

Mindfulness in Therapeutic Presence:
How Mindfulness of Therapist Impacts Treatment Outcome

by

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TABLE OF CONTENTS

| | |
|---|----|
| CHAPTER I: | |
| What is Mindfulness? | 1 |
| Mindfulness Based Therapeutic Interventions | 2 |
| Mindfulness Is Therapeutic | 6 |
| Therapist's own Mindfulness Practice (Mindfulness-Informed Psychotherapy) | 7 |
| Mindfulness Related to Other Constructs | 11 |
| The Working Alliance | 12 |
| How is Mindfulness Measured | 12 |
| Summary and Statement of Problem | 15 |
| Research Questions | 18 |
| Hypotheses | 21 |
| | |
| CHAPTER II: METHODS AND PROCEDURES: | 22 |
| Participants | 22 |
| Patients | 22 |
| Therapists | 22 |
| Inclusion/Exclusion Criteria | 23 |
| Assessment Measures and Procedures | 24 |
| Measures of Mindfulness | 24 |
| Therapist Trait Measures | 24 |
| Process Measures | 25 |
| Therapeutic Outcome Measures | 26 |
| Procedures | 28 |
| Statistical Procedures | 29 |
| | |
| CHAPTER III: RESULTS AND DISCUSSION | 31 |
| Results | 31 |
| Correlations between therapist mindfulness and introject | 31 |
| Correlations between Working Alliance Inventory and KIMS | 31 |
| Therapist mindfulness scores impact on treatment outcome | 32 |
| Discussion | 32 |
| References | 37 |

LIST of TABLES

| | |
|---|----|
| Table 1- Client Demographics | 41 |
| Table 2- Therapist Demographics | 42 |
| Table 3- INTREX Affiliation scale correlated with four scales of Kentucky Inventory of Mindfulness Skills | 43 |
| Table 4- Four Facets of Mindfulness (KIMS) Correlated with Patient and Therapist WAI scores from third session of treatment | 43 |
| Table 5- Four Facets of Mindfulness (KIMS) Correlated with Outcome Measures | 44 |

CHAPTER I:

What is Mindfulness?

Mindfulness has been defined simply as, “bringing one’s attention to the experiences occurring in the present moment, in a nonjudgmental or accepting way”, (Baer et al. 2006). There are many aspects of Mindfulness. It can be used to describe a theoretical construct (mindfulness), a practice of cultivating mindfulness (such as meditation) or a psychological process (being mindful) (Germer, 2005). Mindfulness is a skill that allows us to be less reactive to what is happening in the moment. It is a way of relating to all experience, positive, negative and neutral such that our overall level of suffering is reduced and our sense of well being increased (Magid, 2002). The premise behind this transformation is the realization that suffering occurs as a result of our attachments to objects, thoughts and assumptions about the world around us. This is accomplished by recognizing their transitory nature and the impermanence of all beings. Ultimately, to be mindful is to wake up and recognize what is happening in the present moment while simultaneously detaching ourselves from our thoughts. Mindfulness originates from Eastern meditation traditions and is cultivated through the practice of meditation.

Mindfulness is derived from practice of meditation and its concepts are based on a Buddhist theory of the mind. Essentially the practice of mindfulness meditation is a cognitive process involving the identification of thoughts and changing one’s relationship to them. The cognitive implications of mindfulness have naturally led to its incorporation into many forms of cognitive behavioral therapy. Several mindfulness-based interventions have been shown to reduce anxiety, stress (Kabat-Zinn, 1985, 1990, 1992),

prevent depressive relapse, (Segal, et al. 2004) and treat alcoholism (Marlatt et al, 2004) as well as an effective support for patients with Borderline Personality Disorder (Linehan, 1993). The incorporation of Mindfulness into psychotherapy is still in its infancy. Researchers and practitioners theorize about the ways mindfulness can benefit either as a psychotherapeutic intervention or to facilitate training of therapists themselves.

Mindfulness Based Therapeutic Interventions

In recent years, health practitioners have descended from the traditionally dualistic views of the mind and body and begun to accept the underlying connection between the two. The traditional practice of mindfulness has been modified for practical use in a number of therapeutic interventions. Some examples are Mindfulness Based Stress Reduction Program (MBSR: Kabat Zinn, 1990), Dialectical Behavioral Therapy (DBT: Linehan, 1993), Mindfulness Based Cognitive Therapy (MBCT: Segal, Teasdale et al., 2004) to prevent relapse in patients with recurrent depressive episodes, Acceptance and Commitment Therapy (Hayes et al., 1999), Functionally Enhanced Cognitive Therapy (Kohlenberg & Tsai 1997) and Vipassana Meditation or Insight Meditation as a treatment for Alcohol and Drug Use Disorders (Marlatt et al. 2004).

The Mindfulness Based Stress Reduction program (MBSR, Kabat-Zinn et al 1998) developed at the University of Massachusetts Medical Center by Jon Kabat-Zinn has been advocated for the reduction and management of stress as well as in cancer treatment (Speca, Carlson, Goodey & Angen, 2000), helpful in the management of psoriasis (Kabat-Zinn et al.1998), chronic pain (Kabat-Zinn, 1982, Kabat-Zinn et al, 1985), binge-eating disorders (Kristeller & Harlett, 1999), and anxiety disorders (Kabat-Zinn et al. 1992). The program has been used in an increasing number of hospital and

psychiatric settings throughout the United States and abroad. The 8-week program involves the cultivation of mindfulness skills through developing a daily meditation practice, yoga, mindfulness exercises and various other activities that bring awareness to one's physical body. These exercises cultivate a greater awareness of mind's connection to the body and the ability to influence one's physical condition mentally.

One of the first incorporations of mindfulness into cognitive behavioral therapy was the development of Dialectical Behavior Therapy (DBT) by Marsha Linehan. This mode of treatment was initially developed for patients with diagnosis of Borderline Personality Disorder as a reaction to the scarcity of available effective treatments. DBT is different from other forms of cognitive therapy because of its focus on acceptance and validating behaviors in the moment (Linehan, 1993). "The therapist creates a context of validating rather than blaming the patient, and within that context the therapist blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones" (Linehan 1993). Acceptance is an integral part of DBT deriving from meditation practice as part of accepting the present moment without judgment. The difficult clients that are usually referred for DBT necessitate an extremely accepting attitude from the therapist. Clients are taught and encouraged to use skills for accepting life completely and radically as well as for changing it. Dialectical Behavior Therapy has been shown to reduce the frequency and severity of suicidal and other self injurious behavior, reduce the total days of psychiatric hospitalization and increase treatment retention and overall social and global adjustment of these patients (Koons et al, 2001, Linehan et al, 1991, Linehan et al. 2002).

Mindfulness Based Cognitive Therapy (MBCT) was designed as a treatment to reduce relapse in recurrent major depression (Segal, Teasdale, and Williams, 2004). MBCT incorporates mindfulness training with existing CBT treatment models for depression. Cognitive therapy focuses on the individual's vulnerability to depression. "Vulnerability to relapse and recurrence of depression arises from repeated associations between depressed mood and patterns of negative, self-critical, hopeless thinking during episodes of major depression, leading to changes at both cognitive and neuronal levels", (Segal et al, 2004). Traditional cognitive therapy examines the content of these irrational thinking cycles to attempt change. While attempting to change the content of thoughts, the individual's relationship to their thoughts might also be impacted. As a result in general the identification of negative thoughts allows individuals to make a general shift in perspective on their negative thoughts and feelings, (Segal et al, 2004). Mindfulness training helps the individual adapt a de-centered approach to their thoughts, referred to as metacognitive insight. This insight is a simple act of recognizing your thoughts as thoughts which can free you from distorted reality and allow for more clear-sightedness and a greater sense of manageability of life's experience, (Kabat-Zinn, 1990). The risk of relapse and recurrence could be reduced if patients who have recovered from major episodes of depression could learn to be more aware of negative thoughts and feelings at times of potential relapse/recurrence, and then to respond to close thoughts and feelings in ways that allow them to disengage from ruminative depressing processing, (Segal et al, 2004). Mindfulness Based Cognitive Therapy is structured very similarly to Mindfulness Based Stress Reduction, (Kabat-Zinn, 1990) in that it follows an 8 week group program involving awareness exercises and daily homework so that the eventual goal is for the

individual to develop their own mindfulness practice at home. The increased mindfulness of the individuals eventually allows for them to recognize the early warning signs of an oncoming depressive episode and engage in protective behavior to avoid it.

Acceptance and Commitment Therapy (ACT) aims to produce more psychological flexibility by, (1) establishing psychological acceptance skills; (2) establishing cognitive defusion skills; (3) distinguishing self as context from the conceptualized self; (4) contacting the present moment and establishing self as process skills; (5) distinguish choice from reasoned action and; (6) teaching committed behavioral persistence and behavioral change strategies linked to choose values. ACT takes the view that powerful change is often possible, even in difficult cases. It supports clients in feeling and thinking what they directly feel and think already, and to help clients move in a valued direction, with all of their history and automatic reactions (Hayes, 1999). The first stage of ACT involves examination of the problems of the patient in their situational context. Clients often use a direct, literal approach to problem solving and when it does not succeed often leads to self-blame and criticism and further exacerbate the problem (Hayes, 1999). Suppression of negative experience and avoidant means of coping predict poorer outcomes in depression, survivors of sexual abuse and in alcoholism (Wilson & Murrell, 2004). This experiential avoidance may become a constant activity and the cost is not focusing on what the person truly values in life. Lives are put on hold in the service of managing thoughts and emotions, (Wilson & Murrell, 2004). Clients are focused through mindfulness practice on seeing thoughts as thoughts rather than looking at the world through thoughts. Acceptance in ACT is the main form of achieving this goal. Acceptance involves undefended “exposure” to

thoughts, feelings and bodily sensations as they are directly experienced to be. The treatment consists of identifying these values and the obstacles that might prevent one from achieving them. “The goal is psychological flexibility, which involves taking full responsibility for these behavioral patterns; changing when change is needed, and persisting when persistence is needed” (Hayes, 1999).

Mindfulness is Therapeutic

Many therapists may prescribe meditation as a psychotherapeutic intervention either in session or outside of sessions as homework. The development of a personal meditation practice has many benefits, especially for those suffering from psychological symptoms. A regular meditation practice aids in the reduction of stress, anxiety and depression (Astin 1997, Shapiro, Schwartz & Bonner, 1998). It also aids in the ability to adapt to a new experience or environment, (Astin, 1997) as well as the ability to bring the body into a relaxed state (Lazar, 2004). One belief is that the ability to understand emotions is a dimension of emotional intelligence and a prerequisite for a thoughtful change in one’s emotion (Salovey et al., 1995). The same physical and mental benefits could be accessed directly through one’s own practice. It is however, very challenging to maintain one’s practice without the structure of a group or manualized practice which is why the psychotherapeutic setting is an ideal place to develop this practice. A simple practice of breathing techniques may also help a patient cope with symptoms of anxiety or stress. There are several ways in which mindfulness practice can be incorporated into a psychotherapeutic session. A therapist may also choose a more focused approach to begin to initiate a shift in how an individual relates to their experience or it may be included as a regular part of the session. Before meditation can be incorporated into

psychotherapy, it is recommended that for a therapist to be able to teach meditation to build mindfulness skills, their own practice is essential (Segal et al. 2004).

Therapist's own Mindfulness Practice (Mindfulness-Informed Psychotherapy)

The final way in which mindfulness can be incorporated into psychotherapy is indirectly through the therapist's own meditation practice. The ability to focus on the present moment with awareness and a nonjudgmental perspective is equally important in psychotherapy. Attention is also one of the main challenges in psychotherapy on the part of the therapist (Germer, 2005). Mindfulness as developed through meditation practice is the ability to enhance attention to focus on the present moment. Compassion and empathy are also important qualities in a therapist (Kristeller and Johnson, 2005). Warmth, attentiveness, availability, engagement, genuineness are all examples of therapeutic interventions intended to increase client effectiveness and knowledge, (Linehan, 2004). Mindfulness may be an effective way of cultivating and maintaining these qualities (Sweet & Johnson, 1990).

It is difficult to teach the important and vital skills of empathy and compassion necessary for a successful therapeutic interaction. Graduate programs focus on the clinical and theoretical aspects, but the prospective students ability to be warm, compassionate and empathize is unknown and is often left for clinical experience to hopefully nurture these qualities. Mindfulness may be the only way to enhance these qualities in an individual (Germer, 2005). Buddhist meditation intends to develop insight and compassion. Empathy towards others is the natural extension of the compassion towards oneself cultivated in mindfulness practice. Buddhist theory also proposes that compassion for ourselves arises from opening to our own suffering (Magid, 2002).

Mindfulness offers a way to change our relationship to suffering by surrendering our need to reject it. This is an act of kindness towards ourselves. This in turn contributes to compassion for others by understanding that no one is exempt from suffering and that everyone wishes to be safe from it. In addition, as mindfulness begins to dissolve the artificial boundaries that define our separateness, we begin to experience our innate affinity with all beings. Compassion towards others is a natural extension of this growing perception of our interdependence. In short, it teaches us humility (Magid, 2002).

Meditation Enhanced Empathy Training (MEET: Sweet and Johnson, 1990) defines the development of empathy through meditation practice. The goals of meditation are prosocial and empathic attitudes such as friendliness, compassion, and joy, and acceptance are natural byproducts. The method enables the patient to reach a central interpersonal aim of psychotherapy by relating to others in a friendly and non-controlling manner, while maintaining an autonomous identity. The process involves creating statements, which combine friendliness towards oneself and autonomy. Statements are coded using the Structural Analysis of Social Behavior (SASB: Benjamin, 1974). The aim is to produce self statements reflecting self-acceptance and exploration or an empathic attitude towards oneself. The next stage involves directing these positive attitudes towards others in stages, first towards those the subject has positive feelings towards and then in the direction of their enemies. This technique which is very similar to loving kindness meditation practices in Tibetan Buddhism, is proposed for various therapy modalities such as cognitive behavioral and psychodynamic therapy with personality disordered individuals (Sweet and Johnson 1990).

Meditation practice teaches us that emotions are transitory and therefore can be tolerated and accepted as opposed to avoided. This quality enables the therapist to serve as a container for our patient's negative emotions (Safran, 2006, Welwood, 2000 & Magid, 2002). During mindfulness practice intense emotions present themselves and a key part of the practice is learning how to embrace these emotions as opposed to our conditioned behavior to avoid them. Therefore, when we feel overwhelmed by a strong emotion such as fear, being mindful of it will result in feeling less possessed by it and allow for a certain distance to be created. This ability is known as affect tolerance and is especially important in working therapeutically with others (Fulton, 2005). If therapists cannot tolerate their own affects they may find it difficult to tolerate their patient's affect. Not tolerating the patient's emotion might lead to invalidated their experience and damaging the therapeutic work. What mindfulness teaches through practice is that all emotions are transitory and they can be experienced without fear. When therapists are not intimidated by patient's strong emotions, patients are free to bring forward some of their most intolerable affect states. Our receptivity in the face of difficult emotional content reassures patients that they need not censor themselves so much to protect themselves or the therapist. (Magid, 2002). The therapist acts as a container of those emotions. Therefore, the therapist must have their own way of regulating their own difficult and painful feelings constructively and mindfulness can play a role in accomplishing this (Safran, 2006). Mindfulness teaches us how to open to and accept intolerable affect (Fulton, 2003), it "enables therapist to better serve as a container for intolerable affect of patient and maintains our ability to renewable resources of internal refuge", (Germer, 2005)

Mindfulness is acceptance in action. Turning again and again to all that arises including familiar patterns of self-criticism is the practice of self-acceptance. Our own judgments of patients might have negative effects on therapy and may become obvious to the patient. Mindfulness practice is the vehicle for the ongoing practice of acceptance allowing therapists to embrace their judgments and feelings and accept them for their transitory nature without becoming entangled in them. One of the main goals in Dialectical Behavioral Therapy as well as Acceptance and Commitment Therapy is an overall sense of acceptance of all parts of experience and expression. Accepting our limits may be a prerequisite for patients to assume greater responsibility for their own growth and wellbeing. When the patient is unburdened by the need to help the therapist feel effective, they are given the freedom and competency to change on their own. The more accepting a therapist is of their own experience, the more accepting they will be of their patient's experience (Fulton 2005). Mindfulness aids in revealing our true nature, which allows for room to explore our own narcissistic needs as therapists. The need to be seen as "good therapists" may blur our own narcissistic needs with those of our patients. Mindfulness can help us root out the ways our sense of self intrudes on psychotherapy of patients, (Germer, 2005). This also applies to a therapist's participation in enactments. The therapist's ability to be self-reflective and acknowledge their own limitations allows them to identify and disembed from enactments with patients (Safran, 2006).

Finally, the work of a mental health professional can be difficult and trying. Self care for the therapist is extremely important (Newsome et al, 2006). To maintain the ability to tolerate intense affect of our patients the therapist must have a means to prevent burn out and severe stress. Therefore, meditation may be a beneficial way to maintain a

mental health professional's ability to work effectively and maintain one's own sense of wellbeing and health. Students that participated in a Mindfulness Based Stress Reduction program as part of their graduate curricula reported positive physical, emotional, mental and interpersonal changes through maintaining their own meditation practice (Newsome et al., 2006). Mindfulness practice through meditation or yoga aids in reduction of stress and anxiety serving a beneficial function for therapist's daily life and a reliable method of stress reduction and prevention of burnout.

Mindfulness Related to Other Constructs

The construct of mindfulness is related to a variety of indicators of well-being, including: emotional intelligence, attention to feelings, clarity of feelings, mood repair, attention to emotions, openness to experience, life satisfaction and conscientiousness, (Brown and Ryan, 2003, Baer et al. 2004). It was found to be negatively correlated with neuroticism, social anxiety, rumination, alexithymia scales such as difficulty identifying feelings, difficulty describing feelings and external thinking as well as dissociative experiences and experiential avoidance (Baer et al, 2004, Brown & Ryan, 2003). Mindfulness positively correlated with psychological mindedness, self-awareness, and empathy (Beitel et al. 2005). Psychological mindedness related to mindfulness, and cognitive and affective measures of empathy. Mindfulness also related to the cultivation of empathy and compassion supports this finding (Sweet & Johnson, 1990). Therefore we would expect that an individual scoring high on a mindfulness scale would also possess similar positive qualities, report higher satisfaction with life, exhibit an increase in positive mood states, and display increased levels of self-awareness and empathy.

The Working Alliance

The working alliance has been established to be the single most important factor in predicting treatment outcome. The working alliance consists of an affective bond between therapist and patient, increased therapist's involvement in treatment, an empathic understanding displayed by the therapist and an agreement between therapist and patient on the goals and tasks of treatment (Hintikka et. Al 2006). Each participant contributes to the quality of the alliance. A patient's ability to develop and maintain a working alliance in psychotherapeutic treatment may rely on their ability to establish and maintain healthy attachment to others as well as their ability to trust others and engage in the work of self-discovery. Researchers have made several attempts to identify the personality characteristics of the therapist that contribute to a strong working alliance. Truax and colleagues support that genuineness, nonpossessive warmth, and accurate empathic understanding are important qualities of a therapist in an effective therapeutic relationship. (Truax et al. 1971). These qualities are similar to those proposed to be enhanced and possibly created by mindfulness practice.

How is Mindfulness Measured

A few measures of mindfulness were developed due to the interest in empirically validating mindfulness interventions. Brown and Ryan developed the Mindful Attention and Awareness Scale to attempt to capture the single construct of mindfulness. However, mindfulness may involve several components and may not be easily reducible to a single construct. The Kentucky Inventory of Mindfulness Skills (KIMS: Baer et al, 2004) effectively defines mindfulness as a multifaceted construct. Based primarily on

Linehan's DBT, the KIMS hopes to identify the multiple aspects of mindfulness to better operationalize the definition of mindfulness. The first aspect is "Observing" which highlights the importance of observing, and attending to external and internal stimuli as well as cognitions. "Describing" refers to the ability to label these experiences verbally without judgment. Next is "Acting with Awareness" or the ability to act on one thing at a time mindfully. This concept is similar to the DBT qualities of "participating" and "one-mindfully". Participating involves the ability of, becoming one with the activity and entering into it wholly and one-mindfully as doing one thing at a time with awareness. Finally, the last concept is "Accepting or Allowing Without Judgment". This is the ability to refrain from judgment by not applying labels such as, "good" or "bad", but to allow reality to be as it is without trying to change or alter it. This is believed to lead to more adaptable behavior by allowing an individual to respond to a difficult situation in different ways and prevent the automatic maladaptive way of responding. Assessment began as a 77-item measure and was eventually reduced to 39 items after initial administrations led to the exclusion of items. Items are scored on a Likert scale from 1 (never or rarely true) to 5 (almost always or always true). Some items directly measured mindfulness where others indirectly and were therefore reversely scored.

Content validity, internal validity and test-retest reliability were adequately established. The scales were subsequently examined in terms of one another to assess for correlations between them. The correlations were expected to be modest but significant. Significant correlations between the subscales were found except a non-significant correlation between the Observe and Act with Awareness scales as well as a negative correlation between the Observe scale and the Accept without Judgment scale. The

researchers explain this by stating that in non-experienced meditative populations the action of observing may also lead to a judgment made. This aspect should be considered further in applications of the scale. Test-retest reliability was also conducted. Baer et al. found that the KIMS were negatively correlated with neuroticism (Describe $r=-.41$, Accept with Awareness $r=-.42$) and GSI scores on the brief symptom checklist were also negatively correlated with three of the four KIMS scales (Describe $r=-.33$, Acting with Awareness $r=-.38$, and Accept $r=-.29$). Emotional intelligence was significantly positively correlated with the KIMS (Observe $r=.34$ and Describe $r=.54$) as well as Life Satisfaction. The KIMS negatively correlated with Alexithymia (Describe $r=-.66$), Experiential Avoidance (Describe $r=-.35$, Act with Awareness $r=-.30$), and Dissociative experiences (Act with Awareness $r=-.28$).

Finally Baer et al. looked at the KIMS against the only other scale of mindfulness known to them at the time of publishing the article was the Mindful Attention Awareness Scale (MAAS) developed by Brown and Ryan, 2003. Baer et al. proposed that the MAAS would be most similar to the Act with Awareness scale of the KIMS. The results indicated that this correlation was significant as predicted with a correlation of $r=.57$ ($p<.001$). The Observe scale is not significantly related to the MAAS, $r=.02$ with moderate correlations with the other two scales, Describe $r=.24$ ($p<.05$) and Accept without Judgment $r=.30$ ($p<.001$). Finally Baer et al. looked at the difference in scores between a clinical sample and a student sample. The results from this support the assertion that the construct measured by the KIMS is related to well being and psychological mental health.

The KIMS was developed by practitioners of dialectical behavioral therapy to assess their client's level of mindfulness skills. It measures mindfulness as a multifaceted construct that includes several aspects as opposed to a single construct. This assessment measures mindfulness in the general population and not only with experienced meditators. The assessment also tries to use language that is understandable by the general population and not just those with an established mindfulness practice. The assessment also measures mindfulness in daily life and not just directly before or after a mindfulness meditation exercise. Due to the practicality and applicability to the population in this research project, this measure was determined to be the most accurate in measuring an individual's level of mindfulness on a day-to-day basis. An individual with a higher mindfulness score would be expected to display these characteristics as well as with other measures of wellbeing.

Summary and Statement of Problem

The training of clinical psychologists and other mental health professionals relies greatly on the use of theory, research and supervised clinical experience. Through these methods, a beginning therapist slowly develops a psychotherapeutic style of their own which continues to grow and deepen with each year of practice. Personal psychotherapy for the therapist is often recommended but not always enforced or possible given the limited income of a graduate student or sometimes by personal choice. Most often clinicians are not instructed in how their own emotions and ability to navigate their emotional life plays a big role in their ability to navigate the emotional life of others. A set of skills that could be taught in graduate school that would both benefit the psychotherapist personally but also in their work with patients. The skills are a greater

set of insight, understanding and empathic awareness that is invaluable for the work of a clinician. There is also the ability of initiating self care in a line of work devoted to the emotional care of others, a quality often neglected as part of most mental health training programs. Mental health workers are more likely to experience burnout due to the emotional taxing nature of their work making self-care extremely important.

The applications of mindfulness have been proposed to extend beyond clinical based interventions. Mindfulness can benefit many aspects of psychotherapy including benefits to mental health practitioners or psychotherapists. The practice of mindfulness can improve the mental and emotional health of the psychotherapist as well as their work with their patients. A psychotherapist with a balanced and improved ability to remain non-judgmental, accepting and less reactive to overwhelming emotional stimuli can model this way of being and serve as an impetus for the patient to improve their functioning. In this study psychotherapist's natural trait level of mindfulness is measured and compared with aspects of treatment outcome. Perhaps mindfulness would give us a better understanding of how effective therapists activate their skills and contribute to an improved therapeutic outcome for patients.

Past research indicates that therapist's personality traits may be just as important as other factors in predicting treatment outcome. The qualities shown to have positive effects on treatment outcome are warmth and empathy while therapist's hostility was found to be a negative predictor in psychotherapy (Henry, Schacht & Strupp, 1990). In cognitive behavioral therapy, the Rogerian qualities of empathy, non- possessive warmth, unconditional positive regard, and genuineness were found to impact the patient's behavior, (Keijsers, Schapp & Hoogduin, 2000). Many of these positive qualities are

related to the foundation of mindfulness practice and its cultivation of empathy and compassion. Positive correlations between treatment outcome and therapist characterized by patients as “Understanding” and “Accepting” were found by Cooley and associates (Cooley et al. 1980). Mindfulness has been correlated with emotional intelligence, openness to experience, attention to feelings and clarity of feelings (Brown and Ryan, 2003). Training of therapists in graduate programs is limited to theory and technique. It remains unclear how to foster and develop the characteristics essential to an effective therapeutic presence. Perhaps Mindfulness would offer an avenue in which therapeutic qualities could be cultivated in graduate students.

Some studies have already begun to look at how mindfulness enhances patient outcome and therapist qualities. Training therapists that practiced Zen meditation were compared with a similar cohort of non-practicing therapists (Grepmaier et al. 2007). They found that Zen practicing therapists reported improved understanding of their own psychodynamics, difficulties and goals. Their patients reported improved symptoms, better progress towards their goals in therapy and increased adaptive behaviors than non-practicing therapists. Mitterlehner, Low and Bachler, 2007 also found that therapists receiving Zen meditation training vs. therapists that did not receive the training fared better with their patients on clarification of therapeutic process, better understanding of their psychodynamics and improvement in their original mood symptoms. Clinical mental health graduate students were also found to have felt more attentive in their therapy sessions and more comfortable with silence after mindfulness training (Schure, Christopher & Christopher 2008). Mindfulness meditation is also proposed to help individuals sustain attention (Jha, Krompinger, & Baime 2007) and increase therapist’s

empathic concern for others (Shapiro et al. 2007). Continued research in these directions is needed to establish mindfulness practice as an important part of therapist training.

Mindfulness is related to the development and possession of several personal qualities that are essential to an effective therapeutic outcome. A mindful therapist may be better able to work therapeutically by being present and attentive to the patient's needs in the moment, including recognizing when the therapist is focused on their own reactions and how that may be interfering in the overall therapeutic process. The maintenance of empathy and compassion is extremely important in working with difficult patients. The patients in this study with Cluster C Personality Disorders fit into the category of being difficult to maintain a therapeutic alliance and positive therapeutic presence. Therefore, a therapist with skills that enable them to maintain empathy and compassion as well as identify their countertransferential reactions should be especially effective with this patient population. Although there are no specific mindfulness interventions for this group of therapists, it is assumed that individuals will naturally differ in their ability to be mindful and that this difference will contribute to a positive treatment outcome.

Research Questions

Past mindfulness research found strong correlations between trait mindfulness and other positive personality traits such as empathy and compassion. It is valuable for mindfulness research to continue to explore the relationships between mindfulness and other personality variables. This study looked at personality as conceptualized by an internalization of interpersonal interactions measured by the INTREX short form. We would expect that therapists that have a more positive introject to be friendly and helpful

in a therapeutic situation. Those with negative or hostile introjects might be more controlling and defensive in similar therapeutic setting with their patients. Since the tenets of mindfulness are based in encompassing ideas of compassion and non-judgmental awareness, we would expect that a relationship might exist between a therapist's level of mindfulness and their ratings on the INTREX. An established relationship could tell us more about how the qualities of mindfulness are engaged in interpersonal reactions.

The working alliance between therapist and patient is related to positive therapeutic outcome in psychotherapy research. The stronger the perceived relationship between patient and therapist leads to a greater amount of progress in accomplishing therapeutic goals. There is speculation to what elements contribute the most to an effective alliance and therapist personality variables are proposed to have a great impact on the quality of the alliance between therapist and patient. Since mindfulness has been correlated with other positive therapeutic personality traits such as compassion and empathy, we might expect that it will also have a beneficial contribution to the development of an effective therapeutic relationship. Therefore this study contains an exploratory analysis of patient and therapist ratings of the working alliance and therapist's mindfulness levels.

This study proposes that therapists with higher trait levels of mindfulness will be more effective therapists. Their ability to be in tuned with their patients, exhibit empathy and compassion and offer a non judgmental attitude of acceptance would increase their ability to connect with the patient and work towards a mutually beneficial treatment environment. Therefore we would expect psychotherapist's trait levels of

mindfulness to correlate with positive change on treatment outcome measures. Treatment outcome in this study is defined as a reduction of symptoms from intake to termination, improvement of target complaints, a higher global assessment scale rating at termination, and improvement on the Inventory of Interpersonal Problems overall mean completed by both patients and therapists.

Hypotheses

H1: Scores on each of the four sub-scales of the Kentucky Inventory of Mindfulness Skills (Observe, Describe, Act with Awareness and Accept without Judgment) will positively correlate with higher scores indicating a more affiliative introject on the INTREX short form at one's worst.

H2: There will be a positive relationship between patient and therapists ratings on the Working Alliance Inventory and the therapist's scores on the Kentucky Inventory of Mindfulness Skills. Higher levels of mindfulness represented by high scores on the four scales of the KIMS: Observe, Describe, Act with Awareness and Accept without Judgment will correlate positively with higher scores on the patient and therapist rated WAI score from the 3rd session of treatment.

H3: Therapist's mindfulness scores will have a statistically significant relationship with adjusted change in scores on treatment outcome measures from the beginning to the end of the treatment. Higher therapist's mindfulness scores on each of the four scales of the Kentucky Inventory of Mindfulness Skills: Observe, Describe, Act with Awareness and Accept without Judgment will correlate significantly and positively with residual gains on the Global Assessment Scale from intake to termination. Higher therapist's mindfulness scores on each of the four scales of the KIMS will also correlate significantly and negatively (indicating improvement) with the SCL-90, both patient and therapist rated Target Complaint average score as well as both the patient and therapist rated versions of the Inventory of Interpersonal Problems overall mean from intake to termination.

CHAPTER II:

METHODS AND PROCEDURES:

Participants

Patients

The data for 26 patient/therapist dyads were included in this study. Participants from the study were from a sample of patients in the Brief Psychotherapy program at Beth Israel hospital in New York City. They were a community sample recruited by an offering low fee psychotherapy for those willing to participate in a research project. Patients were initially screened using the SCID interview (First, Spitzer, Gibbon and Williams, 1995) to determine their diagnosis. There were 17 women and 9 men from an age range of 24-68 with a median age of 48 (Table 1). They were mostly single patients (57.7%) with 26.9% married and 15.4% divorced. The majority were college graduates (46.2%) with 30.8% having some sort of graduate degree. 24 of the patients were Caucasian, with one Hispanic patient and one African-American patient. 9 patients met criteria for Personality Disorder NOS, 3 met criteria for Avoidant Personality Disorder, 2 with Obsessive Compulsive Personality Disorder a patient with Negativistic PD and one with Depressive Personality Disorder. There were also an additional 9 patients had no Axis II diagnosis.

Therapists

Therapists were from a group of psychology externs and interns, psychiatry residents, and clinical psychologists at Beth Israel Medical Center at the Brief Psychotherapy Research Project. A subsection of 26 therapists were included as part of this study (Table 2). To ensure consistency among the psychotherapists of the project

therapists underwent the same training and supervision appropriate to the therapy modality assigned. Out of these therapists, 18 were women and 8 men. This specific sample consisted of 4 psychiatry residents, 1 clinical psychologist and 20 psychology MA level students either being psychology externs or interns. One of the therapists had 6 years of experience, which was the most from our sample, the majority having 2 or less years of experience. There were 26 total dyads included in this study. There were 12 therapists assigned to Brief Relational Therapy treatment condition and 14 therapists assigned to CBT condition. Each therapist was assigned a patient to conduct weekly therapy sessions and attended a 90-minute group supervision seminar. The group supervision included up to 10 trainees with two supervisors as to provide adequate supervision. Sessions were videotaped and therefore provided an excellent tool for supervision sessions to guide how sessions were conducted. It also ensured there was a limited supervision effect in the outcome data.

Inclusion/Exclusion Criteria

Inclusion criteria for the Brief Psychotherapy Research project are that patients must be between the ages of 18 and 65, endorse a willingness to be videotaped and complete assessment questionnaires, and a proficiency in the English language to communicate with the therapist and complete the questionnaires. The exclusion criteria are the absence of a organic brain syndrome or mental retardation, psychosis or need for psychiatric hospitalization, bipolar disorder or severe major depression, significant medical diagnosis that would prevent the patient from physically participating in the

study, active substance abuse, a history of violent behavior or impulse control, active suicidal ideation and recent use of psychotropic medication.

Assessment Measures and Procedures

Measures of Mindfulness

Kentucky Inventory of Mindfulness Skills (Baer et al, 2004)- To measure therapist's trait level of mindfulness a 39-item scale that defines mindfulness as four qualities Observe, Describe, Act with Awareness and Accepting or Allowing without Judgment was used. This measure of mindfulness was developed as an adjunct to use with Dialectical Behavior Therapy to assess long term change over time. The scale consists of 39 statements which ask the responder to state how much they can identify with each statement on a likert scale from 1 *Never, rarely true* to 3 *Sometimes true* and 5 *Very often or always true*. There are 18 reverse-scored items and the remaining items are scored directly where higher scores indicate higher levels of mindfulness and a highest possible score of 195. This measure was chosen because of its focus on mindfulness as conceptualized by a few features as opposed to one global concept. Since the research on mindfulness is still in its infancy the definition of mindfulness must be further established and explored.

Therapist Trait Measures

The *Structural Analysis of Social Behavior (SASB) INTREX-short form* (Benjamin, 1988) will be used to assess therapists' interpersonal/relational variables. This measure consists of two parts made up of 8 questions each. The measure was derived from a circumplex model that conceptualizes personality as an internalization of social interaction. Previous studies have used the INTREX to evaluate how therapist's interpersonal variables are

related to treatment outcome (Henry, W.P, Strupp, H.H. & Schacht, T.E. 1990). Introject theory states that therapists will treat patients in terms of their own introjects. A therapist with a hostile introject may display defensiveness, be highly critical or negative with their patients. Most research has focused on how therapists with hostile introjects are greatly responsible for increase in negative and complex interpersonal communication (Henry, W.P., Schacht, T.E., Strupp, H.H., et al. 1993). The actual measure includes 16 total items where the rater judges an item to be descriptive of their own behavior. Each item is rated twice once with a statement to describe yourself “at your best” and the second group to describe yourself “at your worst”. The ratings after each statement range from 0-100 where a rating less than 50 indicates an item is *false* and a rating higher than 50 indicating *true*. Responses reveal one’s tendency toward an affiliative introject or self-loving vs. self-hating or autonomous introject which reflects how controlling or freeing one is to oneself. Research supports the use of the Affiliation scale as the most critical when looking at therapeutic qualities including predicting the quality of the therapeutic relationship and outcome. Prior research also recommends the use of the “yourself at your worst” scale since introject “at best” ratings tend to be idealized. (Henry, W.P., Schacht, T.E. & Strupp, H.H., 1990, Bruck, E., Winston, A., Aderholt, S. & Muran, J.C. 2006).

Process Measures

The Working Alliance Inventory (WAI: Horvath and Greenberg, 1989)- A scale used to measure the therapeutic alliance between patient and therapist. The version in this study was derived from the original scale but narrowed down to 12 items (Tracey, T.J. & Kokotovic, 1989). It is made up of three subscales, therapeutic bond, agreement on tasks,

and agreement on goals. Patients and therapists are asked to reflect on the working relationship and report the degree to which they agree with 12 particular statements on likert scale ranging from 1 (*not at all*) to 7 (*completely*). Higher scores on this scale represent a stronger working alliance with therapist/patient. There are two reversely scored items. The WAI has been used extensively to evaluate the relationship between therapist and patient in psychotherapy research. It has also been validated to be a strong predictor of positive outcome (Horvath, A.O., & Symonds, D., 1991).

Therapeutic Outcome Measures

Measures of Treatment outcome include a comprehensive evaluation of the patient's symptoms and current functioning post treatment. This includes interpersonal behavior, personality measures and level of functioning. The measures used to evaluate outcome include:

Target Complaints instrument (Battle et al. 1966), used to assess patient's initial presenting problems. The instrument consists of 5 point scales ranging from *worse* to *a little better* to *a lot better* where patient initially specifies three problems they would like to focus on in psychotherapy treatment. The patient is asked to rate each problem at three different points in time, at intake, and upon termination of treatment in terms of their distress from that problem at that particular moment in time. This measure has been widely used as an outcome measure in psychotherapy research (Kivlighan, D.M., Jr. et al. 2000, Greenberg, L.S. et al. 2008, & Davidson, G.N.S., et al. 1997) and has a high correlation with outcome measures and high test-retest reliability.

Symptom Checklist- 90 Revised (SCL-90) used to assess current psychiatric symptoms. It is one of the most commonly used instruments today to assess symptoms. Used in

diagnosis, inform treatment planning and measure treatment outcomes (Derogatis, L. R., 1983). It is a 90-item instrument where patients rate on a scale from 0-4 the amount of distress they have experienced from each of the 90 symptoms listed where 4 represents the most distress. It serves as an overall index of distress and has high internal consistency and reliability.

Global Assessment Scale (GAS: Endicott et al, 1976)- A clinician scale used to subjectively rate the social, occupational and psychological functioning of adults. It looks at how one is able to perform activities of daily living and to what extent their symptoms interfere. The clinician rates their patients on a scale ranging from 0-100 where 100 (*superior functioning*) and 0 indicates *a persistent desire to hurt oneself or others*.

Inventory of Interpersonal Problems (IIP: Horowitz, Rosenberg, 1988)- A 32 item measure used to identify interpersonal sources of distress that are often the focus of psychotherapy. This measure is based on a circumplex model of interpersonal behavior defined by two horizontal axis, one termed affiliation with poles of friendliness and hostility and another axis named autonomy and control with poles of dominance and submission. The circumplex is commonly divided in 8 ways that correspond to the following 8 scales: overly autocratic, overly competitive, overly cold, overly introverted, overly subassertive, overly exploitable, overly nurturant, and overly expressive. The IIP has high internal consistency from .82 to .94 and high-test retest reliability (Horowitz, 1988). The ability for a patient to improve their interpersonal functioning throughout the course of brief psychotherapy has been supported (Crits-Christoph, P, et al., 2005)

Procedures

Patients were randomly assigned a brief project psychotherapist following their consenting into the project. Their psychotherapy treatment consisted of 30 weekly 45-minute sessions. The patients were also randomly assigned to one of two conditions, Cognitive Behavioral Therapy (Turner and Muran, 1992) and Brief Relational Therapy (Safran & Muran 2000, Muran and Safran, 2002). Cognitive Behavioral Therapy is based on the manualized treatment developed by Beck et al, and is a formulation for treating individuals with Cluster C Personality Disorders as well as Personality Disorder, NOS. The efficacy for this type of treatment has been greatly supported. The treatment began with the identification of primary symptoms and the creation of a problem list for focus of treatment. The problem list also helped to identify core beliefs. The therapy first focused on symptom relief and then attempted to change those aspects of the personality disorder. A typical session involved assigning particular tasks to aid in the management of symptoms as well as homework to be completed outside of session. The second treatment condition was Brief Relational Therapy condition. In this condition the focus was on confronting the interpersonal problems of the patient within the context of the therapeutic relationship. The therapy is based on the combined principles of relational psychoanalysis and humanistic psychotherapy. Psychotherapists would focus on the detection and resolution of ruptures between the patient and therapist. In both conditions, the relationship between the therapist and the patient was a point of interest. An important part of the therapy was for the therapist to establish a safe and friendly place to enhance the working environment with the patient. Treatment conditions will not be looked individually at in this study because a Chi-square test

revealed no significant differences between the two treatment conditions and levels of therapist trait mindfulness. Therefore the 26 dyads will be evaluated as one group without consideration to treatment condition.

Patients and Therapists in both conditions completed a series of measures upon intake, repeatedly throughout treatment and at the end of each session. The therapist completed the INTREX short form, and Kentucky Inventory of Mindfulness Skills at intake. The patients and therapists also completed the Working Alliance Inventory-12 throughout treatment after each session. The patients and therapists also completed the Symptom Check List-90, Target Complaints, Global Assessment Scale and Inventory of Interpersonal Problems at intake and at termination to serve as indicators of treatment outcome.

Statistical Procedures

To investigate the potential relationship between The Kentucky Inventory of Mindfulness Skills four sub scales: Observe, Describe, Act with Awareness and Accept without Judgment and the therapist's introject affiliation scores at their worst were correlated. Another simple correlation looked at the potential relationship between the Working Alliance Inventory and therapist's scores on the Kentucky Inventory of Mindfulness Skills. A Pearson (one-tailed) correlation looked at the four mindfulness attributes with both patients and therapists WAI scores from the 3rd session of treatment. Data from session number 3 was chosen from the WAI because prior research found that the quality of the therapeutic relationship was already well established by the third session of treatment in time-limited therapy (O'Malley, S.S., Suh, C.C. and Strupp, H.H. 1983).

To analyze outcome data, scores from the following measures, Symptom Checklist-90, Target Complaints, Global Assessment Scale and the Inventory of Interpersonal Problems were collected at intake and at termination. This study looked to establish a relationship between therapist's scores on the Kentucky Inventory of Mindfulness Skills and residual gains on each of the treatment outcome measures from intake to termination. To begin analyzing the data, therapist's responses on the KIMS were scored resulting in four sub-scaled scores and an overall score. All outcome measures were also scored for each patient/therapist dyad. Missing values (no more than 5% were present for any of the scores) were replaced by the series mean. To assess adjusted change (residual gains) in treatment, the full sample intake mean was calculated and subtracted from the termination scores on each of the outcome measures. A semi-partial correlation correlated the four sub-scaled mindfulness scores with the adjusted change or residual gain of treatment outcome to termination. This set of calculations was completed for each of the four outcome measures.

CHAPTER III:

RESULTS AND DISCUSSION

Results

Correlations between Therapist's Mindfulness scores and Therapist Introject

The first hypothesis predicted a positive relationship between the four factors on the Kentucky Inventory of Mindfulness Skills and therapist's interpersonal functioning as measured by the INTREX short form (Tables 3) focusing on the measure of affiliation at one's worst. Therapist total scores on the Kentucky Inventory of Mindfulness Skills resulted in a mean of 133, SD= 15. The maximum score was 169 and minimum score was 107. Means for each of the four scales were: Observe 37.8, SD=7.4, Describe 31.0 SD= 5.2, Act with Awareness 30.3 SD= 5.3 and Accept without Judgment 32.7 SD= 7.3. As expected, KIMS Act with Awareness positively correlated with INTREX Worst Affiliation $r=.449$, $p<.05$ and KIMS Accept without Judgment with INTREX Worst Affiliation $r=.525$, $p<.05$. There were no significant relationships found between KIMS Observe or Describe and INTREX Affiliation "at one's worst".

Correlations between the Working Alliance Inventory and the Kentucky Inventory of Mindfulness Skills

A Pearson (one-tailed) correlation performed for these two measures resulted in a significant outcome for both patient and therapist ratings with the KIMS. The KIMS subscale Accept without Judgment and scores on the therapist version of the WAI from the third session of treatment resulted in a positive significant correlation, $r=.595$, $p<.01$, one-tailed (Table 4). There was also a significant positive correlation between the KIMS Act with Awareness scale and the patient WAI score, $r=.379$, $p<.05$.

Therapist's Mindfulness scores impact on Treatment Outcome

As predicted, a directional relationship between mindfulness of the therapist and treatment outcome was supported. The four scales of the Kentucky Inventory of Mindfulness Skills were correlated with residual gains on outcome measures (Table 5). The findings include a significant correlation between the Global Assessment Scale and the Observe scale of the KIMS, $r=.397$, $p<.05$ and on the Accept without Judgment scale, $r=.416$, $p<.05$. The Inventory of Interpersonal Problems also had significant negative correlations (indicating improvement) for both the patient overall mean $r=-.547$, $p<.05$ and the therapist overall mean, $r=-.577$, $p<.05$ with the KIMS Accept without Judgment scale. Significant results were also found with both the patient rated target complaints average and the Observe scale of the KIMS, $r=-.415$, $p<.05$ and the therapist rated target complaints average with the Accept without Judgment scale of the KIMS, $r=-.442$, $p<.05$.

Despite the overwhelming amount of significant correlations between residual gains on outcome measures and some scales of the KIMS, there were also some non-significant results. The Describe and Act with Awareness sub-scales of the KIMS did not have significant correlations with residual gains on any of the treatment outcome measures. Residual gains from the SCL-90 also did not correlate significantly with any of the therapist's scores on the four mindfulness scales.

Discussion

Overall the data provided support for a positive relationship between trait mindfulness and several aspects of psychotherapeutic treatment including outcome, working alliance as measured throughout treatment and therapist's introject styles. The

first hypothesis predicted a relationship between the therapist's scores on the KIMS and INTREX Affiliation at one's worst. Both the Act with Awareness and Accept without Judgment scales correlated significantly with INTREX Affiliation at one's worst supporting the hypothesis. Introject theory states that the therapists will treat their patients the way they themselves have been treated by others. Therefore, a therapist scoring low on the affiliative dimension might be more withholding, defensive and less friendly with patients than therapists scoring higher on affiliation. A therapist being able to adopt a nonjudgmental attitude toward their own present moment experience as well as engaging in an activity with increased attention correlates with a healthy and positive introject. Mindfulness qualities are related to treating others in a positive way due to their correlation with traits like compassion and empathy. Perhaps the presence of healthy and positive introjects also indicates the development of positive personality traits such as increased mindfulness. Positive affiliative introjects have also been proposed to impact treatment outcome and development of a successful relationship. These results provide additional evidence to support the link between therapist mindfulness and treatment outcome.

Qualities of mindfulness also correlated positively with therapist and patient ratings of working alliance. Therefore the therapist's ability to have a nonjudgmental attitude about their present moment experience is related to how positive they rate the working alliance with their patients. The therapist's ability to interact in a mindful manner also correlated with patient's higher ratings of the WAI. These findings help to establish a relationship between a therapist's level of mindfulness and its impact on the treatment process. Perhaps patients are responding positively to their therapist's ability

to be present, attentive and focused on the task at hand, which is contributing to a stronger alliance. It is important to note that with the results, the Accept without Judgment scale items target mostly internal stimuli as opposed to external stimuli so the quality is similar to the therapist's ability to tend to their own internal psychic world and it refers less to their ability to tend to their patient's internal world. This might explain the correlation between Accept without Judgment and therapist's scores on the WAI since we are most likely describing the therapist's attunement with their own experience and perceived alliance with their patients.

As expected, a relationship between trait mindfulness and treatment outcome was found. There were some significant correlations between therapist's scores on the Observe and Accept without Judgment sub-scales of the Kentucky Inventory of Mindfulness Skills and residual gains on several of the treatment outcome measures. These significant correlations highlight the relationship between a therapist's ability to observe the moment and how well their patients did in terms of their patient's view of themselves, the therapist's view of the patient and how their patient viewed their interaction with others at the end of treatment. There were relationships between how the therapist scored on the sub-scales of the KIMS and on almost all of the treatment outcome measures included in this study, the GAS, Inventory of Interpersonal Problems, and the patient and therapist ratings of improvement of patient's target complaints. A therapist's ability to observe a patient's behavior as well as the therapist's feelings, thoughts and emotions was related to their effectiveness with the patient and improvement of the patient's symptoms. This evidence supports theories linking personality qualities of therapist and therapist behaviors with clinical outcome. Although

in this study the working alliance as a process measure was examined to understand a potential link between mindfulness and the working alliance, further research would have to examine other process measures to establish a stronger predictive relationship between therapist trait levels of mindfulness and treatment outcome.

There were some limitations to this study. There was not a mindfulness intervention for therapists. This weakened the results by relying on the inherent mindfulness level of the therapists and possibly lowering the overall mindfulness scores for some therapists. It was also unknown whether therapists in this study had an ongoing mindfulness practice or participated in mindful activities such as yoga. An experimental mindfulness intervention would have enhanced the therapist's mindfulness level and could have strengthened the evidence for a relationship between mindfulness level and actual treatment outcome. Another significant limitation in this study was the size of the sample. This reduced the power of the results and ability to draw conclusions from them. An impacting factor on including more dyads also depends on the return and successful completion of all questionnaires for the study. The missing data on several questionnaires impacted the size of the sample since only dyads with complete data (only 5% of missing data was allowed) were included. Another factor that impacted data collection was that many participants did not reliably complete the mindfulness trait measure when it was first introduced. There was some observed resistance to the measure and it was hypothesized that perhaps asking a beginning therapist to focus on their mindfulness abilities might heighten their anxiety. This resistance was not measured but would be important to consider in terms of how the process of looking inwards does intensify anxiety among beginning therapists. This is also important to consider when

implementing mindfulness skills and techniques into graduate program curricula. There may be resistance to these skills initially and discussing the resistance could be a valuable teaching tool. Another limitation in the study was the reliance of many subjective self-report measures. Although each scale used demonstrates sufficient reliability and internal validity, the limitation of subjective reporting measures must be pointed out.

Mindfulness focused research thus far has mostly tried to validate the efficacy of mindfulness based interventions such as Mindfulness Based Stress Reduction, Dialectical Behavioral Therapy and Acceptance and Commitment therapy. Little research has explored how mindfulness can be a valuable tool to create a better therapist, one that is increasingly empathic, present, and able to cope with the demanding emotional expectations of the job. The previous discussion has offered some preliminary directions of how to continue examining the role of therapist mindfulness and ultimate treatment outcome. Ideally future studies would include multiple methods of measuring mindfulness as well as incorporating a variety of mindfulness interventions. They would also explore the mechanism of how mindfulness works to enhance therapist's ability to gain a better understanding of what components enhance therapeutic ability so that they can be focused on and isolated for professional development and training. The aim of future research would help establish mindfulness training as a valuable component of psychotherapist education and graduate programs.

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Table 1- Client demographics

| | N | Percentage |
|--------------------------|----|------------|
| Sex | | |
| Male | 9 | 34.6 |
| Female | 17 | 65.4 |
| Marital Status | | |
| Single, Never Married | 15 | 57.7 |
| Married, Remarried | 7 | 26.9 |
| Divorced | 4 | 15.4 |
| Patient Education | | |
| HS Grad | 1 | 3.8 |
| Some college | 3 | 11.5 |
| College grad | 12 | 46.2 |
| Some grad school | 2 | 7.7 |
| Grad degree | 8 | 30.8 |
| Race | | |
| Caucasian | 24 | 92.3 |
| Hispanic | 1 | 3.8 |
| Black | 1 | 3.8 |
| Diagnosis | | |
| Personality DO, NOS | 9 | 34.6 |
| Avoidant PD | 3 | 11.5 |
| Obsessive Compulsive PD | 3 | 11.5 |
| Negativistic PD | 1 | 3.8 |
| Depressive PD | 1 | 3.8 |
| No Axis II | 9 | 34.6 |

Table 2- Therapist demographics

| | N | Percentage |
|----------------------------|----|------------|
| Sex | | |
| Male | 8 | 30.8 |
| Female | 18 | 69.2 |
| Race | | |
| Caucasian | 19 | 73.1 |
| Hispanic | 4 | 15.4 |
| Other | 3 | 11.5 |
| Years of experience | | |
| 6 | 1 | 3.8 |
| 5 | 1 | 3.8 |
| 4 | 1 | 3.8 |
| 3 | 1 | 3.8 |
| 2 | 2 | 7.7 |
| 1 | 4 | 15.4 |
| 0 | 11 | 42.3 |
| Degree | | |
| MA | 20 | 76.9 |
| PhD | 1 | 3.8 |
| MD | 4 | 15.4 |

Table 3- INTREX Affiliation scale correlated with four scales of Kentucky Inventory of Mindfulness Skills

| | KIMS Observe | KIMS Describe | KIMS Act with Awareness | KIMS Accept without Judgment |
|--------------------------|--------------|---------------|-------------------------|------------------------------|
| INTREX Worst Affiliation | .093 | -.052 | .449* | .525* |

* p<.05

Table 4- Four Facets of Mindfulness (KIMS) Correlated with Patient and Therapist WAI scores from third session of treatment

| | Therapist WAI Ratings- 3 rd Session of Treatment | Patient WAI Ratings- 3 rd Session of Treatment |
|-------------------------------|---|---|
| KIMS- Observe | .119 | .119 |
| KIMS- Describe | .083 | .104 |
| KIMS- Act with Awareness | .261 | .379* |
| KIMS- Accept without Judgment | .595** | .147 |

*p<.05, **p <.01, one-tailed

Table 5- Four Facets of Mindfulness (KIMS) Correlated with Outcome Measures

| | Observe | Describe | Act with Awareness | Accept without Judgment |
|-------------------------------------|---------|----------|--------------------|-------------------------|
| GAS | .397* | .291 | .034 | .416* |
| SCL-90 | .197 | .227 | -.045 | -.187 |
| IIP- Patient | .076 | -.035 | -.087 | -.547* |
| IIP- Therapist | -.070 | -.377 | -.051 | -.577* |
| Target Complaint Average- Patient | -.415* | -.078 | -.158 | -.142 |
| Target Complaint Average- Therapist | .075 | -.161 | .012 | -.442* |

* p<.05