assessment instruments for this study included both standardized and researcher generated measures. The four instruments were (a) The Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006), (b) The Interpersonal Reactivity Index (IRI; Davis, 1980, 1996), (c) the Session Rating Scale (SRS; Duncan et al., 2003), and (d) a researcher created mindfulness practice log. As part of their normative training

experience all participants (MTP group and control group) completed the SRS (Duncan et al., 2003) measure of therapeutic alliance. MTP participants completed the three additional measures.

Mindfulness Measures

Mindfulness was a significant component of this study. The Five Facet Mindfulness Questionnaire was used to measure CIT mindfulness (FFMQ; Baer et al., 2006). The FFMQ is a well validated measure of mindfulness that has been used successfully with a variety of populations and it has been determined to be effective for use in mindfulness training (Baer et al., 2008). The FFMQ defines mindfulness operationally according to five facets: (a) observing, (b) describing, (c) acting with awareness, (d) non-judging, and (e) non-reacting. Individual differences in mindfulness as well as responses to the MTP intervention were expected to be reflected in CIT scores on the FFMQ. The FFMQ was derived from a number of self-report mindfulness surveys thereby representing a collective understanding of what mindfulness is and how it should be defined and measured (Baer et al., 2006).

Empathy Measures

Empathy was another significant component of this study. The Interpersonal Reactivity Scale (IRI) was used to measure CIT empathy. Individual differences in empathy as well as responses to the MTP intervention were expected to be reflected in CIT scores on the interpersonal reactivity index (IRI; Davis, 1980, 1983). Additionally, the IRI was utilized in this study because it is one of the most widely implemented and comprehensive multidimensional measures of empathy (Cliffordson, 2002).

Therapeutic Alliance Measures

Therapeutic alliance was a key component of this study. It was expected that CITs' and clients' perceptions of the therapeutic alliance would be impacted by an MTP intervention with CITs. These perceptions of therapeutic alliance were reflected in CIT and client scores on the SRS version 3.0 (Duncan et al., 2003). The dependent variable, therapeutic alliance, was operationally defined as four interacting constructs: (a) a relational bond between the counselor and client, (b) agreement on the goals of therapy, (c) the client's view of the counselor's approach, and (d) the client's overall perception of the session (Duncan et al., 2003).

The Mindfulness Practice Log

Self-practice was an important part of developing mindfulness skills. Individual differences in mindfulness practice as well as responses to the MTP intervention were expected to be reflected in the mindfulness practice log. Entries in the log record the amount of time (minutes) and type of mindfulness practice each CIT engaged in for the week. This instrument was developed by the researcher and was informed by the formal practice log format from Stahl and Goldstein (2010).

Major Research Questions

The research questions for this study include:

1. What are the effects of an MTP on CITs', clients', and instructors' perceptions of the therapeutic alliance? It was hypothesized that the MTP participants would establish more satisfactory therapeutic alliances with their clients than a control group.

2. What are the effects of an MTP on CITs' level of mindfulness and empathy? It was hypothesized that the MTP group would increase mindfulness and empathy levels across training sessions.
3. How is CIT mindfulness practice related to outcome measures? It was hypothesized that CIT mindfulness practice would impact the outcome levels of therapeutic alliance, mindfulness, and empathy.
4. What are the experiences of CITs as they apply mindfulness to their personal and professional lives? The results of this question were hypothesized to be emergent and were revealed in the analysis of the CITs' written and verbal feedback.

Statistical analyses were comprised of a mixed-factor, pre-planned, multivariate analysis of variance consisting of a comparison of CIT groups' (participant and non-participant) dependent measures across time phases and in a pre-post format. In addition, single case methodology was used to explore changes within the MTP group across sessions with respect to the mindfulness practice log. A qualitative phenomenological approach was utilized to discover emergent themes. Finally, single-case profiles of the MTP group were presented for inspection of individual differences as well as group trends.

Significance of the Study

Therapist mindfulness has been suggested as a supportive and facilitative practice to enhance the therapeutic relationship (Germer, 2005; Martin, 1997; Shapiro & Carlson, 2009). Research examining the effects of mindfulness training on CITs has shown to improve many qualities that nurture the therapeutic alliance (Birnbaum, 2008; Cohen & Miller, 2008; McCollum & Gehart, 2010; Newsome et al., 2006; Ryback & Russell-

Chapin, 1998). Yet no published studies to date examine CIT mindfulness training and its impact on the therapeutic alliance specifically.

This study was significant because it provided information concerning the mediating effects of a mindfulness training program on CITs' and clients' perception of the therapeutic alliance. It was hypothesized that an MTP would increase counselor therapeutic alliance capabilities (e.g. empathy, relational skills, presence, openness, etc.). The results of this investigation offer counselor training programs an opportunity to consider the benefits of providing mindfulness training for their counseling students. Possible effects of implementation were anticipated as improvement in CITs' personal lives as well as their professional lives. Previous work cited above indicated that, with regard to personal factors, mindfulness training was expected to enhance CITs' self-care and self-compassion, stress management, and overall well-being. With regard to professional factors, mindfulness training was expected to improve CITs' level of mindfulness, level of empathy, level of therapeutic alliance as perceived by the CIT and the client, and ability to improve client outcome.

Basic Assumptions of the Study

- The selected instruments would differentiate levels of mindfulness, empathy, and therapeutic alliance among participants.
- The participants would report honest and accurate responses on instruments, logs, questionnaires, journals, and focus groups.
- CITs participating in this study were an accurate representation of the graduate counseling student population.

- Clients participating in this study were representative of typical clients in a counseling and training clinic setting.
- Instructors participating in this study were an accurate representation of faculty who teach in a CACREP accredited counseling program.

Limitations

- Internal validity could have been compromised by the required clinic format as:
    - CITs conducted counseling sessions in a co-therapist format; treatment and control group CITs could have been paired.
    - CITs' client groups were in a constant state of flux; new clients were accepted at any time and some clients attended regularly, while others did not.
- Internal validity could have been impacted by history effects including:
    - CITs and clients could have encountered factors that impacted their perspectives and scores of therapeutic alliance.
    - Instructors could have encountered factors that impacted their evaluation of CIT therapeutic alliance skills.
    - CITs could have encountered factors that affected the ability to learn and apply mindfulness, empathy, and therapeutic alliance qualities during the semester.
- External validity could have been affected by confounding factors including:
    - The CIT sample (n = 9) was small and non-random.
    - Participants were self-selected volunteers.

- Attrition is possible in any study but was more likely in this one as it was conducted over extended time (16 weeks).
- The SRS, although a very practical and sound instrument, is comprised of only 4 items, which could have been limiting when evaluating therapeutic alliance.

Definition of Terms

Attunement: The act of focusing "attention on others and [taking] their essence into our own inner world" (Siegel, 2010, p. 34). Attunement is proposed as an essential element of the counseling relationship (Shapiro & Carlson, 2009; Siegel, 2010).

Beginner's mind: This quality of mindful awareness is a view of things as novel and fresh, as if for the first time, with a stance of curiosity (Stahl & Goldstein, 2010)..

Body awareness: The result of a body scan brings body awareness. This awareness allows one to focus on stress, physical pain, or emotions in the body (Stahl & Goldstein, 2010).

Body scan: A meditation of deep exploration into the moment-to-moment experiences of the body (Stahl & Goldstein, 2010).

Common factors: These are proposed factors of the client-counselor relationship that positively influence client outcome. The factors are similar or common across theoretical orientations and can include: counselor empathy, warmth, and congruence, as well as the therapeutic alliance (Lambert, 2001).

Empathy: Empathy is one of the common factors that can facilitate positive client outcome (Lambert, 2001). Empathy in this study was comprised of two constructs: (a) perspective taking and (b) empathic concern (Davis, 1980).

Intention, Attitude, Attention (IAA) model of mindfulness: A theory of mindfulness whereby the process of mindfulness is made up of three components or axioms: (1) intention, (2) attention, and (3) attitude (IAA; Shapiro et al., 2006). The first axiom, intention, correlates with paying attention *on purpose*. The second axiom, attention, corresponds with attending to *the present moment*. The third axiom, attitude, connects with paying attention *in a particular way*; non-judgmentally. The axioms serve as the basis for mindful functioning yet they work together; simultaneously contributing to the process.

Interpersonal mindfulness: The process of bringing nonjudgmental present moment awareness to one's interactions with others including mindful communication and listening (Stahl & Goldstein, 2010).

Intrapersonal mindfulness: The process of bringing nonjudgmental present moment awareness to personal thoughts, feelings, and sensations (Stahl & Goldstein, 2010).

Mindfulness meditation: The systematic practice of promoting mindfulness whereby the practitioner intentionally engages in open, curious, and non-judgmental awareness of the present moment (Shapiro & Carlson, 2009). Derived from Buddhist meditation (Kabat-Zinn, 2003), the objective of mindfulness meditation is to cultivate awareness, insight, wisdom, and compassion (Dimidjian & Linehan, 2003).

Mindfulness: The overarching term that encompasses mindfulness practices, philosophies, and psychological processes that guide the practitioner's perspective and intentional way of engaging in life with awareness (Brown, Ryan, & Creswell, 2007; Germer, 2005; Shapiro & Carlson, 2009). Mindfulness is made up of five facets: (a) observing sensations, perceptions, thoughts, feelings; (b) describing with words; (c)

acting with awareness; (d) non-judging of inner experience; and (e) non-reacting to inner experience (Baer et al., 2006).

Mindfulness-Based Stress Reduction (MBSR): An 8-week mindfulness training course utilized for effective treatment of physical and mental health (Kabat-Zinn, 1990).

Mindful yoga: The practice of mindful body movement derived from East Indian hatha yoga (Kabat-Zinn, 2003). It includes slow, focused body movement, stretching, and breathing (Stahl & Goldstein, 2010).

Non-judgment: This quality of mindful awareness involves nurturing impartial observation with regard to any experience; not labeling cognitions, feelings, or sensations as good or bad, right or wrong, fair or unfair, but simply making note of thoughts, feelings, or sensations moment-by-moment (Kabat-Zinn, 1990; Stahl & Goldstein, 2010).

Non-striving: This quality of mindful awareness involves not trying to get anywhere other than where you are; there is no aversion to change or movement away from what comes in the moment (Stahl & Goldstein, 2010).

Presence: Presence in mindfulness is the capacity to simply "be" in the moment; observing and monitoring thoughts, feeling, and sensations without judgment (Kabat-Zinn, 1990); an actively receptive state (Gehart & McCollum; 2008; Siegal, 2010).

Resonance: When the client feels understood by the counselor and both parties are engaged in a two-way relationship of *we* rather than *you and me* (Siegal, 2010).

Self-compassion: This quality of mindful awareness fosters love for self, without criticism or self-blame (Stahl & Goldstein, 2010).

Therapeutic alliance: The collaborative relationship that is developed between a counselor and client during the process of therapy (Horvath et al., 2011). Therapeutic

alliance is comprised of four interacting constructs: (a) a relational bond between the counselor and client, (b) agreement on the goals of therapy, (c) the client's view of the counselor's approach, and (d) the client's overall perception of the counseling session (Duncan et al., 2003).

Trust: Mindful qualities of the counselor can cultivate trust in the helping relationship. Trust between client and counselor creates the safe haven for clients to explore their less than perfect selves and lays the foundation for change (Shafir, 2008; Siegal, 2010).

Wandering mind: This is a normal factor in mindfulness development. It is when the focus of the thoughts will inevitably wander while practicing mindfulness (Kabat-Zinn, 1990; Stahl & Goldstein, 2010).

Organization of Remaining Chapters

Chapter two contains a literature review of the pertinent areas concerning this study. Chapter three includes the specifics of the methodology used in this study. Chapter four will describes the results of the analyses of the data collected and chapter five provides a discussion, implications, and recommendations.

Chapter 2

Literature Review

Empirical approaches involving the use of mindfulness to improve the counseling process, counselor skills, and client outcomes have increased over the past 10 years (Davis & Hayes, 2011, Hick, 2008; Shapiro & Carlson, 2009). Numerous researchers have proposed that mindfulness facilitates key elements of the counseling process, especially core helping skills (e.g. empathy, unconditional positive regard, and congruence), that promote the therapeutic relationship (Andersen, 2005, Martin, 1997; Bien, 2008; Fulton, 2005; Siegel, 2010).

Defining and Describing Mindfulness

Mindfulness meditation originated in Buddhist culture and has been practiced for over 2,600 years (Shapiro & Carlson, 2009; Germer, 2005). The term mindfulness is a translation of the Pali word *sati*. Pali is the sacred language used in the Theravāda Buddhist canon (Neufeldt, 1998). *Sati*, in English, implies awareness, attention, discernment, and remembering (Carlson & Shapiro, 2009; Germer, 2005). Nyanaponika Thera, Buddhist scholar and monk, described *sati* as "a kind of attentiveness that is… good, skillful, or right" (1954, p. 9). Many Western mindfulness practitioners have suggested that mindfulness is a useful approach to living a more enlightened and fulfilling life (Kornfield, 1993; Brown & Ryan, 2003; Stahl & Goldstein, 2010). Yet none have illustrated the impact of mindfulness as powerfully as Kabat-Zinn (1982) via the empirical literature related to his approach to mindfulness stress reduction (Shapiro & Carlson, 2009). For the context of this study, mindfulness-based practices are drawn from the concepts described by Kabat-Zinn (1982, 1990, 1994, 2003, 2005).

The principles of mindfulness were adapted by Kabat-Zinn (1982), sans the traditions and vocabulary of Buddhism, to be more accessible to a Western audience (Baer, 2003). Mindfulness meditation differs from concentration-based meditations, like transcendental meditation, that restrict the focus of attention to a single stimulus such as a word (i.e. mantra), sound, object, or sensation. Instead, mindfulness meditation involves practitioners' observations of continuously changing internal and external stimuli in a process of monitoring and noticing whatever may arise (Baer, 2003). In all mindfulness exercises, practitioners are encouraged to focus their awareness on the intended target (e. g. breathing or walking) and attend to it moment by moment (Kabat-Zinn, 1990). When participants observe sensations, thoughts, or emotions that arise, they are instructed to notice without judgment. When this noticing occurs, practitioners are encouraged to acknowledge what they observe and then return their focus to the intended target. In this way, participants are taught to notice their thoughts and feelings, impartially; without becoming enmeshed in their content (Hick, 2008; Kaba-Zinn, 1982, 1990).

There are two types of mindfulness meditation, formal and informal practice (Germer, 2005; Kabat-Zinn, 1990; Stahl & Goldstein, 2010). Formal practice is associated with planned mindfulness meditation, such as sitting in meditation or implementing yoga in a mindful manner (Germer, 2005). Formal practice may be employed daily or, at minimum, several times per week (Kabat-Zinn, 1990; Stahl & Goldstein, 2010). Much like regularly scheduled physical workouts that lead to physical fitness, formal mindfulness practice is implemented with the immediate intent of being aware from moment to the moment, for a sustained period of time, and a long term intent

of building a type of mental fitness and awareness that can lead to a more fulfilling life (Bien, 2008).

Informal practice involves using mindful awareness with typical daily activities, such as eating, driving, walking, watching your child's basketball game, or doing chores. Informal practice can be implemented multiple times a day with activities that might ordinarily be considered mundane by focusing nonjudgmental awareness on the event or task at hand. For example, mindful driving might bring to awareness the sound of the tires on the road or the vibration of the steering wheel on the hands or the feeling of the foot on the gas pedal. Regular informal practice, interwoven with the experiences of daily living, is the ultimate goal for mindfulness to enhance the practitioner's ability to actively engage and participate in his or her life.

The foundational principle of mindfulness is deceptively simple; it is "moment-to-moment awareness" (Kabat-Zinn, 1990, p. 2). Yet mindfulness practice goes beyond the mere witnessing of events. It is the "capacity to deliberately pay full attention to where we are, to our actual experience, and to learn from it" (Hick, 2008, p. 5). Mindfulness embodies an open, receptive attention but also a discerning attention that facilitates insight (Shapiro & Carlson, 2009). Morgan and Morgan (2005) explain that "mindfulness practice focuses the attention; it is like a firm handshake with one object at a time in the field of experience" (p. 76).

Awareness in and of itself is a straightforward concept, yet the mechanisms of mindfulness and how it works are more inherently complex and elusive. A contemporary theory of mindfulness suggests that the process is made up of three components or axioms: (1) intention, (2) attention, and (3) attitude (IAA; Shapiro, Carlson, Astin, &

Freedman, 2006). This theory directly corresponds with one of the most cited definitions of mindfulness, "…paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4). The first axiom, intention, correlates with paying attention *on purpose.* The second axiom, attention, corresponds with attending to *the present moment*. The third axiom, attitude, connects with paying attention *in a particular way*; non-judgmentally. The axioms serve as the "building blocks" for mindful functioning yet they work together; simultaneously contributing to the process (Shapiro et al., 2006, p. 375).

Intention is *why* someone practices mindfulness. As Kabat-Zinn (1990) explained, "I used to think that meditation practice was so powerful in itself and so healing that as long as you did it at all, you would see growth and change. But time has taught me that some kind of personal vision is also necessary" (p. 46). Shapiro (1992) also found that intention impacted the mindfulness process of practitioners. Results indicated that mindfulness practitioners' purpose for practicing seemed to evolve and that outcomes corresponded with intentions. A continued practice of meditation seemed to move intention to deeper levels of personal understanding from self-regulation, to self-exploration, and ultimately to self-liberation (liberation from the separate self) or wholeness (Shapiro, 1992; Shapiro et al., 2006). Shapiro (1992) also discovered that practitioners were able to attain or make gains toward their goals when they intended to manage stress with self-regulation, engage in self-exploration, or seek a deeper sense of wholeness through self-liberation. The notion that intention is ever-evolving permits mindfulness practitioners to adjust and progress with more meaningful practice, awareness, and understanding (Shapiro et al., 2006).

Attention is the second axiom of mindfulness. This is the action of not merely observing but paying attention to both internal and external experiences; the "awareness of awareness" (Siegal, 2010, p. 28). It is attending to the "contents of consciousness, moment by moment" (Shapiro et al., 2006, p. 376). Attention and awareness are the foundation of mindfulness practice and a mindful way of life (Kabat-Zinn, 1990). In the mental health field, the strategic use of attention has been proposed as a vital part of the therapeutic process. In client-centered theory, Rogers and Wood (1974) suggest that a therapist's function is to be "immediately present and accessible to his client and relying on his moment-to-moment experiencing in the relationship to facilitate therapeutic movement" (p. 214). Gestalt therapy involves clients' in the moment awareness to connect with the here and now as Perls (1969) stated, "And I believe this is the great thing to understand: that awareness per se, of and by itself, is curative" (p. 15-16). Cognitive behavior therapy also involves attention as clients are taught to attend to internal thoughts and external conditions (Segal, Williams, & Teasdale, 2002).

Attitude is the third axiom of mindfulness. This refers to the manner in which the mindful person pays attention. Practitioners are invited to have an open, curious, kind, and accepting attitude about whatever arises in the moment (Kabat-Zinn, 1990). Similar characteristics of attitude have been explained as "curiosity, openness, and acceptance that equal love" (Siegal, 2010, p. 55). Additionally, the qualities of kindness and openness can be applied to internal and external experiences, even if the experiences are negative or dissonant, creating a more neutral or non-judgmental stance with which to explore them (Kabat-Zinn, 1990; Shapiro et al., 2006). For example, during mindfulness practice, if the mind wanders to a task that needs to be done later, the wandering is noted

with acceptance and compassion, and then the practitioner returns to the exercise. This method is not to make the wandering mind go away or be replaced by kindness and curiosity; it is to simply notice what arises in the field of experience without passing judgment (Shapiro & Carlson, 2009). It is a method of observing what *is* in a certain way. In mindfulness practice, attitude is critical (Kabat-Zinn, 1990; Shapiro et al., 2006). Furthermore, "keeping particular attitudes in mind is actually part of the training itself" (Kabat-Zinn, 1990, p. 32).

Mindfulness use in Counseling

The modern concept of mindfulness, relevant to counseling literature, is rooted in the Mindfulness Based Stress Reduction (MBSR) program (Kabat-Zinn, 1990). Initially, MBSR was utilized with patients, in accord with their medical treatment, to relieve stress, facilitate the reduction of pain and other symptoms, and promote overall wellness (Kabat-Zinn, 1990). The program is implemented as an 8-week course for groups of no more than 30 participants who are instructed in the practice of mindfulness meditation skills for 2 to 2.5 hours per week. The program's effectiveness has been supported by numerous studies indicating MBSR as a promising intervention for treatment of physiological and psychological symptoms (Baer, 2003; Bishop, 2002; Grossman, Niemann, Schmidt, & Walach, 2004). Currently over 200 medical centers, clinics, and hospitals offer MBSR (Kabat-Zinn, 1990) worldwide.

Mindfulness-based Counseling Interventions

Mindfulness practices, in the context of counseling, stem from the concepts of MBSR (Kabat-Zinn, 1990) and have been utilized to improve client outcomes with mindfulness-based treatments. The empirical success of MBSR, relating to improved

mental health across populations and disorders (Baer, 2003; Fjorback, Arendt, Ørnbøl, & Walach, 2011), led mental health practitioners to examine its effectiveness in client interventions. As a result, therapeutic mindfulness approaches were developed and utilized directly with clients to facilitate improved outcomes. Empirically supported mindfulness interventions include: mindfulness based cognitive therapy (MBCT; Segal, Williams, & Teasedale, 2002), acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), and dialectical behavior therapy (DBT; Linehan, 1993).

MBCT (Segal et al., 2002) is currently listed in the National Registry of Evidence-based Programs and Practices (NREPP). NREPP provides information about empirical evidence in support of a range of substance abuse and mental health interventions (Hennessy, Finkbiner, & Hill, 2006). MBCT reduces depression relapse in clients with major depressive disorder (Teasdale, Moore, Hayhurst, Pope, Williams, & Segal, 2002). Reminiscent of MBSR (Kabat-Zinn, 1990), MBCT involves an 8-week intervention that incorporates components of cognitive therapy to develop clients' ability to observe thoughts in a detached manner with metacognitive awareness (Teasedale et al., 2002). This objective approach is also applied to physical sensations and emotions. MBCT utilizes mindfulness skills to focus on negative thoughts and feelings rather than a range of internal and external experiences, as in MBSR (Brown, Marquis, & Guiffrida, 2013).

ACT (Hayes et al., 1999) is also listed in the NREPP as a reputable mindfulness based intervention. ACT is implemented to increase effective action; reduce dysfunctional thoughts, feelings, and behaviors; and relieve psychological distress for clients with an array of problems including mental disorders, coping with chronic illness,

and workplace stress (NREPP, 2012). In ACT, the goal of treatment is psychological flexibility which necessitates the willingness to accept thoughts and feelings in the moment, as they are. In this format, mindfulness is employed to facilitate acceptance (Hayes, Follette, & Linehan, 2004).

DBT (Linehan, 1993) was developed as a cognitive and behavioral method to work with clients with borderline personality disorder (BPD). It is also an NREPP approach and has been found to be effective in the reduction of severe suicide ideation and associated symptoms of BPD (Linehan et al., 2006). Dialectic refers to the notion that reality is made up of opposing forces; the most fundamental of these is acceptance and change. Clients are guided to accept themselves and their situations, as they are, while making efforts to change their behaviors and environments to develop a better life. As in MBSR, participants are taught to notice and observe without judging their emotions, thoughts, sensations and the environment. Clients take part in weekly skills groups and complete two training modules that also develop interpersonal effectiveness, emotion regulation, and distress tolerance capabilities (Baer, 2003; Linehan 1993). DBT also involves manualized approaches to formal and informal mindfulness practice.

The success of mindfulness-based interventions with clients led mental health practitioners to examine mindfulness as a means to facilitate the overall counseling process including the therapeutic relationship (Escuriex & Labbé, 2011). Proponents of mindfulness-based approaches in counseling have suggested that counselors can connect with the present moment with the promise of both personal and professional benefits (Martin, 1997; Gehart & McCollum; 2008; Hick, 2008; Siegal, 2010). Consequently, counselors who engage in mindfulness practice on a personal level may be more adept in

providing effective services on a professional level (Excuriex & Labbé, 2011; Shapiro & Izett, 2008; Bien, 2008; Shapiro & Carlson, 2009; Siegel, 2010). More specifically, mindfulness qualities such as awareness, presence, acceptance, compassion, and non-judgment may help counselors be more effective in facilitating a therapeutic relationship or alliance and improving client outcomes (Bien, 2008; Labbé, 2011; Germer, 2005; Fulton, 2005; Shapiro & Carlson, 2009).

History of Therapeutic Alliance

Zetzel (1956) was the first to use the term therapeutic alliance although the concept of alliance can be traced to Freud (1913/1958) when he wrote about the partnership between therapist and client in their endeavor to overcome the client's anguish. Greenson (1965, 1967) used the term working alliance to refer to the client's cooperation with the process of analysis and the term therapeutic alliance to refer to the ability of the therapist and client to form a bond. Luborsky (1976) was the first to conceptualize therapeutic alliance sans the psychodynamic concepts; his description was more universal. He posited that the therapist and client alliance progressed in two phases. The first phase, Type I alliance, referred to the client's view of the therapist as a powerful resource and the therapist as being supportive and helpful. The second phase, Type II alliance, referred to the client's contribution, trust, and commitment to the process of therapy.

Bordin (1979, 1994) suggested a slightly different pan-theoretical description of alliance: the working alliance. Bordin's definition also had psychodynamic origins but, like Luborsky, he deviated from that paradigm and created a new theory that could be applied across therapeutic genres. Bordin (1979) believed the working alliance was made

up of three elements: (a) agreement on the goals of therapy, (b) agreement on the therapeutic tasks, and (c) a therapist-client bond.

The key feature of the contemporary definition of the alliance is that consensus and collaboration are vital (Bordin, 1979; Hatcher, Barends, Hansel, & Gurfreund, 1995; Luborsky, 1976). Prior to the publications of Luborsky and Bordin, definitions of alliance emphasized the therapist's role (Rogers & Wood, 1974) or the unconscious relationship between therapist and client. The modified theory of alliance emphasizes the earnest collaboration of therapist and client (Horvath et al., 2011).

Significance of Therapeutic Alliance

The empirical literature on therapeutic relationship has emphasized therapeutic alliance as relevant to counseling outcomes. This is because one of the most consistent findings in therapy outcome research is that the therapeutic relationship, operationalized and measured as the therapeutic alliance, is a key contributor to client progress (Lambert & Simon, 2008). The alliance between counselor and client has been found to be a highly influential factor in therapeutic success, accounting for as much as 30% of the variance in outcome (Lambert, 1992; Norcross, 2001). Multiple meta-analyses also support the notion that therapeutic alliance, regardless of the theoretical orientation of the therapist, has a significant influence on client outcome, second only to client factors (Horvath & Barley, 2001; Horvath & Symonds, 1991; Lambert, 1992; Martin et al., 2000; Norcross, 2001). A more recent meta-analysis of 201 studies confirmed earlier findings about therapeutic alliance and client outcome across theoretical orientations. The researchers asserted that therapeutic alliance was one of the most robust and strong predictors of client outcome that science has been able to record (Horvath, Del Re,

Flückiger, & Symonds, 2011). Duncan and Miller (2000) went so far as to suggest that the relationship *is* the treatment.

The therapeutic alliance is constructed with the client via the counselor's therapeutic relationship skills. These skills are the counselor's contributing factors to the therapeutic relationship and include "several interlocking elements (empathy, responsiveness, creating a secure environment, etc.)" (Horvath et al., 2011, p. 56). The therapeutic alliance is a way to describe what has been achieved with the appropriate application of the therapeutic relationship (Horvath et al., 2011). Consequently, the therapeutic relationship, including the counselor's characteristics, lays the foundation for therapeutic alliance to occur.

Measuring Therapeutic Alliance

While there is agreement that therapeutic alliance involves a collaborative relationship, there is disparity regarding the specific components of alliance (Elvins & Green, 2008; Horvath et al., 2011). Accordingly, various terms have been used to describe the relationship between counselor and client including: therapeutic alliance, working alliance, therapeutic bond, and helping alliance (Martin et al, 2000). Furthermore, there are discrepancies as to the measurement of the alliance (Martin et al., 2000; Elvins & Green, 2008; Horvath et al., 2011).

In a recent meta-analysis of therapeutic alliance and outcome across 201 studies, Horvath et al. (2011) reported that no fewer than 30 different measures of alliance were employed. The variety of alliance scales reflects the fact that they are each founded on different theoretical conceptualizations of alliance and therefore utilize different methods of measurement (Martin et al., 2000). Despite the differences in alliance measures,

numerous meta-analyses across scales consistently record therapeutic alliance as a significant contributor to client progress (Horvath & Symonds, 1991; Martin et al., 2000; Horvath et al., 2011). While discrepancies exist, there are several scales that seem to be more effective when measuring alliance in relation to outcome (Elvins & Green, 2008). In their analysis of 32 alliance measures, Elvins and Green (2008) examined psychometric properties as well as construct, criterion, discriminant, and predictive validity. They found that studies using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), and the California Psychotherapy Alliance Scales (CALPAS; Marmar, Weiss, & Gaston, 1989) demonstrated a strong association between alliance and client outcome across client groups and treatment methods. As these alliance scales seem to be superior when examining alliance in relation to outcome, these will be explained in further detail.

The WAI (Horvath & Greenberg, 1989) was created to measure Bordin's (1979) theory of the alliance. Furthermore, the WAI was developed to measure alliance across therapy type, to demonstrate the connection between the measure and the theoretical concepts behind it, and to associate the measure with a theory of therapeutic change (Horvath, 1994). In order to remain grounded in the theoretical foundation, the WAI measured Bordin's three factors of the alliance: agreement on tasks, consensus on goals, and the bond. As such, the WAI has three subscales devoted to each of Bordin's (1979) factors. Three versions of the WAI were created for patient, therapist, and observer ratings. The initial version of the WAI has 36 items and there is strong support for its reliability ($r = 0.85 – 0.93$; Horvath & Greenburg, 1989). The observer version of the

WAI correlates highly with other alliance measures including the CALPAS and the VTAS (Elvins & Green, 2008).

The WAI has been updated twice since its inception. The working alliance inventory short form (WAI-S; Tracey & Kokotovic, 1989) has 12 items and the same three subscales as the WAI: goals, task, bond. Two versions of the WAI-S were created: one for therapist use and one for client use. Internal consistency estimates of the total scores for client and therapist versions were .98 and .95, respectively (Tracey & Kokotovic, 1989).

The update to the WAI-S is called the working alliance inventory, short form revision (WAI-SR; Hatcher & Gillaspy, 2006). Hatcher and Gillaspy (2006) performed a confirmatory factor analysis (CFA) with WAI data from two samples of adult clients (n = 231 and n = 235) and their therapists. They found a three level factor-structure corresponding to the three subscales (goals, task, and bond) that was consistent across both samples. The resulting WAI-SR has 12 items and reliability subscale score alphas ranged from .85 to .90 while total score alphas ranged from .91 to .92 (Hatcher & Gillaspy, 2006). Correlations between the WAI-SR and the WAI total scores ranged from .94 and .95 for both samples indicating the WAI-SR could be used in place of the WAI, if warranted.

The VTAS (Hartley & Strupp, 1983) is a derivation of the Vanderbilt Psychotherapy Process Scales (VPPS; Gomes-Schwartz, 1978). The VPPS (Gomes-Schwartz, 1978) was initially based on dynamic and integrative conceptualizations of the alliance (Strupp & Binder, 1984) as well as the theories by Greenson, (1965), Luborsky (1976), and Bordin (1979). Although the VPPS was designed to measure the therapist-

client relationship it did not specifically measure alliance (Martin et al., 2000). Thus the 44 item VTAS (Hartley & Strupp, 1983) was developed so that observers could rate the alliance during a therapy session. The VTAS was comprised of three subscales: therapist contribution, patient contribution, and therapist-patient interaction (Hartley & Strupp, 1983). Internal consistency ranged from r = .95 (Hartley & Strupp, 1983) to r = .91 (Krupnick et al., 1996). Theoretical shifts in perceptions of the alliance led another team of researchers (Diamond, Liddle, Dakof, & Hogue, 1996) to revise the VTAS by removing the therapist contribution subscale so the focus remained on the patient contribution and the therapist-patient interaction subscales. This new version of the VTAS was the Vanderbilt therapeutic alliance scale, revised (VTAS-R; Diamond et al., 1996). The VTAS-R had 26 items and demonstrated "adequate reliability" (Shelef & Diamond, 2008). The VTAS-R was an adequate measure of alliance but labor intensive as it required raters to be trained and sessions to be coded. The VTAS-R short form was developed to make the instrument more practical and reduce barriers to use. This 5 item scale has internal reliability ranging from .90 to .91 (Shelef & Diamond, 2008).

The California psychotherapy alliance scale (CALPAS; Gaston 1991) has 24 items and is based on alliance theories by Bordin (1979), Freud (1913/1958), Greenson (1967), and Luborsky (1976). The CALPAS was also created to measure Gaston's (1990) four features of the alliance: (a) therapeutic alliance, (b) working alliance, (c0 therapist's contribution to the alliance, and (d) patient-therapist agreement on treatment goals and tasks. The CALPAS has 24 items and is available in patient, therapist, and observer versions. The total score demonstrates strong internal reliability ($\alpha = .83$).

Another, more contemporary, alliance scale utilized more for practical application in a counseling setting is the Session Rating Scale (SRS V.3; Duncan et al., 2003). Like the aforementioned key instruments, the theoretical orientation of the SRS stems from Bordin's (1979) elements of alliance (goals, tasks, bond). The SRS is also influenced by Gaston's (1990) stance on alliance, similar to the CALPAS. Also, like the VTAS-R short form, the SRS is a brief measure. The 4-items on the SRS assess the client's perception of a counseling session including: (a) the counselor-client relationship, (b) pertinent goals, (c) the counselor's method, and (d) the overall experience. Concurrent validity between the SRS and the WAI has been reported with significant and consistently moderate correlations between SRS items and WAI subscales ranged between .37 and .63. (Campbell & Hemsley, 2009). Furthermore, the SRS V.3 demonstrates good internal consistency estimates with a variety of client populations (α = .88 - .93) and is recognized as an effective measure of therapeutic alliance (Duncan et al., 2003; Campbell & Hemsley, 2009).

The number of alliance instruments with various theoretical underpinnings indicates the lack of agreement in how therapeutic alliance is conceptualized and measured. Yet the alliance between counselor and client continues to be a significant variable in relation to client outcome across measures and client populations (Horvath & Symonds, 1991; Martin et al., 2000; Horvath et al., 2011). There is some agreement among different alliance measures, which indicates that some components of the therapeutic alliance are consistent. These have been called *common factors* of alliance (Lambert, 1992). One of the proposed common factors of the therapeutic alliance is counselor empathy (Lambert, 1992). Empathy is discussed in further detail in the section

entitled empathy and the therapeutic relationship. Another one of the proposed common factors in the therapeutic alliance is counselor mindfulness (Martin, 1997; Andersen, 2005).

Mindfulness and the Therapeutic Relationship

Advocates for mindfulness practice in counseling propose that it can have an impact on practitioners' capacity to relate to their clients (Andersen, 2005; Germer, 2005; Hick, 2008; Shapiro & Carlson, 2009; Siegal, 2010). Some of the benefits of mindfulness practice have been described as a greater sense of presence, attunement, resonance, and trust that begin with the self and then can be applied while working with clients (Siegal, 2010). Presence in mindfulness is the capacity to simply "be" in the moment; observing and monitoring thoughts, feelings, and sensations without judgment (Kabat-Zinn, 1990). Presence is an actively receptive state (Gehart & McCollum; 2008; Siegal, 2010). Learning to be present with the self precedes and facilitates a counselor's capacity for presence with clients. By being present with themselves, counselors develop focus, thoughtfulness, self-awareness, and perspective that support them as individuals and assist them in helping and being present with clients (Siegal, 2010). This personal presence can be viewed as the most essential element of helping others heal (Bien, 2008; Rogers, 1957; Siegal, 2010).

Attunement builds upon a mindful presence. Once the counselor is present and aware, attunement is when a counselor deciphers whatever messages the client is sending through her words, body language, and demeanor. Attunement includes when the counselor connects with a sense of being *tuned in* to the essence of the client's experience (Shapiro & Carlson, 2009; Siegal, 2010; Bruce et al., 2010). During this process of

attuning to the client, the counselor is also checking in or tuning into her own sensations about this exchange, noticing her own perceptions (self-attunement), and then making choices about what to do with them. For example, a counselor might be working with a client who has an alcohol addiction. While the client blames others for her behavior, the counselor notices his stomach tightening and realizes that he is beginning to feel irritated with the client's continual lack of ownership of the addiction. By noticing his own irritation and not letting it block his receptiveness and sense of judgment, he can either use it in a constructive way to gently confront the client or make note of it, let it go, and refocus on the client and what she is experiencing.

When clients can feel a counselor's nonjudgmental, accepting presence and that the counselor is attuned to who they are, they feel *heard* (Bruce et al., 2010; Rogers, 1957, 1975; Siegal, 2010). When a client feels heard or understood, this opens the door of opportunity for client-counselor engagement. Siegal (2010) calls this two way exchange resonance; when both parties are engaged and participating in a relationship of *we* instead of *you and me*. Resonance can also be felt within the self as a counselor finds a balance between where he is, in the moment, and where he *chooses* to be. In this way the counselor's actions are in harmony with who he is.

Presence, attunement, and resonance with clients build the foundation for a relationship of trust. Trust between client and counselor creates the safe haven for clients to explore their less than perfect selves; it creates the environment for change (Shafir, 2008; Siegal, 2010). Trust between counselor and client also involves the counselor's trust in the self which has been developed by practicing awareness and presence of self, attunement to self, and resonating with self. Mindfulness can help counselors develop a

deeper understanding and trust in themselves so that they, in turn, can bolster the trust in their therapeutic relationships (Shafir, 2008; Siegal, 2010)

Mindfulness and the Core Conditions

The concepts of presence, attunement, resonance, and trust might be considered contemporary indicators of the core conditions proposed by Rogers (1957) in an effort to describe the relevance of the therapeutic relationship to counseling outcomes. Rogers (1957) conditions were centered on the counselor qualities of congruence, unconditional positive regard, empathic understanding, and that these qualities would be sensed by the client. The mindful stance of presence could be likened to congruence. Congruence or genuineness is the counselor's ability to openly be himself "with his actual experience accurately represented by his awareness of himself" (Rogers, 1957, p. 242). Accordingly, the mindful practice of presence or *being* promotes the counselor's awareness of self.

The mindful practice of presence is also comparable to unconditional positive regard. Unconditional positive regard is described as a "warm acceptance" of the client (Rogers, 1957, p. 243). Acceptance is a core facet of a mindful presence that stems from the stance of non-judgment whereby events are neither good nor bad, they simply are. This acceptance allows the counselor to have an open and receptive stance toward clients; viewing clients where they are, in the moment.

The mindful practice of attunement is very similar to empathic understanding. Rogers describes empathic understanding as the counselor's ability "to sense the client's private world as if it were your own" (1957, p. 243). Attunement in the counseling process is the counselor's ability to connect with the client's physical person as well as

her perceptions and experiences. This connection allows the counselor to deeply appreciate the client and her unique situation.

Finally, the mindful process of resonance relates to the hypothesis that the client must somehow sense or perceive that the counselor is conveying congruence, positive regard, and empathy (Rogers, 1957). Resonance is the way the counselor communicates what he has discerned from being present and attuned to the client. The counselor's message, via resonance, is vital to the client's perception of having been heard and understood; that the counselor has connected with the client's world.

Empathy in Counseling

Counselor empathy has been emphasized as an element of the therapeutic process since Rogers (1957) introduced the core conditions for therapeutic change (empathy, congruence, and unconditional positive regard). Rogers' (1980) more recent conceptualization of empathy is widely used in mental health literature and is explained as, "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference…" (p. 85)…"It means entering the private perceptual world of the other….being sensitive, moment by moment, to the changing felt meanings which flow in this other person. It means sensing meanings of which he or she is scarcely aware…" (p. 142).

Defined in this way, empathy was viewed by Elliott et al. (2011) as a multi-dimensional construct comprised of three modes of expressing therapeutic empathy: (a) empathic rapport, (b) communicative attunement, and (c) person empathy. Empathic rapport is when a counselor demonstrates a compassionate stance and tries to convey that

she understands the client's experience. Communicative attunement, a kind of process empathy, involves an active, continuous "effort to stay attuned on a moment by moment basis with the client's communications and unfolding experience" (Elliott et al., 2011, p. 44). Attunement may be shared in many ways but most likely via empathic responses. Person empathy (Elliott, Watson, Goldman, & Greenberg, 2003) is a more holistic understanding of the client's world and includes a persistent effort to comprehend the client's experiences, in the past and the present, which create the backdrop for the client's current perspective.

Another perspective of empathy portrays it as a process that includes both cognitive and emotional components (Bohart & Greenburg, 1997; Duan & Hill, 1996; Rogers, 1975). Cognitive empathy involves the ability to perceive the client's experience intellectually as in Rogers' (1957) "as if" perspective (p.243). Meanwhile, emotional empathy involves an emotionally felt response to the client's experience.

Others have defined counselor empathy in various ways, including: a trait or response skill (Truax & Carkuff, 1967), a process of identifying with the client by "becoming" his or her experience (Mahrer, 1997), and an interpretive process (Watson, 2001). Additionally, Barrett-Lennard (1981) described empathy with regard to three distinct perspectives: the therapist (empathic resonance), the client (received empathy), and the observer (expressed empathy).

Empathy, with regard to the general population, was also examined by Hoffman (1984) as a pro-social behavior, made up of affective and cognitive components. Empathy was described as the processes that facilitate a person's appropriate feelings toward another's circumstances as opposed to over identifying with personal feelings or

reactions. Consequently, in an affective state, one reacts to events derived from oneself; in empathy, one reacts affectively to events derived from someone else (Hoffman, 1984).

Empathy and the Therapeutic Relationship

Counselor empathy is viewed as an essential element of the therapeutic relationship regardless of theoretical preference and the empirical literature connecting empathy to therapeutic outcome is substantial (Bohart, Elliott, Greenberg, & Watson, 2002; Elliot, Bohart, Watson, & Greenberg, 2011; Norcross, 2001). In a meta-analysis of research, Bohart et al. (2002) demonstrated that empathy was more strongly related to client outcome than the overall construct of therapeutic alliance. In a more recent analysis across studies (Elliot et al., 2011), supporting results for the link between empathy and outcome were found. Elliot et al. (2011) utilized empathy-outcome data culled from 257 studies that included 3,599 clients. Results indicated that not only was empathy a moderate predictor of outcome ($r = .31$) but client measures, as opposed to observer and therapist measures, predicted the outcome best ($r = .32$). The researchers concluded that empathy is a moderate predictor of outcome and that client perception of being understood by their counselor is a robust predictor of outcome (Elliot et al., 2011). Furthermore, they suggested that counselor empathy is a key change agent in the therapeutic process (Elliot et al., 2011).

Measuring Empathy

Empathy is plagued with a lack of agreement as to its definition, theoretical basis, and dimensionality (Elliott et al., 2011). This is reflected in the number and type of assessments that measure empathy. In the mental health field, most scales fall into categories related to a person evaluating the therapists' empathy including: client ratings,

therapist ratings, observer ratings, and empathic accuracy (Elliot et al., 2011). The Barrett-Lennard relationship inventory (BLRI, Barrett & Lennard, 1962) is the most frequently utilized, client-rated measure of empathy (Elliott et al., 2011). The BLRI is an operational definition of Rogers' (1957) hypothesis that client perceptions of the therapist's core conditions (empathy, positive regard, and congruence) facilitate client progress. The internal consistency of the BLRI is high (α = .80 to .85; Barrett-Lennard, 1986).

Another empathy scale, used primarily with the general population, is the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983). The IRI measures affective and cognitive elements of the empathic response. It is one of the most extensively utilized measures of empathy for social psychological research (Cliffordson, 2002; Fields et al., 2011). The four subscales of the IRI have demonstrated an internal consistency ranging from .70 to .78 (Davis, 1980) as well as .75 to .82 (Pulos et al., 2004). Davis (1980) views empathy as a multidimensional construct therefore a global score of the four subscales is not encouraged for the IRI.

Mindfulness and Empathy

There is an increasing amount of literature on the use of mindfulness to cultivate empathy (Andersen, 2005; Lesh, 1970; Morgan & Morgan, 2005; Pearl & Carlozzi, 1994; Shapiro & Carlson, 2009; Shapiro & Izett, 2008; Shapiro, Schwartz, & Bonner, 1998; Siegel, 2010; Sweet & Johnson, 1990). Mindfulness practice is viewed as a method that can enhance empathy by integrating affective, cognitive, intrapersonal, and interpersonal factors (Beddoe & Murphy, 2004). Furthermore, mindfulness meditation allows the practitioner to identify and understand personal feelings, creating insight as to these same

feelings in others (Andersen, 2005; Beddoe & Murphy, 2004; Shapiro & Izett, 2008; Siegel, 2010). An example of this process is described as Gendlin (1974) makes a clear though unintended connection between empathy and mindfulness in counseling. Student therapists were instructed on how to have empathy in session as Gendlin explained,

> These days we introduce listening on an experiential base. We do not first give therapists the puzzling instructions to repeat what their clients say. Rather we convey what it is like to get into yourself, to accord yourself a friendly hearing, to allow, without rebutting, the coming up of anything that will be there inwardly. We convey that in relationship to oneself, one must not immediately argue with what comes, or put oneself down for it, or explain it; rather one must gently allow it to be there , just exactly in what ever way it comes up to be felt. When this attitude is understood, listening is presented as how one would help people take that attitude toward themselves, within themselves (p. 220).

This description is very nearly identical to instructions typically given to novice meditators (Andersen, 2005). Furthermore, Gendlin seems to suggest that interpersonal empathy emerges from empathy directed at the self and this supports the notion that the capability for empathy might be cultivated by meditation (Andersen, 2005; Shapiro & Izett, 2008).

Empirical literature.

Empirical literature on mindfulness and empathy has obtained promising results. One of the first investigations was a quasi-experimental study conducted by Lesh (1970) with counseling psychologist students who participated in a meditation intervention. The

intervention group practiced zazen meditation for 30 minutes per week for 4 weeks. Zazen meditation is similar to mindfulness meditation and involves sitting motionless, concentrating on the in and out breath, and gently redirecting wandering thoughts back to the breath (Maupin, 1962 as cited in Lesh, 1970). It is comparable to the breathing meditation in MBSR (Kabat-Zinn, 1990). The study included three groups: (a) 16 students who were taught Zen meditation, (b) 12 students interested in learning Zen meditation but in a wait-list group, and (c) 11 students who were not interested in learning meditation. Lesh (1970) reported that participants in the meditation group recorded significant increases in empathy, openness to experience, and self-actualization as compared to the control groups. In the study students' empathy was measured as accuracy in assessing emotions demonstrated by a videotaped client.

A randomized control trial examined the effects of an 8-week intervention, modeled after MBSR (Kabat-Zinn, 1990), on health care students' empathy (Shapiro, Schwartz, & Bonner, 1998). The 78 participants were randomized to either the intervention group or to a wait-list control group. Both groups were comprised of medical and premedical students. The treatment group exhibited a significant increase in empathy while the control group demonstrated a decrease in empathy. The control group then took part in the intervention and recorded similar increases in empathy.

Another study investigating the impact of MBSR on counseling psychology students demonstrated significant increases of empathy at post-intervention (Shapiro, Brown, & Biegel, 2007). Mindfulness scores increased after the intervention as well as empathy and self-compassion scores. The researchers concluded that mindfulness mediated the changes in empathy and self-compassion. The notion that self-compassion

increased as well as empathy supports the hypothesis described earlier that the mindfulness practice of understanding and accepting feelings within the self promotes this same quality with others.

Bentley-Greason and Cashwell (2009) explored mindfulness and self-efficacy as well as the mediating role of empathy and attention with master's counseling interns and doctoral counseling students. Participants (n = 179) were surveyed to determine levels of and correlations between the aforementioned constructs. The researchers found that mindfulness did significantly predict empathy although empathy did not predict counseling self-efficacy and was not a mediator of that relationship. They also reported the mindfulness was a predictor of counseling self-efficacy and that attention was a mediator of those relationships.

In a 4-year qualitative study, Schure, Christopher, and Christopher (2008) instructed CITs (*n* = 33) in a 15-week course modeled after MBSR, which included hatha yoga, meditation, and qigong. The CITs reported a greater capacity for empathy and compassion. Additionally, the students described positive physical, emotional, mental, spiritual, and interpersonal changes as well as effects on their therapeutic relationships and skills.

Several doctoral candidates, via their dissertation work, have also examined the relationship of mindfulness and empathy in counseling students with mixed results. One study supports the idea that mindfulness can improve CIT empathy while two studies were not in agreement with this premise. Vinca (2009) conducted a mixed method, case study to explore the relationship of mindfulness and presence to empathy, anxiety, and session progress from CIT and client perspectives. The participant, a doctoral counseling

psychology student, was selected based on his *median* level of experience with meditation. Median level of practice was calculated across all participants who volunteered to be part of the study but was not explicitly described. Quantitative results indicated that mindfulness and presence were related to all of the dependent variables. Qualitative findings suggested that mindfulness contributed to the therapist's presence and empathy as well as anxiety reduction while in session. The mixed method data indicated that the therapist is more effective in the relationship with the client by being aware with a nonjudgmental stance.

Zanetich (2012) explored the relationship between CIT (n = 86) self-reported mindfulness and countertransference management factors (self-insight, anxiety management, and empathy). The countertransference factors were rated by supervisors during CITs' sessions with clients. Results suggested that trait mindfulness was not significantly correlated with any of the criterion variables. However, CIT history of mindfulness training significantly and positively correlated with anxiety management indicating a predictive link.

Spragg (2011) utilized a true experimental design with wait-list control group to investigate whether an MBSR program would improve levels of mindfulness, self-awareness, and empathy while reducing levels of burnout with therapist trainees. The participants took part in an 8-week MBSR program implemented by an instructor with 10 years of MBSR training experience. Pre, post, and follow-up test scores were evaluated with self-report measures and none of the hypothesized changes occurred in the dependent variables.

Aiken (2006) interviewed psychotherapists who were experienced mindfulness practitioners; they were asked to discuss their views on how mindfulness practice influenced their cultivation of empathy with clients. Participants explained that mindfulness facilitates empathy in many ways: (a) it permits complete awareness of mind and body experiences, (b) it allows the therapist to help clients slow down and learn from and about themselves, (c) it fosters a nonjudgmental presence with whatever the client presents, (d) it helps the therapist be calmer and less reactive with clients, and (e) it nurtures a feeling of loving-kindness toward the client.

Theoretical and empirical literature frequently supports the premise that mindfulness can facilitate empathy (Aiken, 2006; Andersen, 2005; Lesh, 1979; Shapiro & Brown, 2007; Schure, Christopher, & Christopher, 2008) as well as the overall therapeutic relationship (Christopher & Maris, 2010; Shapiro & Carlson, 2009; Siegal, 2010; Wexler, 2006). As such, mindfulness has been proposed as a necessary component of mental health training programs (Bruce et al., 2010; Davis & Hayes, 2011; Fauth, Gates, Vinca, Boles, & Hayes, 2007; Fulton, 2005; Hick, 2008). The following section will discuss the current hypotheses and research related to uses of mindfulness training with counseling students.

Mindfulness and Counselor Training

Research illustrating the effectiveness of mindfulness as a means to develop therapeutic relationship skills has gained momentum in recent years (Christopher et al., 2006; Bentley Greason & Cashwell, 2009; McCollum & Gehart, 2010; Schure et al., 2008; Shapiro, Brown, & Biegel, 2007). This promising literature has led researchers to suggest that mindfulness may be an effective resource for training counselors of any

theoretical orientation as it provides a method to influence the factors that affect outcome the most (Fulton, 2005; Germer, 2005). A foundational skill of the art of therapy is the counselor's capacity to listen and be present in a skillful way; a way that is warm, receptive, accepting, and lacking judgment (Bien, 2005; Rogers, 1957, 1975). This method of listening reveals to the client that the counselor is more interested in understanding than assessing, diagnosing, or fixing. In addition, the mindful counselor attitude and presence fosters the therapeutic relationship (Bien, 2008; Fulton, 2005, Siegal, 2010).

The practice of counseling, like mindfulness, can seem deceptively simple to explain but is not as easy to implement (Bien, 2008). In training, the complex process of counseling is typically broken down into components, called microskills, where the focus is the development of observable skills (Ivey, 1971; Ridley, Mollen, & Kelly, 2011; Truax & Carkhuff, 1967). Examples of these skills include attending behaviors such as eye contact, body positioning, vocal tone, and statements that reflect the client's feelings, paraphrasing, or summarizing. In tandem with skills training there is an emphasis on theory and its application to practice (Fulton, 2005).

This knowledge base provides a necessary foundation for making informed decisions about client conceptualizations and applicable treatment. Yet, there is the possibility of confusing models and theories for the *truth* of what is experienced with a client (Fulton, 2005), especially as a novice counselor. Consequently, Bien (2008) suggests that "while traditional training for psychotherapists involves gaining a knowledge base and a set of techniques, little attention has been paid to the cultivation of

the kind of attitude that might facilitate the therapeutic relationship and therapeutic outcome" (p. 41).

This attitude, facilitated by mindfulness, is comprised of a broad range of qualities that may enhance the helping environment with clients. Some of these nurturing qualities have been proposed as counselor attention, presence, empathy and attunement with clients, as well as self-directed compassion, attunement, emotion regulation, and countertransference management (Bruce et al., 2010; Shapiro & Carlson, 2009). Siegel (2010) proposes that mindfulness can promote the counselor qualities of presence, attunement, resonance, and trust that first begin with the self and then can be provided to the client. Fulton (2008) also posits that many counselor attributes can be advanced with mindfulness as they are applied to self and then to others. These attributes include attention, affect tolerance, acceptance, empathy and compassion.

Empirical literature.

Counselor therapeutic qualities.

Connections between mindfulness and counselor helping qualities have been investigated in several studies. Escuriex and Labbé (2011) conducted a review of the empirical literature examining mindfulness and mental health care providers' therapeutic attributes. The researchers found six related studies, five of which included therapists in training. The remaining study included practicing therapists. Three of the studies were qualitative; one was non-randomized, cohort-controlled; one was quasi-experimental; and one was a survey study.

The reviewers explained that participants who took part in mindfulness-based interventions reported decreases in stress, rumination, anxiety, and overall negative affect

(Christopher et al., 2006; Hyden, 2009; Shapiro et al., 2007). Also, following participation in the interventions, individuals conveyed increases in calmness, self-compassion, positive affect, and improvements in overall physical and mental health (McCollum & Gehart, 2010; Schure et al., 2008; Shapiro et al., 2007). Participants who did not take part in an intervention but who had higher trait levels of mindfulness reported lower levels of job-related burnout and higher levels of work satisfaction and positive affect (May & O'Donovan, 2007).

Beyond the personal benefits of the interventions, participants also believed the mindfulness training would be valuable and applicable to the counseling process. Participants reported improvements in: (a) ability to conceptualize clients' cases, (b) attention to the therapy process, (c) awareness of their own and clients' experiences during therapy, and (d) ability to be in the moment while in session (Christopher et al., 2006; McCollum & Gehart, 2010; Schure et al., 2008). In summary, the Escuriex and Labbé (2011) review indicated that counselors not only had positive personal gains in psychosocial functioning with mindfulness-based interventions, they also perceived enhanced capabilities in their therapeutic interactions.

A study by Bentley Greason and Cashwell (2009) indicated that mindfulness was related to counselor attributes that may promote the therapeutic relationship. In their survey of counseling graduate students, they found that trait-mindfulness predicted empathy, attention, and counseling self-efficacy. They concluded that mindfulness is related to attention and empathy and that mindfulness should be considered a skill that could facilitate the therapeutic relationship (Bentley Greason & Cashwell, 2009).

Two qualitative dissertations were conducted to investigate the relationship of mindfulness with counselor qualities that contribute to the therapeutic relationship. Lau (2009) explored the experiences of psychology graduate students as they took an academic course on mindfulness. Initial and follow-up interviews as well as field notes were utilized for data analysis. The analysis resulted in nine themes: (a) previous knowledge of mindfulness, (b) mindful definition, (c) mindfulness principles adopted for individual distress, (d) mindfulness as fulfilling as multifaceted, (e) mindfulness clinical application, (f) mindfulness changes in self, (g) mindful clinician, (h) regulation of emotions, and (i) secondary gains. Two of the nine themes could be viewed as having direct therapeutic relevance: mindfulness clinical application and mindful clinician. An additional two themes could be viewed as having influence on the therapist's ability to affect the therapeutic environment: regulation of emotions and mindfulness principles adopted for individual distress.

In another qualitative dissertation, Evers Killebrew (2012) investigated the experiences of doctoral psychotherapists in training as they attended a 10-week mindfulness course that included theory, research, and practice based on MBSR. Themes from the participants' journals and final papers gathered over two summers were described in five categories: (a) intellectual understanding, (b) relationship to practice, (c) effects of practice, (d) reflection on course, and (e) application. Participants reported that mindfulness improved well-being, ability to cope, capacity to shift perception of negative events, compassion for self and others, and capability to relax during a stressful event. Additionally, individuals described a deep appreciation for the ability to be

mindful as it impacted their personal relationships and professional abilities (Evers Killebrew, 2012).

Therapeutic alliance and client outcomes.

With regard to counselor mindfulness, therapeutic alliance, and client outcomes, mixed results have been reported (Escuriex & Labbé, 2011). Nine studies consisting of counselor-client dyads were reviewed including: one historical control study, one randomized control trial, six correlational investigations, and one mixed methods project. Grepmair et al., (2007a, 2007b) conducted two studies that were favorable for the mindfulness-outcome link. In the preliminary study, student therapists underwent mindfulness training. Following the intervention, patients of the participant therapist trainees evaluated their individual therapy experience with significantly higher scores than patients who were treated prior to the therapists' mindfulness instruction. Additionally, patients seen after the therapists' training reported improved comprehension of personal difficulties, psychological processes and progress, and capabilities in developing new behaviors (Grepmair, 2007b). In a second study, student therapists were randomly assigned to either a control or experimental group (Grepmair, 2007a). The therapists in training practiced mindfulness meditation with a Zen meditation master, weekdays, from 7:00am to 8:00am, for 9 weeks. Results were positive as clients who were seen by therapists in the mindfulness intervention had significantly different outcomes from the control group clients. The experimental group patients' emotional and symptomatic stress decreased and they reported higher scores on their evaluations of their individual therapy sessions.

Two correlational studies supported the mindfulness and outcome association. Wexler (2006) examined therapist-client dyads to find the relationship between therapist self-reported mindfulness and therapeutic alliance. Significant correlations were reported between therapists' global mindfulness and both the clients' and therapists' assessments of the alliance. Also, Padilla (2010) posited that a positive relationship would exist between therapists' mindfulness, therapists' relational behaviors, therapists' and client's alliance ratings, and clients' outcome scores. Participants were psychologists, interns, and residents at a metropolitan medical center as well as their individual clients. Results indicated that therapist mindfulness levels were significantly related to the therapist's interpersonal abilities and to clients' and therapists' ratings of therapeutic alliance. Levels of therapist mindfulness were also significantly correlated to gains on outcome scores related to psychosocial functioning, interpersonal sources of distress, and initial presenting problem. However, therapist mindfulness was not correlated with outcome scores related to psychiatric symptoms.

In three correlational studies, therapist trait-mindfulness was explored and no association between mindfulness and outcome was demonstrated. Stanley et al. (2006) measured trait-mindfulness in doctoral interns using a manualized psychotherapy with adult clients. Therapist mindfulness was compared with client symptom severity and improvement as well as overall functioning. No significant relationships were found to indicate mindfulness as a predictor of positive treatment outcomes. Stratton (2006) explored the relationship between therapist trait-mindfulness and client outcomes in a university venue. Two-year longitudinal and archived data were examined for the participating therapists' client outcomes. No correlations between therapist mindfulness

levels and treatment outcomes were found, indicating that increased levels of mindfulness were not related to improved client outcomes over time. Finally, Bruce (2009) explored correlations between counselor trait-mindfulness, therapeutic alliance, and treatment outcome. Mindfulness scores of doctoral and master's level therapists were correlated with alliance and outcome scores from their respective clients. Outcome scores included clients' depressive symptoms and percentage of client symptom remission in the therapists' caseload. Again, no significant correlations were found between mindfulness and the comparative variables suggesting no connection between level of counselor mindfulness, therapeutic alliance, and treatment outcome.

Kaplan (2013) explored correlations between therapist mindfulness, treatment process, and outcomes with mixed results. Participants were interns, externs, psychiatry residents, and clinical psychologists at an urban medical center as well as their correlating clients. Therapist self-reported mindfulness level was found to correlate strongly with therapist ratings of the therapeutic alliance, and client-therapist, inter-subjective scores in the reporting of ruptures during treatment. Inter-subjective scores have been hypothesized as a measure of attunement and understanding between client and therapist perceptions of therapy (Rozmarin et al., 2008). Therapist mindfulness was not correlated with client ratings of the therapeutic process (alliance, rupture resolution, and session evaluation) or client outcome scores (psychiatric symptoms, initial presenting problem, overall mental health, and interpersonal sources of concern).

Finally, a mixed methods study including a brief intervention with psychology students had positive results. Moore (2008) utilized a brief mindfulness training consisting of 10 minute mindfulness practice implemented in 14 sessions over a one

month period. Quantitative results included significant improvement in mindfulness and in the self-care subscale of the Neff Compassion Scale (NCD; Neff, 2003). However, there was and no significant change in perceived stress. Qualitative findings suggested that participants had new insights into their personal cognitions and emotions. Additionally, the participants recognized the benefits of incorporating mindfulness into their personal and professional life.

In summary, the empirical research tentatively suggests that mindfulness training for counselors can enhance their personal and professional lives by improving their well-being as well as cultivating their therapeutic relationship qualities, respectively (Escuriex & Labbé, 2011). However, this premise is supported by mostly qualitative and correlational research and could be reinforced with more representation from true experimental and mindfulness intervention studies. Meanwhile, the hypothesis that therapists who either practice mindfulness or have greater levels of mindfulness will produce better client outcomes has not been clearly supported in the literature (Escuriex & Labbé, 2011). With regard to the therapist mindfulness and outcome connection, a preponderance of research examines counselor trait-mindfulness versus counselor mindfulness as a result of training and practice. To support the notion that therapist mindfulness can contribute to therapeutic outcomes, more randomized-controlled studies are needed as well as more studies that include a mindfulness intervention for counselors.

Conclusion

The quality of the counselor-client relationship seems to impact the therapeutic process (Rogers, 1957, 1975; Miller & Duncan, 2000). Counselor and client working together in an atmosphere of trust, operationalized as a working-alliance, is a significant

contributor to positive outcomes (Lambert, 1992; Martin et al., 2000; Horvath et al., 2011). Mindfulness concepts such as non-judgment, presence, acceptance, and compassion promote the counselor's ability to establish a healing relationship with the client (Fulton, 2005, Hick, 2008; Siegel, 2010). Counselor training that reflects mindfulness concepts has been shown to increase personal well-being as well as empathy, attention, and other counselor qualities that nurture the therapeutic bond (Christopher et al., 2006; Grepmair, 2007a, 2007b; Hyden, 2009; McCollum & Gehart, 2010; Shapiro, Brown, & Biegel, 2007). This study examines further the effect of a mindfulness intervention with counselors in training. This project contributes to the limited existing body of literature by specifically analyzing the effects and experiences of a mindfulness program with counselors in training. It explores how a mindfulness intervention directly impacts CITs' mindfulness, empathy, and therapeutic alliance levels as well as CITs' perceptions of learning, practicing, and applying mindfulness methods in their personal and professional lives.

Chapter 3

Methodology

Mixed Methods

This project employed a mixed methods, convergent parallel design (Creswell & Plano Clark, 2011) to explore the effects of a systematic mindfulness training intervention on the therapeutic alliance established between counselors and their clients in a university, counseling training clinic. Quantitative and qualitative data were collected at the same time and results from each data set were compared for agreement, discrepancy, or a combination thereof (Creswell & Plano Clark, 2011; Jick, 1979).

Mixed methods rationale.

Woolley (2009) explained that quantitative and qualitative components within the same study can be "mutually illuminating, thereby producing findings that are greater than the sum of the parts" (p. 7). In this study, a mixed method design affords the unique opportunity to explore the multifaceted (Baer et al., 2006), personal, and fluid phenomenon of mindfulness (Kabat-Zinn, 2004) particularly in the context of its impact on counselors in training (Bruce, Manber, Shapiro, & Constantino, 2008). A mixed methods approach enabled the researcher to address a unique combination of research questions not typically supported by either a purely quantitative or qualitative investigation.

Additionally, while qualitative (Aiken, 2006; McCollum & Gehart, 2010; Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008) and quantitative (Grepmair et al., 2007a, 2007b; Shapiro, Brown, & Biegel, 2007) studies have been conducted with regard to mindfulness training for

student therapists, only one mixed methods study has been performed to date (Moore, 2008). The current mixed methods study is unique in that it included client outcomes as they related to CIT outcomes and personal experiences while the CITs participated in a mindfulness training program.

Quantitative research questions for this study include the following:

- What are the effects of a mindfulness intervention with CITs?
    - What are the effects of the intervention on therapeutic alliance outcomes as reported by CITs, clients, and instructors?
    - What are the effects of the intervention with regard to CIT mindfulness and empathy?
    - How is CIT mindfulness practice related to outcome measures?

Qualitative research questions for this study included the following:

- What are the experiences of CITs as they participate in a mindfulness intervention?
    - How will these experiences manifest in the personal and professional lives of CITs?

The quantitative portion involved a single-case, multiple baseline across individuals design (O'Neill et al., 2011; Kazdin, 2011). The qualitative portion consisted of a phenomenological format (Moustakas, 1994; van Manen, 2001).

Quantitative Method

The multiple baseline single-case research design was selected for this project to examine and demonstrate "functional relationships between independent and dependent variables" (O'Neill et al., 2011, p. 1). A functional relationship is determined when the

data validates that the independent variable (MTP) reliably creates change in the dependent variable (therapeutic alliance; Baer, Wolf, & Risley, 1968). Furthermore, single-case methods provide the opportunity for interventions to be implemented in counseling environments where large numbers of participants are typically not available. Single-case design is conducive to counseling practice and training, thereby increasing its relevance for use in counseling settings (Heppner, Wampold, & Kivlighan, 2008; Foster, 2010).

Single-case design includes a number of distinct features that differentiate it from group design. In a single-case research study the focus is on data at an individual case level rather than at the group level (O'Neill et al., 2011). Typically, it involves baseline and treatment phases. During the baseline phase, data are collected prior to the implementation of the intervention to establish how the individual case or participant has been performing on the dependent variable. During the treatment phase, an intervention is applied which is expected to affect the dependent variable. In single-case design outcome variables are repeatedly measured over time. During the baseline and treatment phases, data are collected at regular intervals. In this study, data were collected in baseline, treatment, and follow-up phases to investigate the effects of the mindfulness intervention over time.

The distinct features of single-case designs, including multiple baseline, yield several strengths that make them particularly practical in the development of interventions (Heppner, Wampold, & Kivlighan, 2008; O'Neill et al., 2011). Multiple baseline designs are recommended for studies that involve new types of treatment because they allow rigorous examination of the treatment effect in each participant at

regular intervals (Kazdin, 2011). Treatment effect is analyzed via a comparison of an individual's typical performance (e.g., baseline) versus performance after the implementation of an intervention or treatment (Kazdin, 2011). Therefore, participants serve as their own controls and individual effects are not lost within the mean scores as in group comparison design (Heppner, Wampold, & Kivlighan, 2008; O'Neill et al., 2011).

In single-case design, repeated data collection, controls for threats to internal and external validity by demonstrating replication of treatment effects at repeated points in a study (O' Neill et al., 2011; Sidman, 1960). The ability to observe experimental effects over time is exceptionally valuable when utilizing an intervention because it reinforces the argument that an intervention is functioning in a particular manner for various participants (Horner et al., 2005). Knowing how the intervention functions over time with various participants allows a researcher to assert the effect of an intervention (functional relationship) more conclusively. In multiple baseline across participants designs, when an anticipated change from baseline to intervention phase occurs with a minimum of three participants, the experimental effects are considered clear and convincing (Horner et al., 2005; Kennedy, 2005; O' Neill et al., 2011).

Qualitative Method

The qualitative portion of the study involved a phenomenological approach. This type of research explores participants' personal experiences regarding a specific phenomenon (Moustakas, 1994). Phenomenology focuses on "descriptions of experiences, not explanations or analyses" (Moustakas, 1994, p. 58). This type of inquiry requires a stance much like the mindfulness trait of a non-judgmental, open, and curious mind (Kabat-Zinn, 1990; Shapiro & Carlson, 2009; Siegel, 2010). Epoché is the term

used by phenomenologists to describe how the researcher requires an attitude of wonder whereby his or her own presuppositions and biases are tucked away in order to enter fully into the world of the participants' situation (Husserl, 1931; Wertz, 2005). This open immersion into the participants' experience is the font from which meanings, via intentional analysis, effervesce (Wertz, 2005). Meanings or themes represent the essences; essential, common qualities of participants' experience of a phenomenon (Husserl, 1931; Moustakas, 1994).

In this study, the phenomenon was the CITs' experience of learning and practicing mindfulness based meditation. Phenomenology was chosen for this study to elicit a more personalized context that could then be compared and evaluated with the quantitative results. The CITs' perspectives of mindfulness training and practice were examined and compared with quantitative outcomes. Through this approach, the CITs' struggles, triumphs, and insights were included as part of the analyses and inferences of this project. In order to establish the integrity of the qualitative aspects of this study, several strategies were utilized.

Trustworthiness of data collected.

Trustworthiness is essential in establishing quality or rigor in qualitative work and allows the reader to assess the credibility of a study (Hunt, 2011; Lincoln & Guba, 1985). Furthermore, researchers should clearly illustrate the methods utilized to demonstrate trustworthiness (Hunt, 2011). The methods the primary investigator employed to ensure a valuable and meaningful study included:

- triangulation,
- prolonged engagement,

- persistent observation,
- member checking,
- peer debriefing,
- thick description,
- an audit trail,
- and reflexivity (Lincoln & Guba, 1985; Patton, 2002).

Triangulation improves a study's rigor by combining several methods (Hunt, 2011; Patton, 2002). This approach is used to test for consistency in the results (Patton, 2002). For this project, the primary researcher utilized data triangulation and methods triangulation. Data triangulation involved the use of multiple data sources (MCIT journal, log, focus group, instructor questionnaire, and researcher journal) and methods triangulation involved the use of multiple methods (quantitative and qualitative; Denzin, 1978).

Prolonged engagement is the "investment of sufficient time to achieve certain purposes" including: learning the culture of the participants in the situation being studied, building trust, and testing for misinformation (Lincoln & Guba, 1985, p. 301). During the semester (16 weeks), the primary researcher learned about the culture of the CITs in their environment at the Counseling and Training Clinic by spending one to two days per week in the clinic during operating hours. This included simply observing the tone and operations of the clinic as well as monitoring and providing feedback for counselor/client sessions. The researcher also spent one class period per week with each CIT during the six week training program where insights and struggles concerning mindfulness were exchanged during every session.

These multiple types and levels of interaction with the CITs facilitated the development of a trusting relationship with the participants. Trust is not only a vital part of prolonged engagement, it is also essential for the inquiry process of mindfulness instruction (McCown, Reibel, & Micozzi, 2011). Earning participant confidence was essential to create an environment where the CITs felt comfortable exposing their inner most thoughts and reactions to learning mindfulness via their journals, practice logs, the focus group, and during class sessions.

Finally, testing for misinformation requires the researcher to be immersed in a site long enough to detect distortions (personal and/or participant) that could influence the data (Lincoln & Guba, 1985). Personal distortions are checked through the process of examining the researcher's interpretations to ensure they are evolving; not fixed on the original hypothesis (Lincoln & Guba, 1985). The researcher's personal distortions about this study were shared in the *reflexivity* section as well as in the transparent analysis of the data. Participant distortions are checked by the researcher as she spends enough time in the setting to notice and account for participants who either attempt to please or deceive the researcher (Lincoln & Guba, 1985). In this study, the researcher spent 16 weeks with the CITs. She read their journals, discussed their mindfulness practice in class sessions, worked with them at the clinic, and asked for feedback at the focus group. This multifaceted and extensive interaction allowed for the perception of participant distortions that were reported in the body of the data analysis and in the single-case analysis, specific to each participant.

Persistent observation is utilized to identify elements of the phenomenon that are most pertinent to the studied issue and then concentrating on them in detail (Lincoln &

Guba, 1985). This includes examining not only convergent data but also discrepant and inconsistent data. The primary investigator addressed persistent observation via a detailed description of the qualitative data analysis.

Member checking is a trustworthiness method to explore participants' reactions to researcher findings and to ensure the reflections of participants are included in a study (Hunt, 2011). During the focus group (week 9), participants were asked for their feedback regarding initial themes gathered from their journals. In the discussion, participants were specifically asked for their critical responses and whether they thought any relevant topics related to their experiences were missed. All participants (n = 5) in the focus group concurred with the initial themes. Counselor 12 stated, "I think you caught the spectrum of insight. I see myself in all those areas (themes)."

Peer debriefing is "a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind" (Lincoln & Guba, 1985, p. 308). Two peer debriefers were utilized for this study. The primary peer debriefer was a Counseling Education instructor who teaches qualitative research methods and has published qualitative studies in peer-reviewed journals. The secondary peer debriefer was the co-instructor who has over 20 years of experience as a Counselor Educator and has published qualitative work in refereed journals. Although this person could be considered an *interested* peer, he also had 3 years of experience with mindfulness practice and instruction. Both of these experts critically examined themes, insights, possible biases, and the audit trail for integrity. They also made suggestions and recommendations for improving and refining the findings.

Thick description is an in depth, rich, or satiated depiction of the participants' experiences and the context of those experiences (Geertz, 1973; Morrow, 2005). Thick description allows the reader to decipher whether there is a connection between the participants' perspectives and environment and the emerging analysis and findings (Patton, 2002). Thick description was honored in this study by utilizing in vivo coding (Straus & Corbin, 1998) to capture the literal verbiage and voice of the participants. This method grounded the analysis in the participants' literal perspectives rather than the researcher's interpretations. In addition, context was explained in the single-case analyses as well as in the description of the training clinic and classroom environments.

An *audit trail* is a carefully detailed account of research processes and events that depict how the findings were derived (Morrow, 2005). This trail should illustrate a clear path back to the raw data (Lincoln & Guba, 1985). Descriptions of the analyses were recorded in the thematic analysis process notes and the ongoing reflexive journal that included insights, hypotheses, and struggles with decisions about themes, outliers, or noncompliant data.

Reflexivity is important to establish trustworthiness because "researchers need to be clear to readers about their roles in a study, including describing their assumptions and potential biases about the phenomenon in question and how they were addressed throughout the study" (Hunt, 2011, p. 297). In order to be transparent about personal biases and assumptions about this topic, the principal investigator kept a journal. Entries included thoughts, questions, and insights regarding personal perceptions of factors and events that came into the researcher's field of awareness during the course of the semester.

The primary *researcher's role* was influenced by personal experience with mindfulness. Mindfulness practices made a positive impact on the researcher while she was enrolled in a counseling wellness class as part of a doctoral curriculum. Mindfulness practice instigated a heightened awareness of self and personal perceptions relating to the world. Initially there was a discovery of the ability to tune in with a new appreciation of the physical self. By becoming aware of and listening to the body there was a realization that it communicated a message: your neck and shoulders are tight, your eyes are tired, you are feeling relaxed. Being aware of physical sensations allowed the researcher to appreciate what was well and to adjust what was not.

Mindfulness also impacted the principal investigator's personal relationships. In a few weeks of practice there was insight as to how mindfulness helped with parenting. Instead of knee-jerk, angry reactions to squabbling children, mindfulness facilitated more intentional, receptive observations of the researcher's internal state. First, there was an awareness of physical and emotional feelings of irritation. Second, there was an open acknowledgement of those experiences. Third, once recognized, the feelings were released in order to refocus with intent and proceed with more creative and informed solutions to problems. The process of mindfulness not only had a positive effect on the researcher's interactions with her children, it improved the relationship overall.

Mindfulness sparked the researcher's interest as dissertation topics were examined. There was a heartfelt desire to conduct a meaningful intervention with counseling students that could help them in their personal and professional lives. Wellness, stress management, and mindfulness topics were explored. Consequently, the research documenting the success of mindfulness in the medical and the behavioral

sciences was discovered. Additionally, there was a gap with regard to mindfulness in counselor training. Voila! A mindfulness intervention could be created and implemented for counseling students to explore the results via quantitative and qualitative means. The primary researcher practiced mindfulness techniques for approximately 10 months prior to proposing this study. Although a self-described beginner of mindfulness practices, the researcher utilizes and supports the power of nonjudgmental, moment-to-moment awareness.

The primary investigator was intensely involved with the creation and co-implementation of this mindfulness intervention. The protocol, was based on the MBSR (Kabat-Zinn, 1990) format, which included weekly session themes. The themes guided the subject matter and experiential activities of each class session. The researcher practiced each of the selected experiential activities to ensure the exercises were valid for the course. Consultation with the co-instructor was implemented for each class session to cross-check the in-class agenda and teaching objectives for agreement.

The primary researcher was actively engaged with the participants in the study. During the semester, one to two days per week were spent at the Counseling and Training Clinic in observation of the daily practice of students and supervisors on their quest to help clients. During the six week program, the researcher met with the students once a week to co-conduct the class. All class attendees engaged in some didactic but mostly experiential and discussion formats where the students and instructors shared their perspectives of learning and practicing mindfulness skills. Throughout the semester the co-instructors fielded participants' questions about mindfulness. Invitations to practice, record activity, and journal were implemented by the primary researcher who sent weekly

emails with a mindfulness quotation for encouragement. In turn, participants were invited to share their triumphs, challenges, and insights about mindfulness both verbally and in written form.

Study Participants

A total of 5 groups (n = 72) were recruited to take part in the study. Participants in the MTP sample included one group of CITs identified hereafter as mindfulness CITs (MCITs; n = 9), one group of corresponding clients (Mclients; n = 27), and one group of counseling instructors (n = 5). The control group sample included one group of CITs (CGCITs; n = 8) and one group of their corresponding clients (CGclients; n = 40). Seventeen of the clients were counseled by both MCITs and CGCITs. MTP participants included a nonprobabilistic, purposeful (Creswell & Plano Clark, 2011) sample of CITs who volunteered to take part in the mindfulness intervention. A nonprobabilistic sample was used in the quantitative design and involves the selection of participants who are available and can be studied (Creswell & Plano Clark, 2011). A purposeful sample was used in the qualitative design to intentionally select individuals who have experience with the subject or phenomenon under examination in the study (Creswell & Plano Clark, 2011). The client and instructor participant groups were asked to volunteer based on CIT participation in the study. As a result, the client and instructor groups were also nonprobabilistic, purposeful samples.

CIT Participants.

The MCITs in the MTP and the CGCITs were enrolled in a CACREP accredited, master's level counseling program at a moderately sized university in the southwestern United States. All participants were enrolled in practicum, internship 1, or internship 2

courses gaining clinical experience at the on-campus, Counseling and Training Clinic. Practicum courses involve the first semester of clinical training while internship 1 and internship 2 involve the second and third semester of clinical training, respectively. The mindfulness CIT (MCIT) group was comprised of 45% (n = 4) practicum students, 22% (n = 2) internship 1 students, and 33% (n = 3) internship 2 students. For the control group CITs (CGCITs), 12.5% (n = 1) were practicum students, 12.5% (n = 1) were internship 1 students, and 75% (n = 6) were internship 2 students.

Each CIT volunteered for the study. Eleven MCITs began the mindfulness training. Ten MCITs (91%) completed all six sessions of training and one MCIT (9%) completed three sessions. Each MTP session was video recorded so that if participants missed a class, they could make it up on their own time and not miss any material. Six MCITs viewed one make-up video while two MCITs viewed two make-up videos. Two MCITs were not compliant with the journal and log homework. One of these MCITs also only attended three MTP classes. Therefore, these two MCITs were not included in the data analysis portion of the study leaving a balance of nine participants. Eight CGCITs and their clients (n = 40) were included for the duration of the study.

One hundred percent (n = 9) of the MCITs were female. The mean age of the MCIT group was 35 years of age (SD = 11.43) with a range from 25 to 57 years. There were 5 Caucasians (56%), 3 Hispanic/Latinos (33%), and 1 (11%) of Asian heritage. The average GPA for this group was 3.69 and the average number of counseling program hours completed was 48.27. Seven (64%) of the MCITs indicated that they had no history using mindfulness, either as a personal practice or as a counseling technique. Three (33%) MCITs reported that they engaged in a variety of mindfulness-type

practices, including meditation, yoga, and stretching. The occurrence of these practices was varied, ranging from "daily" to "sporadic" to "as needed".

Client Participants.

All client participants (n = 50) agreed to be involved in research studies as part of the terms of the university based Counseling and Training Clinic program. Clients remained anonymous throughout the study as only a clinic-issued, client identification number was utilized for each participant. The client information included demographic and client-reported session evaluation data. The clients were not in direct contact with the researcher and attended their sessions in a business as usual format. All clients completed demographic forms and session evaluations as part of regular protocol at the Counseling and Training Clinic. As such, the evaluation data were collected, scored, and forwarded to me by a non-participant, data management CIT. The demographic data were collected and forwarded to the researcher by the MCITs in the study. Each MCIT completed a demographic form for their clients using the clinic issued, client number for confidentiality.

The ethnicities of the client group consisted of 48% (n = 13) Caucasians, 37% (n = 10) Hispanic/Latinos, 7% (n = 2) Middle Easterners, 4% (n = 1) African Americans, and 4% (n = 1) Native Americans. The mean age of the client group was 42.11 (SD = 12.41). Clients' primary presenting concerns included 37% (n = 10) partner relational issues, 22% (n = 6) depression, 7% (n = 2) Post Traumatic Stress Disorder (PTSD), 7% (n = 2) anxiety, 7% (n = 2) adjustment and behavioral concerns, 4% (n = 1) anger issues, 4% (n = 1) addiction/dependency issues, 4% (n = 1) self-esteem problems, 4% (n = 1) family discord, and 4% (n = 1) career concerns.

University faculty participants.

The instructors for this study were counseling faculty with MCITs enrolled in either their practicum or internship class during the course of the semester. The instructors evaluated all of their students (participants and non-participants) in a blind review of two counseling sessions submitted as regular course assignments. The blind evaluation of all students was intended to minimize evaluator bias. Instructors also completed a questionnaire at the end of the semester about participant CITs.

All the participant instructors were female and 80% (n = 4) held doctoral degrees from CACREP counseling programs while 20% (n = 1) graduated from a non-CACREP program. Forty percent (n = 2) of instructors were Hispanic/Latino, 20% (n = 1) were Caucasian, 20% (n = 1) were African American, and 20% (n = 1) indicated Caucasian and Hispanic Latino ethnicity. The instructors averaged 9.8 (SD = 4.76) years of counseling practice and 4.55 (SD = 3.84) years of experience as Counselor Educators. Forty percent (n = 2) of the instructors were Licensed Practicing Counselor – Supervisors (LPC-S), 40% (n = 2) were LPCs, and 20% (n = 1) were LPC – Interns. Twenty percent (n = 1) of the instructors were Licensed Marriage and Family Therapists (LMFT), and 40% (n = 2) were Certified School Counselors (CSC).

Participant protection.

Participant confidentiality, safety, and well-being were paramount to the design of this study. The project was approved by the university Institutional Review Board [July 5, 2012; #49-12] (see Appendix A). Every precaution was taken to protect the participants' confidentiality. With regard to the MCIT group, all paperwork was identified with the counselor number issued by the Counseling and Training Clinic (e.g.,

demographic forms, journals, logs, pre-post tests, and SRS forms). This number was only utilized at the clinic for the therapeutic alliance (SRS) forms and was not a primary identifier; therefore the MCITs were not familiar with their colleagues' counselor numbers. Client confidentiality was maintained as they were also identified with clinic generated numbers. Clients' corresponding paperwork (e.g. demographic and SRS forms) was stored in locked file cabinets at the clinic. Instructor confidentiality was established with pseudonym identifiers that the instructors chose for the course of the study. All instructor forms (e.g. SRS and instructor questionnaire) were identified with their corresponding pseudonyms. While the client data remained at the Counseling and Training Clinic under lock and key, the remainder of the physical data including my personal research journal, all CIT information, and instructor information was stored in a locked filing cabinet at the primary researcher's residence.

Setting of the Study

The study was implemented in a moderate-sized university in the southwestern United States. The university's student-body consists of a large number of non-traditional students. The university is also qualified as a Hispanic-serving institution. The counseling program at the university includes master's and a doctoral program that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The counseling program offers master's degrees in addictions counseling; clinical mental health counseling; marriage, couple, and family counseling; and school counseling. The doctoral program offers a doctorate of philosophy in counselor education. The MTP classes took place in two classrooms.

Classroom description.

The initial MTP class and proceeding morning classes were held in the counseling doctoral library. This intimate room had a bright window and was recently filled with modern, tan furniture (one couch, two oversized chairs with small writing tables attached, and three small round tables with chairs). There was also a bookcase and a dry erase board. This room feels more like a cozy den than a classroom which is why the other instructor and I thought it would be a good place to help participants feel comfortable and contribute to quality discussions. The morning class was small (typically 3-4 students) so it was easy to move the tables and use yoga mats for the mindfulness exercises.

The fourth class, introducing the second module of the MTP, and the evening classes were held in the cafeteria/gym of the elementary school located in the same building on the university campus as the counseling program and the doctoral library. This was a large space with big windows also facing the ocean. Gymnastic mats were stored in this room making them available for participants to use during the activities. Before each class the mats were arranged in a circle including the instructors' mats to improve the dynamics of the discussion format.

In order to set a relaxing mood for each class, recorded music was played during the 10 minute journal time. This technique was also utilized to allow the MCITs to relax, calm their minds, and notice their thoughts so they could focus on their writing rather than engage in conversation. Either classical or meditation style music was played during the journaling process.

Counseling and training clinic description.

The University Counseling and Training Clinic is located in a building on the edge of campus with multi-room, enclosed, and secure offices that are accessed via a shared hallway. This building housed other university offices but student traffic is minimal and the environment is conducive to client privacy. Inside the clinic, there are four therapy rooms, one video monitoring room, a waiting room, and the director's office. All the therapy rooms are equipped with video cameras as all sessions were recorded for instructional purposes.

The clinic has a very professional appearance in its décor. There are comfortable chairs in all the rooms. All of the therapy rooms have a couch and chairs, except one room which is outfitted with children's furniture and shelves of toys. Artwork is carefully placed on each wall. The rooms are well lit and two of the therapy rooms have windows which allowed for natural lighting. Additionally, the white noise machines regularly whir outside each therapy room door.

During the fall semester, the clinic was always alive with activity whether students were preparing for their next client or sitting in supervision reviewing a recent session in the director's office. The student counselors were very supportive of each other. They took turns sitting up front welcoming clients to the waiting area. They cleaned up the office before closing each evening. They conferred with each other about challenging clients or successful breakthroughs. There was a sense of camaraderie and it was a positive environment for working, learning, and helping others.

Procedure

After receiving permission from the Counseling and Training Clinic director and the university Institutional Review Board, the CITs were recruited through the

Counseling and Training Clinic. CITs were informed about the study by the researcher at the clinic orientation meeting before the beginning of the fall 2012 semester. Those who accepted, completed consent forms, demographic surveys, and the pre-intervention surveys after the orientation meeting had adjourned. In appreciation for completing the study, all CIT participants were offered a $10 gift card from Wal-Mart.

CIT participants (n = 11) volunteered to participate in all phases of the study - baseline, intervention, and follow-up. The baseline phase consisted of 4 weeks prior to the intervention phase. During this time, the time series data was utilized to monitor the baseline phase for signs of regularity and maturation (Heppner, Wampold, & Kivlighan, 2008).

Baseline, intervention, and follow-up phase lengths were determined based on prior research (Aggs & Bambling, 2010; Richards & Martin, 2012), expert recommendations (Kazdin, 2011), and the necessity to complete the study within one semester. Finalizing the study in one semester increased the internal validity of the study by minimizing external factors (e.g., semester breaks) that might have impacted the dependent variables.

Quantitative and qualitative data were collected simultaneously in accord with the convergent parallel design (see Table 1; Creswell & Plano, 2011). Quantitative data were collected in two formats (time series and pre-post). Time series data for the CITs and the clients were collected from weeks 1 through 14 (therapeutic alliance) and weeks 5 through 14 (mindfulness practice time). The MCIT pre-intervention data were collected at the Counseling and Training Clinic three weeks prior to the beginning of the semester. Post-intervention data were collected after the last MTP session in week 9. Pre- and post-

intervention data (therapeutic alliance) were gathered from the instructors in weeks 15 and 16.

Table 1

Data Collection and Intervention Schedule

Weeks in Semester	-1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
MTP Intervention					X	X	X	X	X	X							
Therapeutic Alliance Data (CITs, Clients)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Alliance Data (Instructors)				X							X						
Pretest Data FFMQ 1/IRI 1	X																
Posttest Data FFMQ 2/IRI 2										X							
MCIT Journals										X							
MCIT Practice Logs										X					X		
Focus Group															X		
Questionnaire (Instructors)															X	X	

Qualitative data were collected via MCIT journals and practice logs, the MCIT focus group, and the instructor questionnaire. The MCIT journal data were acquired in week 9, at the end of the MTP. The mindfulness practice log data were collected in week 9 and week 14. The MCIT focus group data were collected in week 14 and the instructor questionnaire data were obtained in week 15 and 16.

Mindfulness Training Program

The intervention for this study was the mindfulness training program (MTP) taught to MCITs in 6 sessions over a 6 week period. In order to improve attendance, the

MTP was implemented with a morning and evening session so that participants could choose one of the options each week. The morning and evening sessions were identical and offered on six consecutive Fridays in weeks 4 to 9. The instructors for the MTP were the principal researcher and a faculty advisor. The principal researcher had approximately 10 months experience in mindfulness practices while the faculty member had four years of experience and was formally trained in cognitive behavioral mindfulness practice (Segal et al., 2002). The MTP was informed by MBSR (Kabat-Zinn, 1990; Stahl & Goldtstein, 2010;) as well as counselor-focused mindfulness methods (Shapiro & Izett, 2008; Siegel, 2010; Surrey, 2005).

MTP training sessions.

The MTP consisted of two modules: (1) mindfulness for personal development, and (2) mindfulness for professional development. The curriculum included didactic, experiential, and discussion/reflection formats in each class as well as daily and weekly homework assignments. During the course of the program, MCITs were asked to practice mindfulness at least 15 minutes per day, keep a log of their practice, and journal weekly about their experiences. Sessions 1 and 4 were 2.5 hour classes and introduced each of the modules. Sessions 2, 3, 5, and 6 were each a 1 hour class.

Module 1 (sessions 1-3) built a foundation of mindfulness concepts and experiential activities for personal growth. Session 1 was 2.5 hours and the theme of the class was Mindfulness: It's not what you think. The first 40 minutes were spent learning and practicing the mindfulness techniques of mindful walking (Stahl & Goldstein, 2010). The participants were escorted outside for this exercise and were then led back to the classroom. Immediately after the exercise, the MCITs were asked to

journal for 10 minutes about their perceptions of the mindful walk. The next 15 minutes were spent in discussion and inquiry about the MCITs' experiences with the mindfulness exercise. Following a 10 minute break, the next part of class included 30 minutes of didactic instruction on the history and definition of mindfulness (Kabat-Zinn, 1990), current research, formal versus informal practice, and the intention, attention, attitude (IAA) model of mindfulness (Shapiro et al., 2006). The next 30 minutes included two mindfulness exercises: (a) mindful eating and (b) the body scan (Stahl & Goldstein, 2010). The final 15 minutes were spent giving homework instructions and discussing how the MCITs might build their practice into their schedules. The instructors also fielded questions about the logistics of the study including the assignments and overall perceptions of participation.

Session 2 was a 1 hour class and the theme was pleasure and power of presence. The first 10 minutes were allotted for participant journaling. The next 30 minutes were spent in mindfulness practice and included mindful yoga (Stahl & Goldstein, 2010) and a breath awareness exercise (Kabat-Zinn, 2012). After the exercises, the class was asked what they were noticing in that moment and a discussion ensued for 10 minutes. The final 10 minutes were instructional as the IAA model (Shapiro et al., 2006) and the stop, take a breath, observe, and proceed (STOP) method were reviewed (Stahl & Goldstein, 2010). The homework assignment was also administered and any participant questions were answered.

Session 3 was a 1 hour class and the theme was shadow of stress and unpleasant events. The first 10 minutes were allotted for journaling. The next 10 minutes were instructional and included a review of IAA (Shapiro et al., 2006) and STOP (Stahl &

Goldstein, 2010). New material included information about monitoring the self and being reactive versus receptive during stressful events. This included a new model: recognize, acknowledge, investigate, and non-identify (RAIN; Stahl & Goldstein, 2010). Thirty minutes were spent in experiential techniques: a monitoring exercise (Siegal, 2010), a standing yoga exercise, and a sitting meditation (Stahl & Goldstein, 2010). The final 10 minutes were spent in inquiry and discussion as well as homework dissemination.

Session 4 was 2.5 hours long. This session introduced the concept of mindfulness as a counseling process skill and the theme was interpersonal mindfulness. The first 10 minutes, MCITs wrote in their journals. The next 25 minutes the instructors led a mindful check-in exercise (Stahl & Goldstein, 2010) so that the MCITs might notice their own thoughts, sensations, or emotions about their experience with mindful practice over the previous weeks. A discussion about participants' responses to this exercise followed. The next 30 minutes were used for inquiry and discussion of questions posed to the group: How do you think your mindfulness practice may have impacted your relationships? How do you think your mindfulness practice may have impacted your relationships with clients? How do you think mindfulness could influence the core conditions? The next 45 minutes MCITs were introduced to interpersonal mindfulness activities including: (a) an instructor created mirroring exercise, (b) a breathing-with exercise (Surrey, 2005; see Appendix C), and (c) a mindful listening and speaking exercise (Shapiro & Izett, 2008; see Appendix C). The final 40 minutes were spent in discussing a question: As you reflect on our session today, what stands out for you? Homework was assigned at the end of class.

Session 5 was 1 hour long and the theme was cultivating kindness and compassion for self and others. The first 10 minutes of class were allotted for participant journaling. The next 15 minutes were spent in a loving-kindness meditation (Stahl & Goldstein, 2010). A 15 minute inquiry and discussion about participants' perceptions of the meditation came next. The following 20 minutes began with another exercise entitled client's shoes and counselor greeting (Morgan & Morgan, 2005; see Appendix C) and then the instructors initiated discussion with several questions: What were you feeling and thinking as you were imagining yourself as the counselor? The client? What were your sensations or emotions? Homework was assigned and questions were answered.

Session 6 was 1 hour and 15 minutes long. The theme for the class was connecting mindfulness to counseling as well as maintaining momentum of practice. First, 10 minutes were allotted for journal writing. Next was a 20 minute query to explore if and how MCITs were using mindfulness in counseling. Then 15 minutes was devoted to an inquiry and discussion about the specific mindfulness exercises each MCIT preferred and how they envisioned maintaining their practice. A resource list of mindfulness books, websites, and local yoga classes was given to all MCITs to support their practice. Next, 10 minutes were spent in practicing and then discussing the utility of the 3-minute check-in exercise (Stahl & Goldstein, 2010). In the last 20 minutes, the MCITs completed the 2 post-tests for the study.

Instrumentation

Assessment instruments for this study included both standardized and researcher generated measures. The instruments were (a) the Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006), (b) the Interpersonal Reactivity Index (IRI; Davis, 1980,

1996), (c) the Session Rating Scale (SRS; Duncan et al., 2003), (d) the researcher created mindfulness practice log, (e) MCIT journals, (f) the MCIT focus group, and (g) an instructor questionnaire.

Mindfulness: Five Facet Mindfulness Questionnaire (FFMQ).

The dependent variable, mindfulness, was operationally defined as five facets: (a) nonreactivity to inner experience, (b) observing, noticing, and attending to sensations, perceptions, thoughts, and feelings, (c) acting with awareness, concentration, and nondistraction, (d) describing or labeling with words, and (e) nonjudging of experience (Baer et al., 2006). Mindfulness was measured with the Five Facet Mindfulness Questionnaire (FFMQ) which was derived from a number of self-report mindfulness surveys (Baer et al., 2006, see Appendix B). As a result, the FFMQ represents a collective understanding of mindfulness including its definition and measurement. The FFMQ was developed to provide an improved understanding of particular skills found to be key elements of a comprehensive mindfulness construct (Baer et al., 2006). Baseline strengths and weaknesses in mindfulness skills can be assessed with the FFMQ in order to determine whether training in mindfulness affects advancement in these skills (Baer et al., 2008).

The FFMQ measures five facets of mindfulness: (a) observing, (b) describing, (c) acting with awareness, (d) nonjudging of inner experience, and (e) nonreactivity to inner experience (Baer et al., 2008). Baer et al. (2008) explain that:

- *observing* involves "noticing or attending to internal and external experiences, such as sensations, cognitions, emotions, sight, sounds, and smells",
- *describing* involves the act of "labeling internal experiences with words",

- *acting with awareness* involves "attending to one's activities of the moment and can be contrasted with behaving mechanically while attention is focused elsewhere…",
- *nonjudging of inner experience* involves "taking a nonevaluative stance toward thoughts and feelings",
- and *nonreactivity to inner experience* involves "the tendency to allow thoughts and feelings to come and go without getting caught up in or carried away by them" (p. 330).

The five facets are combined to represent a global assessment of mindfulness. The FFMQ has 39 items and employs a 5-point Likert-type scale (1 = never or very rarely true, 5 = very often or always true; Baer et al., 2008). Sample questions include "I notice the smells and aromas of things" and "I perceive my feelings and emotions without having to react to them" (Baer et al., 2008, p. 330). Participants answer questions in the way that best describes what is typically true for them. The FFMQ takes approximately 5 to10 minutes to complete and higher scores are associated with a stronger sense of mindfulness.

The FFMQ was designed via an extension of research into the "facet structure of the mindfulness construct" (Baer et al., 2006, p. 28). Baer et al. (2006) investigated the psychometric qualities of five mindfulness measures: (a) Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2004), (b) the Freiburg Mindfulness Inventory (FMI; Buchheld, Grossman, & Walach, 2001), (c) the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004), (d) the Cognitive and Affective Mindfulness Scale (CAMS; Feldman, Hayes, Kumar & Greeson, unpublished manuscript, as cited in

Baer et al., 2006), and (e) the Mindfulness Questionnaire (MQ; Chadwick, Hember, Mead, Lilley, & Dagnan, unpublished manuscript, as cited in Baer et al., 2006). In the first phase of a multi-stage study, Baer et al. (2006) investigated the set of questionnaires for internal consistency, convergent and discriminant validity, and correlations with each other as well as meditation experience. In phase two, the researchers utilized an exploratory factor analysis to examine the facet structure of the five mindfulness measures, which included a compilation of all items. In phase three, Baer et al. (2006) performed a confirmatory factor analysis to explore the replicability of the facet structure derived from phase two.

For phases one and two, the mindfulness assessments were combined and administered concurrently with measures of other psychological constructs to undergraduate psychology students (n = 613). Baer et al. (2006) reported good internal consistency for all five mindfulness measures and moderate to large correlations in the predicted directions with all but one of the psychological construct measures. Exploratory factor analysis "yielded a five-factor solution accounting for 33% of the variance after factor extraction" (Baer et al., 2006, p. 33). Additionally, the five factors were only moderately intercorrelated. This suggested that the factors measured distinct but related components of mindfulness.

In stage three of the study, Baer et al. (2006) employed a confirmatory factor analysis to explore whether the five-facet model could be replicated in a second sample of undergraduate psychology students (n = 268). Convergent and discriminant validity were investigated at the facet level. The researchers reduced the initial item pool from 112 to 39 items and created the FFMQ (Baer et al., 2006). In order to improve internal

consistency and produce a measure of practical length, "items with the highest loadings on the five factors… were selected for inclusion in the facet scales" (Baer et al., 2006, p. 36). The alpha coefficients for each of the facets were reported as describing (.91), acting with awareness (.87), nonjudging (.87), observing (.83), and nonreacting (.75; Baer et al., 2006). Correlations between facets ranged from .15 to .34, indicating that each facet is unique from the other four (Baer et al., 2006).

Researchers have explored the psychometric characteristics of the FFMQ via administration with college undergraduate students (Baer et al., 2006; Baer et al., 2008), adult meditators (Baer et al., 2008), mental health practitioners (Baer et al., 2008), and adults diagnosed with depression and anxiety (Bohlmeijer et al., 2011). The researchers concluded that the FFMQ was a reliable and valid instrument for these populations. Baer et al. (2006) indicated that the FFMQ measures discrete components of mindfulness and that the facets have strong internal consistency. The FFMQ was deemed a good fit for this study because it is a sound measure, it has been used successfully with a variety of populations, and it has been determined to be effective for use in mindfulness training (Baer et al., 2008). The global score, including all the five facets, was used for this study.

Empathy: Interpersonal Reactivity Index (IRI).

Empathy is another significant component of this study. Individual differences in empathy as well as responses to the MTP intervention are expected to be reflected in MCIT scores on the Interpersonal Reactivity Index (IRI; Davis, 1980, 1983, see Appendix B). The IRI was used to measure MCIT empathy (Davis, 1980, 1983). The dependent variable, empathy, is operationally defined as a set of two constructs including: (a) perspective taking and (b) empathic concern (Davis, 1980). The IRI is a

multidimensional measure, which examines affective and cognitive components of empathic response (Davis, 1983). The IRI is partly based on Hoffman's (1977) theory of the development of prosocial motives and empathy. Hoffman asserts that empathy is a "process of vicarious affect arousal" (1977, p. 175). Additionally, a key aspect of empathy, the ability for perspective-taking, will gradually develop as a child shifts from an egocentric, self-orientation to a non-egocentric, other-orientation. Before this shift, children are not able to differentiate between the emotions of others and the emotions of self. Observing others in distress provokes personal distress. However, as the capacity for perspective-taking increases, personal distress, while observing others in anguish, decreases (Hoffman, 1977).

The IRI is a self-report instrument with 28 items. Items are statements such as, "When I'm upset at someone, I usually try to 'put myself in his shoes' for a while," and "I am often quite touched by things that I see happen" (Davis, 1980, p.11). The measure comprises four subscales that represent unique characteristics of global empathy including: (a) perspective taking, (b) empathic concern, (c) fantasy, and (d) personal distress.

Each subscale contains 7 items and utilizes a 5-point Likert-type scale that ranges from 0 (does not describe me well) to 4 (describes me very well). The perspective-taking subscale measures the "tendency to adopt the point of view of other people in everyday life" (Davis, 1983, p. 117). An item example is, "I sometimes try to understand my friends better by imagining how things look from their perspective" (Davis, 1980, p. 11). The empathic concern subscale "measures the tendency to experience feelings of warmth, compassion, and concern for other people" (Davis, 1983, p. 117). An item example is, "I

often have tender, concerned feelings for people less fortunate than me" (Davis, 1980, p. 11). Davis (1980) believed these two subscales reflected higher levels of empathy.

The fantasy subscale "measures the tendency to transpose oneself into the feelings an actions of fictitious characters in books, movies, and plays" Davis, 1983, p. 117) An item example is, "When I watch a good movie, I can very easily put myself in the place of a leading character" (Davis, 1980, p. 10). The fantasy subscale involves intermediate aspects of empathy typically experienced by adolescents (Hatcher et al., 2005). The personal distress subscale "assesses one's own feelings of personal unease and discomfort in reaction to the emotions of others" Davis, 1983, p. 117. An item example is, "I sometimes feel helpless when I am in the middle of a very emotional situation" (Davis, 1980, p. 11). The personal distress subscale indicates susceptibility to over identify with the concerns of another. The fantasy and personal distress subscales represent intermediate and lower levels of empathy, respectively (Davis, 1980). Additionally, Davis (1980) reported that the personal distress scale was negatively correlated with the other three subscales.

An analysis of the hierarchical structure of the IRI resulted in two second-order factors, general empathy and emotional control (Pulos, Elison, & Lennon, 2004). General empathy, correlated with empathic concern (r = .79), fantasy (r =.61), and perspective taking (r =.51) but corresponded minimally with personal distress (r =.04). The report that personal distress correlated nominally with the general empathy factor substantiates the hypothesis that empathy and personal distress are distinct concepts (Hoffman, 1977; Lennon & Eisenberg, 1987). Emotional control correlated positively with perspective taking (r = .42) and negatively with personal distress (r = -.50).

Researchers have reported the IRI subscales to be reliable and valid measures of the four components of empathy (Carey, Fox, & Spraggins, 1988; Cliffordson, 2002; Davis, 1980, 1983; Pulos et al., 2004). Davis (1980) reported the four subscales had internal consistency reliabilities that ranged from .70 to .78. Pulos et al. (2004) recorded comparable reliabilities for the subscales that ranged from .79 to .82. No reports of internal consistency for a total empathy score have been documented. Test-retest reliabilities vary from .62 to .71 for a two month phase (Davis, 1980) and .50 to .62 for a two year timeframe (Davis & Franzoi, 1991).

Concurrent validity of the IRI was evaluated in a comparison with the Hogan empathy scale (Hogan, 1969) and the emotional empathy scale (EETS; Mehrabian & Epstein, 1972; Davis, 1983). The Hogan empathy scale measures cognitive empathy and the EETS measures affective empathy. As hypothesized, the perspective-taking subscale correlated highest with the Hogan empathy scale (r = .40) and the least with the EETS (r = .20) as compared with the other three subscales (Davis, 1983). The personal distress scale correlated significantly as well as negatively with the Hogan scale (r = -.33) and positively with the EETS (r = .24). As anticipated, correlations for the empathic concern (r = .60) and fantasy scales (r = .52) were higher with the EETS (Davis, 1983). These outcomes substantiate the multifaceted qualities of the IRI (Davis, 1983).

Construct validity of the IRI has been evaluated in a variety of venues with a range of populations: (a) undergraduate students (Beitel, Ferrer, & Cecero, 2005; Davis, 1980, 1983; Joireman, Needham, & Cummings, 2002; Joireman, Parrott, &

Hammersla, 2002), (b) medical personnel (Bellini & Shea, 2005; Shanafelt et al., 2005), and (c) therapists and counselors (Bentley Greason & Cashewell, 2009; Constantine & Gainor, 2001; Hatcher et al., 2005).

Researchers have suggested that a "higher order empathy scale" would not include the personal distress scale (Pulos et al., 2004, p. 359) and that the fantasy scale represents more intermediate aspects of empathy (Davis, 1980; Hatcher et al., 2005). As a result, only the empathic concern scale and the perspective taking scale were utilized to assess overall empathy in the current study.

One caveat with the IRI is that it does not evaluate empathy in the counseling session which could limit the interpretation of the findings. Several researchers have proposed that empathy in the counseling relationship may be distinct from empathy in social settings as it involves the counselor's conveyance of understanding to the client (Barrett-Lennard, 1981; Keefe, 1976; Rogers, 1975). However, the IRI is one of the most extensively used and inclusive measures of empathy that is accessible (Cliffordson, 2002; Fields et al., 2011, Pulos et al., 2004).

Therapeutic alliance: Session Rating Scale (SRS).

Therapeutic alliance was a key component of this study. It was expected that CITs' and clients' perceptions of the therapeutic alliance would be impacted by an MTP intervention with CITs. These perceptions of therapeutic alliance were reflected in MCIT and Mclient scores as well as instructor rating scores via the Session Rating Scale version 3.0 (SRS V.3; Duncan et al., 2003). The SRS V.3 was utilized to measure client perception of the therapeutic alliance (see Appendix B). The researcher-derived, counselor and observer versions of the SRS V.3 were used to measure CIT and instructor

perceptions of CIT therapeutic alliance, respectively (see Appendix B). The dependent variable, therapeutic alliance, was operationally defined as four interacting constructs: (a) a relational bond between the counselor and client, (b) agreement on the goals of therapy, (c) the client's view of the counselor's approach, and (d) the client's overall perception of the session (Duncan et al., 2003).

The initial SRS (Duncan et al., 2003) was developed specifically as a practical, brief alliance measure for session-to-session use. Several instruments influenced the creation of the SRS including: (a) the Working Alliance Inventory (WAI; Horvath & Greenburg, 1989), (b) the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1980), and (c) the Empathy Scale (ES; Burns & Nolen-Hoeksema, 1992). The WAI reflects Bordin's (1979) description of alliance as three elements: bond, tasks, and goals. The SEQ assesses the depth and smoothness of the session. The ES measures the relationship and is also intended for regular clinical use.

The original version of the SRS combined components from each instrument into a 10-item, Likert-scaled measure. It was initially psychometrically tested with 39 clients in a brief psychotherapy clinic in the western United States (Stanford, 1999). Analysis of items resulted in a Cronbach's alpha reliability coefficient of .89 (Duncan et al., 2003). The first six items that measured therapeutic alliance also demonstrated a high alpha (.96). Items 7, 9, and 10, measured session impact and resulted in an alpha of .79. Concurrent validity was not investigated during this analysis.

Using the SRS in practice allowed Duncan et al. (2003) to assess the instrument in live therapy settings as well as in consultation with several mental health agencies and third-party payers. They discovered that a 10-item instrument was not amenable to

clients' and clinicians' time (particularly clinicians). Similar challenges were experienced administering the WAI (a 12-item instrument) making the 19-item, revised helping alliance questionnaire (HAQ-II; Luborsky et al., 1996), impractical as well. Consequently, the SRS V.3 was derived as a concise alternative to longer alliance measures with a research orientation. This was in direct response to complaints from clinicians and to increase utilization of a feasible alliance measure (Duncan et al., 2003).

The SRS V.3 is a 4-item scale derived from Bordin's (1979) and Gaston's (1990) theories of alliance. Bordin postulated that the therapeutic alliance consisted of three elements: tasks, goals, and bond. Tasks refer to the behaviors and cognitions that occur during counseling that form the substance of the counseling process. In a strong alliance, both parties must perceive these tasks to be relevant and effective and take responsibility to perform these acts. Goals or outcomes refer to the idea that counselor and client must mutually endorse and value the goals of therapy. Bond refers to the positive personal connections between client and counselor such as: mutual trust, acceptance, and confidence (Bordin, 1979). Gaston (1990) viewed alliance in a similar manner as Bordin but emphasized that agreement between the client's and counselor's beliefs about how people change in therapy is imperative for a healthy alliance.

The SRS V.3 items are measured on four 10-cm horizontal analog scales, with instructions to place negative reactions, via a hash mark on the line, further to the left of the scale and positive reactions further to the right (Duncan et al., 2003). This results in four scores between 0 and 10; the global high score is 40 while the low score is 0. The global score, including all four subscales of the SRS V.3, were used for this study.

The first item measures relationship and rates the session on a continuum from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected" (Duncan et al., 2003, p.6). The second item measures goals, and rates the session on a continuum from "We did not work or talk about what I wanted to work on or talk about" to "We worked on or talked about what I wanted to work on or talk about" (Duncan et al., 2003, p. 6). The third item measures the counselor's approach or method, and rates the session on a continuum from "The therapist's approach is not a good fit for me" to "The therapist's approach is a good fit for me" (Duncan et al., 2003, p. 6). Finally, the fourth item measures the client perception of the session and rates the overall session along a continuum from "There was something missing in the session today" to "Overall, today's session was right for me" (Duncan et al., 2003, p. 6).

The SRS V.3 demonstrates good internal consistency estimates across a range of client populations ($\alpha = .88$ to .93) and is recognized as an effective measure of therapeutic alliance (Duncan et al., 2003; Campbell & Hemsley, 2009). Independent confirmation of reliability of the SRS V.3 was conducted by the center for clinical informatics using a sample of nearly 15,000 administrations (Miller et al., 2006). Coefficient alpha was found to be .96, particularly high for a four item measure. The SRS V.3 correlates positively (.29, $p < .01$) with outcome assessments such as the Outcome Rating Scale (ORS; Miller & Duncan, 2000).

Concurrent validity between the SRS and the WAI as well as the HAQ-II was substantiated (Duncan et al., 2008; Campbell & Hemsley, 2009). "All correlations between SRS items and WAI subscales were within a range of .37 to .63" (Campbell & Hemsley, p. 6). Furthermore, the correlations between the SRS items and the WAI

subscales, were relatively equal between all subscales. Correlations between SRS total score and the HAQ-II total score correlated at .48 ($p < .01$; Duncan et al., 2003). Correlations between SRS items and HAQ-II items ranged from .39 to .44. The correlations of the SRS to the HAQ-II indicate that the "SRS items are assessing the same constructs as the HAQ-II" (Duncan et al., 2003, p. 9). The correlations of the SRS to the WAI "support the idea that the SRS is measuring a construct of therapeutic alliance" (Campbell & Hemsley, p. 7). Moreover, the "SRS is a brief alternative for global strength of the alliance similar to that measured by other longer, research oriented alliance measures" (Duncan et al., 2003, p. 9).

Test-retest reliability for the 4-item SRS over six administrations was .64 compared to .69 ($p < .01$) for the 19-itemHAQ-II (Duncan et al., 2003). A second evaluation of test-retest reliability by The Center for Clinical Informatics for close to 15,000 administrations was reported at .50 (Miller et al., 2006). Ratings of alliance have a tendency to change over time so the finding that test-retest reliability was lower across multiple administrations was reasonable (Duncan, et al., 2003).

Feasibility of the SRS V.3 was a key aspect of its inception. Duncan et al. (2003) found that many measures of alliance were time consuming and were therefore not used in clinical settings. Utilization rates of the 4-item SRS V.3 as compared to the 12-item WAI were found to be 96% versus 29%, respectively. This provided evidence that the SRS is a practical tool for assessing therapeutic alliance in clinical settings.

Mindfulness practice log.

Self-practice is a vital part of developing mindfulness skills (Kabat-Zinn, 1990). Individual differences in mindfulness practice as well as responses to the MTP

intervention were reflected in the mindfulness practice log (see Appendix B). This instrument was developed by the researcher utilizing Stahl and Goldstein's (2010) formal practice log as a format guide. MCITs were asked to record their daily mindfulness practice during the MTP intervention (weeks 4 to 9) and post- intervention (weeks 10 to 14). Each MCIT was asked to record the date, type of mindfulness practice, amount of time spent in practice, and any thoughts or feelings they experienced during and after each mindfulness practice. Type of practice data were qualified as informal or formal mindfulness practice. Informal practice is mindfulness on the go such as while driving or walking or doing the dishes. Formal practice is planned mindfulness that is done typically in a quiet setting over a longer period of time such as 15 minutes to 1 hour. Practice data were analyzed to identify the most utilized mindfulness methods. Time spent in practice was averaged weekly over the 6 week MTP intervention and the 5 week post-intervention period. Reactions to practice were analyzed with qualitative methods to look for patterns and themes (Boyatzis, 1998; Braun & Clarke, 2006; Patton, 2002).

Mindfulness journals.

The experiences of MCITs, as they learned and practiced mindfulness skills, were recorded in weekly journals. These journals were assigned as homework during the MTP. Each MCIT wrote about her unique perspectives in response to a prompt each week.

1st Week: Tell me about your week. What stands out for you?

2nd Week: Tell me about your week. What stands out for you?

3rd Week: Tell me about your week. What have been your challenges and/or successes?

4th Week: What have you noticed about your interactions with others this week?

5th Week: As this is your last week of journaling, what would you like to share about your experience?

6th Week: Journals were collected in class.

MCIT focus group.

The MCIT focus group was conducted in week 14, five weeks after the last MTP session. Questions for the focus group were generated based on topics that were elicited via a preliminary thematic analysis (Boyatzis, 1998; Braun & Clark, 2006) of the MCIT weekly journals (see Appendix B). Initial, emergent themes from the journals included the following: stress was universal for the MCITs; they experienced positive physical responses and challenges with mindfulness practice; participants had insights about themselves and about themselves in relation to others; and participants had varied practice preferences. Discussion questions for the focus group were distributed to the participants in the Focus Group Handout (see Appendix B).

Instructor questionnaire.

The instructor questionnaire was developed by the primary researcher (see Appendix B). The purpose of the questionnaire was to elicit instructor perspectives about the participant CITs' personal and professional development during the semester. The two dimensional format, personal and professional development, was informed by the literature which suggests that CITs who undergo mindfulness training may enrich both of these aspects of their lives (Christopher & Maris, 2010; Davis & Hayes, 2011; McCollum & Gehart, 2010; Moore, 2008). The instructor questionnaire was collected in weeks 14 and 15 so that the professors could reflect on the MCITs' development over the course of

the semester. See Table 1 for a complete summary of the data collection and intervention schedules.

Data Analysis

Data for this study were analyzed following a mixed methods paradigm. Quantitative data related to therapeutic alliance, mindfulness, and empathy were analyzed with preplanned, focused multivariate methods. Qualitative data were examined with thematic analysis to find major, emergent themes based on MCITs experiences from the MTP program and based on instructors' observations of the MCITs in their classrooms. Finally, quantitative and qualitative data were integrated to portray each MCIT's outcomes and perceptions from the study in single-case profiles.

Quantitative data analysis.

A number of quantitative data analytic approaches were used to fully address the research questions in this study. Multivariate, repeated measures analysis of variance was used to explore changes in therapeutic alliance (SRS) across all phases of the study, within subjects (MCIT group) and between subjects (MCIT and CGCIT groups). Multivariate, repeated measures of analysis of variance was also used to explore changes in therapeutic alliance (SRS) based on instructors' scores within groups (MCIT group) and between groups (MCITs and classmates group). Multivariate, repeated measures of analysis was used to examine the impact of the MTP on changes in MCITs' mindfulness (FFMQ) and empathy (IRI) levels in a within subjects model. Additional simple effect analysis included a multivariate, repeated measures approach to assess the impact of the MTP on significant changes in MCIT mindfulness practice across phases of the study. Finally, single case methodology was utilized to explore the impact of the MTP on

dependent measures across phases as well as to explore individual profiles of MCIT experience with the group.

In the single case format, the MCIT and Mclient outcomes were examined by visually observing characteristics of level, trend, variability, and immediacy of effect (O'Neill et al., 2011). Level refers to the mean or average performance for each phase of a study. Variability refers to how much the data varies within each phase and is somewhat comparable to the standard deviation of a set of data (O'Neill et al., 2011). Trend refers to the slope of the data points and whether they are increasing, decreasing, or remaining flat across the phase. Immediacy of effect refers to the magnitude of change in the data points from the end of one phase to the beginning of another.

Within subjects statistical analysis included calculating the percentage of non-overlapping data (PND; Scruggs & Mastropieri, 1998). PND can be used as an approximation of effect size for the treatment outcome to illustrate meaningfulness (Scruggs & Mastropieri, 1998).

PND was determined by counting the number of intervention phase points that were higher than the highest baseline point, dividing by the total number of intervention phase points, and multiplying by 100.

Other quantitative dependent variables examined in the single-case analysis included instructor therapeutic alliance (SRS) scores and MCIT mindfulness practice records.

Qualitative data analysis.

Qualitative data were examined via thematic analysis (Boyatzis, 1998; Roulston, 2001). "Thematic analysis is a method for identifying, analyzing, and reporting patterns

(themes) within data" (Braun & Clark, 2006, p. 79). This requires the researcher to search across a data set to find recurring patterns of meaning (Boyatzis, 1998). As such, data from the participant journals and practice logs, the focus group, and the instructor questionnaires were examined with this method.

Multiple paradigms were used to conduct thematic analysis including realist, semantic, and inductive methods. A realist paradigm was primarily used to analyze the reality of participants, their experiences and meanings (Braun & Clark, 2006). A semantic paradigm was used to identify themes in order to stay true to the voice of the participants. Semantic approaches focus on the literal meaning of the data as opposed to latent, underlying ideas or assumptions about the data (Boyatzis, 1998; Braun & Clark, 2006). Additionally, inductive methods were implemented to find themes that emerged from the data (Boyatzis, 1998; Patton, 2002).

Braun and Clarke's (2006) six phases of thematic analysis were implemented to organize the process of finding themes. The six phases are: (1) familiarize yourself with your data; (2) generate initial codes, (3) search for themes, (4) review themes, (5) define and name themes, and (6) produce the report. In *phase one*, the primary researcher read the journals in an engaged manner and became immersed in the data. Interesting words were sought out and underlined and notations were made in the margins regarding preliminary themes, next to the pertinent text. Then, due to time constraints, analysis moved to *phase three* and general initial themes were drawn from the participants' journals for use in the focus group. During phase three, the qualitative research question was written at the top of the notation page to guide the analysis process. Initial themes were examined by the co-instructor for validity and then used to generate questions and

discussion in the focus group. The initial themes were also presented to the focus group as a member check with the participants. As explained in the procedure section of this chapter, the participants had affirming responses to the initial themes.

After the focus group, *phase two* of analysis was readdressed with the MCIT journals. The journals were reread and all interesting aspects of verbiage from the MCITs' journals were notated with in vivo coding (Bruan & Clark, 2006). In vivo coding utilizes the actual words or language of the participants in the form of a single word or phrase (Saldaña, 2009; Straus & Corbin, 1998). It is a data-driven type of code, rather than theory-based, inductively derived from the raw information and highly sensitive to the context of the data (Boyatzis, 1998). These initial codes were labeled with the MCIT identification number, the page number in the journal, and the phrase number on the page to track the original data source.

In *phase three*, initial codes were examined and sorted to search for patterns or themes using pattern coding. Pattern coding is a method used to group the initial (in vivo) codes into fewer sets or themes with broader meaning (Miles & Huberman, 1994). All codes were considered and categorized including codes that did not fit into the main themes. The codes that did not correlate with any of the themes were initially housed in a miscellaneous category.

In *phase four*, the preliminary themes were reviewed and refined. In reviewing the themes, all codes within each theme were examined to be sure they represented a coherent pattern reflected in the overall theme. This process resulted in several iterations of the themes. Next, the categories were refined by reading through the initial codes

again to ensure the themes were valid and to seek out any additional data that may have been missed in earlier phases. The resulting MCIT themes are illustrated in Table 8.

In *phase five*, defining and naming themes, the intent was to describe the range and essence of each theme in a couple of sentences. This included the story behind each theme that was drawn from the MCITs' experiences.

After themes were constructed from the journal data, the focus group verbal and written responses, as well as the mindfulness practice log comments, were cross-referenced with the journal themes to determine if there were any new or discrepant data. The logs and the focus group data corresponded with the journal data and no additional themes were found. Next, the instructor questionnaire data were investigated via Braun and Clarke's (2006) five step process to find major themes in the instructors' perspectives about the MCITs. These final MCIT and instructor driven themes were utilized to stand alone as the findings of the phenomenological study and as data to compare and evaluate with the quantitative outcomes.

Mixed method data analysis.

After the quantitative and qualitative data were analyzed, a mixed methods interpretation was implemented to look across both sets of results and findings to make an assessment of how the information attended to the research questions (Creswell & Plano Clark, 2011). Creswell and Plano Clark's (2011) guidelines for mixed methods data analysis with convergent designs were implemented. Consequently, the two data sets were examined to find congruent as well as discrepant data. The guidelines include 7 steps:

1. Collect the quantitative and qualitative data concurrently.

2. Independently analyze both data sets using methods best suited for the research questions.
3. Specify the dimensions of the results that will be compared from the two data sets.
4. Identify the information that will be compared across the dimensions.
5. Compare refined quantitative and qualitative analyses to generate the required comparison information.
6. Represent or present the comparisons.
7. Interpret how the combined results answer all the research questions (Creswell & Plano Clark, 2011).

In accord with step 1, quantitative and qualitative data were collected concurrently during the fall semester. Then, for step 2, both sets of data were analyzed; statistical and visual methods were utilized with the quantitative data and thematic analysis was implemented with the qualitative data. Next, for step 3, the dimensions of the results to be compared were clarified as the true results from each quantitative and qualitative set. No data were merged or extrapolated to fit into another format (e.g., quantifying qualitative data) for comparison. With regard to step 4, quantitative outcomes were compared with the qualitative themes that were constructed from the MCIT and instructor data. In accord with step 5, the data were analyzed and refined as planned in step 4. The comparisons between quantitative and qualitative results were executed across cases as well as within cases, in a single-case format for each participant. Next, the results of the quantitative and qualitative analyses and comparisons were reported in chapter 4, as instructed in step 6. Finally, step 7, the interpretation of the

combined results and how the research questions were answered, was addressed in chapter 5.

Chapter 4

Results and Findings

Quantitative Results

All sets of quantitative data were formatted for analysis including: mindfulness (FFMQ) and empathy (IRI) pre-post tests; client, CIT, and instructor therapeutic alliance scores (SRS); and MCIT mindfulness practice (researcher generated practice log). All data were cleaned via the detection and editing of faulty cases (Van den Broeck, Cunningham, Eeckels, & Herbst, 2005). The mindfulness and empathy pre- and post-tests did not have missing data and were processed intact. The client and CIT therapeutic alliance scores (SRS) had some missing data (25%) across all phases. Missing scores occurred due to client or CIT absence or because a client chose not to complete the SRS form. The missing SRS data were interpolated and replaced with each participant's median score for the phase where the deficit occurred. The median score was utilized to reduce the influence of extreme scores during each phase. Instructor therapeutic alliance scores (SRS) were complete and were kept intact for analysis. The MCIT mindfulness practice data were complete within the training phase. However, the post phase had missing data due to MCIT lack of compliance. Of the nine participants who completed practice logs in the training phase, only four turned in post practice logs. The primary researcher contacted four of the five MCITs with missing data and three of them reported their daily practice during the post phase via email. Consequently, seven MCITs reported mindfulness practice for the post phase. These data were used in the final analysis of MCIT mindfulness practice. Next, descriptive statistics were calculated for each quantitative set.

To explore the hypotheses regarding the impact of the MTP, a series of preplanned, focused analyses were conducted on the SRS from CITs, clients, and instructors and on the IRI and FFMQ self reports from MCITs. The focused analyses were subjected to multivariate repeated measures procedures in SPSS software. The resulting tests of within subjects contrasts were reported.

Research question 1 concerned changes in self-reported therapeutic alliance (SRS) scores across phases. Table 2 and 3 display the descriptive statistics for client and CIT SRS scores, respectively. There was no significant overall difference between treatment and control group client and CIT SRS scores across phases, Wilk's $\lambda = .67$, $F(4,14) = 1.51$, $p = .51$, $\eta^2 = .09$, or client SRS scores across phases, $F(1,15) = .293$, $p > .05$, $\eta^2 = .019$. There was however, a significant linear increase in CIT reported SRS scores, $F(1,15) = 5.26$, $p = .037$, $\eta^2 = .26$. This pattern indicated that the mean scores for clients' SRS remained fairly stable over the three phases while CITs tended to increase. Individual MCIT profiles are reported using single-case methodology later in this chapter.

Table 2

MTP and Control Group Client Therapeutic Alliance (SRS) Global Mean Scores

DV	Phase	MClient			CGClient		
SRS Scores		*N*	*M*	*SD*	*n*	*M*	*SD*
	Baseline	9	37.15	2.23	8	36.92	2.68
	Training	9	37.37	2.95	8	36.74	2.73
	Post	9	36.65	2.94	8	38.36	0.83

Note: DV = dependent variable, Mclient = MTP clients, CGclient = control group clients

Table 3

MTP and Control Group CIT Therapeutic Alliance (SRS) Global Mean Scores

DV	Phase	MCIT			CGCIT		
SRS Scores		*N*	*M*	*SD*	*n*	*M*	*SD*
	Baseline	9	31.85	4.83	8	34.04	3.53
	Training	9	34.63	3.04	8	35.25	2.99
	Post	9	35.24	4.28	8	37.06	3.10

Note: DV = dependent variable, MCIT = mindfulness group, CGCIT = control group

Research question 1 also concerned changes in therapeutic alliance (SRS) scores across phases, based on instructor ratings. The instructor (SRS) scores were examined to explore within and between subjects effects of the MTP on treatment and control group CITs. The control group consisted of CITs enrolled in the same classes as the MCITs. Descriptive statistics for the therapeutic alliance scores are shown in Table 4. Results indicated that only the goals subscale was significantly higher at post-test (within subjects), $F(1,29) = 4.33$, $p < .05$, $\eta^2 = .13$; the remaining subscales, relationship, approach, and overall were not significantly different (p's > .05).

Table 4

Instructor Ratings of CIT Therapeutic Alliance (SRS) Mean Scores

	MCIT Group					CGCIT Group				
	Pretest		Posttest			Pretest		Posttest		
SRS Subscales	M	SD	M	SD	*n*	M	SD	M	SD	*n*
Relationship	7.63	1.89	8.19	1.36	9	7.19	2.43	7.13	2.34	22
Goals	7.61	2.03	8.87	0.87	9	6.76	2.67	7.21	2.48	22
Approach	7.18	1.88	7.74	1.84	9	5.73	2.85	6.78	2.93	22

Overall	7.36	2.03	7.74	1.58	9	5.72	3.14	6.72	3.10	22
Total	29.78	7.60	32.52	5.05	9	25.39	10.26	27.84	10.24	22

Note: MCIT = mindfulness group, CGCIT = control group

Research question 2 concerned changes in mindfulness (FFMQ) scores pre- and post-intervention. Table 5 presents the descriptive statistics for the five subscales and global scores on the FFMQ. The results indicated that global mindfulness increased for the MCITs. Specifically, t-test comparisons revealed statistically significant improvement in the observing ($p < .01$); nonreactivity of inner experience ($p < .05$); and global scores ($p < .01$). Effect sizes were large for each variable and were reported at d = 1.47, .80, and 1.04 respectively. There were nonsignificant differences among describing, acting with awareness, and non-judging of inner experience (p's $> .05$) scores. However, all subscale scores improved from pretest levels.

Table 5

MCIT Mindfulness (FFMQ) Mean Scores

FFMQ Subscales	Pretest			Posttest		
	M	*SD*	*n*	*M*	*SD*	*n*
Observing	26.11	6.11	9	33.56	5.20	9
Describing	29.78	5.81	9	30.22	5.00	9
Acting with awareness	27.78	5.89	9	30.89	4.05	9
Nonjudging	29.67	4.61	9	31.11	5.23	9
Nonreactivity	22.67	5.52	9	25.11	4.31	9
Global Score	136.00	19.99	9	150.89	15.84	9

Research question 2 also concerned changes in empathy (IRI) scores pre- and post-intervention. Table 6 depicts the descriptive statistics for the four subscales and the global scores for the IRI. The results demonstrated that global empathy increased for the MCITs. In particular, t-test comparisons recorded statistically significant improvement in the empathic concern ($p < .05$) and global ($p < .05$) scores. Effect sizes for both variables were large (empathic concern, $d = .83$; global empathy, $d = .88$). There were nonsignificant differences among perspective taking, fantasy, and personal distress (*p's* > .05) scores. Yet all IRI subscale scores improved in general.

Table 6

MCIT Empathy (IRI) Mean Scores

	Pretest			Posttest		
IRI Subscales	*M*	*SD*	*n*	*M*	*SD*	*n*
Empathic Concern	29.78	3.31	9	31.22	3.73	9
Perspective Taking	26.78	6.26	9	28.33	4.98	9
Fantasy	24.78	6.16	9	25.67	4.42	9
Personal Distress	17.56	4.72	9	16.22	4.09	9
Global Score	56.56	8.67	9	59.56	7.38	9

As explained in Chapter 3, the fantasy and personal distress subscales were not utilized to measure empathy in this study as they were determined to measure lower levels of empathy (Davis, 1980). Additionally, although the personal distress scale indicated a decrease, it is negatively correlated with the other subscales. This subscale measures personal feelings of anxiety while observing others' distress. Therefore, a

lower score on the personal distress subscale was preferable. Consequently, all the subscales of the IRI indicated desirable changes in empathy levels for the MCITs.

Research question 3 concerned the relationship of CIT mindfulness practice to outcome measures for this study. The MCIT's weekly mean scores of minutes in mindfulness practice increased from treatment phase to post phase (see Table 7). One outlier score in the post phase influenced the higher mean score for that phase. Removing this extreme score resulted in a mean score for the post phase of 131.48 minutes of weekly practice. Also, there were nine MCITs who kept a mindfulness log during the treatment phase while only seven MCITs participated in the post phase. Mindfulness practice seemed to support the improvement in MCIT mindfulness, empathy, and therapeutic alliance scores.

Table 7

MCIT Mindfulness Practice Log Weekly Mean Scores

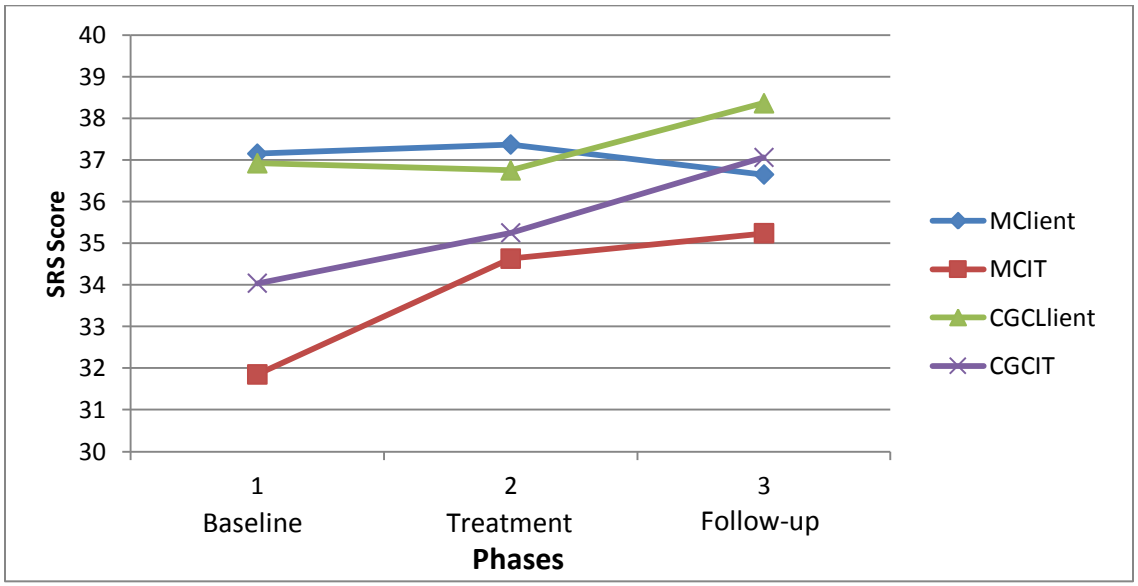
Dependent Variable	Phase	M	SD	*n*
Weekly Minutes in Mindfulness Practice	Baseline	-	-	9
	Training	126.78	67.37	9
	Follow-up	151.14	162.29	7

Once descriptive calculations were complete, all CIT and client therapeutic alliance mean scores were examined by phase across subjects utilizing visual, single-case methods including level and trend (O'Neill et al., 2011). Figure 1 illustrates the SRS mean scores by phase of the MCITs and their clients as well as the CGCITs and clients. Numerals 1, 2, and 3 on the horizontal axis denote baseline, treatment, and follow-up phases, respectively. A visual analysis of the Mclient scores (diamonds) and the CGclient

scores (triangles) illustrates a similar, level, trend in the baseline and treatment phases but a divergence in the post phase; the Mclient SRS scores decreased slightly while the CGclient SRS scores demonstrated a modest increase. Despite these differences, both client groups reported relatively high alliance scores across phases as the maximum score is 40. Most notably, in viewing a comparison of the Mclient scores (diamonds) to the MCIT scores (squares), there is increased agreement with the level of these scores across phases.

Figure 1

MTP and Control Group Mean Therapeutic Alliance (SRS) Scores by Phase



Note: MClient = MTP client group, MCIT = MTP group CIT, CGClient = client control group, CGCIT = CIT control group

Next, CIT outcomes were examined within subjects via single-case profiles. The participant single-case profiles are reported following the group qualitative findings.

Qualitative Findings

Two groups of qualitative data were explored for the inherent meanings that emerged from the responses and voices of the MCITs as well as the instructors who taught them. The MCIT based themes reflected their experiences as they learned and implemented mindfulness practices and philosophies. These themes were elicited from the participants' journals, mindfulness practice logs, and the focus group. The instructor based themes were rooted in the instructors' reflections about the MCITs who had been under their tutelage while also participating in the MTP. These themes were drawn from the instructor questionnaire collected at the end of the semester.

After being intimately immersed in the MCIT and instructor data through a process of *thematic analysis,* explained in Chapter 3, major themes were identified for each group. Six major themes emerged from the MCITs' reflections and reactions to the experience of learning and implementing mindfulness. Meanwhile, five major themes were discovered in the instructors' perspectives about the MCITs' learning and application of counseling skills in a practicum or internship class. A descriptive depiction of each of the themes is included in this chapter.

MCIT themes.

The themes from the MCITs were constructed to gain a deeper understanding of the MCITs' triumphs, struggles, and contemplations while on their mindfulness journey. The six themes that emerged from the MCITs' experience were

- *physical responses to mindfulness,*
- *affective responses to mindfulness,*
- *cognitive responses to mindfulness,*
- *behavioral responses to mindfulness,*

- *challenges to practice,*
- and *reactions to the MTP* (see Table 8).

In order to give voice to the MCITs, the principal investigator attempted to tell their story and extract the meanings they imparted from their experience. Representative reflections were selected from the MCITs' journals, logs, and focus group responses to illustrate prevalent themes in the corpus of data. While the themes did not necessarily occur with complete group consensus, the repetition of similar ideas from numerous participants brought particular experiences to the forefront, whereby the researcher elicited the resulting themes. For the sake of anonymity, the MCITs were given study names by the researcher to make reference to particular participants and their stories.

Table 8

MCIT Themes

Themes	Subthemes
1. Physical Responses to Mindfulness	▪ Awareness of body sensations
	▪ Symptom reduction
	-Anxiety
	-Psoriasis
	-Overeating
2. Affective Responses to Mindfulness	▪ Positive outlook
	▪ Peacefulness
3. Cognitive Responses to Mindfulness	▪ Personal insight
	-Self-care without guilt
	-A sense of gratitude

	-Deep personal reflection
	-Reflections on mindfulness
	▪ Relational insight
	-Personal relationships
	-Client relationships
	-Connectedness
4. Behavioral Responses to Mindfulness	▪ Self-care
	▪ Overcoming obstacles
	▪ Enhancing interactions
	-Personal interactions
	-Professional interactions
5. Challenges to Practice	▪ Busy mind
	▪ Maintaining focus
	▪ Group support
6. Reactions to the MTP	▪ Required class
	▪ Continuing practice
	▪ Useful class exercises
	▪ Homework challenges

Theme 1: Physical responses to mindfulness.

The first theme, *physical responses to mindfulness,* consisted of repeated remarks involving the MCITs' noticing their bodies and the sensations they felt during mindfulness practices of *being* in the moment. In their reflections, they were describing a

discovery of embodiment; they were becoming tuned in with their physical selves. The MCITs' comments consisted of their awareness of sensations perceived in their bodies as well as reports of reduced physiological symptoms. These two concepts were constructed as two subthemes: (a) *awareness of body sensations* and (b) *symptom reduction*.

The subtheme *awareness of body sensations* involves the MCITs' perceptions as they noticed their bodies. MCITs experienced a range of awareness from overall bodily sensations and functioning to very specific anatomical states. MCIT A expressed her general body sensation as "relaxed and twitching a little." MCIT H wrote, "I was able to be aware of the stress taking a toll on my body physically." With regard to more specific bodily responses, MCIT G explained, "I was noticing during my breathing how tense I feel in certain parts of my body." MCIT I wrote in her journal, "I felt the pain… flowing back and forth between my spine and right lower back." MCIT E reflected, "I was able to pay attention to my body and each step and how the muscles in my body move." MCIT D even tuned in to her sense of smell and wrote, "I just realized that some of the buildings on campus have a distinct odor."

The subtheme *symptom reduction* consists of three examples generated from several participants' reports that they were able to reduce or even manage their physiological symptoms over the course of the study. Examples of symptom reduction included: (a) *anxiety*, (b) *psoriasis*, and (c) *overeating*. With regard to *anxiety*, four MCITs explained that they were able to control or reduce their symptoms with the use of mindfulness. MCIT I wrote, "I think this mindfulness study helps me reduce my anxiety level" and MCIT D shared that she had "learned to control these anxieties." MCIT G

reported in her practice log, "I am a high anxiety person by nature so it was very relaxing to just be and allow myself to be silent and de-stress." She also wrote in her journal, "I have done things to calm my anxiety." Furthermore, MCIT H explained how she managed a self-proclaimed anxiety attack. "I… felt all the sensations that came with the anxiety and it was interesting. I was so aware of it happening and was able to just breathe it away!"

One participant's compelling experience with *psoriasis* represented an example of symptom reduction. MCIT F disclosed that psoriasis had been a part of her life since childhood. She described her symptoms as "miserable; under the skin is just a burning itch that can't be relieved. Affected areas are dry and cracked and bleeding. I've tried several medications, baths, diets, vitamins, shots, oral medications… It is at a severe level now and I am desperate for treatment." In her last journal entry, MCIT F excitedly wrote, "… the affected areas are very mild at this point. Usually the medication takes longer to see this level of results. So I am convinced it (mindfulness) helps!"

Finally, one student reported that mindfulness may have influenced her weight loss, which exemplified *overeating* as a symptom reduction. MCIT A revealed in her first journal entry that she intended to use mindfulness with eating on a regular basis. "It's so important to enjoy what I eat and feel satisfied by it but this often does not happen. I want to really try to do this at every, or almost every, occasion." She wrote in her journal that she had overeaten in the past. In her last journal entry she wrote, "I have also lost a little weight recently and it may be because of my mindful eating practices. I didn't practice the mindful eating consciously as much as I would have liked but it may have seeped into my unconscious, which I am very happy with."

Theme 2: Affective responses to mindfulness.

The second theme, *affective responses to mindfulness*, reflected the MCITs' feelings and moods as they learned mindfulness skills and practices and applied them in their daily lives. The MCITs were genuinely moved by the way mindfulness affected their lives in positive ways. This theme came to life as recurring ideas were fleshed out in the MCITs' journals and focus group feedback. Two subthemes were elicited from the data: (a) *positive outlook* and (b) *peacefulness*.

The subtheme *positive outlook* involves the MCITs repetitive accounts of their contented and even upbeat attitudes experienced during the course of the study. Consequently, there was an abundance of positive emotion that emanated from the group. MCIT B wrote, "I am happy" and "Mindfulness is bliss." MCIT H shared that she felt "positive ease." Her journal was interspersed with nine smiley faces which appeared to reflect her general sentiment about the content of her entries. MCIT H also shared in the focus group, "I have now been able to be more positive and spread the positivity among co-workers, friends, and family." In her last journal entry, MCIT A shared that she had been "noticeably happy the past few weeks." Furthermore, MCIT E revealed, "…when I breathe mindfully and am present, I often get in a better mood." Finally, MCIT C shared that she was "excited" about how mindfulness had helped her in her relationship with a difficult person and MCIT G was "excited" to use mindfulness with clients.

The subtheme *peacefulness* was another prevalent emotional response to both practice and a mindful disposition. This sense of tranquility permeated the MCITs journals and practice logs in particular. MCIT C wrote "I felt peaceful" in her practice log in response to a particular exercise. MCIT I's practice log was filled with numerous

reflections of peace. There were ten instances when she wrote "peaceful" in her entries. MCIT H utilized a whole page in her journal to write one statement using large letters, "Feeling at…" Then she inserted the symbol of peace instead of the word to complete her entry. MCIT B's journal read like poetry as she used phrases and thoughts instead of sentences. She wrote, "Greater peace. Growth in self."

Theme 3: Cognitive responses to mindfulness.

The third major theme revealed by the participants' perspectives was *cognitive responses to mindfulness*. This theme represented the MCITs' abundant insightful realizations during the course of the study. These reflections developed into two subthemes: (a) *personal insight* and (b) *relational insight*. Within each subtheme, additional micro-themes were constructed based on the MCITs' reflections of their experiences.

The first subtheme was *personal insight* which involved the MCITs' heightened sense of awareness and their realizations as they began to see themselves from a new perspective. An excellent example of this process was portrayed earlier when MCIT H noticed her bodily sensations during an anxiety episode. She was able to maintain a stance of non-judgment while noticing her physical sensations, rather than becoming wrapped up in them, and then cognitively concluded that she was experiencing intense anxiety. With this insight, she was able to respond and manage her situation. There were four micro-themes within this subtheme: (a) *self-care without guilt,* (b) *a sense of gratitude,* (c) *deep personal reflection,* and (d) *understanding mindfulness.*

The first micro-theme that made its presence known from CITs' insightful reflections was *self-care without guilt*. This theme deals with the participants'

realizations that stress comes in many forms, it can manifest in the body in many ways, and it can and should be addressed. A newfound awareness of stress and its negative effects on them personally, led the CITs to realize they needed to make efforts to manage their stress in effective ways. While most of the participants already knew that self-care was something they should practice, experiencing the stress mindfully helped them realize that making time for themselves to recharge was just as important as eating or sleeping.

As participants began to practice mindfulness and feel the byproduct of relaxation, they realized that they did not typically make time for self-care. MCIT F wrote, "I realized that I hardly ever relax and breathe deeply". MCIT H wrote, "I need to be comfortable with allowing time for myself." MCIT A wrote, "It was nice to focus on myself and not feel guilty. I did have time for some self-care when I really planned it." MCIT I reflected, "I learned to take time for myself." MCIT G exclaimed, "I was actually able to take a set amount of time out of my day to just relax and have some me time". Finally, in her last journal entry MCIT E shared that, "being mindful increases my awareness of self-care."

The second micro-theme, *a sense of gratitude,* was made up of repeated ideas from the MCIT journals, practice logs, and the focus group. This theme involved the MCITs' insight about being grateful for the opportunities that came with a mindful perspective. Participants' newfound awareness gave them the opportunity to help themselves feel better, physically and emotionally. This awareness also facilitated the opportunity and the ability to savor the moment.

As reflected in the corpus of data, participants seemed grateful for learning mindfulness as a method. MCIT C wrote, "I am grateful to have mindfulness guide me through my feelings and thoughts." She also said, "I am grateful to have this opportunity to try a new approach with my kids." MCIT G explained, "I am very grateful for getting this opportunity to be able to learn how to 'just be' and recognize your sensations." Two participants shared their gratitude with the primary researcher by writing specific thank you notes in their journals. MCIT I said, "Thank you for allowing me to be a part of (this) study." MCIT B conveyed, "Thank you… for allowing me this time to share my message. To share peace. To connect. To love."

As participants took part in the MTP and expressed their thoughts in written form, they seemed to become acutely aware of many ordinary things and that these things were taken for granted. In her new awareness of the details, MCIT G wrote, "I never stop to enjoy even the small things." MCIT H had the same sentiments as she said she was "aware of taking things for granted." MCIT A realized, "I don't spend any time on the journey."

This developed sense of awareness brought a new appreciation and gratefulness for the little things in everyday life. MCIT A wrote in her journal, "I've felt… positive about a lot of mundane things". She also explained that "being mindful of listening to a song or brushing my hair… makes life more enjoyable." MCIT B wrote about her gratefulness for the gift of her smile. MCIT D shared that she was "grateful for what I have to eat." She also said she uses mindfulness as a "reminder… to stop and smell the roses." Finally, MCIT A had this realization, "I don't want to go through life, even months or days, and feel like I missed it."

The third micro-theme, *deep personal reflection*, involves the profound and uniquely individual realizations about themselves. Accordingly, the participants made some very insightful and wise observations about themselves. Two CITs reflected on anger. MCIT C said she realized that, "…coming unglued does not solve anything or accomplish anything productive." MCIT D wrote that "getting angry or losing it will not get me anywhere. If anything, it is a hindrance. It does not allow me to think straight and make rational decisions." On a more personal note, she also realized that "many things create anxiety for me." MCIT H wrote about her ability to "feel more comfortable with being emotional" and she noticed that she is "somewhat uncomfortable in the silence" with clients.

Various other insights were also revealed. In examining herself MCIT F wrote, "I find I am almost always buzzing like a bee and working on several projects and chores at once. I wonder about my effectiveness and if I am." She also declared, "I… notice how I rush everyone and I'm trying to be patient." Ultimately she disclosed, "I need counseling." MCIT E reflected that, "I never noticed how much self talk I use throughout the day. I hear myself thinking, keep going, don't give up, you can do it." She also wrote, "I have become more confident and not worried about other peoples' reception but rather have felt comfortable with my own thoughts and opinions." Finally, MCIT B revealed, "I'm building a strong sense of who I am and what I want." Continuing that thought in a different journal entry she wrote, "We forget sometimes how important it is to re-establish and continue to establish ourselves and our identity." In yet another entry she added, "I am full of knowledge and I am ready." theme

The fourth micro-theme that presented itself abundantly throughout the data was *reflections on mindfulness*. This micro-theme included participants' comments about their perceptions of mindfulness and the meanings they drew from their mindful experiences. The participants shared many observations about mindfulness. MCIT G wrote, "It's an activity that takes time and thought and causes you to just be." MCIT A felt that mindfulness was "a really important skill to have." MCIT F also sensed that "spending time to just be is important." MCIT E explained that she "truly enjoyed the clarity and insight and peace from mindfulness." MCIT H wrote that mindfulness practices "even changed my perspective at times." MCIT I said, "It was rewarding to be able to process and examine myself." Finally, MCIT B wrote, "Mindfulness allows me to see me."

The second subtheme, *relational insight*, was a recurring topic in the participants' data. This theme involved the CITs accounts of their realizations regarding interactions with others as well as their connections with the broader environment. Three micro-themes were prevalent within the subtheme of relational insight and consisted of repeated ideas from the MCIT data. The micro-themes were (a) *personal relationships*, (b) *client relationships*, and (c) *connectedness.*

The first micro-theme, *personal relationships*, involved the MCITs new awareness of how they relate with others. The MCITs were able to have an awareness of self as they related and attuned to others in their personal lives. Accordingly, MCIT E wrote specifically, "I use mindfulness to be aware when interacting with others." Two CITs were parents who shared how they utilized their newfound skills to communicate with their children during difficult situations. MCIT I realized her lack of awareness with

regard to interpersonal communication and wrote, "I don't really pay attention to my interactions with others. It seems to challenge me because I do not really talk to people." Later in her journal, with her new awareness, she shared, "There are more interactions than I thought there would be." MCIT C utilized interpersonal mindfulness skills to improve her situation in a difficult relationship. She wrote, "…his words no longer determined my mood or feelings about myself." MCIT B explained that it was "…strange to me the overwhelming energy I put off on others when my body-mind are unbalanced". In another entry she realized "when I smile specifically, others attune to my energy." She had noticed that her mere energy had impacted others in an interpersonal exchange.

The second micro-theme of *client relationships* was extracted from the MCITs' accounts of their mindful interactions with clients. MCIT F said, "Prior to mindfulness I felt impatient with clients who wouldn't communicate or progress as rapidly as I like." She also wrote, "I think mindfulness training has helped me 'tune-in' on the client's agenda and not so much on my agenda." MCIT I shared, "mindfulness is helpful, especially in a counseling session." Later she wrote, "I still need to work on confidence in session or in front of public." Three pages later in her journal she said, "I feel more comfortable with clients." On the following page she explained,

> "I feel more confident to ask them (clients) questions." MCIT G seemed to gain confidence as well, as she explained in her journal from week five, In regards to my sessions, I have noticed that I am not as nervous and I am just being present and 'aware' of what is going on. I feel like I am able to better focus on how I may come across to others sometimes and am more aware of my action and reactions toward people.

Finally, MCIT E shared about her interactions with clients as she wrote:

> I was able to use mindfulness throughout the week to really center myself and be aware when interacting with others and to really take in all my experiences. I have really noticed a difference in how being present with clients really helps with being an effective communicator. Being present also helps in being able to react appropriately to situations as well as with being pro-active to problems because you are able to sense the direction of situations.

The third micro-theme within relational insight was the MCITs' realization of their *connectedness* with the environment and other human beings. Awareness of the immediate environment is the first step in feeling a connection to it. Several of the MCITs reflected on the mindful walk they took during the first class session. In addition, many of them found this exercise useful and implemented mindful walking regularly in their own practice. MCIT E wrote about her perceptions during the walk in class, "I was able to notice the bay and how clear it was. The sky was gorgeous above the deep blue ocean. I was able to see birds diving for fish and at a point I looked up and saw the moon glowing white in the sky." MCIT D was also moved by the walk. She recalled many details as she wrote in her journal afterwards,

> Self-awareness. Outside. Great. Coolness around, wind blowing, the sound of the passing vehicles. Feet shuffling. As I concentrated more on the silence, I felt as if I was floating in the air. Going up and down the small hills! The warmth of the sun…then suddenly I heard a splash sound. Water hitting on something! Sprinkler on the cement wall. Smells.

Several participants shared their sense of a more general connection to the environment. MCIT H wrote tentatively at first, "I am not sure if it is my practicing of being mindful but I feel more sensitive to my surroundings." Later she realized, "I am definitely much more aware of everything. In a sense it is as if becoming much more aware has opened my eyes to see the world I live in. It is such a great feeling." In her practice log she wrote, "My walk was short but it definitely helped to feel to be a part of nature." MCIT C also reflected, "I now strive to notice things in my environment with intent." MCIT I had this insight about connection, "Mindfulness is not a purpose of calmness only but also [to] be aware of what [is] happening [to] our body, our mind, and our surroundings." Finally, MCIT B exclaimed, "I am one with the universe. One piece of the puzzle."

A number of participants referred to their connections with others. MCIT E noted, "I appreciated thinking about the process of how the food was brought to us and how we are connected to the people that process and cultivate the foods we eat." MCIT C shared, "The practices have given me insight as to how I personally can impact my environment and influence how myself and others think/feel." MCIT B realized, "Everyone else is a reflection of me." She also wrote that she felt, "A greater connection to others. A greater sense of love… I am never truly alone. I am connected."

Theme 4: Behavioral responses to mindfulness.

The fourth major theme was found via the repeated instances of participants putting mindfulness to use in their personal and professional lives. This theme, *behavioral responses to mindfulness,* involves the stories and anecdotes of how the students applied mindfulness throughout their daily living when they desired to tap into

the power of *being*. Three subthemes were culled from the data: (a) *self-care*, (b) *overcoming obstacles,* and (c) *enhancing interactions*.

The first subtheme, *self-care*, was harvested from the participants' practice logs, ripe with examples, as they recorded their active implementation of mindfulness to maintain a general sense of balance in body and mind. MCIT G wrote, "I used to get stressed when I would drive home from work in traffic but I just sit and listen to music and breathe and feel better." After a yoga exercise she also exclaimed, "I really enjoy just lying down and relaxing. I caught myself wanting to fall asleep." A loving-kindness meditation elicited this reflection, "I am hard on myself about things so I felt refreshed after doing this and reminded myself about loving myself." Following a breathing exercise MCIT I exclaimed, "I felt that I have power to control my own body." Mindfully listening to music drew this reaction from MCIT I, "It was joyful. I noticed the power of the music can change or impact my life." Even MCIT H, who practiced the least overall minutes, appreciated the self-care benefits of mindfulness. Following a breathing exercise she wrote, "Tense to calm." She also proclaimed, "Feels nice to be outside at night, different sights and sounds. Relaxing!" and "Breathing in and out really helps, even if for 5 minutes. I am back to feeling calm."

The second subtheme, *overcoming obstacles,* was constructed from the MCITs' accounts of using mindfulness to help them with specific personal challenges or problems. Several MCITs implemented mindfulness to help them sleep. MCIT A explained, "Sat in bed and breathed until fell asleep." In retrospect, MCIT C wrote about using a body scan exercise, "Helped me to relax and I fell asleep toward the end." MCIT D took a mindful bath and wrote, "Had a rough week, did this and wanted to go to sleep."

MCIT I went walking and reflected, “Calm and peaceful, took my mind away, helped with sleep.”

Many participants utilized mindfulness to find the eye in the center of their personal storm. MCIT A shared, “Had an emotional Monday, this [mindfulness] was nice to get my mind off of it.” MCIT D reflected that she, “took a walk on campus to blow off some steam.” MCIT G said, “I get stressed out easily so taking time to step back and be calm and breathe really helps.” MCIT F shared her experience in her practice log.

> Woke with a slight headache. I had a session at noon, clients were fighting in session and arguing. My head pounded. I was trying to breathe and relax but my head and their yelling continued. I ended up not going to class and going home because my head was pounding. I listened to many recordings because I had to be in the dark. It was difficult because I had so much to do. I fell asleep listening to the recorded mindfulness. I woke up about three to four hours later and it was significantly reduced. I went back to bed and continued listening to the mindfulness and woke up the next day. I felt so much relief.

The third subtheme, *enhancing interactions*, came to fruition as a result of the MCITs’ multiple accounts of implementing mindfulness in both personal and professional relationships. Mindfulness was utilized as a method to intentionally improve the outcomes of these exchanges with others. Two micro-themes were constructed from the *enhancing interactions* subtheme: (a) *personal interactions* and (b) *professional*

interactions. With regard to *personal interactions*, one participant shared her tale of using mindfulness with parenting challenges.

> My daughter didn't want to get out of bed today. She's been fighting me in the AM. Today without thought, I just let it go. I didn't get anxious as usual and feel my heart racing and blood rushing. I just let her move at her time. I did her hair for her and told her I'd wait in the car. I just waited and breathed. I told her in a calm way, not in a "mean crazy mommy" way. She came to the car about 7:50. By the way, most days she gets in the car crying. We headed to school and I knew we'd be late. I worked on keeping relaxed and focusing on driving. We arrived at 8:05. I parked…she took her time putting her shoes on. I kept thinking that this girl has no sense of urgency but it is probably because she'd never experienced the consequence and to just let her be late. She's nearly ten and I can't save her from every consequence and this is not that big a deal. After school she reported that she needed to get up earlier because she was the last one in and it was really embarrassing.

Another MCIT told her account of using mindfulness in a personal relationship. She explained,

> I previously would engage in fighting with him in hopes of "winning" any arguments with him. It has been a slow process, but I have been diligent in focusing on letting him own his negative feelings and actions and not making them mine as well. Over the past few days, he tried to pick a couple fights, but I didn't plug-in, emotionally or physically, and his

> efforts fizzled. I am so excited to acknowledge that I truly have very little emotional entanglement with him at his point.

With regard to the micro-theme *professional interactions*, the MCITs recorded abundant descriptions of using mindfulness to improve client service and outcome both in and out of session. With the fate of her client in mind, MCIT E shared how she used mindfulness before, and during, a court proceeding.

> Sometimes when I have to testify in court that stuff is just so… because I know that the words coming out of my mouth can literally change… what is going to happen so that's a lot of pressure to know that what you're saying is going to affect someone's life indefinitely. So I get really, really, really nervous when it comes to that. There's a little bit of prayer there too, to guide my words. But definitely the breathing steps that help with the physical anxiety… I go into the bathroom stall and just knock it out (the breathing). It's funny because the one time I did that the attorney came up to me later and said, "You are the most natural witness. I've never seen somebody just naturally speaks so confidently. You know how Tiger Woods has like a natural stroke at golf? You have a natural witness delivery." I'm like, you have NO idea. Ha! Ha! Ha! It's NOT like that. I've been on the stand before with the same attorney and he never noticed that before.

MCIT B shared in the focus group how she implemented mindfulness in session with a challenging client.

> I've recently noticed becoming in-check with myself when I'm in session with her. She's such a roller coaster, up and down. So I always was walking out of session completely drained! Just this week I was energized because I was able to check-in with myself, establishing my feelings separate from hers and not getting sucked into the details of everything she was experiencing, feeling, sharing and so THAT was empowering for me; to continuously separate myself from her and try to me mindful of what I'm experiencing. What I know is my truth and not hers…being able to help her from my self rather than my self being sucked in with her.

Many other participants used mindfulness to help them enhance their interactions in counseling sessions. MCIT F wrote about a client who was locked up like "Fort Knox". She said, "In my last session I really worked on following the client's lead, paying attention to what happens in the moment and asking her non-threatening questions and she became very talkative." MCIT C shared that, "With clients I tried to be diligent about being present and genuine, accepting, and empathic." MCIT G noticed, "I was able to be less stressed during the day which prepared me better for my sessions." MCIT F actively used mindfulness with clients. She said, "Doing mindfulness in the beginning of sessions helped my clients with focusing on the key issue. They were more relaxed and yielded to more progress."

Theme 5: Challenges to practice.

The fifth major theme was drawn from the participants' recurring descriptions of the difficulties of mindfulness practice. The theme, *challenges to practice*, depicts the participants' struggles with learning and developing the difficult skills required for

mindfulness. The three sub-themes for challenges to practice were (a) *busy mind,* (b) *maintaining focus,* and (c) *group support.*

The sub-theme, *busy mind*, refers to the numerous participants who wrote about the difficulty in controlling mental activity during practice. This notion was repeatedly reflected in the MCITs' comments about their mindfulness practice. MCIT I said, "My mind never stopped thinking or working" and "I felt restless and my mind never stops." MCIT C explained that her "mind was still racing from the day's events." MCIT A had a "very hard time turning off thoughts." MCIT G said, "I found it hard to be able to totally focus on my formal/informal practice because of how much stuff I have had on my mind."

Related to busy mind, the second sub-theme of challenges to practice was *maintaining focus*. This theme became evident as the CITs' practice logs were perused, but similar comments were in their journals. MCIT H wrote that it was "difficult to stay focused." MCIT C shared, "I had to focus extra hard and block out any distractions." In addition MCIT H wrote in her log, "It was hard to focus but it was easy to be aware of it."

Additionally, general frustrations with practice were sprinkled throughout the journals and practice logs as well. Examples of these comments included: "Just being and being with my breath was hard." "Just being in the moment is hard." "I tried to practice mindfulness but it did not work out."

The final sub-theme of challenges to practice was *group support*. This concept was drawn from repeated ideas that were discussed in the focus group and written in the participants' journals. Several of the MCITs made unsolicited remarks about the utility

of the group inquiry sessions included in each class. MCIT C shared her ideas about the group discussions.

> I enjoyed hearing the perspectives of other students in regard to how they were affected by utilizing mindfulness in their everyday lives. Hearing their experiences led me to be open and aware of how I was being affected in ways other than those I had indentified.

Theme 6: Reactions to the MTP.

The sixth theme, *reactions to the MTP*, emanated from the CITs' journals and logs, but mostly from the focus group. Five of the CITs attended the focus group and the remaining four submitted written responses on the focus group handout (see Appendix B). Overall, the MCITs shared positive reactions about the course. However, they also imparted several useful suggestions regarding improvements. Four sub-themes were developed from this body of data*:* (a) *required class,* (b) *continuing practice,* (c) *useful class exercises,* and (d) *homework challenges.*

The first subtheme, *required class,* refers to the fact that all five participants who were able to attend the focus group agreed that the MTP should be a required class. MCIT H was the first to suggest the idea during the discussions and the others approved. MCIT H also said, "My whole perspective changed, even my own personal attitude, to a positive perspective." MCIT E said the class, "…exceeded my expectations…it really helped with interactions with others. I learned to agree to disagree. I found peace with that philosophy." MCIT C wrote in her focus group handout, "I have benefitted greatly from participating in our mindfulness training."

The second subtheme, *continued practice*, was based on all nine participants' reports that they planned to continue using mindfulness in the future. Most of them said that informal practice would be utilized more often than formal practice. In addition, the focus group participants agreed that mindful walking, eating, and breathing were the most beneficial techniques that they learned. However, several others liked mindful yoga and the body scan exercise.

The third subtheme, *useful class exercises*, was drawn from the MCITs' eagerness to share their favorite experiential activities conducted during class. With regard to personal mindfulness, the eating, breathing, and monitoring exercises were well received. With regard to interpersonal mindfulness, the MCITs seemed to prefer the mindful listening and speaking exercise, the client's shoes exercise, and the breathing-with exercise.

The fourth sub-theme, *homework challenges*, was elicited mostly from the MCITs' journals and the focus group. One dilemma that several MCITs had with the course was the necessity to journal *and* keep a log. MCIT C wrote in her journal, "remembering to write is difficult" and that it was "difficult to keep up with the log" because she was "doing the exercises but forgetting to log." During the discussion at the focus group several students reported that remembering to log and/or journal was challenging. One student suggested combining the journal and log so that instead of a weekly journal and a daily practice log, a daily journal would include practice as part of the writing assignment. Another proposed that the journal be more structured with more specific topics to write about or sentence stems to stimulate the writing process.

Students offered a number of other useful suggestions for the course. One MCIT thought it would be interesting to attend, as a group, another mindfulness or meditation or yoga class. Another student wanted "more training on using it (mindfulness) with clients." MCIT B thought a beginner course in mindfulness and an intermediate course should be offered.

In summary, the resulting MCIT themes were derived from a lengthy and in-depth thematic analysis of participants' journals, practice logs, and focus group responses. The themes were significant in that they represented the essence of the participants' perspectives as they experienced and made meaning out of learning, practicing, and implementing mindfulness skills and philosophies. Overall, the participants expressed positive reactions to the mindfulness course. During the focus group, the MCITs were intentionally probed for negative or even lukewarm feedback yet all participants agreed that the MTP was an enriching and worthwhile experience.

University instructor themes.

The instructor themes were derived from repeated ideas conveyed in the instructor questionnaires. These themes were developed to obtain a more intimate understanding of instructors' perceptions of the participant MCITs' overall performance in class as well as their ability to apply counseling philosophies and skills with clients. Five themes emerged from the data:

- *improved confidence,*
- *improved therapeutic skills,*
- *thirst for knowledge,*
- *deeper understanding,*

- and *positive personal qualities.*

The instructors chose pseudonyms to identify themselves for the study. These identifiers are used in the theme descriptions for anonymity in reporting the findings.

Theme 1: Improved confidence.

The theme, *improved confidence*, was the first that came to fruition from the body of data due to its strong and repeated presence. This theme reflected the instructors' notions and inferences that mindfulness MCITs were able to work through their apprehension, both personally and professionally, over the course of the semester. As a result, two-micro themes were constructed from this theme: (a) *personal confidence* and (b) *professional confidence*. *Personal confidence* was portrayed as the MCITs' sense of trust in self. *Professional confidence* was conveyed as the MCITs' perception of competence in applying counseling concepts and techniques.

Evidence of the MCITs' development of *personal confidence* was abundant. Numerous accounts from the instructors declared its occurrence. In writing about MCIT E, instructor Lens relayed, "Her ability to shed any inhibitions and work on personal courage grew." Instructor Lens also said of MCIT E, "She was less anxious about her own performance and better able to trust the client in the process."

Another story of personal confidence was reflected in instructor Lens's account of MCIT D. Instructor Lens remarked, "Supervisee was high-anxiety at first but she developed better self-control of it as the semester progressed. She was fearful of coping with her own issues at first but gained confidence…there was more growth in maturity level than seen in many others."

Other instructors' comments also supported the growth in personal confidence. Instructor MA shared that MCIT G "had worked through issues of anxiety." Instructor Nicole reflected on MCIT C, "She seemed to relax more as the semester progressed." Finally, instructor MA shared similar thoughts on MCIT B, "She was more relaxed presenting in session."

Descriptions of MCIT progress in *professional confidence* were also plentiful. Several instructors noticed that the MCITs' interactions with peers improved during case conceptualization dialogue in class. Instructor Lens said of MCIT E, "Her participation in collaboration during class case management increased." Instructor Lens noticed the same in MCIT D and wrote, "Interactions with colleagues increased." Instructor MO also remarked on MCIT H's interactions, "She… began opening up and giving feedback to others." Instructor MA said of MCIT B, "Her confidence level appeared to improve as seen through her interactions with others in group supervision."

Other examples of professional confidence centered on work with clients. Instructor Lens said that MCIT D was "less inhibited with clients". Instructor Nicole shared that MCIT C was "executing various techniques with clients that other students seemed to still be unsure (of) or just completely stuck for next steps." Instructor Nicole also wrote that MCIT C, "was very confident in the information regarding skills and interventions as well as her ability to aid her clients."

A final illustration of personal *and* professional confidence was shared by instructor MA as she reflected on a written assignment submitted by MCIT B. In the assignment, MCIT B declared, "I am growing to become a counselor of confidence and a

woman of competence." In response, instructor MA surmised, "I believe she accomplished her dream."

Theme 2: Improved therapeutic skills.

The theme, *improved therapeutic skills,* was readily developed from the instructor data due to the specific counseling terminology used to describe the MCITs' performance while in session with clients. The instructors recounted numerous examples of MCIT relational skill advancement. Instructor Lens shared her perceptions of MCIT E:

> She increased her ability to restate client's responses, letting the client know he/she was heard. In other words, her active listening skills improved. She began to refrain from jumping in to a client's response. She gained better use of open-ended questions. She greatly decreased the tendency to give advice to clients.

MCIT G made numerous improvements in her relational skills according to instructor MA:

> The last taped session included a co-counselor. Student was the most focused in a session as compared to other sessions. Her demeanor was calm and attentive. She allowed for appropriate silence and the co-counselor contributed more to the session. Her tone of voice was less challenging and more understanding. Even confrontational statements were delivered in a more empathic way. Student demonstrated growth and maturity in her ability to engage in a therapeutic session versus an advice giving session.

Several instructors shared brief descriptions of MCIT progress including "her body language improved" and "insight into skills increased" and "she grew to think more of the client's need than her own." Finally, instructor MA wrote about MCIT B's in-session skills, "The client felt heard and she connected in a meaningful way with the client."

Theme 3: Thirst for knowledge.

The theme, *thirst for knowledge*, was gleaned from the data based on the instructors' recurring reports of MCITs who went beyond the typical student's efforts to learn. Three MCITs approached their instructors and asked for extra video tape reviews with feedback. One instructor wrote that MCIT 10 "brought two extra tapes for feedback of a particularly difficult case." Two MCITs conducted additional research on their clients' issues and related interventions. According to one instructors' comments, MCIT C, "…readily looked up research and interventions to better help her with her clients..." while "…other students were not as interested in the research related to theory and practice." In sum, five of the nine participants expended time and effort to do more than the standard class requirements.

Theme 4: Global growth.

The theme, *global growth*, was evident in the instructors' recurring comments about the MCITs' development and synthesis of both personal understanding and professional knowledge related to counseling. Descriptions of personal growth carried a sense of MCITs' abilities for insightful reflection. Illustrations of professional growth reflected MCITs' capacity to integrate their knowledge for a deeper appreciation of the counseling profession and their counselor role.

Comments about MCIT personal growth related to the MCITs' ability to explore and connect to a deeper sense of self. Instructor MA wrote about MCIT B: "Student's depth of reflection sets her apart from others." Furthermore, instructor Lens remarked on MCIT E, "She was better able to disclose what she believed to be necessary improvement in her skills than many other students." Instructor Lens also wrote about MCIT D and said, "There was more growth in maturity level than seen in many others." Finally, instructor MO said of MCIT H, "[She] really came into her own this semester…her insight into herself… increased."

There were many instructor reflections about MCIT professional growth. Instructor Bonnie said of MCIT F, "She recognized the greater responsibility of the counseling program." With regard to conceptualization of a client, instructor MA wrote about MCIT B: "… she gave an excellent understanding of art majors that helped a peer work with a client through an understanding of [the] client's creative art." Instructor MO remarked on MCIT H's disclosure with her: "She told us the feedback was really starting to "click" for her". Instructor MO added her own assessment of MCIT H and remarked, "… her counselor identity grew". Finally, instructor Nicole said of CIT C, "She really understood the marriage of having a counselor identity in order to help her clients. Overall, [the] student really stood out from other students in her development as a clinician and in her professional identity."

Seven of the nine MCITs earned positive reviews related to growth. The remaining two MCITs did not make as much progress, according to their instructors. One of the MCIT's received a lukewarm appraisal. Instructor Bonnie explained that MCIT F was "too preoccupied with personal business and completing required hours to

make time for extra learning." The other MCIT was assessed at making minimal progress. Instructor MO wrote, "Unfortunately her biggest struggle was using the English language and speaking up in session. She had a really tough time."

Theme 5: Positive personal qualities.

At first the codes for this theme were sorted into a miscellaneous category. Then the codes were reread to decipher whether any would fit into another theme or if a new theme was taking form. Ultimately, these codes were found to describe *positive personal qualities* of the participants that the instructors recognized. Most of the codes were statements initiated by the prompt on the questionnaire: Tell me about any differences from other typically developing students you noticed. This question was worded in a neutral manner, purposefully, so that the instructors could respond with positive or negative differences. Consequently positive comments and one negative remark were relayed.

When compared with other students, the MCITs seemed to be different in a mostly positive manner. Instructor B reported that MCIT A "handles responsibility in better ways". Regarding MCIT B, her instructor wrote, "…student appeared to be more serious about life in general" and "she was more creative than most students". This same instructor shared about MCIT G, "She is more willing than most to endure a difficult situation" and "student is persistent and committed". In instructor Bonnie's perspective, MCIT F "did not quite fit in with other students but she took the challenge". Finally, with respect to MCIT C, instructor Nicole explained, "She got concepts more quickly and needed less direction than most of the other students in the course." One instructor

shared negative feedback about a participant's personal qualities and described the MCIT as "quite flighty".

In summary, the instructor themes were developed from a thorough thematic analysis of responses from the instructor questionnaire. These data were included as a means to share a detailed portrayal of the instructors' perceptions of the participant MCITs as they learned and applied counseling concepts and skills during the course of the semester. The five themes described serve to represent the essential spirit of the instructors' sense of the MCITs' development while under their supervision.

In conclusion, the MCIT and instructor data and their respective themes yielded primarily encouraging findings regarding the MTP. The MCITs' perceptions indicated that by learning and practicing mindfulness, they were able to enhance their lives physically, emotionally, cognitively, and behaviorally, despite the challenges of being mindful. Furthermore, they were able to fruitfully apply their newfound skills, mindset, and appreciation of *being* to their personal and professional lives.

The instructors' perspectives of the MCITs were also essentially positive but represented the viewpoint of expert observers which added value to this study. In their reflections, the instructors conveyed that the participants improved their confidence and depth of knowledge at both personal and professional levels. Furthermore, the instructors relayed that the participants improved their therapeutic skills, had a thirst for knowledge, and possessed positive personal qualities.

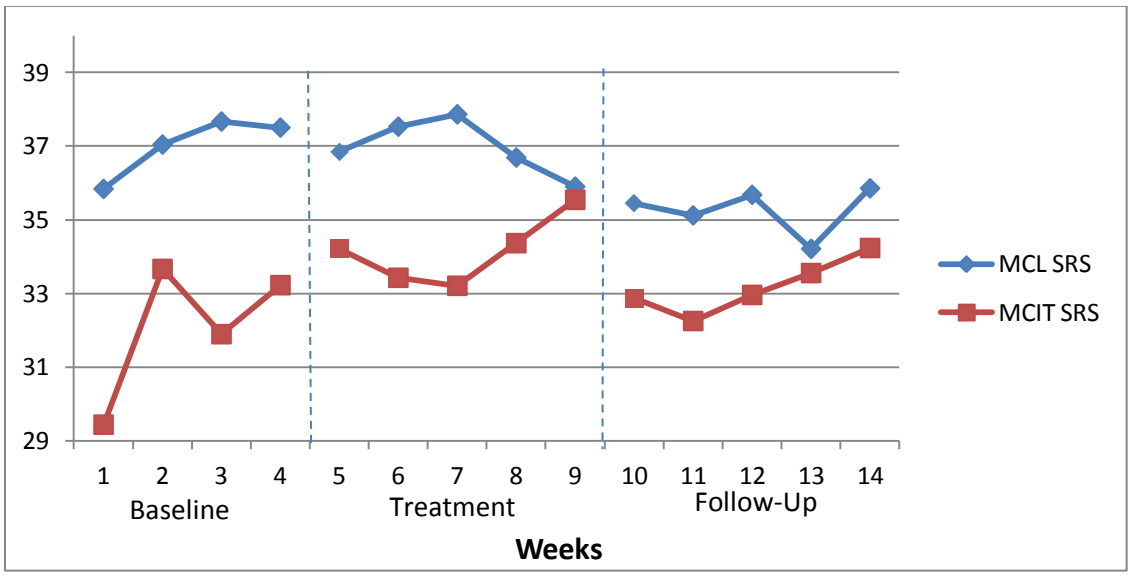
Single-Case Analysis: Profiles of Experience

Individual profiles of MCIT and Mclient SRS ratings are presented along with single case analytic measures including: (a) level, (b) trend, (c) immediacy of effect, and

(d) PND. Key elements of the graph are interpreted by slope of line across phases indicating an increase in reported therapeutic alliance (SRS) scores for the MCITs and a slight decrease for their clients. Also convergence across time indicates a correspondence between therapist and client perceptions of the quality of the therapeutic working alliance. In such cases, it might be interpreted that increasing convergence over time reflects *attunement* and or *resonance* (Siegel, 2010). The SRS ratings for the MTP group and their clients are presented in Figure 2 to provide an overall context for interpretation of individual profiles.

Figure 2

Mindfulness CIT and Client Therapeutic Alliance (SRS) Group Scores Across Phases



Note: MCL = mindfulness client, MCIT = mindfulness CIT

Utilizing single case methods, the MTP group outcomes were examined for level, variability, trend, immediacy of effect, and percentage of non-overlapping data (PND; Scruggs & Mastropieri, 1998). Level refers to the mean or average performance for each phase of a study. Variability refers to how much the data varies within each phase and is

somewhat comparable to the standard deviation of a set of data (O'Neill et al., 2011). Trend refers to the slope of the data points and if they are increasing, decreasing, or remaining flat across the phase. Immediacy of effect refers to the magnitude of change in the data points from the end of one phase to the beginning of another.

PND was determined by counting the number of intervention points that were higher than the highest baseline point, dividing by the total number of intervention points, and multiplying by 100. This calculation can be used as an approximation of effect size for the treatment outcome to illustrate meaningfulness (Scruggs & Mastropieri, 1998). PND scores greater than 90 (e.g., 90% of treatment scores exceeded the highest baseline scores) represent very effective treatments, scores from 70 to 90 represent effective treatment, scores from 50 to 70 are questionable, and scores less than 50 are ineffective.

With the MCIT group, therapeutic alliance (SRS) levels were low initially but increased across phases (see Figure 2). SRS levels for the client group were high in the baseline phase and decreased slightly over time. Variability for the MCIT group was greatest in the baselines phase and for the client group in the follow-up phase. The trend for the MCIT group SRS scores was an increase over time. The trend across phases for the Mclient group was a slight decrease. Immediacy of effect from baseline to treatment phase was moderately positive for the MCIT group and slightly negative for the Mclient group. From treatment to follow-up phase, a negative immediacy of effect was registered for both MCITs and Mclients. PND for clients was not calculated as there was a negative trend in scores. PND for all MCITs was 60% indicating a questionable effect for the group. However, for four of the MCITs, PND ranged from 80% to 100% indicating a large effect for those individuals.

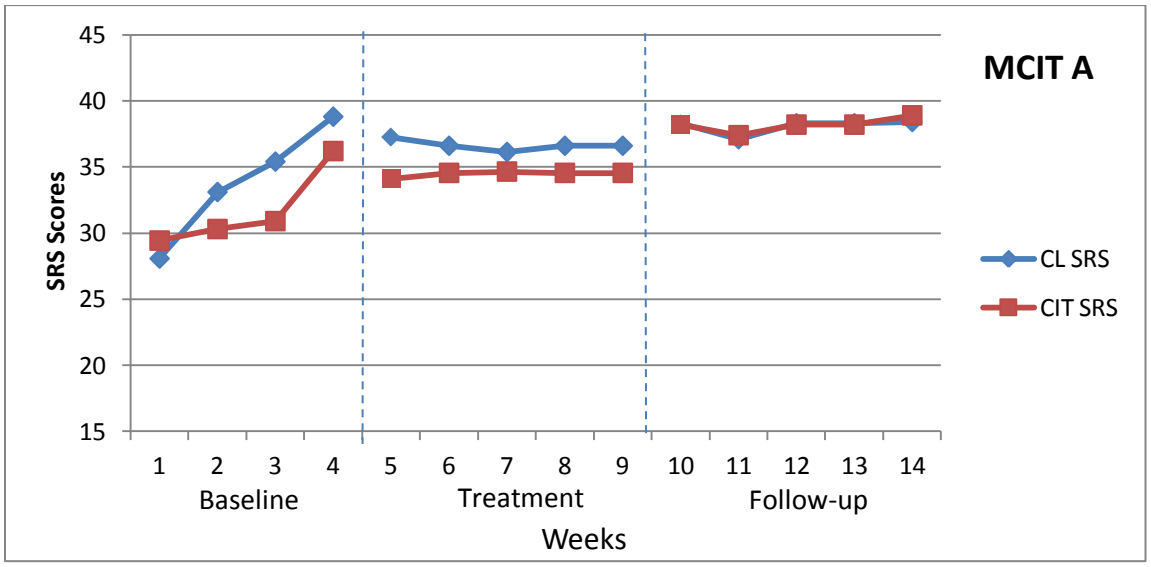
Single-Case Profiles.

The single-case profiles were analyzed utilizing quantitative and qualitative data to portray a detailed account of each CITs outcomes and experiences during the course of the study. Quantitative data integrated into this process included: (a) client and CIT therapeutic alliance (SRS) scores, (b) instructor-based therapeutic alliance (SRS) scores, and (c) mindfulness practice data. Qualitative data incorporated into the analysis included: (a) MCIT journals, (b) MCIT mindfulness practice log comments, (c) MCIT focus group feedback, and (d) instructor responses from the instructor questionnaire.

Individual MCIT and Mclient therapeutic alliance (SRS) data, for all nine participants, are displayed across phases in the following profile figures.

Figure 3

MCIT A and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT A: internship 2; *Caseload:* 2 clients

Baseline: Not stable for MCIT A and clients, increased.

Level: MCIT A levels moved from low to moderate to high. Client levels moved from low to moderate to high.

Trend: MCIT A trend increased across phases. Client trend increased across phases.

Variability: Both MCIT A and clients exhibited highest variability in the baseline phase. Other phases were relatively stable for both.

Attunement: Increased across phases

PND: MCIT A = 0, Clients = 0

Immediacy of effect: Both MCIT A and client scores decreased slightly from end of baseline to beginning of treatment phase and then increased to a corresponding level from treatment to follow-up.

Mindfulness Practice Profile: 134 minutes/week in treatment phase, 3:1 Formal/Informal

Profile Commentary:

In the baseline phase there is a visible difference in SRS scores between clients and MCIT A. However, this difference decreases slightly in the treatment phase and in the follow-up phase the scores are similar.

Researcher perspective:

MCIT A was diligent in her attendance to class and a willing participant in the experiential exercises. She did not share very often during the inquiry sessions in each class. She seemed to be a reserved and private person. However, her journals were very expressive and she shared openly about her frustrations as well as her triumphs in her weekly entries.

University instructor perspective:

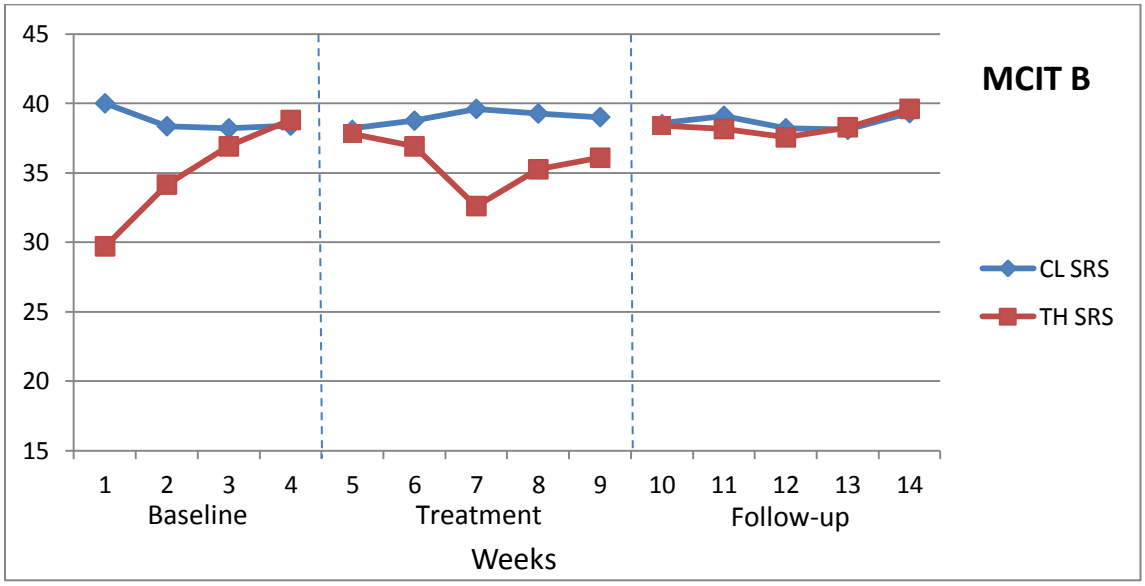
The instructor's score for MCIT A's pretest SRS was 14.4 and her post score was 30.6. These scores were based on live counseling sessions submitted before and after the MTP as part of regular class assignments. The increase in the therapeutic alliance score indicated that the instructor viewed MCIT A as making marked progress in her ability to build a constructive relationship with her client. The instructor also described MCIT A as focused, settled, mature, and responsible.

MCIT Journal, Log, and Focus Group:

MCIT A appreciated the benefits of mindfulness. In her focus group handout she wrote, "I learned that I was not very mindful before his class and it helped me to realize that and notice the little things." She also shared, "I learned some good techniques to try with clients when I become brave enough. It has also helped to be in the moment and really focus and listen to who is with me at any particular moment."

Figure 4

MCIT B and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT B: internship 1; *Caseload:* 3 clients

Baseline: MCIT B not stable, indicated an increase. Clients mostly stable.

Level: MCIT B levels moved from low to moderate to high. Client levels remained high across phases.

Trend: MCIT B trend increased across phases. Client trend remained stable across phases.

Variability: Both MCIT B and clients exhibited highest variability in the baseline phase. MCIT B also indicated some variability in the treatment phase while clients were stable. The follow-up phases was relatively stable for clients and MCIT B.

Attunement: Increased across phases.

PND: MCIT B = 0, Clients = 0

Immediacy of effect: Both MCIT B and clients increased slightly from baseline to treatment phase and then MCIT B increased to a corresponding level with clients from treatment to follow-up.

Mindfulness Practice Profile: 168 minutes/week during treatment, 4:1 Formal/Informal

Profile Commentary: In the baseline phase there is a notable difference in SRS scores between the client and MCIT B. However, this difference decreases slightly in the treatment phase and in the follow-up phase the scores become similar.

Researcher perspective:

MCIT B was an avid mindfulness practitioner prior to the study. Because of her more advanced skills, she specifically chose to be more of a listener and learner, rather than a leader in the class. During the treatment phase, MCIT B approached the primary researcher to share her angst about feeling a little bit overqualified for the course and the

researcher listened with openness. During the conversation MCIT B said she felt this experience was presented to her for some reason. Even if she felt frustrated by it she was trying to be open to the value of what lesson she might learn. Ultimately she shared later that the relationship mindfulness portion of the course was very helpful and new for her.

Instructor perspective:

The instructor's SRS scores for MCIT B were 38.8 for the pretest and 39.2 for the posttest. These high scores suggest that MCIT B already possessed a fairly high level of therapeutic alliance skills prior to the MTP. In the instructor's responses about MCIT B, she emphasized that this student was very reflective and advanced in her ability for insight. Yet, the instructor also conveyed that MCIT B seemed to gain confidence in herself and as a counselor over the semester.

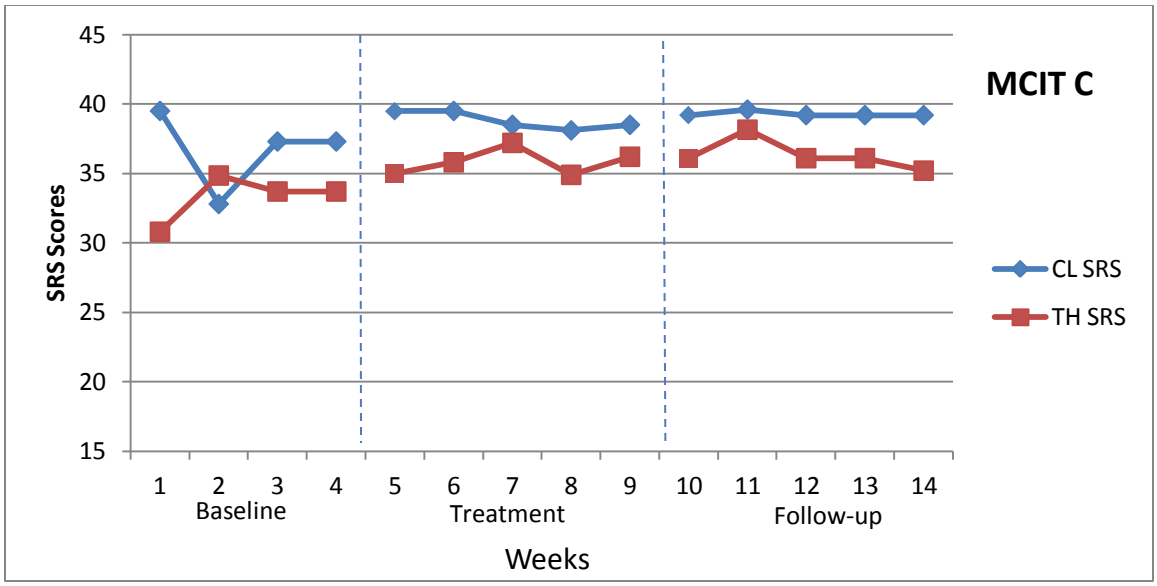
MCIT journal, log, and focus group:

In her journal, MCIT B wrote her thoughts like poetry:

> This is my practice. When I awake, I open my eyes and once again, I am reminded I am alive. I am living today. I am now. I close my eyes, and I can see. I can see what transcends beyond my body. Beyond the sun through the light. This is my practicing meditation. It is my truth. The truth no one else sees but me – my spirit.

Figure 5

MCIT C and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT C: internship 2; *Caseload:* 2 clients

Baseline: MCIT C and clients were not stable until weeks 3 and 4.

Level: MCIT C levels moved from lower to moderate to slightly higher. Client levels moved from moderately high to high across treatment and follow-up phases.

Trend: MCIT C trend increased across phases. Client trend increased slightly across phases.

Variability: Both MCIT C and clients exhibited highest variability in the baseline phase. Other phases exhibited minimal variability for both MCIT C and clients.

Attunement: Increased across phases.

PND: MCIT C = 100%, Clients = 40%

Immediacy of effect: Both MCIT C and clients' scores increased slightly from baseline to treatment phase. MCIT C scores remained level from treatment to follow-up and client scores increased slightly.

Mindfulness Practice Profile: 89 minutes/week during treatment and 145 minutes/week during follow-up, 1:2 Formal/Informal

Profile Commentary: The difference between MCIT C SRS scores and client scores decreased slightly across phases.

Researcher Perspective:

MCIT C was a dedicated and eager student. She regularly contributed during the class inquiry sessions about her successes and challenges with mindfulness practice. Her disclosure and transparency during the discussions made it apparent that she was applying mindfulness techniques in her personal and professional life. In one class she shared that mindfulness had made a "profound" impact on her.

Instructor Perspective:

The instructor issued MCIT C a score of 26.6 on her pretest therapeutic alliance (SRS) and a score of 34.6 on her posttest. Comments by the instructor corroborate with the improvement in the therapeutic alliance (SRS) scores. The instructor wrote, "At the beginning of the semester (she) did not have as much confidence as you would expect developmentally for students taking the last practicum." She went on, "By the end, this student was very confident in the information regarding skills and interventions as well as her ability to aid clients. It was a wonderful process to witness."

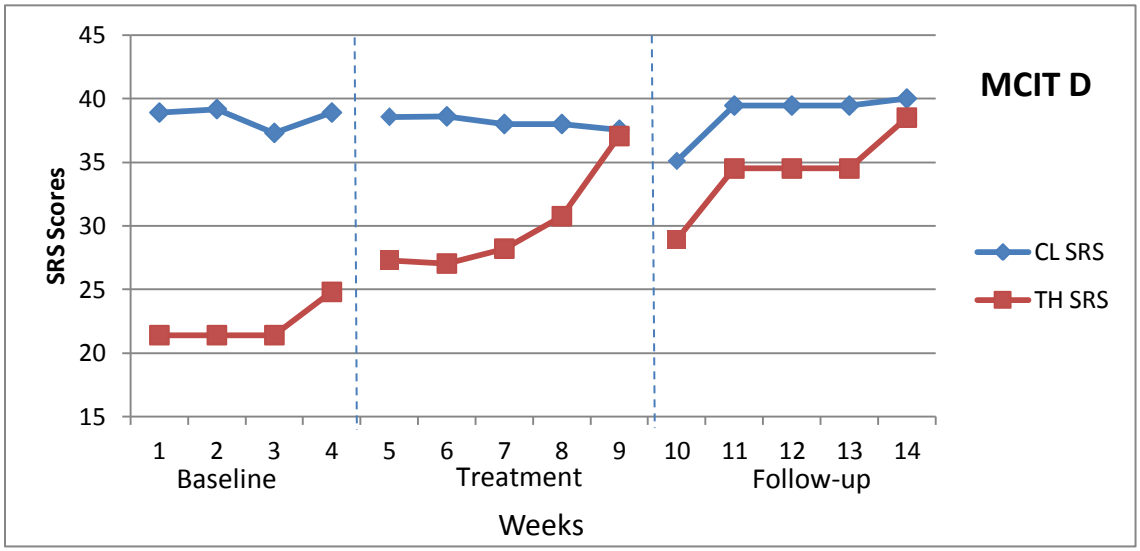
MCIT journal, log, and focus group:

In the focus group handout MCIT C shared her perspective that supports the instructor's assessment, "Overall, I think it (mindfulness) helped me to focus on what is important in the profession of counseling... helping clients to learn to help themselves. In previous semesters, my focus was primarily on acquiring book knowledge, with little insight as to

how it would be applied. By participating in mindfulness, I have been able to reflect back on what I learned in the classroom and more readily apply it to my clients and their needs. I was able to make a conscious effort to do this." She also shared, "I was also more focused on applying the core conditions in my sessions. In previous practicum and internship semesters, I was primarily concerned with asking the correct counseling-like questions without as much regard for what the client was actually feeling as they answered the questions."

Figure 6

MCIT D and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT D: practicum; *Caseload:* 3 clients

Baseline: MCIT D and clients were fairly stable.

Level: MCIT D levels moved from lower to moderate to slightly higher. Client levels remained mostly high across phases with a slight increase in the follow-up phase.

Trend: MCIT D trend increased across phases. Client trend increased slightly across phases.

Variability: MCIT D exhibited moderate variability across phases. Clients exhibited minimal variability over time.

Attunement: Increased across phases.

PND: MCIT D = 100%, Clients = 0%

Immediacy of effect: MCIT D scores increased slightly from baseline to treatment phase while client scores remained level. MCIT D and client scores decreased from treatment to follow-up. *Mindfulness Practice Profile*: 25 minutes/week during treatment and 249 minutes/week during follow-up, 1:2 Formal/Informal. MCIT D had two full days of mindfulness practice in the follow-up phase that elevated her average score.

Profile Commentary:

There is a notable difference in SRS scores between clients and MCIT D in baseline. However, this difference decreases in the treatment phase and again in the follow-up phase. The closer proximity between MCIT D scores and the client scores over time suggested improved connection in their views of the therapeutic alliance.

Researcher perspective:

MCIT D was a committed participant and attended all of the MTP classes. She turned in all of her assignments without extra prompts. In the beginning, she appeared to struggle with stress at work and spoke of back pain regularly. Over time she seemed to develop a sense of being more comfortable with herself and with sharing her thoughts and opinions during the mindfulness class.

University instructor perspective:

The instructor gave MCIT D 28.2 points for the therapeutic alliance (SRS) pretest and 28.2 points for the posttest. These stable scores did not indicate a change in therapeutic

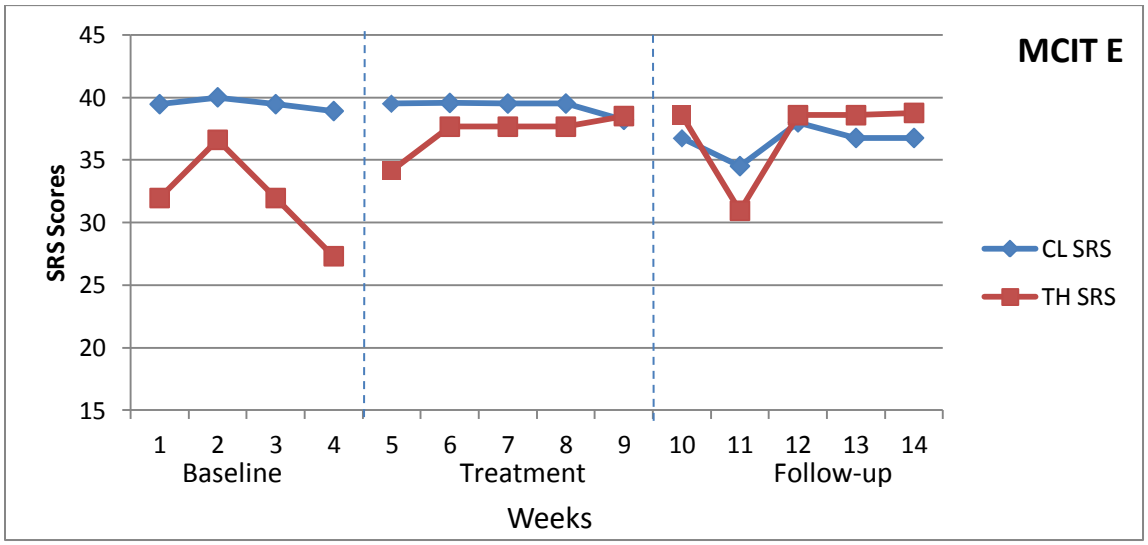
alliance ability between the two assignments. However, the instructor shared these thoughts about MCIT D, "Overall, she became more focused on her clients and her counseling skills than on herself or her concern with how others would see her. Her body language improved, as she became less stiff than in her earlier tapes."

MCIT journal, log, and focus group:

In the focus group handout, MCIT D's remarks seem to coincide with the instructor's and the researcher's notions of her ability to relax into herself. MCIT D wrote, "I have become patient and more in control of myself and my surroundings." In her journal MCIT D relayed, "I used this (mindfulness) as a reminder to practice being aware of myself. Also to "stop and smell the roses"."

Figure 7

MCIT E and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT E: practicum student; *Caseload:* 4 clients

Baseline: MCIT E was not stable. Clients were fairly stable.

Level: MCIT E levels moved from lower to moderate to slightly higher. Client levels remained high in baseline and treatment phases and decreased in follow-up

Trend: MCIT E trend increased across phases. Client trend deccreased slightly across phases.

Variability: MCIT E exhibited high, minimal, and then moderate variability across phases. Clients exhibited minimal variability in baseline and treatment phases with an increase in the follow-up phase.

Attunement: Increased across phases.

PND: MCIT E = 80%, Clients = 0%

Immediacy of effect: MCIT E scores increased from baseline to treatment phase while client scores increased slightly. MCIT E scores increased minimally from treatment to follow-up while client scores decreased.

Mindfulness Practice Profile: 50 minutes/week during treatment, 210 minutes/week during follow-up, 1:1 Formal/Informal.

Profile Commentary:

Reduction in differences between MCIT E and client scores across phases was difficult to ascertain with visual inspection. Therefore, score calculations were warranted. The difference between the mean phase scores was 7.5 for baseline, 2.13 for treatment, and -.52 for follow-up. This change in scores suggested that MCIT E was becoming more attuned with her clients regarding the assessment of therapeutic alliance.

Researcher perspective:

MCIT E was an engaged learner throughout the MTP. She maintained a stressful, full time job while participating in the master's program. She spoke openly, but

professionally, about her experiences working in high stakes situations with clients who were being assessed in parental competence. She seemed to be working to manage the high amount of stress in her daily life as well as make a shift in her professional identity from caseworker to counselor.

University instructor perspective:

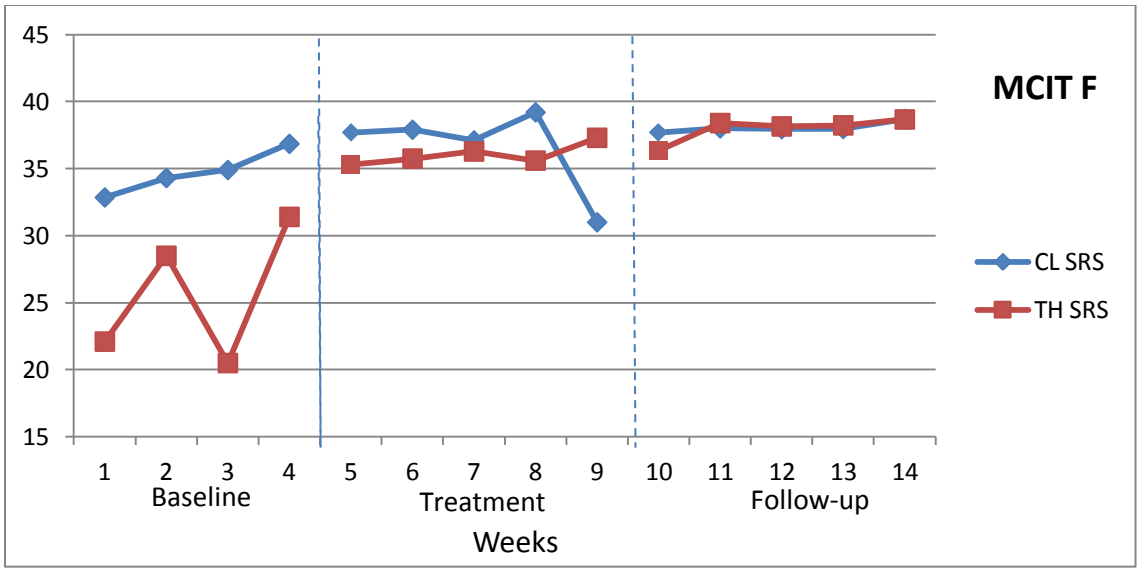
The instructor scores for MCIT E's pre and post SRS scores were 34.2 and 32.3, respectively. Her therapeutic alliance skills, as measured by the SRS, were not as strong in her second video as they were in her first. However, the instructor wrote about MCIT E's efforts, "She asked for more feedback and brought an extra tape for review." She also commented on MCIT E's progress, "She greatly decreased her tendency to give advice to clients. She increased her ability to restate client's responses, letting the client know he/she was heard. In other words, her active listening skills improved."

MCIT journal, log, focus group:

In agreement with the instructor, MCIT E said, "This experience really helped with my listening skills. I found that applying mindfulness really helped with not worrying about a response but rather focusing on the client and the messages they were sending." On a more personal note, in her journal she wrote, "I have truly enjoyed the clarity and insight and peace that being mindfulness can bring."

Figure 8

MCIT F and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT F: internship 1; *Caseload:* 5 clients

Baseline: MCIT F was not stable. Clients were not stable.

Level: MCIT F levels moved from lower to moderate high to slightly higher. Client levels moved from moderate to high in baseline and treatment phases and remained high in the follow-up phase.

Trend: MCIT F trend increased across phases. Client trend increased across phases.

Variability: MCIT F exhibited high variability in baseline phase and minimal variability in remaining phases. Clients exhibited some variability in baseline, moderate in treatment, and minimal in follow-up.

Attunement: Increased across phases.

PND: MCIT F = 100%, Clients = 80%

Immediacy of effect: MCIT F and client scores increased from baseline to treatment phase. MCIT F scores decreased minimally from treatment to follow-up while client scores increased.

Mindfulness Practice Profile: 178 minutes/week during treatment, 70 minutes/week during follow-up, 0:1 Formal/Informal.

Profile Commentary:

The disparity between MCIT F scores and client scores decreased across all phases suggesting an increased agreement in their perception of the therapeutic alliance.

Researcher perspective:

MCIT F openly shared in class about her challenge to slow herself down. She was a person who managed a small business, actively participated at her children's school, and attended the graduate counseling program. She was a high energy person but she seemed to lack a sense being grounded and focused at the beginning of the semester. She seemed to be pulled in a lot of directions at first. The principal researcher wondered if she would be able to fit the MTP sessions into her schedule. Ultimately, MCIT F attended all the class sessions and she made some positive changes for herself.

University instructor perspective:

The instructor's SRS scores for MCIT F were 29.8 for the pretest and 28.3 for the posttest. MCIT F's therapeutic alliance skills were evaluated as being more effective in the pre-treatment video. The instructor described MCIT F as "quite flighty" and "too preoccupied with a personal business." However, the instructor also said that MCIT F had "returned after a lengthy hiatus" and "didn't quite fit but took the challenge."

MCIT journal, log, focus group:

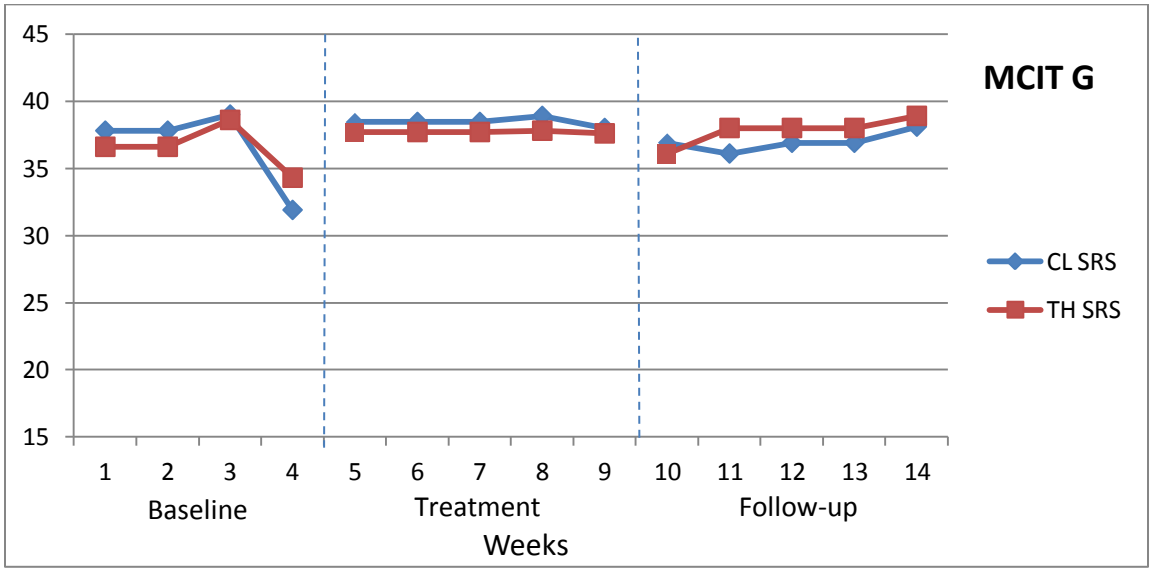
Throughout her journal MCIT F gave numerous examples of how she was actively using mindfulness with her self, her children, and her clients, throughout her life. She was very

excited about the changes she was seeing and she wrote, “I feel like I am a salesman for mindfulness.” In her focus group handout she wrote,

> This experience helped me learn I don’t take time to relax and appreciate the environment or people around me. It has helped me focus in, during conversations and therapy sessions, on what the client is saying, feeling, and doing. It has helped me identify when I am becoming overwhelmed and stressed and given me some tools to unwind.

Figure 9

MCIT G and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT G: internship; *Caseload:* 1 client.

Baseline: MCIT G and clients were not stable.

Level: MCIT G and client levels remained mostly high and fairly stable across phases.

Trend: MCIT G trend increased slightly across phases. Client trend remained level across phases.

Variability: MCIT G and client scores exhibited some variability in baseline phase and minimal variability in remaining phases.

Attunement: Remained stable and closely parallel across phases.

PND: MCIT G = 0%, Clients = 0%

Immediacy of effect: MCIT G and client scores increased from baseline to treatment phase after both dropped in the baseline phase. MCIT G and client scores decreased slightly from treatment to follow-up phase.

Mindfulness Practice Profile: 174 minutes/week during treatment, 78 minutes/week during follow-up, 3:1 Formal/Informal.

Profile Commentary:

The congruence between MCIT G scores and client scores was consistent across all phases suggesting maintained agreement in their perception of the therapeutic alliance.

Researcher perspective:

MCIT G was a quiet but agreeable participant in the MTP class. She did not share often during the inquiry and discussion time in class when we talked about our mindfulness practice. She worked full-time in, what seemed to be, a fairly stressful atmosphere. She expressed anxiety about studying for, and taking, the National Counselor Exam (NCE) during the MTP.

University instructor perspective:

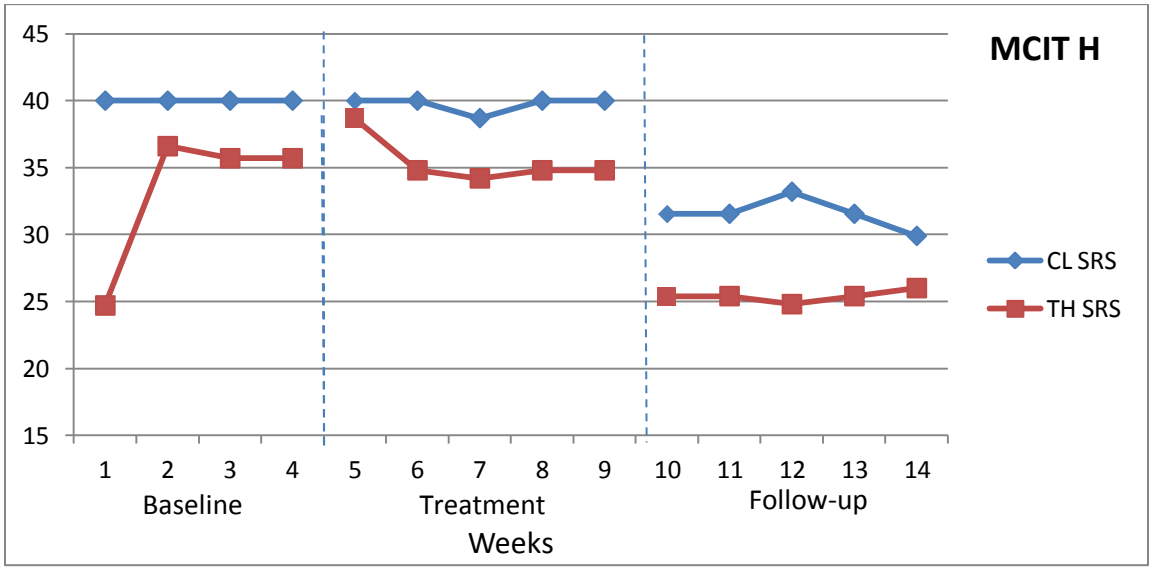
The instructor issued MCIT G a score of 36 on her SRS pretest and a score of 38.2 on her posttest indicating a slight increase in therapeutic alliance skills. The instructor also wrote about MCIT G in the instructor questionnaire, "Student demonstrated growth and maturity in her ability to engage in a therapeutic session versus an advice giving session."

MCIT journal, log, focus group:

In the focus group handout, MCIT G wrote about mindfulness with counseling, "It helped me to become more aware of myself, in the room, and my client as well. During silence I would become aware of it and (be) more comfortable in the session. I would be more aware of my client's non-verbal reactions."

Figure 10

MCIT H and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT H: practicum: *Caseload:* 2 clients

Baseline: MCIT H scores were moderately stable. Client scores were stable.

Level: MCIT H levels moved from moderately high in baseline and treatment to lower levels in follow-up. Client levels moved from high in baseline and treatment phases to lower levels in the follow-up phase.

Trend: MCIT H trend decreased across phases. Client trend decreased across phases.

Variability: MCIT H exhibited some variability in baseline, moderate variability in treatment, and miniumal variability in follow-up phase. Clients exhibited no variability in baseline, minimal in treatment, and moderate in follow-up.

Attunement: Increased initially and then decreased in the follow-up phase.

PND: MCIT H = 0%, Clients = 0%

Immediacy of effect: MCIT H scores increased from baseline to treatment and decreased from treatment to follow-up. Client scores remained high from baseline to treatment and then dropped from treatment to follow-up.

Mindfulness Practice Profile: 92 minutes/week during treatment, 74 minutes/week during follow-up, 1:2 Formal/Informal.

Profile Commentary:

Discrepancy between client and MCIT H mean scores decreased from baseline to treatment (6.8 to 4.24). Yet differences between the two scores increased again in the follow-up phase to 6.15.

Researcher perspective:

MCIT H was a devoted attendee of the MTP. She willingly participated in class activities but she rarely spoke during the inquiry time when we shared about our experiences using mindfulness. During the program I wondered if she was finding mindfulness to be useful. It was not until I read her journal after the end of the course that I realized she was using mindfulness to make many positive changes in her life.

Instructor perspective:

The instructor scored MCIT H's SRS pretest at 36.1 and her posttest at 36.8. There were slight gains in therapeutic alliance skills from pre to post assessment. The instructor also

had encouraging things to share about MCIT H, "[She] was at the top end of the class re: skills and development". The instructor also wrote that MCIT H "… really came into her own this semester. Her counselor identity grew and the insight into herself and her skills increased."

MCIT journal, log, and focus group:

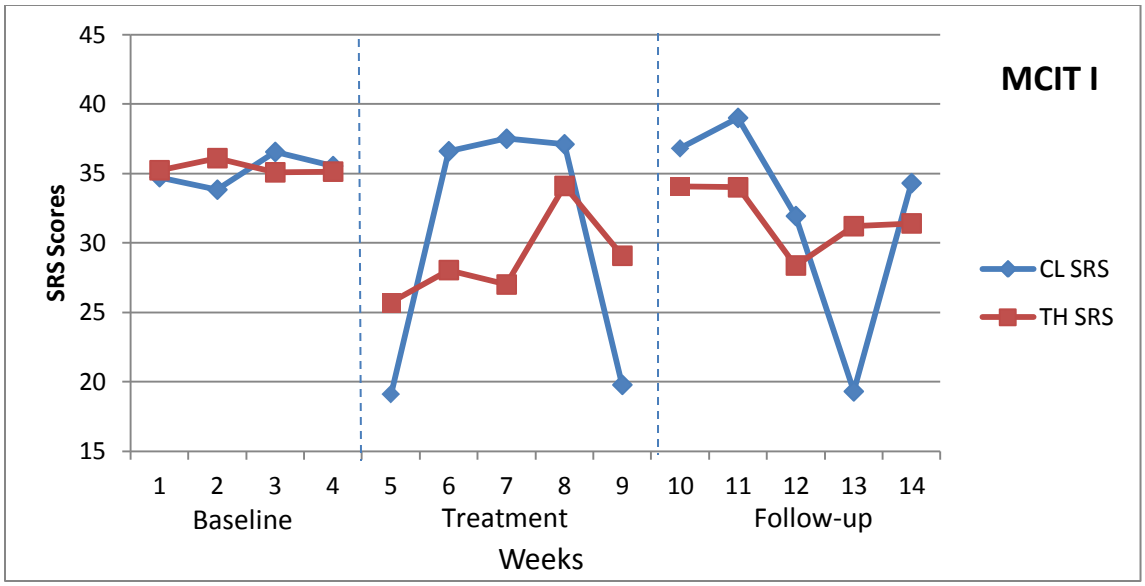
In her journal, MCIT H said,

> My week was stressful but what stood out was that I was able to be aware of the stress taking a toll on my body physically and emotionally. Being able to take some breaks and come to awareness around me was very helpful. It even changed my perspective at times which I really enjoyed. I now know that I need to slow down.

She also wrote in the focus group handout, "It (mindfulness) helped me become aware of negativity I had within myself that I may have been spreading to others. I have now been able to be more positive and spread the positivity among co-workers, friends, and family."

Figure 11

MCIT I and Client Therapeutic Alliance (SRS) Weekly Mean Scores



Note: CL SRS = Mclient SRS, CIT SRS = MCIT SRS

MCIT I: practicum; *Caseload:* 7 clients

Baseline: MCIT I and client scores were mostly stable.

Level: MCIT I's score level moved from moderately high in baseline, to a lower level in treatment, and slightly higher in follow-up. Client score level moved from moderately high in baseline, to moderately low in treatment, and lower still in follow-up.

Trend: MCIT I trend decreased across phases. Client trend decreased across phases.

Variability: MCIT I exhibited minimal variability in baseline, high variability in treatment, and high variability in follow-up phase. Clients exhibited little variability in baseline, high in treatment, and high in follow-up.

Attunement: Not evident.

PND: MCIT H = 0%, Clients = 60%

Immediacy of effect: MCIT I and client scores decreased from baseline to treatment and increased from treatment to follow-up.

Mindfulness Practice Profile: 231 minutes/week during treatment, 232 minutes/week during follow-up, 2:1 Formal/Informal.

Profile Commentary:

Differences between MCIT I and client scores were minimal in the baseline phase. In the treatment and follow-up phases, differences between scores increased substantially. The dissonance in scores indicated that therapeutic alliance perceptions were not in concert between MCIT I and the client group over time.

Researcher perspective:

MCIT I was a shy but thoughtful student. Additionally, English was not her primary language. She attended every MTP class and was committed to her journal and practice log. During class time she would not speak unless prompted by one of the instructors. Some of this behavior might have been due to her native culture. Her journal entries were very insightful and revealed her thoughts that were not shared in class. At the Counseling and Training Clinic, other students and the clinic supervisor noticed her lack of interaction with clients while in session. In order to build her confidence to interact with clients, the students voluntarily staged a mock counseling session to allow her to practice interacting.

Instructor perspective:

The instructor SRS scores for MCIT I were recorded at 23.9 for pretest and 24.5 for posttest indicating a slight improvement. The instructor also shared the following about MCIT I, "Because of the language issues, I didn't see the normal development I would have seen in other students." The instructor also reported that MCIT I struggled to speak up in session.

MCIT journal, log, and focus group:

In her journal, MCIT I wrote entries that aligned with the instructor's comments and with what the primary researcher noticed in the MTP classes and the Counseling and Training Clinic. She said, "Meditation (mindfulness) helps me gain some focus. It is very helpful especially in counseling session. But I do still need to work on my confidence and being comfortable in the session or in front of [the] public." In response to the journal prompt, what did you observe about your interactions with others this week, she wrote, "It seems to challenge me because usually I do not really talk to people. I do not really pay attention to my interaction[s] [with] others either. But once I did, it was interesting to observe… The lesson I learned from it; there are more interactions than what I thought [there] would be." In her final journal entry she wrote about her overall experience, "It was rewarding to be able to process and examine myself."

In summary, an important trend, clearly illustrated by the single-case analyses, was the increasing similarity, across phases, of the client and MCIT therapeutic alliance scores for most participants. The MCIT SRS scores were initially several points lower in the baseline phase but increased and became more in sync with their clients over time. This is significant because it suggests that the MCITs' perceptions of the therapeutic alliance were becoming more attuned with their clients' views of the alliance.

Additionally, four of the MCITs demonstrated increases from baseline to treatment phase with PNDs that ranged from 80% to 100% indicating a large effect. Furthermore, the progress of these four MCITs represents a convincing, clear experimental effect as a result of the dependent variable, the MTP (Horner et al., 2005; Kennedy, 2005; O'Neill et al., 2011).

The instructors' perspectives of alliance (SRS) scores and feedback from the instructor questionnaire generally supported the idea that the MCITs made strides in their personal and professional development. Most of the participants improved in their post alliance (SRS) scores. Furthermore, the instructors' responses indicated that MCITs made gains in their personal and professional confidence and their counseling competence.

Mindfulness practice was embraced by each MCIT in their unique way as evidenced by their consistent but varied reports. They all practiced mindfulness at some level but there appeared to be no trend regarding preference toward formal versus informal practice. Tailoring practice to personal preferences and time constraints is one of the appealing aspects of mindfulness. Participants were asked to practice 15 minutes per day and most of them met or exceeded the minimum amount. Also, the MCITs reported having difficulties remembering to log their practice so it is likely that their true practice times were even greater than what was recorded.

Summary of Findings

The following research questions were addressed in this mixed methods study of a mindfulness training program with CITs:

1. What are the effects of a mindfulness intervention on therapeutic alliance outcomes as reported by CITs, clients, and instructors?

Treatment and control group CITs' perception of alliance increased in a statistically significant manner across phases, collectively. Yet there were no significant differences between the two CIT groups' alliance (SRS) scores reported over time. Treatment and control group client perceptions of therapeutic alliance (SRS) indicated no

significant changes, within or between groups, across phases. Instructors' perspectives of CIT alliance (SRS) did not distinguish the treatment group from the control group as all CITs generally improved from pre- to post-assessment.

Most notably, both the treatment and control group CITs' alliance (SRS) scores demonstrated an increased *correspondence* with their respective clients' alliance (SRS) ratings across phases. However, further examination of this phenomenon revealed that when the increase in scores was compared between groups, the increase in the MCITs' alliance (SRS) scores was more dramatic than the control group over time. In other words, the treatment CIT group exhibited greater gains in attaining correspondence with their clients' alliance scores. This correspondence or attunement between MCIT and Mclient alliance scores over time was supported and even more pronounced in most of the MCIT single-case profiles.

2. What are the effects of the intervention with regard to CIT mindfulness and empathy?

MCIT global mindfulness (FFMQ) scores demonstrated statistically significant increases from pre- to post-test. Two of the five subscales, observe and non-reactivity of inner experience, also recorded significant increases. The remaining subscales, describing, acting with awareness, and non-judging of inner experience, did not demonstrated statistically significant differences but did indicate increases from pre- to post-test.

MCIT global empathy (IRI) scores demonstrated statistically significant increases from pre-to post-test. The global score included the empathic concern and perspective taking subscales only. One of the empathy subscales, empathic concern, also recorded a

statistically significant increase. The remaining subscales, perspective taking, fantasy, and personal distress did not report statistically significant differences but did improve in the desired directions.

3. How is CIT mindfulness practice related to outcome measures?

MCIT mindfulness practice increased dramatically from baseline to treatment phase and then remained fairly stable in the follow-up phase. As there were no significant changes in client therapeutic alliance scores, mindfulness practice did not likely affect that result. However, the amount and consistency of MCIT mindfulness practice across phases seemed to suggest that mindfulness (FFMQ) and empathy (IRI) outcomes were impacted by practice from pre- to post-test. Furthermore, as mindfulness CIT therapeutic alliance (SRS) scores demonstrated increased congruence with their clients' scores across phases, one could surmise that mindfulness practice outside the counseling session made an impact on MCITs' ability to be present an attuned to the client within the counseling session.

4. What are the experiences of CITs as they participate in a mindfulness intervention? How will these experiences manifest in the personal and professional lives of CITs?

Qualitative themes indicated that the mindfulness CITs had mostly positive responses to the intervention as evidenced by their journals, logs, and focus group feedback (see Table 8). The participants made improvements in physical, affective, cognitive, and behavioral aspects of their lives despite the difficulties inherently involved with mindfulness practice. Furthermore, the MCITs were actively utilizing mindfulness methods to improve their well-being as well as their personal and professional

relationships. Ultimately, the MCITs were using mindfulness in counseling sessions to improve their ability to intentionally be present with their clients. Qualitative themes from the MCITs' instructors corroborated with the MCIT themes suggesting that the intervention made a positive impact on the participants due to their improved confidence and therapeutic competence in their practicum or internship course.

Chapter 5

Discussion

This study involved the relationships among mindfulness, empathy, and therapeutic alliance in a counselor training context. The working hypothesis was that teaching counseling students mindfulness practices would improve their ability to develop healing relationships with their clients and improve client outcome (Shapiro & Carlson, 2009; Hick & Bien, 2008; Germer, Siegel, & Fulton, 2005). Furthermore, it was expected that counselor mindful awareness and mindful practice could nurture the therapeutic relationship (Andersen, 2005; Martin, 1997; Shapiro & Carlson, 2009). In this study, MCITs participated in a 6 week MTP and therapeutic alliance scores were collected from MCITs, their clients, and their instructors. The results were, in general, consistent with the proposed outcomes. Counselors became more mindful and empathic across the clinical training experience. Counselors demonstrated increases in their therapeutic alliance scores over time.

Faculty ratings of student-client session tapes confirmed that MCIT alliance skills improved from pre- to post-test and final evaluations indicated positive development in observable helping skills. Most MCITs practiced mindfulness beyond the requested minimum of 15 minutes per day. The majority of the MCITs showed an increasing degree of correspondence with the client ratings of "how the session went" indicative of increases in counselor *attunement* and *resonance* (Siegel, 2010). The results suggest that the counselors were increasing their interpersonal sensitivity within the session. The exploration of individual profiles and analysis of journals, practice logs, and focus group

feedback illuminated individual variation in utilization of mindfulness in MCITs' personal and professional lives.

Phenomenological thematic analysis uncovered a number of experiences that seemed "typical" of most of the participants. Consistent with a componential model of mindful awareness (IAA Model, see Shapiro, Carlson, Astin, & Freedman, 2006), the MTP group seemed to accept the invitation to practice with deliberate *intention,* notice with acute *attention,* and maintain an *attitude* of open curiosity in each moment of their experience. The MTP group indicated in varying degrees how this *being mindful* made sense or was useful in both their personal and professional lives – and especially in their work with clients. In sum, the mindfulness training intervention seemed to be impactful for the MTP group, despite the inherent challenges of mindfulness practice. The MCITs were busy graduate students with full schedules brimming with activities that competed for their time including the mindfulness training and practice commitment to this study. The MCITs were challenged to be in the moment, attend every class, write in their journals, and practice and log their mindfulness exercises. Yet in spite of these obstacles, the results of this study extend previous literature on mindfulness, empathy, and therapeutic alliance in a number of specific ways.

Mindfulness.

Mindfulness has gained increased support as an attitude and method that enhances counselor relational qualities thus impacting the therapeutic alliance (Germer et al., 20005; Hick & Bien, 2008; Shapiro & Carlson, 2009; Siegel, 2010). In the current study, participants' recorded statistically significant improvements in mindfulness from pre- to post-test. This outcome supports the literature regarding the effectiveness of mindfulness

training. MBSR, which informs this MTP, is a nationally registered evidence-based program (NREPP). Additionally, other researchers have successfully implemented various mindfulness interventions to improve therapists' mindfulness (Cohen & Miller; 2009; Christopher & Maris, 2010; Moore, 2009; Shapiro, Brown, & Biegel, 2007).

Qualitative themes generated from participants' experiences support the quantitative findings that mindfulness improved in this study. The phrase "Mindfulness; it's not what you think" was displayed on the dry-erase board the first day of the MTP. This expression was borrowed from Jon Kabat-Zinn (1990) who explains mindfulness is a way of *being*, not a way of thinking. While the students were engaging in mindfulness practices, they began to feel and notice the fruits of their labor. They gained an understanding of what mindfulness *really* means and how it was making an impact on their lives. Positive responses to mindfulness training were discovered in physical, affective, cognitive, and behavioral domains. Consequently, mindfulness made an impact on participants' personal and professional lives.

At a personal level, one MCIT wrote,

> The practice of mindfulness helped me to realize that I breeze through life without really 'experiencing' a lot of things. It made me more conscious of staying in the present. It helped me appreciate experiences that I previously took for granted and it helped me to be deliberate about enriching experiences in which I am participating...

On a professional level, another participant shared,

> [Mindfulness] helped me to become more aware of myself in the room and [of] my client as well. During silence I would become aware of

it and more comfortable in the session. I would be more aware of my client's non-verbal reactions.

Other qualitative inquiries found similar personal and professional benefits for participants as a result of mindfulness training (McCollum & Gehart, 2010; Moore, 2008; Newsome, Christopher, Dahlen, & Christopher, 2006; Schure, Christopher, & Christopher, 2008).

Empathy.

Empathy has been reported as a vital component of the therapeutic relationship and is a moderately strong predictor of client outcome (Elliott, Bohart, Watson, & Greenberg, 2011). In this study, mindfulness training impacted CITs' empathy levels as there was a significant increase from pre- to post-test. This outcome supports the results of other studies that empathic qualities can be enhanced with a mindfulness intervention (Lesh, 1970; Schure et al., 2008; Shapiro & Brown, 2007; Shapiro, Schwartz, & Bonner, 1998).

Participant experiences and resulting themes reflected their improved empathic capabilities. The two sub-themes of *relational insight* and *enhancing interactions* involved MCITs' increased understanding and implementation of mindfulness practices in interpersonal exchanges, respectively. One MCIT wrote how mindfulness helped her understand her clients,

"I was more readily able to put myself in the shoes of the client" and " …in previous… semesters I was primarily concerned with asking the correct sounding counseling-like questions without as much regard for what the client was actually feeling as they answered the questions."

Another participant shared her compassionate response to a client who seemed to shut down based on her co-counselor's questioning technique, "I would use more encouraging statements that let her know I was present and restatements to let her know I understood. I think she needs a counselor who is sensitive to her."

Therapeutic alliance.

There is no shortage of evidence that the therapeutic alliance between counselor and client is a key contributor to client outcome (Horvath, Del Re, Flückiger, & Symonds, 2011; Lambert, 1992; Martin, Garske, & Davis, 2001). Researchers have explored the relationship between mindfulness training and the *qualities* of the therapist that facilitate the therapeutic alliance (Christopher & Maris, 2010; McCollum & Gehart, 2010; Moore, 2008; Newsome, Christopher, Dahlen, & Christopher, 2006; Schure et al., 2008). However, the current study is one of the first to implement an MTP involving mindfulness practice with CITs to examine its effects with therapeutic alliance, specifically.

CIT results.

Statistically significant changes were reported with regard to treatment and control group (within groups) CIT perceptions of the therapeutic alliance over time. This corresponded with several other studies' results that trait mindfulness correlated with therapist perceptions of alliance (Kaplan, 2013; Padilla, 2010; Wexler, 2006). Further examination of this outcome, in the current study, demonstrated interesting results.

When the treatment and control group alliance scores were explored in a between subjects format, the treatment groups' scores recorded greater gains in agreement with their clients' scores than the control group. This could suggest that the mindfulness CITs

were becoming more *attuned* to their clients' perceptions of the therapeutic alliance over time. Similar results have been recorded in other studies. Kaplan (2013) found that therapist and client agreement in the reporting of ruptures was correlated with therapist mindfulness. Also, other qualitative researchers implemented a mindfulness training with CITs and found that the participants reported positive effects on their therapeutic relationships including being more attentive and *attuned* with oneself and clients (Newsome et al., 2006; Schure et al., 2008).

MCITs' alliance scores demonstrated *typical* development or maturation as they gained experience in their clinical and attending skills and the MTP may not have been a significant influence on their change. Yet, the qualitative data from this study reflect the notion that the MCITs were using mindfulness practices that could have facilitated improved *attunement* with their clients over time. This was exemplified in emergent MCIT and instructor themes. First, within the MCIT theme of *cognitive responses to mindfulness*, the participants' reported gaining relational insight with regard to client relationships. The second half of the MTP was devoted to the development of interpersonal mindfulness. The last three classes were more informed by the literature on mindfulness and its impact on the therapeutic relationship (Germer et al, 2005; Hick & Bien, 2008; Shapiro & Carlson, 2009; Siegel, 2010). In each of the three classes, participants engaged in mindful activities that applied their skills to *being* with others. The activities included practice in presence, attunement, monitoring, listening and speaking, and breathing-with (Shapiro & Izett, 2008; Siegel, 2010; Surrey, 2005). The learning and understanding that occurred as a result of these activities manifested in the participants' experiences and resulting data. A representative example of a comment

involving relational insight was expressed by an MCIT who wrote in her journal, "I think the mindfulness training has helped me "tune in" on [the] client's agenda and not focus so much on my agenda."

Another MCIT theme that reflected the development of therapeutic alliance and attunement capabilities was *behavioral responses to mindfulness*. This theme involved participants' reports that they were implementing mindfulness methods to enhance their interactions with clients. A participant shared these reflections, "I found that clients can sense when you are fully engaged and are truly listening and trying to comprehend what they are saying" and "it (mindfulness) also helped me to stay present-focused instead of frequently thinking of what I was going to ask next." The participants' reports of using mindfulness with clients in an attentive and focused manner support that they were engaging in methods that could facilitate attunement. Finally, one instructor theme supported the idea that the MCITs developed alliance and attunement skills during the study. The theme of *improved therapeutic skills* represented the instructors' accounts of the MCITs' development of relational abilities with clients. An illustrative account of this theme was expressed as an instructor recalled the performance of an MCIT in a post-treatment counseling session. The instructor wrote,

> [The] student was the most focused in a session as compared to other sessions. Her demeanor was calm and attentive. She allowed for appropriate silence and the co-counselor contributed more to the session. Her tone of voice was less challenging and more understanding. Even confrontational statements were delivered in a more empathic way.

Finally, the improved congruence or attunement in the MCIT therapeutic alliance scores compared to the CGCIT group is noteworthy considering that two unavoidable factors could have had confounding effects on the therapeutic alliance data collection process. First, due to the counseling format established at the Counseling and Training Clinic, each counseling session was conducted in a co-counselor configuration whereby an MCIT could have been paired with a CGCIT during any given session. Although the client was asked to rate the therapeutic alliance skills of each CIT independently, the co-counselor arrangement could have impacted the client and CIT therapeutic alliance results.

Second, the client group for each CIT in both groups varied and was not consistent during the course of the study. Consequently, the therapeutic alliance scores reflected mature as well as first-time and intermittent counseling relationship contexts. While some clients were very reliable in keeping their appointments, others only attended one session, still others attended sporadically, and new clients were accepted throughout the study as part of the standard policy of the clinic. As a result, the CITs were working to build new relationships as well as develop established relationships over the course of the study. An attempt to reduce variability in alliance scores was enacted through the use of weekly mean scores. However, the reality of a working clinic was that in some weeks, CITs counseled with only one or perhaps two clients where the counselor-client relationship ranged from mature to completely new. The phenomenon of client variability over time could have influenced the client and CIT alliance scores of the treatment and control groups. In summary, despite several factors that could have

influenced therapeutic alliance scores, both CIT groups' scores improved significantly and MCIT's made greater gains in congruence with their clients' scores over time.

Client results.

Therapeutic alliance scores for clients in the treatment and control group did not change significantly across phases, within or between groups. Several factors could have affected client outcomes. As with the CIT therapeutic alliance scores, the co-counselor format and the variability in clients over time could have impacted client alliance scores. Also, a ceiling effect in the client scores could have influenced the client results.

The co-counselor format could have affected client therapeutic alliance scores even though each client evaluated each counselor, individually, post-session. As part of clinic policy, CITs were assigned to clients based on an arrangement that worked best for the client. Therefore MTP and control group CITs were paired, as needed, throughout the semester confounding the effects of the mindfulness training on client therapeutic alliance.

Client variability could have influenced client therapeutic alliance scores. Theoretical underpinnings of therapeutic alliance posit that alliance between client and counselor is developed in a relational process that occurs over time (Bordin, 1979; Duncan et al., 2003; Horvath & Greenburg, 1989). Yet CITs did not necessarily experience the same client(s) across time during the course of the study. For some CITs, clients were consistent while others had new clients that were introduced sporadically throughout the study. This variability could have influenced client scores in that this phenomenon reflected not only mature counseling relationships but new and intermittent relationships as well.

Another influence on client therapeutic alliance outcomes was a ceiling effect due to client scores that were initially high and remained fairly elevated. Other researchers have also reported that clients are likely to report high scores on all alliance measures (Duncan et al., 2003). Consequently, the occurrence of high scores over time did not allow much room for the therapeutic alliance to improve in a statistically significant manner. Also, Duncan et al. (2003) explained that the SRS was not designed for empirical purposes but for clinical utility, which might have impacted client results considering the context of this investigation.

Training and Clinical Implications

Mindfulness training and meditation practices can be useful to develop CIT therapeutic alliance skills. This is significant because despite the fact that the counseling relationship has been proven to be a key element of the therapeutic process and client outcome (Lambert, 1992), training programs emphasize models of treatment, procedure-driven therapy, and techniques over the nuances of CIT relational qualities and the *person* of the counselor (Fulton, 2005; Gehart & McCollum, 2008). The results indicate the MTP enhances CIT personal and professional development including therapeutic, relational qualities in particular. Numerous instructors have reported success with CIT mindfulness interventions in counselor education settings (Gehart & McCollum, 2008; Morgan & Morgan, 2005; Schure et al., 2008; Shapiro & Izett, 2008). Additionally, an MTP can be implemented in a relatively brief format making it a time- and cost-efficient approach. Consequently, counselor education programs could benefit from offering mindfulness training as it can be an economical and effective method to improve trainee's alliance skills.

The mindfulness practices introduced in this study are well suited for clinical practitioners to enrich their personal and professional lives. Counselors are looking to sharpen their skills and improve client outcomes as well as reduce stress with caseload increase. Mindfulness training could be a useful approach (Bien, 2008). Fulton (2005) suggests that mindfulness can be used to improve the counselor's presence with clients, apply mindfulness theory to clinical work, and teach clients skills through the application of mindfulness practices. Participants' qualitative themes and quantitative outcomes in this study corroborate Fulton's proposition. Results of this study indicate that significant improvement in mindfulness, empathy, therapeutic alliance skills, and overall well-being can be attained via a six week, nine hour, course. Therefore, practitioners would likely benefit from a relatively brief program that focuses on the development of a personal mindfulness practice and a way of *being* that may be applied to clinical work (Aggs & Bambling, 2010).

Limitations

There are several potential limitations of this study. The number of participants was small (n = 9) and nonprobabilistic, limiting the generalizability or external validity of the results. The lack of a control group for the mindfulness and empathy outcomes as well as the self-selected participants limits reliability of the findings. Two features of the established process for clinical training at the Counseling and Training Clinic could have limited internal validity in the study: (a) the co-counseling format and (b) variability in the client group over time.

Another threat to internal reliability was the possibility of a CIT learning or maturation effect. The mission of the training clinic is to help the students improve their

counseling skills. Accordingly, CIT's were expected to improve their counseling and therapeutic skills as part of their clinical training and experience. Other factors besides mindfulness practices certainly contributed to MCIT improvements in their therapeutic alliance, empathy, and mindfulness scores.

Additional limits to internal validity existed in this study. The SRS is a self-report assessment and these types of measures are susceptible to bias by the participant (Heppner, Wampold, & Kivlighan, 2008). Although it was assumed that the CITs were truthful in their responses, it was possible that the CITs responded with socially desirable answers which could have inflated their scores. Yet, self-report assessments are the most popular method to collect data in counseling research because they can measure private cognitions, feelings, and behaviors and they are an accepted format (Heppner, Wampold, & Kivlighan, 2008). Finally, researcher bias could have impacted results as the primary investigator implemented the MTP and had predetermined expectations of CIT outcomes. Furthermore, the thematic analysis was performed primarily by the principal researcher, although two peer debriefers reviewed and approved the findings.

Research Recommendations

The counseling field would benefit from future research endeavors in mindfulness practices and training. Researchers are encouraged to replicate the current study, corroborate findings, and establish evidenced-based practices in counselor training. The design of this study was intended for potential replication in counselor training program formats. Single-case designs are well suited for counseling research and this format is recommended by research experts (Foster, 2010; Heppner, Wampold, & Kivlighan, 2008; Horner et al., 2005; Kazdin, 2011; O'Neill et al., 2011).

More research is needed on effective and practical means of teaching counselors mindfulness practices. One area to explore relates to instructor qualifications. While formal training is required to teach MBSR (Kabat-Zinn, 1990), literature with regard to mindfulness based curricula and teaching mindfulness practices is a fledgling field (McCowen, Reibel, & Micozzi, 2011). Researchers could examine the relationship between the experience and practice of mindfulness instructors who implement mindfulness training and student participant outcomes. Other studies related to instruction could investigate methods to integrate mindfulness practices into practicum, supervision, and counselors' continued development. Given that MBSR is already an established program that has been used with CITs in this study as well as others (Shapiro, Brown, & Biegel, 2007), MBSR may be an established means for counselors to integrate mindfulness practices into a practicum class or group supervision or clinical practice.

Other aspects of mindfulness that could be explored are its relationship or effects with important counseling constructs such as cognitive complexity, affect tolerance, compassion, and presence. More studies are needed that explore how mindfulness practices impact measureable counseling skills in both trainees and counselors. Investigating how experienced counselors can develop their own presence, well-being, or empathy through mindfulness methodologies would be another valuable project. Ultimately, more studies should be conducted that investigate the relationship between counselors who practice mindfulness and client outcomes.

Conclusion

The present study supported the premise that mindfulness training can improve CITs' therapeutic relationship skills. Mindfulness practices and philosophies hold great

promise for counselor training as they can enhance self-reflection, self-care, and relational capabilities. According to Rogers and Wood, "The… therapist's function is that of being immediately present and accessible to [the] client and relying on [the] moment-to-moment experiencing in the relationship to facilitate therapeutic movement." (1974, p. 214). Mindful awareness can help CIT's accept the invitation to be fully with themselves and fully with their clients. While the benefits of mindfulness show promise for CIT's, it also seems well suited for many aspects of counseling including personal wellness, practitioner development, and client intervention. Mindfulness has even been proposed as a common characteristic across all types of therapy (Martin, 1997; Shapiro, Carlson, Astin, & Freedman, 2006). Although it is a fairly new phenomenon in the realm of counseling, mindfulness methodologies are based in over 2,600 years of Buddhist psychological tradition (Shapiro & Carlson, 2009; Germer, 2005). Consequently, the numerous benefits of mindfulness contribute to its longevity as well as its potential, which is just being discovered in the Western world.

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APPENDIX A

Institutional Review Board Approval

and Consent Forms

Institutional Review Board Approval Letter

ERIN L. SHERMAN, MAcc, CRA, CIP
Research Compliance Officer
Division of Research,
Commercialization and Outreach

6300 Ocean Drive, Unit 5844
Corpus Christi, Texas 78412
O 361.825.2497 • F 361.825.2755

July 5, 2012

Dear Ms. Schomaker,

The research project entitled "The Effects of a Mindfulness Intervention on Therapeutic Alliance" (IRB# 49-12) has been granted approval through an expedited review under category 7.2.1(9) by the Texas A&M University – Corpus Christi Institutional Review Board (IRB). You are authorized to conduct the project as outlined in the IRB protocol application.

IRB approval is granted for one year from the date approval is granted. You must submit an IRB Continuing Review Application for IRB committee review and approval should the project continue beyond July 5, 2013. Please submit the IRB Continuing Review Application at least one month prior to the approval expiration date to allow time for IRB review.

Please submit an IRB Amendment Application for ANY modifications to the approved study protocol. Changes to the study may not be initiated before the amendment is approved. Please submit an IRB Completion Report to the Compliance Office upon the conclusion of the project. Both report formats can be downloaded from IRB website. All study records must be maintained by the researcher for three years after the completion of the study. Please contact me if you will no longer be affiliated with Texas A&M University – Corpus Christi before the conclusion of the records retention timeframe to discuss retention requirements.

We wish you the best on the project. Please contact me with any questions.

Sincerely,

Erin L. Sherman

Erin L. Sherman

Texas A&M University-Corpus Christi

Department of Counseling and Educational Psychology
Counseling and Training Clinic
Natural Resources Center, Suite 2700 (361) 825-3988
6300 Ocean Drive Corpus Christi, TX 78412

CLIENT CONSENT FOR COUNSELING

We provide a variety of mental health services to individuals and families in the community at no charge. If you need more information, feel free to ask the counselor for assistance before signing this form.

Consent for Counseling

All counseling services are voluntary and free of charge. Graduate students, supervised by licensed clinical faculty/staff provide the services. The clinic is a teaching facility, and all sessions are recorded and observed. Sessions are only observed by counseling students and faculty supervisors. You may end the counseling process at any time.

Potential Risks of Counseling

You may find that while changes may be mostly positive, some areas of life may become problematic as a result of change. Change is seldom easy or without consequence. You may feel emotionally worse at times before working through issues.

Confidentiality Statement:

I understand that personal information about me, or what I say or write while I am in the counseling process, will be kept confidential, and will not be divulged to any person or agency without my written permission, except:

1) Statements I may make about any intention to harm others or myself.
2) Statements indicating I have committed or intend to commit acts of abuse with a child or vulnerable adult.
3) Personal information needed by medical personnel in the event of a medical emergency.

I also understand that certain information, which will not include anything that could identify me, will be collected and used for research and instructional purposes. Such information will include things like age, gender, ethnicity, presenting problem, prior treatment status, and evaluation of sessions. This information will never be linked with my name or other identifying information.

By signing this form, I acknowledge that I have read and fully understand the above.

- ✓ I am consenting to counseling for myself or my child
- ✓ I understand confidentiality and limits of confidentiality in the counseling process.
- ✓ I understand I may receive confirmation calls or follow up letters.
- ✓ I have had the opportunity to ask and receive answers to questions.

Signed: _____ Date: _____

Co-signed if needed: _____ Date: _____

Witness: _____ Date: _____

Consent Form – Counselor-in-Training

The Effects of a Therapeutic Skills Program on Counselors-in-Training

Introduction

The purpose of this form is to provide you with information that may affect your decision to participate in this research study. If you decide to participate in this study, this form will also be used to record your consent.

You have been asked to participate in a research project studying therapeutic skills in counseling. The purpose of this study is to assess the effects of a skills development intervention on counseling students' personal and professional experiences. You were selected to be a possible participant because you are a counselor-in-training.

What will I be asked to do?

If you agree to participate in this study, you will be asked to participate in a 16 week research study. There will be two intervention groups in this project.

After the clinic orientation: All participants will be asked to complete a short demographic form and two brief surveys about therapeutic skills. One is 39 items and one is 28 items.

Week 1-16: All participants will be asked to transfer information from the 4-item session rating scale after every counseling session. The session rating scale will have already been completed as part of clinic protocol.

Week 4-8 or 9-13: You will be asked to participate in a five-week therapeutic skills training program that will include lecture, experiential exercises, and discussion. During the first and fourth week of training, class will be 2.5 hours. The remaining three weeks will be one hour classes.

You will also be asked to keep a journal about your experiences and a log about your skills practice during the training program.

Week 8 or 13: You will be asked to complete the two, therapeutic skills surveys again.

Week 16: You will be asked to participate in a focus group luncheon to investigate your experiences with therapeutic skills training and the impact it had on your personal and professional life. Your participation will be audio and/or video recorded during the focus group.

Week 3 & 16: Your practicum/internship instructor will be asked to evaluate your counseling skills using the recorded counseling sessions you turn in for regular assignments (2). This evaluation will be utilized for this study only and will not be reflected in your grade for the class.

What are the risks involved if I participate in this study?

The risks associated with this study are minimal and are not greater than risks ordinarily encountered in daily life. Such risks would be limited to some discomfort with evaluating your counseling session with clients, learning new counseling skills, and having the client and instructor evaluate your counseling skills. However, the evaluation of the session completed by you and the client are a regular part of the counseling and training clinic protocol.

What are the possible benefits if I participate in this study?

The possible benefits of participation include the opportunity to learn therapeutic skills, connect more effectively with clients, and improve the counseling process. While this may cause minimal discomfort in some participants, others may experience the process as empowering as they are contributing to what is known about current counselor training practices. This study may benefit society in that it aims to inform the counseling field about

effective techniques for counselor-in-training development. This training methodology could prove to create more competent counselor graduates. Consequently, if they become professional practitioners they are better prepared to work with individuals' mental health needs.

Do I have to participate?
No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus Christi being affected.

Will I be compensated?.
Participants who complete the study will be given a $10 gift card to a local retailer (e.g. Barnes & Noble, Starbucks, etc.) as a thank you for participation.

Who will know about my participation in this research study?
This study is confidential and the records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published or presented. Research records will be stored securely and only Stefani Schomaker will have access to the records.

Whom do I contact with questions about the research?
If you have questions regarding this study, you may contact Stefani Schomaker by phone at 808-489-7046 or by e-mail at sschomaker@islander.tamucc.edu or Dr. Richard Ricard at 361-825-3725 or by e-mail at richard.ricard@tamucc.edu.

Whom do I contact about my rights as a research participant?
This research study has been reviewed by the Research Compliance Office and/or the Institutional Review Board at Texas A&M University-Corpus Christi. For research-related problems or questions regarding your rights as a research participant, you can contact Erin Sherman, Research Compliance Officer, at (361) 825-2497 or erin.sherman@tamucc.edu.

Agreement to Participate
You agree to participate in the study by completing this consent form and the following demographic and counseling skill surveys. Participants must be 18 years of age or older. Please do not complete the surveys if you do not wish to participate in this study.

Signature
Please be sure you have read the above information, asked questions, and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to participate in this study and you certify that you are 18 years of age or older.

Signature of Participant:_____ **Date:**_____

Printed Name:_____

Signature of Person Obtaining Consent:_____ **Date:**_____

Printed Name: **Stefani A. Schomaker** **Date:**_____

Consent Form – Practicum/Internship Instructor

The Effects of a Mindfulness Training Program on Counselors-in-Training

Introduction

The purpose of this form is to provide you with information that may affect your decision to participate in this research study. If you decide to participate in this study, this form will also be used to record your consent.

You have been asked to participate in a research project studying therapeutic skills in counseling. The purpose of this study is to assess the effects of a skills development intervention on counseling students' personal and professional experiences. You were selected to be a possible participant because you are a practicum/internship instructor.

What will I be asked to do?

If you agree to participate in this study, first you will be asked to complete a consent form and demographic survey. Then you will be asked to evaluate participating students' therapeutic skills who are enrolled in your practicum or internship class(es) in the fall semester of 2012. Student participants will be seeing clients at the Counseling and Training Clinic at TAMUCC. Current practicum and internship classes require students to turn in two counseling session recordings for instructor review. You will be asked to do a blind review of these two videos/tapes using the 4-item Session Rating Scale–Observer (SRS-O) for classes that include study participants. At the end of the semester you will also be asked to complete a 5-item Instructor Questionnaire about the participant students in your class(es).

What are the risks involved if I participate in this study?

The risks associated with this study are minimal and are not greater than risks ordinarily encountered in daily life. Such risks would be limited to some discomfort with evaluating students' therapeutic skills with clients and the extra time involved in completing the project rating scale and questionnaire.

What are the possible benefits if I participate in this study?

The possible benefit of participation is the opportunity to make a significant impact on counselor training research. While this may cause minimal discomfort in some participants, others may experience the process as empowering as they are contributing to what is known about current counselor training practices. This study may benefit society in that it aims to inform the counseling field about effective techniques for counselor-in-training development. This training methodology could prove to create more competent counselor graduates. Consequently, if they become professional practitioners they are better prepared to work with individuals' mental health needs.

Do I have to participate?

No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus Christi being affected.

Will I be compensated?.

Participants will receive $10 gift cards from HEB as a thank you for participating in the study.

Who will know about my participation in this research study?

This study is confidential and the records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published or presented. Research records will be stored securely and only Stefani Schomaker and Dr. Richard Ricard will have access to the records.

Whom do I contact with questions about the research?
If you have questions regarding this study, you may contact Stefani Schomaker by phone at 808-489-7046 or by e-mail at sschomaker@islander.tamucc.edu or Dr. Richard Ricard at 361-825-3725 or by e-mail at richard.ricard@tamucc.edu.

Whom do I contact about my rights as a research participant?
This research study has been reviewed by the Research Compliance Office and/or the Institutional Review Board at Texas A&M University-Corpus Christi. For research-related problems or questions regarding your rights as a research participant, you can contact Erin Sherman, Research Compliance Officer, at (361) 825-2497 or erin.sherman@tamucc.edu.

Agreement to Participate
You agree to participate in the study by completing the following demographic and gatekeeping surveys. Participants must be 18 years of age or older. Please do not complete the surveys if you do not wish to participate in this study.

Signature
Please be sure you have read the above information, asked questions and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to participate in this study and you certify that you are 18 years of age or older.

Signature of Participant:_____ **Date:**_____

Printed Name:_____

Signature of Person Obtaining Consent:_____ **Date:**_____

Printed Name: **Stefani A. Schomaker** **Date:**_____

APPENDIX B

Instruments and Questionnaires

Survey #1 (FFMQ)

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1 Never or very rarely true
2 Rarely true
3 Sometimes true
4 Often true
5 Very often or always true

_____ 1. When I'm walking, I deliberately notice the sensations of my body moving.

_____ 2. I'm good at finding words to describe my feelings.

_____ 3. I criticize myself for having irrational or inappropriate emotions.

_____ 4. I perceive my feelings and emotions without having to react to them.

_____ 5. When I do things, my mind wanders off and I'm easily distracted.

_____ 6. When I take a shower or bath, I stay alert to the sensations of water on my body.

_____ 7. I can easily put my beliefs, opinions, and expectations into words.

_____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.

_____ 9. I watch my feelings without getting lost in them.

_____ 10. I tell myself I shouldn't be feeling the way I'm feeling.

_____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.

_____ 12. It's hard for me to find the words to describe what I'm thinking.

_____ 13. I am easily distracted.

_____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.

_____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.

_____ 16. I have trouble thinking of the right words to express how I feel about things

_____ 17. I make judgments about whether my thoughts are good or bad.

_____ 18. I find it difficult to stay focused on what's happening in the present.

_____ 19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.

_____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

_____ 21. In difficult situations, I can pause without immediately reacting.

_____ 22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

_____23. It seems I am "running on automatic" without much awareness of what I'm doing.

_____ 24. When I have distressing thoughts or images, I feel calm soon after.

_____ 25. I tell myself that I shouldn't be thinking the way I'm thinking.

_____ 26. I notice the smells and aromas of things.

_____ 27. Even when I'm feeling terribly upset, I can find a way to put it into words.

_____ 28. I rush through activities without being really attentive to them.

_____ 29. When I have distressing thoughts or images I am able just to notice them without reacting.

_____ 30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.

_____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

_____ 32. My natural tendency is to put my experiences into words.

_____ 33. When I have distressing thoughts or images, I just notice them and let them go.

_____ 34. I do jobs or tasks automatically without being aware of what I'm doing.

_____ 35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____ 36. I pay attention to how my emotions affect my thoughts and behavior.

_____ 37. I can usually describe how I feel at the moment in considerable detail.

_____ 38. I find myself doing things without paying attention.

_____ 39. I disapprove of myself when I have irrational ideas.

Survey #2 (IRI)

Counselor ID#_____Date_____

Please indicate the degree to which the items describe you.

Use the scale below and place the appropriate number beside each question.

1	2	3	4	5
Does not describe me	**Mostly does not describe me**	**Neutral**	**Describes me a little**	**Describes me well**

_____1. I daydream and fantasize, with some regularity, about things that might happen to me.

_____2. I often have tender, concerned feelings for people less fortunate than me.

_____3. I sometimes find it difficult to see things from the "other guy's" point of view.

_____4. Sometimes I don't feel very sorry for other people when they are having problems.

_____5. I really get involved with the feelings of characters in a novel.

_____6. In emergency situations, I feel apprehensive and ill-at-ease.

_____7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

_____8. I try to look at everybody's side of a disagreement before I make a decision.

_____9. When I see someone being taken advantage of, I feel kind of protective towards them.

_____10. I sometimes feel helpless when I am in the middle of a very emotional situation.

_____11. I sometimes try to understand my friends better by imagining how things look from their perspective.

_____12. Becoming extremely involved in a good book or movie is somewhat rare for me.

_____13. When I see someone get hurt, I tend to remain calm.

_____14. Other people's misfortunes do not usually disturb me a great deal.

_____15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

_____16. After seeing a play or a movie, I have felt as though I were one of the characters.

_____17. Being in tense emotional situations scares me.

_____18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

_____19. I am usually pretty effective in dealing with emergencies.

_____20. I am often quite touched by things that I see happen.

_____21. I believe that there are two sides to every question and try to look at them both.

_____22. I would describe myself as a pretty soft-hearted person.

_____23. When I watch a good movie, I can very easily put myself in the place of a leading character.

_____24. I tend to lose control during emergencies.

_____25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

_____26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

_____27. When I see someone who badly needs help in an emergency, I go to pieces.

_____28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

SESSION RATING SCALE (SRS V.3.0)

CLIENT Version

Note: This is an example only. Do not use this form as it may not be to scale.

Client ID# _____
Counselor ID# _____
Session # ____ Date _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience with this counselor.

Relationship

I did not feel heard, understood, and respected. |----------| I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. |----------| We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. |----------| The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. |----------| Overall, today's session was right for me.

Institute for the Study of Therapeutic Change
www.talkingcure.com

Derived from the Session Rating Scale (SRS V.3.0)

Counselor Version

Note: **This is an example only. Do not use this form as it may not be to scale.**

Client ID# _____
Counselor ID# _____
Session # ____ Date _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience. *Complete the form as if you were the client responding about this session.*

Relationship:

I did not feel heard, understood, and respected.	I----------I	I felt heard, understood, and respected.

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about.	I----------I	We worked on and talked about what I wanted to work on and talk about.

Approach or Method:

The therapist's approach is not a good fit for me.	I----------I	The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today.	I----------I	Overall, today's session was right for me.

Reference:
Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The session rating scale: Preliminary psychometric properties of a "working alliance" measure. *Journal of Brief Therapy, 3,* 3-12.

Derived from the Session Rating Scale (SRS V.3.0)

Observer Version

Note: **This is an example only. Do not use this form as it may not be to scale.**

Instructor Pseudonym _____ Today's Date:_____

Student Counselor Name/Initials _____

Tape Session #1____ Tape Session #2____Date of session if known: _____

Please rate today's session by placing a vertical mark on the line nearest to the description that best fits your perception of the counselor's ability in the following areas:

Relationship:

The counselor did not help the client feel heard, understood, and respected. I----------I The counselor helped the client feel heard, understood, and respected.

Goals and Topics:

The counselor did not work on or talk about what the client wanted to work on and talk about. I----------I The counselor worked on and talked about what the client wanted to work on and talk about.

Approach or Method:

The counselor's approach is not a good fit for the client. I----------I The counselor's approach is a good fit for the client.

Overall:

With this counselor, there was something missing in the session today for the client. I----------I With this counselor, today's session was right for the client.

Reference:

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The session rating scale: Preliminary psychometric properties of a "working alliance" measure. *Journal of Brief Therapy, 3,* 3-12.

Mindfulness Practice Log			
Project Pseudonym			
Date	Type of Practice	Time Spent	Thoughts, feelings, sensations that arose during this practice and how you felt afterwards.
Example 8/31/12	*Mindful Check-in*	*10 min.*	*My mind kept wandering to all the work I had to do today. I noticed that my neck was stiff. That stiffness was stress but the tension had decreased slightly and I felt more calm after the practice.*

Reference:
Stahl, B., & Goldstein, E. (1998). *A mindfulness-based stress reduction workbook*. Oakland, CA: New Harbinger.

Counselor ID #_____

Focus Group Questions

(For MCITs who did not attend the Focus Group. Questions were the same for attendees.)

Please take your time to think about the following questions and respond to each one. You may type directly into this document and email it back to me when you are done OR print it and put it in my box in the clinic.

I deeply appreciate your participation and your feedback!! Thank you!!

I. Questions about the Class and your Practice

Please write a few sentences.

1) What was your favorite activity/information *during class*?

2) What was your least favorite part of class?

3) If you could improve the class, what would you do differently?

II. Your Thoughts on Mindfulness

Please jot down <u>any</u> ideas or thoughts that come to your mind.

A. Reflect back over the semester. Recall our 6 weeks of class and your mindfulness practice.

1) How, if at all, do you think this experience helped you learn about yourself?

B. In your journals I found that many of you had some insight about how you interact with others (friends, family/kids, boss, etc.).

2) How, if at all, do you think this experience helped you learn about your interactions with others?

C. Many of your journals reflected your use of mindfulness in your counselor role, both in and outside of session.

3) How, if at all, do you think this experience helped you as a counselor?

D. As a prac./intern student, you've been in the counseling program for a while now. You know what it's been like to go through several semesters without using mindfulness philosophies and practices.

4) How, if at all, was this semester different (or not different) from your other semesters as a result of this experience?

E. Since the class ended 5 weeks ago, you've been on your own to incorporate mindfulness as you choose.

5) Now that you've had this time to use mindfulness independently, how, if at all, do you think you will use mindfulness in the future?

Instructor Questionnaire

Instructor Pseudonym:_____ Date: _____

Counselor-in-Training Name:_____

Researcher use only: CIT ID:_____

Directions: Please recall this student's development from the beginning of this semester until now. To the best of your ability, complete the following:

---

1) What did you notice about this student's personal development over the course of the semester?

1a) Tell me about any differences from other typically developing students you noticed.

2) What did you notice about this student's professional development over the course of the semester?

2a) Tell me about any differences from other typically developing students you noticed.

3) Are there any additional observations you would like to share about this student?

APPENDIX C

Mindfulness Exercises

Breathing-With Exercise

Skill development: being present with the client, attuning to self and client

Partner exercise: 1 counselor/1 client, roles will switch

Exercise Script:

I invite you to get comfortable……. Focus on your own breath… The ebb and flow of our own breathing… **Now I invite the counselor to attend to the client by following the breath of the client….As you attune your breathing to the client's breathing, s*ilently* follow in words to yourself "breathing in…. breathing out…breathing in….breathing out…… (1 min.)

Now I encourage the counselor to follow the client's breath with words or phrases, spoken out loud that simply feel right…you may choose to say "opening up" for an inbreath…. Or "letting go" for an outbreath…. You may also say "breathing in… breathing out…" if that feels most comfortable for you….. When you are ready, you may begin to attend to your client's breath with your spoken voice….. (1 min.)

Now I invite both partners to breathe with self-awareness and reflect on this experience…. (1 min.)

SWITCH PARTNERS/Roles. Repeat script with minor adaptations so participants will remain engaged. Discuss.

Derived from:

Surrey, J. L. (2005). Relational psychotherapy, relational mindfulness. In C. K. Germer, R. D. Siegel, & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp.55-72). New York: Guilford Press.

Mindful Listening and Speaking

Skill development: being present, attuning to self and to client, resonating with client, empathic skills

Partner exercise: 1 counselor/1client, switch roles

Explain Format Before Beginning Exercise:

1) Counselor prompts the client with a statement (explained below).

2) The counselor practices deep, mindful listening as the client tells their story about their experience. (1 Min.)

3) Then the counselor takes a minimum of two breaths and listens to their thoughts, emotions, and body sensations to feel a summarizing statement or word about what the client has just shared. This message is conveyed to the client (1 min. or less)

4) The client will share her response to the statement or word. (1 min.)

Roles switch. Discuss. I will guide you through this process.

Exercise Script:

I invite you to get comfortable and simply breathe for a moment… as we begin this deep listening and authentic speaking exercise I encourage our counselors to pay attention and not interrupt until the client is completely finished speaking. Notice when your mind wanders off into thoughts or analyzing… When this happens… just become aware of it… and then gently bring your attention back to listening. When people feel listened to… not only do they feel more connected to you… they also feel less on guard or defensive…. See if you can practice listening with an attitude of curiosity…

Now…. I will guide you through this mindful listening and speaking exercise….

1) While you are listening to the client, let go of what you are going to say and simply be present…

2) Counselors please allow your clients 1-2 minutes to respond to the statement: "Tell me about your mindfulness practice"… Begin. (Wait for client to explain, 1 – 2 minutes)

3) Counselors if you have not done so already… take a moment to breathe… clients may also breathe while the counselor contemplates your experience…… Now counselors notice what arises in your thoughts… emotions… and sensations… about the client's experience…. Trust that you know what to say… Remember to practice forgiveness with yourselves and others as no one is perfect at this… Take another breath... When you are ready counselors… share what you noticed about the client's story in a word or a statement that resonates with you …. (1 min. to reflect/respond)

4) Now clients please share with the counselor your thoughts about their word or statement….(1 min.)

5) Take a moment to breathe and reflect on this exchange….(1 min.)

Switch Roles. Discuss.

Derived from:

Shapiro, S. L., & Izett, (2008). Meditation: A universal tool for cultivating empathy. In S. F. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (pp. 161-175). NY: The Guilford Press.

Client's Shoes & Counselor Greeting Exercise

Skill development: role of counselor/client, embodiment of roles, compassion/empathy

Exercise Script:

I invite you to take a moment to notice the rise and fall of your breath. We will begin by putting ourselves in the shoes of our clients…. When you are ready…. I invite you to think about something that has troubled you today (it could be related to school, it could be related to your personal life or health)… something that you'd like to talk about with a receptive person…. A person who will care about your experience with this problem… please notice your body sensations while you imagine yourself sitting in the clinic waiting room feeling concerned about your situation…. If you could put your physical sensations into a word or phrase what would it be? How does your body feel right now? There are no right or wrong answers, just simply what you are feeling in your role... When I ring the bell I would like for you to write your word or phrase that seems to summarize your body's sensations as a person seeking help….. RING….

Now imagine yourself in your counselor role… I invite you to find a comfortable seated position and simply breathe…. Imagine that you are in the video room at the clinic and you've been informed that your client has arrived…. As you prepare to meet with your client imagine a person in the waiting room who is a fellow human being…. This human being is someone who is suffering, who has hopes and dreams, who has tried to be happy and only partially succeeded, and who is coming to you, believing that you can relieve his or her suffering…. If you could put your bodily sensations into a word or phrase as you imagine your client in this way, what would it be?..... There are no right or wrong answers, just simply what you are experiencing at this moment... When I ring the bell I

would like for you to quietly write a word or phrase that seems to summarize your perceptions of the present moment….

RING…….

Discuss the perceptions that arose for the client and the counselor roles.

Derived from:

Morgan, W. D., & Morgan, S. T. (2005). Cultivating attention and empathy. In C. K. Germer, R. D. Siegel, & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp.55-72). New York: Guilford Press.