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Effects of Mindfulness Training on First Year Doctoral Students’ Therapeutic Relationships

Joel Simons

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Effects of Mindfulness Training on First Year Doctoral Students’ Therapeutic Relationships

by

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Effects of Mindfulness Training on First Year Doctoral Students’ Therapeutic Relationships

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Abstract

The quality of the relationship established between client and clinician during psychotherapy has been found to be a robust, common, and curative factor regardless of clinician theoretical orientation. The positive impact of therapeutic relationships remains distinct from technique and accounts for the greatest amount of therapeutic change that is within clinicians’ control. The growth of effective mindfulness-based treatments has led some to postulate that mindfulness may improve clinicians’ ability to establish positive therapeutic relationships. If that is true, then mindfulness practice may be particularly relevant to early clinical training when students are learning basic relational skills. This study examined the effects mindfulness training had on first year doctoral students’ ability to establish positive therapeutic relationships with volunteer pseudotherapy undergraduate students. An experiment was conducted comparing an experimental group which received mindfulness training to an active control group which watched training videos. Ability to establish therapeutic relationships with pseudoclients was
measured comparing multiple pre- and post-treatment measures. As predicted, students practicing mindfulness achieved greater levels of self-rated mindfulness. However, contrary to prediction, students practicing mindfulness had less positive therapeutic outcomes, similar “therapeutic alliance,” and similar “therapeutic presence,” as rated by their pseudoclients. Also contrary to prediction, students receiving mindfulness training rated their own therapeutic presence similarly to controls; supervisor ratings of clinical competency also did not differ between groups. As predicted, students practicing mindfulness perceived their training as more beneficial to their clinical competency than their non-mindfulness counterparts, particularly in the domains of self-care and self-reflection. Therefore, mindfulness training may be particularly relevant to developing clinicians’ subjective impression of growth in self-care and reflective practices, although these impressions were not found to translate into more positive client perceptions of the therapy experience.
Table of Contents

Approval Page ............................................................................................................................................

Abstract ..............................................................................................................................................

List of Tables .....................................................................................................................................

List of Figures ...................................................................................................................................

Chapter 1: Introduction .......................................................................................................................1

  Relationship in Psychotherapy ............................................................................................1

  Mindfulness in Psychotherapy ............................................................................................4

  Effects of Mindfulness ........................................................................................................6

    Cognitive Effects ........................................................................................................6

    Emotional Effects ..................................................................................................7

    Physical Effects .....................................................................................................8

    Spiritual Effects ....................................................................................................8

    Interpersonal Effects ............................................................................................8

Mindfulness for Therapists .................................................................................................................9

Mindfulness in Clinical Training .................................................................................................11

Current Study ...............................................................................................................................12

  Hypothesis 1 ...............................................................................................................13

  Hypothesis 2 ...............................................................................................................13

  Hypothesis 3 ...............................................................................................................13

  Hypothesis 4 ...............................................................................................................13

  Hypothesis 5 ...............................................................................................................14
Hypothesis 6 .....................................................................................................................14
Hypothesis 7 .....................................................................................................................14

Chapter 2: Method .............................................................................................................15

Participants .....................................................................................................................15
Measures .........................................................................................................................17

Toronto Mindfulness Scale ...................................................................................17
Outcome Rating Scale ............................................................................................18
Session Rating Scale .................................................................................................19
Therapeutic Presence Scale – Client .......................................................................20
Therapeutic Presence Scale – Therapist ...................................................................21
Supervisor Questionnaire .......................................................................................22
Student Questionnaire .............................................................................................22
Mindfulness Questionnaire .....................................................................................23
Video Questionnaire .................................................................................................23

Procedures .....................................................................................................................24

Chapter 3: Results .............................................................................................................28

Hypothesis 1 – TMS .....................................................................................................28
Hypotheses 2 – ORS ...................................................................................................30
Hypotheses 3 – SRS ....................................................................................................33
Hypothesis 4 – TPS-C .................................................................................................33
Hypothesis 5 – TPS-T .................................................................................................35
Hypothesis 6 – Supervisor Questionnaire ..................................................................39
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothesis 7 – Student Questionnaire</td>
<td>40</td>
</tr>
<tr>
<td>Supplemental Analysis 1</td>
<td>41</td>
</tr>
<tr>
<td>Supplemental Analysis 2</td>
<td>45</td>
</tr>
<tr>
<td>Supplemental Analysis 3</td>
<td>45</td>
</tr>
<tr>
<td>Supplemental Analysis 4</td>
<td>46</td>
</tr>
<tr>
<td>Chapter 4: Discussion</td>
<td>50</td>
</tr>
<tr>
<td>References</td>
<td>60</td>
</tr>
<tr>
<td>Appendix A Competencies</td>
<td>79</td>
</tr>
<tr>
<td>Appendix B Modified Toronto Mindfulness Scale</td>
<td>83</td>
</tr>
<tr>
<td>Appendix C Outcome Rating Scale</td>
<td>85</td>
</tr>
<tr>
<td>Appendix D Session Rating Scale</td>
<td>87</td>
</tr>
<tr>
<td>Appendix E Therapeutic Presence Scale – Client</td>
<td>89</td>
</tr>
<tr>
<td>Appendix F Therapeutic Presence Scale – Therapist</td>
<td>91</td>
</tr>
<tr>
<td>Appendix G Supervisor Questionnaire</td>
<td>93</td>
</tr>
<tr>
<td>Appendix H Student Questionnaire</td>
<td>95</td>
</tr>
<tr>
<td>Appendix I Mindfulness Questionnaire</td>
<td>97</td>
</tr>
<tr>
<td>Appendix J Video Questionnaire</td>
<td>99</td>
</tr>
<tr>
<td>Appendix K Informed Consent</td>
<td>101</td>
</tr>
<tr>
<td>Appendix L Mindfulness Trainings</td>
<td>103</td>
</tr>
</tbody>
</table>
List of Tables

Table 1  TMS Means and SDs for Mindfulness and Video Groups ...........................................30
Table 2  ORS Means and SDs for Mindfulness and Video Groups ...........................................32
Table 3  SRS Means and SDs for Mindfulness and Video Groups ...........................................34
Table 4  TPS-C Means and SDs for Mindfulness and Video Groups ...........................................36
Table 5  TPS-T Means and SDs for Mindfulness and Video Groups ...........................................38
Table 6  Supervisor Questionnaire Means and SDs for Mindfulness and Video Groups .................................................................40
Table 7  Student Questionnaire Means and SDs for Mindfulness and Video Groups .................................................................42
Table 8  TMS Means and SDs for Mindfulness Group, CBT Class, and MBSR Patients .................................................................44
Table 9  TPS-C Means and SDs for Mindfulness Group Without a Masters Degree and With a Masters Degree and With a Masters Degree .................................................................46
Table 10  TPS-C Means and SDs for Mindfulness Group Without Clinical Concerns and With Clinical Concerns and Video Group Without Clinical Concerns and With Clinical Concerns .................................................................47
Table 11  TPS-C, TPS-T, and SRS Internal Consistency, Test-Retest Reliability and Means and SDs of First Year Doctoral Students .................................................................47
Table 12  TPS-C, TPS-T, SRS and ORS Correlations of First Year Doctoral Students .................................................................49
List of Figures

Figure 1  SRS Scores for Mindfulness and Video Groups over 10 Therapy Sessions ..........35
Figure 2  TPS-C Scores for Mindfulness and Video Groups over 10 Therapy Sessions ..........37
Figure 3  TPS-T Scores for Mindfulness and Video Groups over 10 Therapy Sessions ..........39
Chapter 1

Introduction

**Relationship in Psychotherapy**

“Everyone has won and all must have prizes,” announced the dodo bird in Carroll’s (1865) *Alice’s Adventures in Wonderland*. In the psychotherapy world, the dodo bird verdict aptly summarizes psychotherapy effectiveness outcome research, which has repeatedly shown that all therapeutic orientations basically produce the same effect size (Lambert & Ogles, 2004; Luborsky, Singer, & Luborsky, 1975; Rosenzweig, 1936; Wampold et al, 1997), leading some to take a common factors approach to psychotherapy (Messer & Wampold, 2002). While it is true that certain therapeutic techniques have been shown to be more efficacious for certain referral problems (e.g., CBT for panic disorder; Butler, Chapman, Forman, & Beck, 2006), Messer and Wampold (2002) suggested that even symptom-specific strategies are efficacious only within the context of a specific therapeutic environment. Research consistently shows greater effect size differences within theoretical orientations than between them, with the largest therapist-controlled variable being the ability to form therapeutic relationships (Baldwin, Wampold, & Imel, 2007; Martin, Garske, & Davis, 2000, Messer & Wampold, 2002).

The therapeutic relationship is a robust common and curative factor across orientations that remains distinct from technique and accounts for the greatest amount of therapeutic change within clinicians’ control (Horvath & Symonds, 1991; Lambert & Ogles, 2004; Martin, et al., 2000; Schore, 2011; Shedler, 2010). Though clinical training tends to emphasize therapeutic
techniques, Lambert’s (1992) analysis showed techniques account for 15% of the effects of therapy, while the therapeutic relationship accounts for 30%. The emphasis on techniques in clinical training and practice may be the result of the field’s movement toward evidence-based practice (EBP). The 3-pillar model of EBP, established by the American Psychological Association (APA; 2006), stressed the importance of incorporating the best research evidence, clinical expertise, and patient values and preferences in clinical work. Though the EBP model is oft cited as solidifying the importance of utilizing therapeutic techniques that have been researched and shown to be effective, the EBP model also gives significance to therapist and patient factors that affect treatment. APA’s interdivisional Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011) affirmed the quality of the relationship between therapist and patient is a key component to positive therapeutic outcomes.

Carl Rogers (1957) believed in the power of the therapeutic relationship so strongly that three of his six necessary and sufficient conditions for therapeutic change were central ingredients of relationship: therapist warmth, congruence, and unconditional positive regard. While clinicians may dispute the sufficiency of these conditions, Rogers’ emphasis on therapists creating the relational environment for change conclusively infused the therapy world (Goldfried, 2007). The importance of therapeutic relationships became codified in the common factors movement in the term “therapeutic alliance” (Horvath, Del Re, Flückiger, & Symonds, 2011), defined by Gelso and Carter (1985) as “the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed” (p. 159). However, Horvath (2006, 2011) asserted the homogenization of language related to therapeutic
relationships minimizes true differences in theoretical conceptualizations of therapeutic relationships.

Toward the end of his career, Rogers (1980) began to speak of “therapeutic presence” as something related to, yet distinct from, his necessary and sufficient conditions, and that therapeutic presence was at the core of the therapeutic relationship. Shari Geller and Leslie Greenberg (2012) defined therapeutic presence as “the state of having one’s whole self in the encounter with a client by being completely in the moment on a multiplicity of levels – physically, emotionally, cognitively, and spiritually” (p. 7). Their view of therapeutic presence incorporated the bio-psycho-social-spiritual model of health and draws on Martin Buber’s (1958) I-Thou relational frame.

Therapeutic presence is not a therapeutic technique but a metatheoretical approach to “being” when establishing and maintaining therapeutic relationships. Therapeutic presence has been discussed in a variety of ways by clinicians from a variety of therapeutic orientations. In the psychoanalytic community, Freud’s concept of “evenly suspended attention” gets at the idea of presence (Epstein, 2007, p. 101), while more relationally-oriented psychoanalytic approaches deal more directly with the significance of moment-to-moment connection in therapeutically mutual relationships (Benjamin, 1988). Within the field of interpersonal neurobiology, therapeutic presence is discussed as a way to foster a holding space for the integration of patient affect (Siegel, 2010). Experiential orientations such as Roger’s person-centered therapy (1957) and Fritz Perl’s (1969) Gestalt therapy explicitly incorporated Buber’s perspective on relationships and sought to connect clients to authentic, present, and relational moments.
Tannen and Daniels (2010) noted diverse theoretical expressions of presence, the importance of therapeutic presence, and the unfortunate dearth of research related to presence. Yet, establishing therapeutic presence remains difficult to teach beyond relatively simplistic behavioral prescriptions for posture, responses, and attitudes that often miss the essence of what it means to be in relationship in a therapeutic way. Geller and Greenberg (2012) suggested that mindfulness exercises might be a way of promoting therapeutic presence.

**Mindfulness in Psychotherapy**

Mindfulness seems to be a related and relevant construct to therapeutic presence. Mindfulness has its roots in Buddhism, but it has been incorporated into a variety of therapeutic modalities including psychodynamic (Muran & Safran, 2002), experiential (Greenberg & Watson, 2006), existential (Claessens, 2009), and particularly within cognitive behavioral therapy’s third wave (Hayes, 2004). Jon Kabat-Zinn (2003), who brought mindfulness to mainstream psychology and Western medicine when he introduced his Mindfulness Based Stress Reduction program (MBSR) in 1979, defined mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment” (p. 145). This definition includes attention and attitudinal dimensions that correspond to Bishop et al.’s (2004) two-component definition:

- the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment” and
- “adopting a particular orientation toward one’s experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance. (p. 232)
While all mindfulness practices contain these essential elements, how they are manifest can be rather heterogeneous. For example, MBSR utilized passive forms of meditation, such as sitting meditation and body scanning, as well as physically active styles of meditation, such as Tai Chi and yoga, and it encouraged patients’ incorporation of mindfulness into their daily routines. Kabat-Zinn designed MBSR to treat stress and chronic pain, but Segal, Williams, and Teasdale (2002) adapted it to create Mindfulness Based Cognitive Therapy (MBCT) for the treatment of depression.

Marsha Linehan (1993), drawing from Zen meditation, incorporated mindfulness practices as a central component in her Dialectical Behavior Therapy (DBT) for clients diagnosed with borderline personality disorder. DBT utilizes mindfulness techniques to increase patients’ ability to observe, describe, and participate in even distressing events, emotions, and behaviors. DBT also employs mindfulness to help patients take a non-judgmental stance, focus on one thing at a time, and be effective in their attempts.

Steven Hayes, Kirk Strosahl, and Kelly Wilson (2003) infused Acceptance and Commitment Therapy (ACT) with mindfulness at the theoretical and technical level. In their view, the main cause of clients’ distress is psychological inflexibility, so the main goal of therapy should be increasing psychological flexibility, no matter what the diagnosis. Mindfulness meditation exercises are used in ACT to help patients accept experiences, defuse maladaptive cognitive processes, and view the self as context – not for the purpose of decreasing patients’ pain, but for changing patients’ relationship to pain to a more adaptive view.

While some may feel uneasy utilizing a technique that has its roots in Buddhism, Hayes (2002) suggested the field of psychology should feel free to “interpret, analyze, and transform”
Mindfulness Training

(p. 105) spiritual traditions outside of their origins into psychological theory and practice while being careful not to merely hijack pertinent psychological tricks. Symington and Symington (2012) articulated a Christian model of mindfulness, moving beyond Tan’s (2011) review of mindfulness therapies from a Christian perspective. Integrating mindfulness into other religious, spiritual, or cultural traditions seems plausible as reflective, meditative practices are encouraged in most religious traditions.

While mindfulness has been incorporated into the third wave of cognitive behavioral therapy, it is important to note what distinguishes it from the previous two waves. In contrast to the first wave of behavioral therapies that focused on changing events (stimulus, response), and the second wave of cognitive techniques that emphasized changing content (thoughts, feelings), mindfulness interventions work at changing the relationship to events (openness, acceptance) (Hayes, 2004). Thus, mindfulness works on the meta-level, focusing on process rather than product, emphasizing how instead of what.

**Effects of Mindfulness**

**Cognitive effects.** Research suggests that mindfulness training positively affects executive control functioning including self-regulation (Sahdra et al, 2011; Tang et al, 2007), self-control (Friese, Messner, & Schaffner, 2012), selective attention (Hodgins & Adair, 2010; Jensen, Vangkilde, Frokjaer, Hasselbalch, 2012; Jha, Krompinger, & Baime, 2007), sustained attention (Semple, 2010), cognitive flexibility (Moore & Malinowski, 2009), working memory (Jha, Stanley, Kiyonaga, Wong, & Gelfand, 2010), and awareness (Anderson, Lau, Segal, & Bishop, 2007). Practicing mindfulness enables practitioners to better engage in present experiences free of expectations (Anderson et al., 2007), which also helps decrease ruminative
patterns (Campell, Labelle, Bacon, Faris, & Carlson, 2011; Chambers, Lo, & Allen, 2008; Deyo, Wilson, Ong, & Koopman, 2009; Ramel, Goldin, Carmona, & McQuaid, 2004). Mindfulness demonstrated executive control benefits in non-clinical samples (Semple, 2010) as well as participants with borderline personality disorder (Soler et al., 2012), bi-polar disorder (Stange et al., 2011), women with cancer (Campell et al., 2012), and military samples in high-stress environments (Jha et al., 2010). Lutz et al. (2009) found mindfulness not only improved performance on executive functioning tasks, but it also resulted in decreased cortical effort, and improved neuronal stability and consistency during tasks of attention. Thus, mindfulness practice increases the efficiency and effectiveness of attention processes (Cahn & Polich, 2009; Kozasa et al., 2012; Lutz et al., 2009; Moore, Gruber, Derose, & Malinowski, 2012).

**Emotional effects.** Research on mindfulness indicates it improves practitioners’ ability to regulate their emotions (Arch & Craske, 2006; Goldin & Gross, 2010; Ortner, Kilner, & Zelazo, 2007), and meta-analyses have shown mindfulness-based interventions to be efficacious in the treatment of anxiety and depression (Hoffman, Sawyer, Witt, & Oh, 2010; Klanin-Yobas, Cho, & Creedy, 2012; Piet & Hougaard, 2011). Mindfulness may significantly alter cortical regions involved in self-referencing, increasing practitioners’ experiential awareness, expanding their window of tolerance, and decreasing their negative self-evaluations that are implicated in anxiety and depression (Chiesa, Brambilla, Serretti, 2010; Farb et al., 2007; Lazar et al., 2005; Paulus & Stein, 2010). Hyperarousal of amygdala regions is associated with affect dysregulation, including anxiety (Evans et al., 2008) and depression (Siegle, Thompson, Cameron, Steinhauser, & Thase, 2007), and there is some evidence to suggest that the practice of mindfulness decreases activity in these regions (Chiesa, et al., 2010; Way, Cresswell, Eisenberger, & Lieberman, 2010). These
brain changes are consistent with mindfulness theory, which focuses on becoming less reactive to troubling emotions rather than changing the emotions directly.

**Physical effects.** The metacognitive and metaemotional benefits of mindfulness have implications on physical functioning (Villemure & Bushnell, 2002). Mindfulness practice may activate the parasympathetic nervous system, thereby decreasing practitioners’ experience of stress (Baer, Carmody, & Hunsinger, 2012), increasing their experience of relaxation (Agee, Danoff-Burg, & Grant, 2009), and improving physiological markers such as heart rate variability (Burg, Wolf, & Michalak, 2012; Peressutti, Martín-González, & García-Manso, 2012), cortisol levels (Brand, Holsboer-Trachsl, Naranjo, & Schmidt, 2012; Matousek, Pruessner, & Dobkin, 2011), and sleep (Brand, et al., 2012; Britton, Haynes, Fridel, & Bootzin, 2012). Mindfulness has repeatedly demonstrated effectiveness in managing chronic pain (Baer, 2003), and it may decrease practitioners’ reactivity to pain (Schütze, Rees, Preece, & Schütze, 2010).

**Spiritual effects.** Spirituality is an important dimension of being (Eberst, 1984) that is related to dimensions of health and overall quality of life (Sawatzky, Ratner, & Chiu, 2005). Consistent with Eastern and Western views of well-being (Wallace & Shapiro, 2006), research has found mindfulness, with its roots in spiritual practice, to be related to spiritual well-being (Birnie, Speca, & Carlson, 2010; Carmody, Reed, Kristeller, & Merriam, 2008). Mindfulness-induced increases in spiritual well-being may even mediate other aspects of quality of life improvements (Greeson et al., 2011).

**Interpersonal effects.** Of course, the demonstrated intrapersonal benefits of mindfulness have implications on relationships as well. Research suggests that mindfulness is related to positive interpersonal styles and relationship satisfaction (Barnes, Brown, Krusemark, Campbell,
Mindfulness may foster compassion, empathy, and acceptance in relationships (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Kristeller & Johnson, 2005; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel 2007; Shapiro & Izett, 2008), which could be seen as the opposite of Gottman’s (1994) relationally destructive “Four Horsemen of the Apocalypse:” criticism, defensiveness, contempt, and stonewalling. The efficacy of MBSR prompted Carson, Carson, Gill, and Baucom (2004) to adapt it for couples, creating the Mindfulness-Based Relationship Enhancement (MBRE), which they found to improve the relationship quality of non-distressed couples.

**Mindfulness for Therapists**

The intrapersonal and interpersonal effects of mindfulness are not only clinically relevant to patients, but also pertain to clinicians’ lives and their ability to work in therapeutic relationships. Practicing mindfulness can be seen as a form of self-care (Christopher & Maris, 2010); it has been linked with decreases in clinician anxiety (Cohen & Miller, 2009; Shapiro et al., 2007; Waelde et al., 2008), stress (Cohen & Miller, 2009; Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003; Shapiro et al. 2005; Shapiro, et al., 2007), and rumination (Rimes & Wingrove, 2011; Shapiro et al., 2007), and increases in emotional intelligence (Cohen & Miller, 2009), self-efficacy (Greason & Cashwell, 2009), self-compassion (Rimes & Wingrove, 2011; Shapiro et al., 2005; Shapiro et al., 2007), social connectedness (Cohen & Miller, 2009), and sense of well-being (Cohen & Miller, 2009).

Mindfulness may help clinicians develop in important areas of self-reflection (Schure, Christopher, & Christopher, 2008), empathy for patients (Block-Lerner et al., 2007; Shapiro, Schwartz, & Bonner, 1998), affect regulation (Safran & Belotserkovsky, 2009), establishment of
Mindfulness Training

therapeutic alliance (Keane, 2013; Ryan, Safran, Doran, & Muran, 2012), and facilitation of therapeutic presence (Geller & Greenberg, 2012; McCollum & Gehart, 2010).

These benefits of mindfulness for clinicians may translate into improved therapeutic outcomes, though the current research is mixed. For example, Stanley et al. (2006) found a negative correlation between trait mindfulness and therapeutic outcome while Ryan, et al. (2012) found a positive relationship between clinician mindfulness and patients’ improvements in interpersonal functioning but no correlation with symptom improvements in other domains. Neither study incorporated a mindfulness intervention that might have controlled for self-rating bias of mindfulness traits. In Germany, Grepmair et al. (2007) randomly assigned 18 female psychologists in training at an inpatient hospital to either a Zen mindfulness group that practiced mindfulness one hour before each workday for nine weeks, or a non-mindfulness group that received no alternative training. All therapists were at the same level of clinical training, and mean ages of the two groups were similar (mindfulness: 29.3 yrs. ± 3.2 yrs.; non-mindfulness 30.4 yrs. ± 2.9 yrs.). 124 patients at an inpatient hospital were randomly assigned for treatment by one of the therapists in training. Both patient groups consisted of approximately 80% females and 20% males and had similar mean ages (mindfulness: 38.9 yrs. ± 10.9 yrs.; non-mindfulness 39.8 yrs. ± 12.3 yrs.). The mindfulness group (MG) and non-mindfulness group (NMG) each consisted of similar number of clients with various psychiatric diagnoses: adjustment disorders/stress reaction (MG: 30; NMG: 28), mood disorders (MG: 24; NMG: 25), personality disorders (MG: 14; NMG: 13), somatoform disorders (MG: 11; NMG: 12), anxiety disorders (MG: 10; NMG: 12), substance abuse (MG: 4; NMG: 5), obsessive-compulsive disorders (MG: 2; NMG: 2). All therapists and patients were blinded to their treatment condition. At the end of
the study, patients of the MG therapists indicated greater perceived symptom improvement on seven of nine symptom scales and on the Global Severity Index of the Symptom Checklist-90-Revised (Franke, 2002). On the Global Severity Index, patients of the MG had a pre-treatment mean $T$ score of 72.6 and a post-treatment mean $T$ score of 50.7; whereas patients of the NMG group had a pre-treatment mean $T$ score of 65.6 and a post-treatment mean $T$ score of 60.1. Therefore, patients of the MG demonstrated approximately one-and-a-half standard deviations greater improvement than patients of the NMG group ($p = < .01$). Similar results were found on an additional measure of clients’ perceptions of their symptoms, the Questionnaire of Changes in Experience and Behavior (Zielke & Kopf-Mehnert, 1980). In addition, on a measure that assessed patients’ perceptions of the psychotherapy process, the Session Questionnaire for General and Differential Individual Psychotherapy (Krampen & Petry, 2002), MG patients’ pre-to post-intervention perspectives on dimensions of clarification and problem solving changed approximately one-and-a-half standard deviations more positively ($p = < .01$) than the NMG patients’. Interestingly, no significant difference between the two groups emerged on the relationship dimension.

**Mindfulness in Clinical Training**

Mindfulness practice may be particularly useful to therapists in training (Bruce, Shapiro, Constantino, & Manber, 2010; Fauth, Gates, Vinca, Boles, & Hayes, 2007; Gockel, 2010), since mindfulness seems to promote learning in foundational clinical competencies, including reflective practice, self-assessment, self-care, forming relationships, and demonstrating affective skills (Rodolfa et al., 2005). Mindfulness practice may offer an experiential training modality to students who may be frustrated or confused by verbal instructions; it is one thing to tell a student
“be empathetic” and quite another to provide skills that foster empathy. McCollum & Gehart’s (2010) qualitative study showed that 13 master’s level practicum students undergoing mindfulness training believed that training positively affected their ability to be present in a positive therapeutic way with their patients. The impact of therapeutic relationships on therapy outcomes would suggest that mindfulness training that improves clinicians’ ability to be therapeutically present should also improve therapy outcomes.

Current Study

The study represented a response to Davis and Hayes’ (2011) encouragement that researchers investigate ways mindfulness could be integrated into clinical training, as well as to examine the effects mindfulness training may have on common factors of effective psychotherapy, such as therapeutic alliance (Norcross & Wampold, 2011) and therapeutic presence (Geller & Greenberg, 2012). The study expanded on Ryan, et al.’s (2012) research, described above, that indicated therapists’ trait mindfulness is significantly and positively related to effective establishment of therapeutic relationships. The study utilized an experimental design to examine the effects perceived therapist state mindfulness has on perceived therapeutic relationship. Whereas Grepmair et al.’s (2007) research focused on therapy outcomes, the current study more closely examined the hypothesis that mindfulness practice may improve therapists’ ability to form therapeutic relationships, thereby potentiating positive therapeutic outcomes.

The standard MBSR format consists of 26 hours of class time made up of eight, 2 ½-hour weekly classes and a 6-hour class at week six (Kabat-Zinn, 2003), but several MBSR studies have adapted the program to make it accessible to particular populations (Carmody & Baer, 2009). Carmody and Baer (2009) reviewed 30 studies that researched various formats of MBSR
and reported pre and post-MBSR effect sizes. Total hours of training ranged from 6 to 28, with a mean of 18.8 ($SD = 5.90$). Effect sizes ranged from .10 to 1.38 with a mean of .66 ($SD = .33$). Their analysis showed no significant relationship between effect size and hours of training ($r = -.25$, $p = .18$). Therefore, the mindfulness training in this study was abbreviated and adapted from MBSR exercises to be easily incorporated into an existing clinical training program.

The mindfulness training was designed to support students’ developmentally appropriate growth in the following competency areas: reflective practice, self-assessment, interpersonal relationships, affective skills, and intervention skills. An extended listing of the training’s learning objectives can be found in Appendix A. This study examined the following hypotheses:

**Hypothesis 1.** Mindfulness training will increase students’ ability to enter a “mindful state.”

**Hypothesis 2.** Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will obtain more positive therapeutic outcomes as perceived by their clients.

**Hypothesis 3.** Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will develop stronger “therapeutic alliances” as perceived by their clients.

**Hypothesis 4.** Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will demonstrate better “therapeutic presence” as perceived by their clients.
Hypothesis 5. Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will perceive themselves demonstrating better “therapeutic presence.”

Hypothesis 6. Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will be evaluated by their supervisors as being more competent in the important clinical domains of reflective practice, self-assessment, interpersonal relationships, affective skills, and intervention skills.

Hypothesis 7. Compared to students engaging in traditional forms of clinical training, students engaging in mindfulness training will evaluate their respective training as being more beneficial to their developing competency in the important clinical domains of reflective practice, self-assessment, interpersonal relationships, affective skills, and intervention skills.
Chapter 2

Method

Participants

This study received approval from George Fox University’s IRB Human Subjects committee. Thereafter, participants were obtained from a convenience sample consisting of the 2012-2013 first year cohort of George Fox University’s doctoral program of clinical psychology. The cohort was comprised of 14 females and 9 males. 19 of the students identified as European American; one student identified as Hispanic; one student identified as American Indian; and one student identified as bi-racial. Ages of the students ranged from 21 to 48 years with a mean age of 26.39 (SD = 5.6). Five of the students had a previous master’s degree in psychology. All members of the cohort volunteered to participate in this research in conjunction with their enrollment in a required Clinical Foundations course that focuses on basic therapeutic skills.

As part of the class, the students were assigned to one of six supervision groups, with three or four students in each group. Each group was led by one of six Clinical Foundations course’s teaching assistants who functioned as the clinical supervisors for those enrolled. The investigator assigned each consenting member of each Clinical Foundations supervision group with a number (1 – 4) and, using an online random number generator, randomly assigned each consenting member of each supervision group to a Mindfulness Group or a Video Group. Random assignment resulted in disproportionate representation greater than 20% of the demographic variables of sex, ethnicity, and previous clinical psychology graduate degree, so the
investigator asked an administrative assistant, blind to the study, to reassign participants randomly until these demographic characteristics met acceptable proportional criteria. The Mindfulness Group consisted of 12 students, seven female and five male, with a mean age of 27.67 ($SD = 7.1$). Two students in the Mindfulness Group identified as minority individuals, and three had previous master’s degrees in psychology. The Video Group consisted of 11 students, seven female and four male, with a mean age of 25.00 ($SD = 3.0$). Results of a post-hoc $t$-test showed the groups did not differ in age. Two students in the Video Group identified as minority individuals, and two had previous master’s degrees in psychology.

As one of the requirements of the Clinical Foundations course, all participants were required to conduct 10 sessions of person-centered therapy with two volunteer undergraduate “pseudoclients” who received Introduction to Psychology course credit for their participation. Teaching assistants for the Clinical Foundations course screened out pseudoclients suspected of having significant psychopathology and paired pseudoclients with student therapists using their clinical judgment and their knowledge of their student therapists. Pseudoclients provided informed consent to participate in the experience and the research. Pseudoclients of the Mindfulness Group consisted of 15 females and 9 males. 17 of the students identified as European American; two student identified as Asian; two student identified as European; one student identified as Hispanic; one student identified as African American; and one student identified as Biracial. Ages of the students ranged from 18 to 41 years with a mean age of 19.63 ($SD = 4.6$). Pseudoclients of the Video Group consisted of 15 females and 7 males. 20 of the students identified as European American; one student identified as Asian; and one student identified as Hispanic. Ages of the students ranged from 18 to 30 years old with a mean age of
19.73 ($SD = 2.8$). A post-hoc $t$-test analysis showed no age difference between the Mindfulness and Video groups.

**Measures**

*Toronto Mindfulness Scale (TMS, Lau et al., 2006).* The TMS is a 13-item, self-report measure that assesses state mindfulness on a 5-point Likert scale. A copy of the scale is found in Appendix B. Consistent with mindfulness definitions that include attention and attitude components, the TMS measures a dimension of “Decentering,” the metacognitive ability to observe one’s experience with some distance (e.g., “I was more concerned with being open to my experiences than controlling or changing them.”) and a dimension of “Curiosity,” an attitude of curiosity about one’s present moment experience (e.g., “I was curious about my reactions to things”; Lau et al., 2006). Utilizing the results of 174 recruited participants that included both meditators and nonmeditators, Lau et al. (2006) found moderately strong internal consistency (Curiosity $\alpha = .88$; Decentering $\alpha = .84$). In a follow up study, Lau et al. (2006) demonstrated the TMS’s discriminate validity in that mindfulness meditators who had more than one year of experience ($n = 23$) scored significantly higher on both Curiosity and Decentering dimensions than mindfulness meditators ($n = 20$) with less than one year of experience. Lau et al. (2006) demonstrated criterion validity for the TMS, finding clinical samples totaling 99 patients with a variety of physical and psychological conditions scored significantly higher on the TMS after participation in an 8-week MBSR program. Lau et al. (2006) did not report test-retest reliability and no additional reliability or validity data have since been obtained (personal communication, October 21, 2012). The investigator of the current study administered the TMS to a sample of second-year doctoral students at the beginning and end of a three-hour cognitive behavioral
therapy class during which the investigator taught mindfulness concepts and incorporated mindfulness experiential exercises. Seventeen students completed pre- and post-class measures, and a stability coefficient for the measure was found to be .66. Pre-class mean was 27.29 (7.47), and post-class mean was 32.71 (5.63). The TMS was used to measure students’ ability to enter a mindful state pre- and post-intervention. An additional item was added to the TMS to assess participants’ frequency of current mindfulness practices including meditation, body scanning, yoga, tai chi, and qigong.

Outcome Rating Scale, Third Version (ORS; Miller & Duncan, 2000b). The ORS consists of four self-report, visual analogue items that measure patient’s perceptions of their functioning, and is administered immediately preceding or following a therapy session. A copy of the scale is found in Appendix C. Each of the four ORS items assesses one of the following domains: individual, interpersonal, social, and an overall rating. Clients respond to the items by making a hash mark on a measurement line to indicate their impression of their functioning. Each item is scored by measuring the location of the hash mark on a 10-centimeter line, rounding to the nearest millimeter; item scores range from 0 to 10. The four items evenly contribute to a total functioning score that can range from 0 to 40. In an outpatient clinical sample of 65 patients, Campbell and Hemsley (2009) demonstrated the ORS has strong internal consistency ($\alpha = .90$) and that its items have moderate to strong inter-correlations ($r$ ranging from .58 to .96). Campbell and Hemsley also showed moderate to strong correlations ($r’s = .24 – .75$) with the subscales of the Outcome Questionnaire-45 (Lambert et al., 1996), a lengthier measure of therapeutic outcomes. Miller, Duncan, Brown, Sparks, and Claud (2003) found a moderate overall correlation ($r = .59$) between the ORS and the Outcome Questionnaire-45 in 335
administrations with 86 nonclinical participants. In this nonclinical sample, Miller, et al. found
the ORS had a stability coefficient of .66 with insignificant changes in scores (p > .1). However,
in their clinical sample of 435 participants, they demonstrated significant increases in ORS
scores (p < .00001), suggesting the measure is sensitive to therapeutic change. Campbell and
Hemsley found the ORS deviated from a normal distribution, however the deviations from
normality did not significantly impact their parametric analysis. The ORS was used to measure
pseudoclients’ perceptions of their functioning at the beginning and end of 10 sessions of
pseudo-therapy.

Session Rating Scale, Third Version (SRS; Miller, Duncan, & Johnson, 2000). The
SRS consists of four self-report, visual analogue items that measure patients’ perceptions of the
therapeutic alliance of a given session, administered immediately following that therapy session.
A copy of the scale is found in Appendix D. Each of the four SRS items assesses one of the
following domains: relationship, goals and topics, approach or method, and an overall session
rating. Clients respond to the items by making a hash mark on a measurement line to indicate
their impression of the therapy session that just transpired. Each item is scored by measuring the
location of the hash mark on a 10-centimeter line, rounding to the nearest millimeter; item scores
range from 0 to 10. The four items evenly contribute to a total alliance score that can range from
0 to 40. In an outpatient clinical sample of 65 patients, Campbell and Hemsley (2009)
demonstrated the SRS has strong internal consistency (α = .93) and that its items are highly
inter-correlated (r ranging from .74 to .86, p < .01), suggesting it is a “global measure” of
alliance (Duncan et al., 2003, p. 8). In a sample of 70 outpatient participants, Duncan et al.
(2003) found the SRS to be moderately correlated (r = .48) with the Helping Alliance
Mindfulness Training

Questionnaire-II (Luborsky et al., 1996) and have a stability coefficient of .64. Campbell and Hemsley (2009) showed moderate to high correlations ($r$’s = .37 – .63) with the subscales of the Working Alliance Inventory – 12 (Horvath & Greenberg, 1986). Both Campbell and Hemsley (2009) and Duncan et al. (2003) found SRS scores to be significantly, though weakly, correlated with treatment outcomes ($r$’s = .27 – .36). SRS results tend to be negatively skewed; Miller and Duncan (2000a) reported that the Center for Clinical Informatics’ independent analysis of over 15,000 SRS administrations showed that fewer than 24% of sessions score less than 36 out of 40. The SRS was used to measure pseudoclients’ perceptions of their student therapists’ ability to establish therapeutic alliances.

**Therapeutic Presence Scale – Client (TPS-C).** The TPS-C consists of four self-report visual analogue items that intend to measure patients’ perceptions of their therapists’ therapeutic presence immediately following a given session. A copy of the scale is found in Appendix E. Each of the four TPS-C items assesses one of the following domains: attention, attitude, authenticity, and connection. Clients respond to the items by making a hash line nearest the pole that best fits their impression of the previous therapy session. Each item is scored by measuring the location of the hash mark on a 10-centimeter line, rounding to the nearest millimeter; item scores range from 0 to 10. The four items evenly contribute to a total therapeutic presence score that can range from 0 to 40. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research based on Geller and Greenberg’s (2012) theory of therapeutic presence (described above) and Kabat-Zinn (2003) and Bishop et al.’s (2004) definitions of mindfulness (described above). While several instruments exist to measure therapeutic alliance, the investigator, after an extensive literature review, found an unfortunate
shortage of adequate instruments for the measurement of therapeutic presence. For example, Geller, Greenberg, and Watson (2010) created client and therapist-rated measures of therapeutic presence, but the measures are couched in language that the investigator found problematic. Tannen and Daniels (2010) elaborated that therapeutic presence has likely been underexplored for the following reasons: “theoretical foreclosure” (p. 8) on the conceptualization of the therapeutic relationship as a therapeutic alliance, “atomistic rather than holistic” (p. 9) approaches to therapeutic relationship research, “unexplained discrepancy” (p. 9) in clients’ and therapists’ perceptions of the therapeutic relationship, meta-analytic research that sacrifices depth of understanding, and positivistic approaches to social science research that have excluded experiences such as therapeutic presence. The TPS-C was used to measure pseudoclients’ perceptions of their student therapists’ ability to establish therapeutic presence.

**Therapeutic Presence Scale – Therapist (TPS-T).** The TPS-T consists of four self-report visual analogue items that intend to measure therapists’ perceptions of their own therapeutic presence immediately following a given session. A copy of the scale is found in Appendix F. Each of the four TPS-T items assesses one of the following domains: attention, attitude, authenticity, and connection. Clients respond to the items by making a hash line nearest the pole that best fits their impression of the previous therapy session. Each item is scored by measuring the location of the hash mark on a 10-centimeter line, rounding to the nearest millimeter; item scores range from 0 to 10. The four items evenly contribute to a total therapeutic presence score that can range from 0 to 40. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research as a parallel measure to
the TPS-C. The TPS-T was used to measure pseudo-therapists’ perceptions of their own ability to establish therapeutic presence.

**Supervisor Questionnaire.** The Supervisor Questionnaire consists of five, 5-point Likert scale items that intend to measure supervisors’ pre- and post-intervention perceptions of their supervisees. A copy of the scale is found in Appendix G. Each of the five Supervisor Questionnaire items assesses one of the following competencies: reflective practice, self-assessment and self-care, interpersonal relationships, affective skills, and intervention skills. All items of the measure contribute evenly to a total competency score that can range from 5 to 25. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research based on competency domains targeted by the intervention. The Supervisor Questionnaire was used to measure teacher’s assistants’ perceptions of their supervisees, the pseudo-therapists.

**Student Questionnaire.** The Student Questionnaire consists of five, 5-point Likert scale items that intend to measure participants’ post-intervention perception of the benefits of training to their clinical competency. A copy of the scale is found in Appendix H. Each of the five Student Questionnaire items assesses one of the following competencies: reflective practice, self-assessment and self-care, interpersonal relationships, affective skills, and intervention skills. All items of the measure contribute evenly to a total competency score that can range from 5 to 25. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research as a parallel measure to the Supervisor Questionnaire. The Student Questionnaire was used to measure pseudo-therapists’ perceptions of the benefits of their respective trainings to their clinical competency.
Mindfulness Questionnaire. The Mindfulness Questionnaire consists of five, 5-point Likert scale items that intend to gauge and possibly increase the Mindfulness Group participants’ training adherence and motivation. It was designed to be completed anonymously to minimize response bias. A copy of the questionnaire is found in Appendix I. Each of the five Mindfulness Questionnaire items assesses one of the following addresses one of the following: participants’ engagement with the training, perception of the training, perception of stress, and disclosure level. All items of the measure are scored independently, with item scores that can range from 0 to 4. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research. The Mindfulness Questionnaire was used to gauge and possibly increase the Mindfulness Group participants’ training adherence and motivation.

Video Questionnaire. The Video Questionnaire consists of five, 5-point Likert scale items that intend to gauge and possibly increase the Mindfulness Group participants’ training adherence and motivation. It was designed to be completed anonymously to minimize response bias. A copy of the questionnaire is found in Appendix J. Each of the five Video Questionnaire items assesses one of the following addresses one of the following: participants’ engagement with the training, perception of the training, perception of stress, and disclosure level. All items of the measure are scored independently, with item scores that can range from 0 to 4. No reliability or validity statistics existed for this measure because the investigator developed the measure for this research as a parallel measure to the Mindfulness Questionnaire. The Video Questionnaire was used to gauge and possibly increase the Video Group participants’ training adherence and motivation.
Procedures

In the first week of the spring semester’s Clinical Foundations class, the professor of the class introduced the investigator of this study. The professor informed the class that it would be randomly divided into a Mindfulness Group and a Video Group in order to provide the students with a higher level of individual attention and to contribute to a research program focused on clinical training in which the investigator was involved. The professor introduced an informed consent procedure to solicit student involvement, which was not mandatory. A copy of the informed consent form is found in Appendix K. The professor informed the class that he and the investigator would alternate leading the two groups, and each group would have approximately equal exposure to both instructors. The professor asked the members of each group not to share their group experiences with members of the other group due to the nature of scientific research, but he stated they would be free to discuss the contents of the trainings with members of their own training group. All students agreed to participate in this study.

To assess all participants’ pre-treatment ability to enter a mindful state, the investigator led the class in a group mindfulness experience, giving the following modified instructions taken from the standardization procedure of the TMS: “For the next 10 minutes, please pay attention to your breathing and anything that might arise during your experience.” Immediately following the TMS experience, participants completed the modified TMS, which took approximately two minutes. The investigator scored the TMS results.

The Mindfulness Group participated in a mindfulness program adapted from Jon Kabat-Zinn’s *Full Catastrophe Living* (2005) consisting of seven 30-minute mindfulness trainings in which participants focus on their breath, body, sounds, thoughts, feelings, others’ thoughts, and
others’ feelings. A copy of the trainings can be found in Appendix L. For approximately the first 15 minutes of the initial session, the investigator introduced the construct of mindfulness and discussed its relevance to clinical training, following the basic outline of the introduction of this document. The investigator then guided the group in approximately 10 minutes of a mindfulness exercise in which participants focused on their breath. The mindfulness practice was followed by approximately five minutes of discussion initiated by the investigator with the question, “How was this experience for you and how might it be relevant to your clinical work?”

Thereafter, one training session occurred weekly for six more weeks, for a total of seven training sessions. The class’s professor and the investigator of the study alternated leadership of the Mindfulness Group to control for potential instructor bias. The class’s professor was absent one week during which one of his teacher’s assistants led the Video Group. For each of the subsequent six training sessions, the investigator or professor guided the group in approximately five minutes of group discussion related to their mindfulness practice and its clinical relevance. Following the discussions, the investigator or the class’s professor lead the group in approximately 15-minute group mindfulness practices that began with participants focusing on their breath before shifting their attention to one or more of the following: their bodies, sounds, their thoughts, their feelings, others’ thoughts, and others’ feelings. Each mindfulness exercise was followed by approximately 10 minutes of group discussion about the exercise and how it might be relevant to their clinical work. Participants were encouraged to practice mindfulness exercises during the week and before each therapy session they conducted and to refrain from sharing content from the trainings with their non-mindfulness counterparts. The Mindfulness
Questionnaire was administered at the end of sessions two through seven to increase motivation and engagement with the training. Each administration took approximately one minute.

In order to compare the effects of mindfulness training with more typical methods of clinical training, the Video Group received a similar amount of time in being trained in non-mindfulness related content, thereby functioning as a treatment-as-usual group. Accordingly, the Video Group participated in seven 30-minute trainings in which they viewed and discussed therapy videos at the same time and in a separate room as the Mindfulness Group. Expert therapist Leslie Greenberg (Brown et al., 2012; Carlson, Greenberg, Brown, & Tullos, 2007) was presented in sessions one through five. Expert therapist Nancy McWilliams (Brown et al., 2012) was presented in session six. Expert therapist Judith Beck (Brown et al., 2012) was presented in session seven. These therapists demonstrated basic therapeutic relationship skills such as reflective, empathic listening, but they did not discuss or demonstrate mindfulness. In the initial session, for approximately 10 minutes, the course professor introduced the relevance of watching therapy videos in clinical training. The group, including the professor, then watched a video segment lasting approximately 15-minutes followed by approximately five minutes of discussion related to their experience of the video and how it might be relevant to their clinical work. For each of the subsequent six training sessions, the professor or the investigator guided the group in approximately 5 minutes of discussion related to their clinical work and the video trainings. Following the discussions, the professor or the investigator guided the group in watching approximately 15-minute segments of therapy videos. Each viewing was followed by approximately 10 minutes of group discussion about the video and how it might be relevant to their clinical work. Those in the Video Group were encouraged to reflect on the skills
demonstrated in the video during the week and before each therapy session they conducted and to refrain from sharing content from the trainings with their mindfulness counterparts. The Video Questionnaire was administered at the end of sessions two through seven to increase motivation and engagement with the training. Each administration took approximately one minute.

At the end of each of the 10 “pseudotherapy” sessions, all pseudoclients completed the SRS followed by the TPS-C, which took approximately one minute total to complete. During this time, the pseudo-therapists completed the TPS-T, which took approximately 30 seconds. These measures were then scored by the pseudo-therapists and kept in a secure location. The week after completion of the mindfulness and video interventions (week 8), participants once again participated in a seated mindfulness exercise after the investigator gave the following instructions: “For the next 10 minutes, please pay attention to your breathing and anything that might arise during your experience.” Participants completed the modified TMS following this experience to assess all participants’ post-treatment ability to enter a mindful state; the TMS administration took approximately two minutes. Participants then also completed the Student Questionnaire, which took approximately 1 minute.

Both at the beginning and the end of the spring semester, the Clinical Foundations class teacher’s assistants completed the Supervisor Questionnaire as a pre- and post-intervention measure, which took approximately two minutes per administration. The investigator scored the Supervisor Questionnaire results.

During the summer term, the investigator and professor met with all first year student participants to inform them about the content of both trainings, to provide them with the content of the training missed, and to discuss how they experienced the trainings.
Chapter 3

Results

Within the Mindfulness Group, one trainee refused to participate in the mindfulness trainings at the end of the first session, preferring to engage in personal prayer instead. Therefore, her data are not included in the analyses reported below. Notably, this trainee’s pre- and post-intervention TMS scores (33.00 and 15.00, respectively) were highly discrepant with the Mindfulness Group’s mean pre- and post-intervention TMS scores (23.73, 33.36), suggesting this trainee’s approach was dissimilar to the mindfulness training.

Hypothesis 1 – TMS. To test for possible differences between Mindfulness Group participants and Video Group participants in their perceived ability to enter into a mindfulness state, a two-way (2 (pre-post) x 2 (treatment group)) repeated measures ANOVA was computed with the pre- and post TMS total scores as the within-subjects factors. Means and standard deviations are found in Table 1. Mauchly’s test indicated the assumption of sphericity had not been violated. Results showed a significant increase in TMS scores for the post-test condition \((F(1, 20) = 4.70, p < .04, \eta^2_p = .19)\). Results also showed a significant treatment group effect was obtained \((F(1, 20) = 5.86, p < .03, \eta^2_p = .23)\), with the Mindfulness Group obtaining higher scores. A significant pre-post x treatment group interaction was found \((F(1, 20) = 5.07, p < .04, \eta^2_p = .20)\), indicating the Mindfulness Group showed greater gains than the Video Group in the post-test condition.
TMS subscales of Curiosity and Decentering, which align with mindfulness definitions that include attitude and attention components, were examined to test for possible differences in their relative impact on the significant difference found between treatment groups in the pre-versus post-intervention TMS total scores. Accordingly, two additional two-way repeated measures ANOVAs were computed using TMS sub-scores Curiosity and Decentering as the within-subjects factors. Means and standard deviations are also found in Table 1. Mauchly’s test indicated the assumption of sphericity had not been violated with either analysis. Results showed no significant change from pre- to post-intervention for Curiosity scores ($F(1, 20) = .65, p < .43, \eta^2_p = .03$). No significant treatment group effect was obtained ($F(1, 20) = 2.95, p < .10, \eta^2_p = .13$). Results showed no significant interaction between treatment groups and pre- versus post-intervention Curiosity scores ($F(1, 20) = 3.33, p < .08, \eta^2_p = .14$). In contrast, results showed a significant increase in Decentering scores for the post-test condition ($F(1, 20) = 11.04, p = .003, \eta^2_p = .36$). No significant treatment group effect was obtained ($F(1, 20) = 3.49, p < .08, \eta^2_p = .15$). Results showed a near significant interaction effect between treatment groups in pre- versus post-intervention Decentering scores ($F(1, 20) = 3.70, p < .07, \eta^2_p = .16$), with the Video Group showing no meaningful change, but the Mindfulness Group demonstrating marked gains. Therefore, consistent to Hypothesis 1, TMS results showed the Mindfulness Group participants increased their self-perceived ability to enter a mindful state, with the bulk of these gains in the Decentering domain of the TMS.
Table 1

*TMS Means and SDs (in parentheses) for Mindfulness (n = 11) and Video (n = 11) Groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Post – Pre Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMS Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mindfulness</td>
<td>23.73 (6.57)</td>
<td>33.36 (8.62)</td>
<td>9.63</td>
</tr>
<tr>
<td>Video</td>
<td>22.64 (7.57)</td>
<td>22.46 (8.07)</td>
<td>-0.18</td>
</tr>
<tr>
<td>TMS Curiosity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mindfulness</td>
<td>12.18 (4.62)</td>
<td>15.00 (4.73)</td>
<td>2.82</td>
</tr>
<tr>
<td>Video</td>
<td>11.36 (4.65)</td>
<td>10.27 (4.15)</td>
<td>-1.09</td>
</tr>
<tr>
<td>TMS Decentering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mindfulness</td>
<td>11.55 (4.08)</td>
<td>18.36 (5.20)</td>
<td>6.81</td>
</tr>
<tr>
<td>Video</td>
<td>11.27 (3.88)</td>
<td>13.09 (5.19)</td>
<td>1.82</td>
</tr>
</tbody>
</table>

*Note:* TMS = Toronto Mindfulness Scale

**Hypothesis 2 – ORS.** To test for possible differences between Mindfulness Group participants and Video Group participants in their clients’ perceived therapeutic outcome, a two-way (2 (pre-post) x 2 (treatment group)) repeated measures ANOVA was computed with the ORS total score as the within-subjects factors. Means and standard deviations are found in Table 2. Mauchly’s test indicated the assumption of sphericity had not been violated. Results showed a significant increase in ORS scores for the post-test condition ($F(1, 38) = 37.77, p < .001, \eta^2_p = .50$). No significant treatment group effect was obtained ($F(1, 38) = .55, p < .46, \eta^2_p = .01$). However, results showed a significant difference between groups across sessions on ORS scores.
Mindfulness Training

(F(1, 38) = 7.09, p < .01, η²₀ = .16), with the Video Group showing greater gains than the Mindfulness Group in the post-test condition.

ORS subscales of Individually, Interpersonally, Socially, and Overall were examined to test for possible differences in their relative impact on the significant difference between treatment groups in the pre- versus post-intervention ORS total scores. Accordingly, four additional two-way repeated measures ANOVAs were computed using the ORS subscores Individually, Interpersonally, Socially, and Overall. Means and standard deviations are found in Table 2. Mauchly’s test indicated the assumption of sphericity had not been violated with each of the four analyses. Results showed a significant increase in Individually scores for the post-test condition (F(1, 38) = 32.05, p < .001, η²₀ = .46). No significant treatment group effect was obtained (F(1, 38) = .04, p < .85, η²₀ = .001). However, results showed a significant difference between treatment groups across sessions on Individually scores (F(1, 38) = 7.74, p < .01, η²₀ = .17), with the Video Group showing greater gains than the Mindfulness Group in the post-test condition. Similarly, results showed a significant increase in Interpersonally scores for the post-test condition (F(1, 38) = 11.96, p < .001, η²₀ = .24). No significant treatment group effect was obtained (F(1, 38) = .20, p < .66, η²₀ = .01). Results showed a significant difference between treatment groups across sessions on Interpersonally scores (F(1, 38) = 4.14, p < .05, η²₀ = .10), with the Video Group again showing greater gains than the Mindfulness Group in the post-test condition. Results showed a significant increase in Socially scores for the post-test condition (F(1, 38) = 24.22, p < .001, η²₀ = .39). No significant treatment group effect was obtained (F(1, 38) = .77, p < .39, η²₀ = .02). However, results showed no significant difference between treatment groups across sessions on Socially scores (F(1, 38) = 2.84, p < .10, η²₀ = .07). Results
showed a significant increase in Overall scores for the post-test condition \((F(1, 38) = 34.12, p < .001, \eta^2_p = .47)\). No significant treatment group effect was obtained \((F(1, 38) = .87, p < .36, \eta^2_p = .02)\). Results showed no differential performance between treatment groups from pre- to post-test sessions on Overall scores \((F(1, 38) = 2.36, p < .13, \eta^2_p = .06)\). Therefore, contrary to Hypothesis 2, ORS results showed that both treatment groups obtained positive therapeutic outcomes, with the Video Group’s clients often perceiving more positive change, particularly in the Individually and Interpersonally domains of the ORS.

### Table 2

<table>
<thead>
<tr>
<th>ORS Means and SDs (in parentheses) for Mindfulness (n = 19) and Video (n = 21) Groups</th>
<th>Group</th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Post – Pre Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORS Total</td>
<td>Mindfulness</td>
<td>30.36 (5.72)</td>
<td>33.06 (5.69)</td>
<td>2.70</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>29.32 (5.29)</td>
<td>36.14 (2.73)</td>
<td>6.82</td>
</tr>
<tr>
<td>ORS Individually</td>
<td>Mindfulness</td>
<td>7.85 (1.08)</td>
<td>8.42 (1.24)</td>
<td>0.57</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>7.36 (1.45)</td>
<td>9.02 (0.72)</td>
<td>1.66</td>
</tr>
<tr>
<td>ORS Interpersonally</td>
<td>Mindfulness</td>
<td>7.56 (2.09)</td>
<td>8.00 (2.50)</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>7.16 (1.68)</td>
<td>8.85 (1.04)</td>
<td>1.69</td>
</tr>
<tr>
<td>ORS Socially</td>
<td>Mindfulness</td>
<td>7.26 (1.91)</td>
<td>8.20 (1.37)</td>
<td>0.94</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>7.13 (2.10)</td>
<td>9.06 (0.79)</td>
<td>1.93</td>
</tr>
<tr>
<td>ORS Overall</td>
<td>Mindfulness</td>
<td>7.71 (1.38)</td>
<td>8.55 (1.24)</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>7.72 (1.43)</td>
<td>9.16 (0.68)</td>
<td>1.44</td>
</tr>
</tbody>
</table>

*Note:* ORS = Outcome Rating Scale
Hypothesis 3 – SRS. To test for possible differences between Mindfulness Group participants and Video Group participants in their clients’ perceived therapeutic alliance, a two-way (10 (sessions) x 2 (treatment group)) repeated measures ANOVA was computed using the SRS total session scores. Means and standard deviations are found in Table 3. Mauchly’s test indicated the assumption of sphericity had been violated, so degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity. Results showed a significant difference across sessions on SRS scores ($F(4.02, 132.59) = 15.72, p < .001, \eta^2_p = .32$). No significant treatment group effect was obtained ($F(1, 33) = .02, p < .90, \eta^2_p = .00$). Results showed no significant difference between treatment groups in SRS scores across sessions ($F(4.02, 132.59) = 1.91, p < .11, \eta^2_p = .06$). Figure 1 shows the pattern of SRS scores over sessions for both groups; SRS scores appear to increase as sessions progress, with the greatest improvements observed in the first few sessions. With respect to Hypothesis 3, contrary to the hypothesis, both groups showed similar overall amounts of improvement in their ability to form therapeutic alliances as perceived by their clients.

Hypothesis 4 – TPS-C. To test for possible differences between the Mindfulness and Video Groups in their clients’ perception of therapeutic presence, a two-way (10 (sessions) x 2 (treatment group)) repeated measures ANOVA was computed using TPS-C total scores. Means and standard deviations are found in Table 4. Mauchly’s test indicated the assumption of sphericity had been violated, so degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity. Results showed a significant difference across sessions ($F(3.62, 108.66) = 5.79, p < .001, \eta^2_p = .16$). No significant treatment group effect was obtained ($F(1, 30) = .16, p < .69, \eta^2_p = .01$). Results showed no significant difference between treatment groups across
Table 3

*SRS Means and SDs (in parentheses) for Mindfulness (n = 16) and Video (n = 19) Groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean (SD)</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRS Total Session 1</td>
<td>Mindfulness</td>
<td>34.36 (3.99)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>36.04 (2.93)</td>
</tr>
<tr>
<td>SRS Total Session 2</td>
<td>Mindfulness</td>
<td>36.96 (2.33)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>35.72 (4.87)</td>
</tr>
<tr>
<td>SRS Total Session 3</td>
<td>Mindfulness</td>
<td>36.70 (3.14)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.60 (2.44)</td>
</tr>
<tr>
<td>SRS Total Session 4</td>
<td>Mindfulness</td>
<td>37.93 (2.37)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.97 (2.31)</td>
</tr>
<tr>
<td>SRS Total Session 5</td>
<td>Mindfulness</td>
<td>38.24 (1.92)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.14 (2.15)</td>
</tr>
<tr>
<td>SRS Total Session 6</td>
<td>Mindfulness</td>
<td>37.73 (3.08)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.07 (2.34)</td>
</tr>
<tr>
<td>SRS Total Session 7</td>
<td>Mindfulness</td>
<td>38.54 (1.56)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.27 (2.45)</td>
</tr>
<tr>
<td>SRS Total Session 8</td>
<td>Mindfulness</td>
<td>38.68 (1.42)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.23 (2.54)</td>
</tr>
<tr>
<td>SRS Total Session 9</td>
<td>Mindfulness</td>
<td>38.51 (1.77)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.43 (1.98)</td>
</tr>
<tr>
<td>SRS Total Session 10</td>
<td>Mindfulness</td>
<td>38.64 (1.68)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.73 (1.87)</td>
</tr>
</tbody>
</table>

*Note: SRS = Session Rating Scale*
Figure 1. SRS Scores for Mindfulness and Video Groups over 10 Therapy Sessions

Figure 2 shows the pattern of TPS-C scores over sessions for both groups; TPS-C scores appear to generally increase for the first few sessions, remain relatively static for a few sessions, and then continue their slow rise. Contrary to expectation but similar to the SRS findings, both groups showed similar amounts of improvement in their ability to form therapeutic presence as perceived by their clients.

Hypothesis 5 – TPS-T. To test for possible differences between the Mindfulness and Video Group participants in their perception of their own therapeutic presence, a two-way (10 (sessions) x 2 (treatment group)) repeated measures ANOVA was computed using the TPS-T total score across sessions. Means and standard deviations are found in Table 5. Mauchly’s test indicated the assumption of sphericity had been violated, so degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity. Results showed a significant increase across
Table 4

*TPS-C Means and SDs (in parentheses) for Mindfulness (n = 15) and Video (n = 17) Groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean (SD)</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPS-C Total Session 1</td>
<td>Mindfulness</td>
<td>36.75 (3.17)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>36.93 (2.71)</td>
</tr>
<tr>
<td>TPS-C Total Session 2</td>
<td>Mindfulness</td>
<td>37.21 (2.44)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>36.76 (4.93)</td>
</tr>
<tr>
<td>TPS-C Total Session 3</td>
<td>Mindfulness</td>
<td>37.51 (2.55)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.14 (3.22)</td>
</tr>
<tr>
<td>TPS-C Total Session 4</td>
<td>Mindfulness</td>
<td>38.06 (2.30)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.85 (2.57)</td>
</tr>
<tr>
<td>TPS-C Total Session 5</td>
<td>Mindfulness</td>
<td>38.55 (1.64)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.97 (2.94)</td>
</tr>
<tr>
<td>TPS-C Total Session 6</td>
<td>Mindfulness</td>
<td>38.33 (1.97)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.92 (2.23)</td>
</tr>
<tr>
<td>TPS-C Total Session 7</td>
<td>Mindfulness</td>
<td>38.35 (2.04)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.09 (2.52)</td>
</tr>
<tr>
<td>TPS-C Total Session 8</td>
<td>Mindfulness</td>
<td>38.58 (1.62)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.31 (2.21)</td>
</tr>
<tr>
<td>TPS-C Total Session 9</td>
<td>Mindfulness</td>
<td>38.62 (1.74)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>38.39 (2.28)</td>
</tr>
</tbody>
</table>

Note: TPS-C = Therapeutic Presence Scale - Client
sessions on TPS-T scores ($F(5.46, 169.11) = 9.27, p < .001, \eta^2_p = .23$). Again, no significant treatment group effect was obtained ($F(1, 31) = .2.33, p < .14, \eta^2_p = .07$). Results also again showed no significant difference between treatment groups in TPS-T scores across sessions ($F(5.46, 169.11) = 1.36, p < .24, \eta^2_p = .04$). Figure 3 shows the pattern of TPS-T scores over sessions for both groups; TPS-T scores show a trend of increasing scores as sessions progress, though the gains are non-linear. Both groups showed similar amounts of improvement in their ability to form therapeutic presence as perceived by themselves.
### Table 5

**TPS-T Means and SDs (in parentheses) for Mindfulness (n = 16) and Video (n = 17) Groups**

<table>
<thead>
<tr>
<th>TPS-T Total Session 1</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>33.12 (4.47)</td>
<td>4.04</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>28.46 (8.72)</td>
<td>9.45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 2</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>32.49 (6.35)</td>
<td>4.67</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>31.72 (5.85)</td>
<td>6.19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 3</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>35.36 (3.73)</td>
<td>1.8</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>33.15 (5.77)</td>
<td>4.76</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 4</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>35.75 (3.73)</td>
<td>1.41</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>32.54 (6.50)</td>
<td>5.37</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 5</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>36.81 (3.49)</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>35.07 (4.46)</td>
<td>2.84</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 6</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>36.83 (3.28)</td>
<td>0.33</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>35.09 (4.97)</td>
<td>2.82</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 7</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>37.01 (2.44)</td>
<td>0.15</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>34.62 (4.90)</td>
<td>3.29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 8</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>34.32 (5.80)</td>
<td>2.84</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>34.52 (5.01)</td>
<td>3.39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 9</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>37.46 (1.71)</td>
<td>- 0.30</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>35.52 (6.37)</td>
<td>2.39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TPS-T Total Session 10</th>
<th>Group</th>
<th>Mean</th>
<th>Difference from Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mindfulness</td>
<td>37.16 (2.60)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>37.91 (2.65)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: TPS-T = Therapeutic Presence Scale - Therapist*
Hypothesis 6 – Supervisor Questionnaire. To test for possible differences between Mindfulness and Video Group participants in their teacher’s assistants’ perception of their competency, a two-way (2 (pre-post) x 2 (treatment group)) repeated measures ANOVA was computed using the Supervisor Questionnaire total score as the dependent variable. Means and standard deviations are found in Table 6. Mauchly’s test indicated the assumption of sphericity had not been violated. Results showed a significant increase in Supervisor Questionnaire scores for the post-test condition ($F(1, 20) = 12.57, p < .01, \eta^2_p = .39$). No significant treatment group effect was obtained ($F(1, 20) = .19, p < .67, \eta^2_p = .01$). Results showed no significant difference between treatment groups with pre- versus post-intervention Supervisor Questionnaire scores.
(\(F(1, 20) = 0.00, p < 1.00, \eta^2_p = .00\)). Therefore, contrary to Hypothesis 6, both groups showed similar improvement in their clinical competency as perceived by their student supervisors.

Table 6

<table>
<thead>
<tr>
<th>Supervisor Questionnaire Means and SDs (in parentheses) for Mindfulness (n = 11) and Video (n = 11) Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Mindfulness</td>
</tr>
<tr>
<td>Video</td>
</tr>
</tbody>
</table>

**Hypothesis 7 – Student Questionnaire.** To test for possible differences between Mindfulness and Video Group participants in their perception of their respective trainings’ benefits to their clinical competency, a one-way (1 (total score) x 2 (treatment group)) ANOVA was computed using the Student Questionnaire total score as the dependent variable. Means and standard deviations are found in Table 7. Mauchly’s test indicated the assumption of sphericity had not been violated. Levene’s test indicated the assumption of equality of variances had not been violated. Results showed the Mindfulness Group rated the benefits of their training significantly greater than the Video Group rated the benefits of their training (\(F(1, 20) = 5.24, p < .03\)).

Student Questionnaire subscales of Self-Reflection, Relationships, Affect, Intervention, and Self-Care were examined to test for possible differences in their relative impact on the significant difference between treatment groups. Accordingly, a one-way (5 (sub-scores) x 2
(treatment group)) ANOVA was computed using the Student Questionnaire sub-scores Self-Reflection, Relationships, Affect, Intervention, and Self-Care as the dependent variables. Means and standard deviations are found in Table 7. Levene’s test indicated the assumption of equality of variances had not been violated. Results showed the Mindfulness Group rated the benefits of their training significantly greater than the Video Group rated the benefits of their training on Self-Reflection ($F(1, 20) = 7.22, p < .01$) and Self-Care ($F(1, 20) = 19.41, p < .001$). Results showed no significant differences between perceived benefits on Relationship ($F(1, 20) = .69, p < .42$), Affect ($F(1, 20) = .17, p < .68$), or Intervention ($F(1, 20) = 1.15, p < .30$). Therefore, compared to the Video Group, the Mindfulness Group perceived their training as more beneficial to their clinical training, particularly in the competency domains of Self-reflection and Self-care.

Upon analyzing the data for the major hypotheses, questions arose as to whether different types of students might have more effectively incorporated the Mindfulness and Video trainings than others. Accordingly, Supplemental Analyses 1 through 3, reported below, were conducted to explore the relative impact of various independent variables upon dependent variables from the major hypotheses.

**Supplemental Analysis 1.** The question arose as to whether students at a more advanced stage of training might more effectively incorporate the mindfulness training content. During the fall semester before conducting the current experiment, the investigator was a teacher’s assistant for a second-year doctoral student Cognitive Behavioral Psychotherapy course. The professor of this course asked the investigator to guest lecture one three-hour class, introducing mindfulness and third-wave Cognitive Behavioral Psychotherapy. The investigator administered the TMS at the beginning of this class with the same modified directions the current study utilized. The
Table 7

Student Questionnaire Means and SDs (in parentheses) for Mindfulness (n = 11) and Video (n = 11) Groups

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Questionnaire Total</td>
<td>Mindfulness</td>
<td>16.91 (4.28)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>12.91 (3.91)</td>
</tr>
<tr>
<td>Student Questionnaire Reflection</td>
<td>Mindfulness</td>
<td>3.55 (1.13)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>2.36 (0.92)</td>
</tr>
<tr>
<td>Student Questionnaire Relationship</td>
<td>Mindfulness</td>
<td>3.27 (1.01)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>2.91 (1.04)</td>
</tr>
<tr>
<td>Student Questionnaire Affect</td>
<td>Mindfulness</td>
<td>3.27 (0.90)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>3.09 (1.14)</td>
</tr>
<tr>
<td>Student Questionnaire Intervention</td>
<td>Mindfulness</td>
<td>3.27 (1.10)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>2.82 (0.87)</td>
</tr>
<tr>
<td>Student Questionnaire Self-Care</td>
<td>Mindfulness</td>
<td>3.46 (0.82)</td>
</tr>
<tr>
<td></td>
<td>Video</td>
<td>1.73 (1.01)</td>
</tr>
</tbody>
</table>

investigator then lectured on mindfulness concepts and theory, incorporating mindfulness experiential exercises during the lecture. At the end of the lecture, the investigator informed the students he was planning to conduct future research related to mindfulness and provided them with the voluntary, anonymous opportunity to complete a post-class TMS for exploratory purposes. The investigator then, once again, administered the TMS utilizing the same modified directions of the current study. As previously indicated, 17 students voluntarily completed pre-
and post-class measures, and a stability coefficient for the measure was found to be .66. Pre-class mean was 27.29 (7.47), and post-class mean was 32.71 (5.63).

To test for possible differences between Mindfulness Group participants and CBT Class participants in their perceived ability to enter into a mindfulness state, three two-way (2 (pre-post) x 2 (treatment group)) repeated measures ANOVAs were computed with the TMS total scores, TMS sub-score Curiosity, and TMS sub-score Decentering as the within-subjects factors. Means and standard deviations are found in Table 8 along with, for comparison purposes, the Curiosity and Decentering means and standard deviations for the TMS validation sample who completed an eight-week manualized MBSR program (Lau et al., 2006). Mauchly’s test indicated the assumption of sphericity had not been violated for all three analyses. Results showed a significant increase in TMS total scores for the post-test condition ($F(1, 26) = 24.63, p < .001, \eta^2_p = .49$). Results showed no significant treatment group effect was obtained ($F(1, 26) = .41, p < .53, \eta^2_p = .02$). Results showed no significant difference between treatment groups with the pre- versus post-intervention TMS scores ($F(1, 26) = 1.94, p < .18, \eta^2_p = .07$). Similarly, results showed a significant increase in TMS Curiosity sub-scores for the post-test condition ($F(1, 26) = 6.32, p < .02, \eta^2_p = .20$), but, again, no significant treatment group effect was obtained ($F(1, 26) = .49, p < .49, \eta^2_p = .02$). TMS Curiosity results also showed no significant difference between groups in the pre- versus post-intervention TMS Curiosity sub-scores ($F(1, 26) = .29, p < .60, \eta^2_p = .01$). With respect to Decentering performance, results showed a significant increase in TMS Decentering sub-scores for the post-test condition ($F(1, 26) = 42.31, p < .001, \eta^2_p = .62$). Results showed no significant treatment group effect was obtained ($F(1, 26) = .27, p < .61, \eta^2_p = .01$), nor was there a significant interaction effect between groups and pre-
versus post-intervention conditions ($F(1, 26) = 2.44, p < .13, \eta^2_p = .09$). Taken overall, the CBT class and the Mindfulness Group showed comparable gains in their ability to enter a state of mindfulness as measured by the TMS. These gains seemed similar in magnitude to those of the TMS’s validation sample, though the TMS validation sample’s mean pre-intervention scores were more than a standard deviation higher than those of the Mindfulness Group or CBT class.

Table 8

*TMS Means and SDs (in parentheses) for Mindfulness Group (n = 11), CBT Class (n = 17), and MBSR Patients (n = 99)*

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
<th>Pre-Treatment</th>
<th>Post-Treatment</th>
<th>Post – Pre Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TMS Total</strong></td>
<td>Mindfulness</td>
<td>23.73 (6.57)</td>
<td>33.36 (8.62)</td>
<td>9.63</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>27.29 (7.47)</td>
<td>32.71 (5.63)</td>
<td>5.42</td>
</tr>
<tr>
<td><strong>TMS Curiosity</strong></td>
<td>Mindfulness</td>
<td>12.18 (4.62)</td>
<td>15.00 (4.73)</td>
<td>2.82</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>13.77 (5.36)</td>
<td>15.59 (3.79)</td>
<td>1.82</td>
</tr>
<tr>
<td></td>
<td>MBSR</td>
<td>19.46 (9.74)</td>
<td>23.37 (8.88)</td>
<td>3.91</td>
</tr>
<tr>
<td><strong>TMS Decentering</strong></td>
<td>Mindfulness</td>
<td>11.55 (4.08)</td>
<td>18.36 (5.20)</td>
<td>6.81</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>13.53 (3.79)</td>
<td>17.71 (3.14)</td>
<td>4.18</td>
</tr>
<tr>
<td></td>
<td>MBSR</td>
<td>19.15 (8.41)</td>
<td>24.01 (7.91)</td>
<td>4.86</td>
</tr>
</tbody>
</table>

*Note: TMS = Toronto Mindfulness Scale*
Supplemental Analysis 2. To further examine the question of whether students at a more advanced stage of training might more effectively incorporate the mindfulness training content, students in the first year cohort with and without a master’s degree in psychology were evaluated. Multiple three-way (2 (pre-post) x 2 (previous masters) x 2 (treatment group)) repeated measures ANOVAs were computed using TMS, ORS, SRS, TPS-C, and TPS-T total scores. Of the five analyses, only the TPS-C ANOVA produced a significant finding between students with and without psychology master’s degrees. Means and standard deviations of the TPS-C are found in Table 9. Mauchly’s test indicated the assumption of sphericity had not been violated. Results showed a significant increase in TPS-C scores for the post-test condition ($F(1, 30) = 18.39, p < .001, \eta^2_p = .38$). No significant treatment group effect was obtained, but a significant previous master’s effect was obtained ($F(1, 30) = 5.80, p < .02, \eta^2_p = .16$) with the non-master’s obtaining higher scores. Results showed no significant interaction effects. Therefore, students without previous master’s degrees in psychology were generally perceived by their clients as having greater therapeutic presence.

Supplemental Analysis 3. The question arose as to whether students at higher levels of clinical competency might more effectively incorporate the training content. Accordingly, a cutoff score of 15 on the Supervisor Questionnaire was used to demarcate those students about whom the teacher’s assistants had clinical concerns (scores of 15 or below) and those about whom they did not have clinical concerns (scores above 15). To test for possible differences between students with and without clinical concerns in both the Mindfulness and Video groups, multiple three-way (2 (pre-post) x 2 (clinical concerns) x 2 (treatment group)) repeated measures ANOVAs were computed using TMS, ORS, SRS, TPS-C, and TPS-T total scores. Of the five
Table 9

<table>
<thead>
<tr>
<th>Previous Masters</th>
<th>Mindfulness Mean (SD)</th>
<th>Video Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPS-C Total Session 1</td>
<td>No</td>
<td>37.42 (2.52)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>34.70 (5.11)</td>
</tr>
<tr>
<td>TPS-C Total Session 10</td>
<td>No</td>
<td>39.12 (0.98)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>36.87 (3.17)</td>
</tr>
</tbody>
</table>

Note: TPS-C = Therapeutic Presence Scale – Client

analyses, only the TPS-C ANOVA produced a significant finding between students with and without clinical concerns. Means and standard deviations of the TPS-C are found in Table 10. Mauchly’s test indicated the assumption of sphericity had not been violated. Results showed a significant increase in TPS-C scores for the post-test condition ($F(1, 29) = 27.89, p < .001, \eta^2_p = .49$). No significant treatment group effect was obtained, but a significant clinical concern effect was ($F(1, 29) = 5.06, p < .03, \eta^2_p = .15$) with the non-clinical concern group obtaining higher scores. There were no significant interaction effects. Therefore, students without clinical concerns were generally perceived by their clients as having greater therapeutic presence.

**Supplemental Analysis 4.** This research served as the initial validation study of the TPS-C and the TPS-T. Accordingly, reliability statistics are reported in Table 11 and correlations with
Table 10

**TPS-C Means and SDs (in parentheses) for Mindfulness Group Without Clinical Concerns (n = 10) and With Clinical Concerns (n = 5) and Video Group Without Clinical Concerns (n = 11) and With Clinical Concerns (n = 7)**

<table>
<thead>
<tr>
<th>Clinical Concerns</th>
<th>Mindfulness Mean (SD)</th>
<th>Video Mean (SD)</th>
</tr>
</thead>
</table>
| TPS-C Total Session 1 | No 38.06 (1.45) 37.32 (2.69)  
            | Yes 34.46 (4.58) 36.53 (2.74)  |
| TPS-C Total Session 10 | No 39.46 (0.52) 38.64 (2.18)  
            | Yes 37.18 (2.46) 38.07 (2.39)  |

*Note:* TPS-C = Therapeutic Presence Scale – Client

Table 11

**TPS-C, TPS-T, and SRS Internal Consistency, Test-Retest Reliability and Means and SDs of First Year Doctoral Students (n = 23)**

<table>
<thead>
<tr>
<th></th>
<th>Internal Consistency*</th>
<th>Test-Retest Reliability**</th>
<th>Mean (SD) Session 1</th>
<th>Mean (SD) Session 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPS-C</td>
<td>.99</td>
<td>.76</td>
<td>37.01 (2.83)</td>
<td>37.19 (3.49)</td>
</tr>
<tr>
<td>TPS-T</td>
<td>.95</td>
<td>.55</td>
<td>30.96 (7.10)</td>
<td>32.37 (5.43)</td>
</tr>
<tr>
<td>SRS</td>
<td>.97</td>
<td>.31</td>
<td>35.62 (3.43)</td>
<td>36.43 (3.75)</td>
</tr>
</tbody>
</table>

*Note:* TPS-C = Therapeutic Presence Scale – Client; TPS-T = Therapeutic Presence Scale – Therapist; SRS = Session Rating Scale

* Calculated sessions 1 – 10.
** Calculated sessions 1 & 2.
the SRS and ORS, reflecting concurrent and discriminant validity, are reported in Table 12. Similar to the SRS, the TPS-C and TPS-T were found to have high internal consistency, .99 and .95 respectively. Measured at Session 1 and Session 2 one week later, the TPS-C and TPS-T demonstrated test-retest reliability, .76 and .55 respectively, that were actually stronger than the SRS’s in this sample (.31). However, Duncan et al. (2003) found the SRS to have a stability coefficient of .64, which is more favorable and comparable to the TPS-C and TPS-T in this study’s sample.

In the current study, the ORS was administered pre- and post-treatment, so Table 12 shows correlations between the ORS, SRS, TPS-C, and TPS-T at Session 1 and Session 10. In the current study, the SRS, TPS-C, and TPS-T Session 1 and Session 10 scores were not significantly related to the ORS at either Session 1 or Session 10. This finding differs from Campbell and Hemsley’s (2009) and Duncan et al.’s (2003) finding that SRS scores tend to be significantly, though weakly, correlated with treatment outcomes ($r$’s = .27 – .36). Table 12 shows the TPS-C and SRS were significantly related, though less at Session 1 than Session 10. At Session 1, the TPS-T was not significantly related to the TPS-C or SRS, but at Session 10, it was significantly related to both the TPS-C and SRS. In other words, it appears that therapists-in-training initially perceived their therapeutic abilities more negatively than their patients did; over time, client and therapist perceptions became more similar. Like the SRS, which tends to be negatively skewed (Miller & Duncan, 2000a), the TPS-C and TPS-T were also found to be negatively skewed in this study. Overall, the TPS-C and TPS-T were found to have acceptable reliability and to measure something distinct from yet related to therapeutic alliance as measured by the SRS, warranting future research and use of these measures.
Table 12

<table>
<thead>
<tr>
<th></th>
<th>TPS-C Session 1</th>
<th>TPS-T Session 1</th>
<th>SRS Session 1</th>
<th>ORS Session 1</th>
<th>TPS-C Session 10</th>
<th>TPS-T Session 10</th>
<th>SRS Session 10</th>
<th>ORS Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPS-T Session 1</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRS Session 1</td>
<td>.57*</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS Session 1</td>
<td>.08</td>
<td>-.17</td>
<td>.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPS-C Session 10</td>
<td>.80*</td>
<td>.16</td>
<td>.44*</td>
<td>.06</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TPS-T Session 10</td>
<td>.47*</td>
<td>.19</td>
<td>.12</td>
<td>.23</td>
<td>.53*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRS Session 10</td>
<td>.85*</td>
<td>.16</td>
<td>.46</td>
<td>.06</td>
<td>.94*</td>
<td>.48*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORS Session 10</td>
<td>.01</td>
<td>-.12</td>
<td>-.02</td>
<td>.46*</td>
<td>.19</td>
<td>.19</td>
<td>.21</td>
<td></td>
</tr>
</tbody>
</table>

Note: TPS-C = Therapeutic Presence Scale – Client; TPS-T = Therapeutic Presence Scale – Therapist; SRS = Session Rating Scale; ORS = Outcome Rating Scale

* p ≤ 0.01(2-tailed).
Chapter 4

Discussion

Research has shown the benefits of mindfulness are extensive, positively impacting cognitive, emotional, physical, spiritual, and interpersonal domains (Brown et al., 2007; Carmody et al., 2008; Davis, & Hayes, 2011). However, this study found the benefits of mindfulness to clinicians in training to be less impactful. Compared to students who participated in a traditional form of clinical training, those students engaged in mindfulness training showed significant improvement in their self-perceived ability to enter a mindful state with particular development in the attentional aspects of mindfulness. However, in contrast to the hypotheses of this study, these gains did not translate into more positively perceived therapy outcomes, therapeutic alliance, or therapeutic presence. Rather, students engaged in mindfulness training obtained significantly less positive client-perceived therapy outcomes than their video counterparts. No meaningful difference between the two groups emerged in how their clients perceived the quality of therapeutic alliance or level of therapist therapeutic presence; both groups showed similar gains across 10 sessions of pseudotherapy. Neither did the student clinicians of the two groups show a difference in perceived improved therapeutic presence across the 10 sessions. In addition, supervisors of the clinicians in training perceived similar competency development for students of both groups. However, students in the mindfulness training did perceive the training as more beneficial to their own self-care and self-reflection than students in the non-mindfulness training.
Both the Mindfulness and Video Groups in this study achieved similar gains in therapeutic alliance, therapeutic presence, and supervisor-rated therapeutic competencies across 10 pseudotherapy sessions, suggesting mindfulness may not be a “silver bullet” for clinical training, but it may be about as effective as a traditional method of clinical training. These results generally align with Stanley, et al. (2006) and Ryan, et al.’s (2012) research that found clinician mindfulness did not, for the most part, positively impact therapeutic outcomes. In contrast, Grepmaier et al. (2007) found clinicians in training who practiced mindfulness had better therapeutic outcomes compared to clinicians not practicing mindfulness.

An important distinction between Grepmaier et al.’s (2007) findings and the results of this research is that Grepmaier et al. used a waiting list control group, but this research used an active control engaged in a video training. Because this study did not also utilize a passive control due to the small sample size available, it is impossible to say if the therapeutic results were due to these trainings or if they were the result of other training that students were receiving. Also notable, the participants in Grepmaier et al.’s (2007) study significantly diverged from the current study’s; whereas the therapists in training in this study were learning person-centered psychotherapy through work with pseudoclients who were screened out for significant psychopathology, the therapists in training in Grepmaier et al.’s (2007) study were learning “depth-psychology based psychotherapy” in an inpatient “psychosomatic hospital” (p. 333).

It is interesting that Grepmaier et al.’s (2007) positive findings occurred with depth-oriented therapists in training, for, while mindfulness has most ardently been incorporated into intervention strategies in third wave cognitive behavioral therapies (Hayes, 2004), this study showed support for contemporary psychodynamic conceptualizations of the benefits of
Mindfulness training for clinicians (Safran & Reading, 2008). The results indicate mindfulness training may, compared to traditional methods of training, foster greater improvement in student therapists’ ability to enter a mindful state, which students may find beneficial to their self-care and self-reflective practices. These self-perceived benefits to trainees’ self-reflective capacities may increase trainees’ awareness of countertransference responses, which is requisite for working through relationally viewed co-constructed enactments and engaging in meta-communication informed by self-awareness (Safran & Reading, 2008). In any case, self-reflection and self-care are foundational competencies (Rodolfa et al., 2005; Sommers-Flanagan & Sommers-Flanagan, 2009), and early training that increases trainees’ competency in these domains may have worthwhile benefits whatever therapeutic modality trainees eventually adopt. It should be noted that the self-perceived benefits of mindfulness on trainees’ self-care and self-reflection not only align with previous research (Christopher & Maris, 2010; Schure, Christopher, & Christopher, 2008), but also reflect historically held views of mindfulness.

Supplemental analyses were conducted to look more closely at factors which may have influenced outcome, specifically the impact of prior training in psychology as well as the level of clinical competency perceived by supervisors. These analyses revealed no significant effect of having an additional semester’s training, a master’s degree, or a higher supervisor’s rating of clinical competency on one’s ability to enter a mindful state, therapeutic outcome, therapeutic alliance as perceived by clients, or therapeutic presence as perceived by therapists. However, counter to what might be expected, clients did perceive significantly higher levels of therapeutic presence in trainees without previous master’s degrees. Perhaps this was because, as a group, students with a master’s degree were less open to a phenomenological therapeutic modality that
values therapeutic presence. In line with expectation, clients also perceived significantly higher levels of therapeutic presence in trainees without clinical concerns expressed by their supervisors, suggesting the brief Supervisor Questionnaire had some utility in differentiating students who were more or less competent, which then translated into more or less therapeutic presence as perceived by their pseudoclients. These differences were not significantly different in the Mindfulness Group or the Video Group, so the current study is unable to support mindfulness as a preferred remedial training for students who struggle to establish therapeutic presence.

The results of this study support Carmody and Baer’s (2009) research indicating the length of mindfulness intervention may be unrelated to outcomes. Though the Mindfulness Group and the CBT class received different amounts and types of training related to mindfulness, approximately four hours (seven 30-minute trainings plus 10 minutes of mindfulness pre- and post-intervention) and approximately three hours (one three-hour lecture and experiential class) respectively, both groups showed similar gains in their ability to enter a mindful state pre- to post-intervention. Both the Mindfulness Group’s and the CBT class’s TMS scores were, on average, lower than the TMS validation sample in both their pre- and post-intervention scores, but both groups showed similar improvement pre- to post-intervention as the TMS validation sample. The fact that the trainees in this study on average scored lower on the TMS than the validation sample could be related to self-selection; participants in the validation sample self-enrolled in a MBSR program whereas the participants in this study were randomly assigned. The trainees’ lower scores in this study also suggest they have continued room for mindfulness development. Theoretically, the Mindfulness Group had greater opportunity to personally
incorporate the training across several weeks during which they treated pseudoclients, but, if those in the CBT class were able to utilize mindfulness content to enter a mindful state about as effectively as the Mindfulness Group, mindfulness might be conveniently taught in clinical trainings in a more condensed format than what occurred in this study. Conversely, it could also be that the mindfulness training was not robust enough to positively impact therapy outcomes, and more intensive training should be conducted to achieve therapeutic results. Trainees in Grempair et al.’s (2007) research participated in one hour of Zen meditation led by a Zen master at the beginning of each workday for nine weeks.

Carmody and Baer’s (2009) assessment about the insignificance of mindfulness intervention length is supported by this study and may well be true, but the TMS scores from this research also calls the validity of the TMS into question. It could be that mindfulness intervention length is irrelevant, but it could also be that the construct of mindfulness as measured by the TMS is suspect. For example, students in the Mindfulness Group rated themselves as being more capable of entering a state of mindfulness post-treatment than the Video Group, but the subjective nature of the TMS allows for the possibility that these students better understood mindfulness terminology but were not necessarily more adept at being mindful. Historically, mindfulness was considered a spiritual practice that required significant time and discipline to reap the full benefits. It would be going against thousands of years of religious understanding to state that a three-hour class in mindfulness is as effective as extended training and practice.

To better understand the ORS differences between the two groups, it is helpful to understand how this study’s sample compared to other samples involved in ORS research.
Miller, et al. (2003) reported a sample of 77 non-clinical cases consisting of graduate students, faculty, and staff at a community family services agency who were administered the ORS four times between 10 days to five weeks without any clinical intervention. This non-clinical sample had a pre-ORS mean of 27.9 ($SD = 6.8$) and a post-ORS mean of 29.4 (7.0) with a non-significant average change of 1.5. Miller, et al. (2003) also reported a sample of 435 clinical cases from this same clinic that received between three and ten session of psychotherapy. This clinical sample had a pre-ORS mean of 19.6 (8.7) and a post-ORS mean of 25.7 (8.7) with a highly significant average change of 6.1 ORS units. In comparison, the current study also consisted of a nonclinical sample that received therapeutic intervention, with the Mindfulness Group’s pseudoclients having a pre-treatment mean of 30.4 (5.7) and post-treatment mean of 33.1 (5.7) with an average gain of 2.7, and the Video Group’s pseudoclients having a pre-treatment mean of 29.3 (5.3) and a post-treatment mean of 36.1 (2.7) with an average gain of 6.8. The current study’s pseudoclients did demonstrate a significant pre- to post-intervention change, with significantly greater gains achieved by the Video Group (6.82) than the Mindfulness Group (2.7). In other words, both the Mindfulness and Video Groups’ pre-treatment mean scores were higher than Miller et al.’s (2003) non-clinical and clinical groups. However the Mindfulness Group’s magnitude of gain was more similar to that of a non-clinical sample, and the Video Group’s gain was more similar to a clinical sample, possibly limiting the weight given to the significant difference found between the Mindfulness Group’s and the Video Group’s pre- to post-treatment gains. Regarding the performance of the SRS in the study, both the Mindfulness Group and the Video Group’ SRS scores were, as expected, negatively skewed, aligning with
Miller and Duncan’s (2000a) indication that fewer than 24% of sessions score less than 36 out of 40 and fewer than 9% score less than 33.

Since this was the first study to utilize the TPS-C and the TPS-T as additional or alternative instruments to the SRS and ORS, the well-researched, ultra-brief, self-report measures of psychotherapy. The current study suggests the new TPS-C and TPS-T measures have promise since they generally performed as well as or better than the “standard-bearers” in the field in terms of internal consistency and test-retest reliability. The first session’s moderate correlation (.57) between the TPS-C and the SRS suggests the two measures are assessing somewhat discreet constructs that then tend to merge as treatment progresses because at session 10 the two measures were highly correlated (.94). The merging of scores over time is likely the result of the restriction of range and limited variability that similarly afflicted the TPS-C and SRS. The TPS-C and TPS-T were virtually unrelated at session one (.16) and moderately correlated at session 10 (.53), which is consistent with research that shows therapists’ and clients’ perceptions of therapy are usually quite different (Bachelor & Horvath, 1999). The TPS-C and TPS-T warrant future research, as they may be useful measures for clinical training and psychotherapy, representing alternative or additional perspectives to popular therapeutic alliance assessments such as the SRS.

This study faced some challenges that limit interpretation of the findings. The study’s small sample size limited the analyses’ statistical power, which was further restricted by missing data for several clients. The minimal diversity in regards to pseudoclient ethnicity, age, and educational experience limits the generalizability of this study to other client populations. The subjective nature of the clinical measures used in this study coupled with their restricted range of
score variability, may have contributed to the lack of significant differences in therapeutic alliance and therapeutic presence between the two treatment groups. In addition, the “pseudo” nature of the therapeutic relationships between first year doctoral students and volunteer undergraduate students limits the generalizability of this study in that most therapeutic work occurs within a therapeutic frame wherein clients expect treatment from a professional, not college credit from a graduate student. While Grepmair et al.’s (2007) research was with therapists in training, they were working in an inpatient psychiatric setting, a key distinction when comparing the modest findings of this research and the more robust findings of Grepmair et al. (2007). Another aspect of the study that limits generalizability is that all therapists in training were first year doctoral students learning person-centered psychotherapy; it may be that more advanced therapists or therapists engaging in a different psychotherapy approach may utilize mindfulness training more effectively. For example, the trainees in this study may have been so focused on basic therapeutic relationship skills such as passive and active listening that they were not able to assimilate the self-reflective benefits of mindfulness into their therapeutic approach.

Norcross (1995) attempted to “put the Dodo bird to a peaceful rest,” yet it lives on and may have flown its way into psychotherapy training. However, Norcross (1995) rightly cautioned clinicians to take a skeptical view of the dodo bird verdict, instead asking “Which psychotherapy works best for this patient?” (p. 502). A similar question may be appropriate for clinical training. This research demonstrated that mindfulness training was generally about as effective as a traditional method of clinical training, but future research could investigate if mindfulness training is more effective for some trainees than others. All students in this study
were first year doctoral students being trained in person-centered psychotherapy, but mindfulness training may impact students at different levels of training and engaged in various therapeutic modalities in differing ways. For example, it would be interesting to compare the effects of mindfulness training on first year doctoral students versus third year doctoral students versus licensed practitioners. Researchers might also compare the effects of mindfulness training on students and licensed practitioners who work from a cognitive behavioral vs. psychodynamic vs. emotion-focused orientation. The self-perceived gains in self-reflection in this study did not translate to improvements in therapeutic alliance, presence, or outcomes, but more advanced students or professionals, particularly those who frequently utilize countertransference, may find greater therapeutic value in clinician mindfulness. Another interesting line of research could be to explore potential sleeper effects of mindfulness-based clinical training using longitudinal designs; mindfulness skills that first year doctoral students did not initially perceive as being beneficial could potentially be later found quite valuable once additional training is received. Also, future research might benefit from examining “real” patients with psychopathology as opposed to the pseudoclients of this study since a “real” sample would be both more ecologically valid and might also have greater score variability.

Admittedly, self-report outcome data do not necessarily reflect the complex, idiosyncratic nature of psychotherapy, but future researchers who attempt to clarify the current murky picture of how clinician mindfulness impacts therapeutic relationships and outcomes might benefit from utilizing alternative clinical assessments, such as the Helping Alliance Questionnaire – II (HAq-II; Luborsky et al., 1996), the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillaspy, 2006), and the California Psychotherapy Alliance Scale (CALPAS; Gaston, 1991),
which are longer but may have greater research potential in finding true differences between mindfulness training and alternative training methods. Researchers examining clinical populations might find value in measuring goal attainment as well as symptom measurement tools, such as the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), or biological assessments, such as measuring cortisol to ascertain stress levels.
References


Mindfulness Training


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Mindfulness Training


Appendix A

Competencies
Mindfulness Training Competencies

Foundational Competencies

**Reflective Practice Self-Assessment** – Practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and a commitment to the development of the profession.

**Readiness for practicum**

A. Reflective Practice

1. Essential Component: willingness to consider one’s own material; basic mindfulness and self-awareness

2. Behavioral Anchor:
   - a. problem solving skills
   - b. critical thinking
   - c. organized reasoning
   - d. intellectual curiosity and flexibility
   - e. willingness/ability to self-disclose personal material

3. Assessment Method(s):
   - a. academic products, performance in seminars or other scholarly experiences (e.g., papers, proposals, contributions to discussions)
   - b. judgments made by faculty

4. Learning Objectives:
   - a. participants will experientially and cognitively understand mindfulness
   - b. participants will be able to enter a mindful state
   - c. participants will be able to identify their own cognitive and emotional processes

B. Self-Assessment and Self-Care

1. Essential Component: knowledge of core competencies; emerging self-assessment re: competencies; understanding of the importance of self-care in effective practice; knowledge of self-care mechanisms; attention to self-care

2. Behavioral Anchor:
   - a. demonstrates the interpersonal and intrapersonal willingness and ability to consider one’s own motives, attitudes, behaviors and one’s effect on others
   - b. basic awareness and attention to self-care
   - c. awareness of clinical competencies for professional training

3. Assessment Method(s)
   - a. performance prior to practicum (e.g., small group experiences, journaling, peer review, etc.)
   - b. faculty, peer, and self judgments (there should be a consideration given to consensual validation)

4. Learning Objectives:
   - a. participants will be able to practice mindfulness as a form of self-care
   - b. participants will be able to self-assess in a non-reactive way
Relationships - Capacity to relate effectively and meaningfully with individuals, groups, and/or communities

Readiness for practicum
A. Interpersonal Relationships
   1. Essential Component: interpersonal skills
   2. Behavioral Anchor:
      a. listens and is emphatic with others
      b. respects and shows interest in others’ cultures, experiences, values, points of view, goals and desires, fears, etc.
      c. demonstrates skills verbally and non-verbally
      d. open to feedback
   3. Assessment Method(s):
      a. performance and behavior in course(s) or evaluation milestones
      b. examination of performance in interviews faculty, peer and self judgment including showing engagement with peers
   4. Learning Objectives:
      a. participants will be able to establish therapeutic relationships grounded in empathy, acceptance, and authenticity

B. Affective Skills
   1. Essential Component: affective skills
   2. Behavioral Anchor:
      a. possesses affect tolerance
      b. tolerates and understands interpersonal conflict
      c. tolerates ambiguity and uncertainty
      d. possesses awareness of inner emotional experience
      e. possesses emotional maturity
   3. Assessment Method(s)
      a. faculty, peer, and self judgments (there should be a consideration given to consensual validation)
   4. Learning Objectives:
      a. participants will be aware and tolerant of their own affect
      b. participants will be aware and tolerant of their clients’ affect

Functional Competencies

Intervention - Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations

Readiness for practicum
A. Skills
   1. Essential Component: basic helping skills
   2. Behavioral Anchor:
a. demonstration of these skills, such as empathic listening, framing problems

3. Assessment Methods(s):
   a. simulations and/or role plays in courses and evaluation milestones
   b. self and peer evaluations

4. Learning Objectives:
   a. participants will be able to attune to their clients’ concerns
   b. participants will gain understanding about clinically effective mindfulness interventions
Appendix B

Modified Toronto Mindfulness Scale
### Toronto Mindfulness Scale

**Name:**

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I experienced myself as separate from my changing thoughts and feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I was more concerned with being open to my experiences than controlling or changing them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I was curious about what I might learn about myself by taking notice of how I react to certain thoughts, feelings or sensations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I experienced my thoughts more as events in my mind than as a necessarily accurate reflection of the way things ‘really’ are.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I was curious to see what my mind was up to from moment to moment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I was curious about each of the thoughts and feelings that I was having.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I was receptive to observing unpleasant thoughts and feelings without interfering with them.</td>
<td></td>
<td></td>
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<tr>
<td>8. I was more invested in just watching my experiences as they arose, than in figuring out what they could mean.</td>
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</tr>
<tr>
<td>9. I approached each experience by trying to accept it, no matter whether it was pleasant or unpleasant.</td>
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<tr>
<td>10. I remained curious about the nature of each experience as it arose.</td>
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</tr>
<tr>
<td>11. I was aware of my thoughts and feelings without overidentifying with them.</td>
<td></td>
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<tr>
<td>12. I was curious about my reactions to things.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13. I was curious about what I might learn about myself by just taking notice of what my attention gets drawn to.</td>
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<tr>
<td>14. I currently engage in mindfulness practices such as meditation, body scanning, yoga, tai chi, and qigong.</td>
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</tbody>
</table>

**Instructions:** We are interested in what you just experienced. Below is a list of things that people sometimes experience. Please read each statement. Next to each statement are five choices: “not at all,” “a little,” “moderately,” “quite a bit,” and “very much.” Please indicate the extent to which you agree with each statement. In other words, how well does the statement describe what you just experienced, just now?
Appendix C

Outcome Rating Scale
Mindfulness Training

Outcome Rating Scale (ORS)

Name: ___________________ Age (Yrs): ____ Sex: M / F
Session #: _____ Date: ____________
Who is filling out this form? Please check one: Self ________ Other _______
If other, what is your relationship to this person? ______________________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill it out according to how you think he or she is doing.

Individually
(Personal well-being)

[ ] [ ] [ ] [ ] [ ]

Interpersonally
(Family, close relationships)

[ ] [ ] [ ] [ ] [ ]

Socially
(Work, school, friendships)

[ ] [ ] [ ] [ ] [ ]

Overall
(General sense of well-being)

[ ] [ ] [ ] [ ] [ ]

Institute for the Study of Therapeutic Change

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Appendix D

Session Rating Scale
Mindfulness Training

Session Rating Scale (SRS V.3.0)

Name ________________________ Age (Yrs): __________
ID# __________________________ Sex: M / F
Session # ___ Date: __________________

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

Relationship

I did not feel heard, understood, and respected. I ________________________________

I felt heard, understood, and respected. I ________________________________

Goals and Topics

We did not work on or talk about what I wanted to work on and talk about. I ________________________________

We worked on and talked about what I wanted to work on and talk about. I ________________________________

Approach or Method

The therapist’s approach is not a good fit for me. I ________________________________

The therapist’s approach is a good fit for me. I ________________________________

Overall

There was something missing in the session today. I ________________________________

Overall, today’s session was right for me. I ________________________________

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Appendix E

Therapeutic Presence Scale – Client
Mindfulness Training

Therapeutic Presence Scale - Client

<table>
<thead>
<tr>
<th>Client Name/ID</th>
<th>Age (Yrs):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Name</td>
<td></td>
</tr>
<tr>
<td>Session #</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Please rate your experience of today’s session by placing a mark on the line nearest to the description that best fits your experience.

Attention

My therapist seemed bored, distracted, or uninterested.

My therapist seemed alert, attentive, and curious.

Attitude

My therapist seemed critical or judgmental.

My therapist seemed open and accepting.

Authenticity

My therapist seemed inauthentic or insincere.

My therapist seemed authentic and sincere.

Connection

My therapist seemed disconnected or out of sync with me.

My therapist seemed connected and in sync with me.
Appendix F

Therapeutic Presence Scale – Therapist
### Therapeutic Presence Scale - Therapist

<table>
<thead>
<tr>
<th>Therapist Name</th>
<th>Client Name/ID</th>
<th>Age (Yrs):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please rate your experience of today’s session by placing a mark on the line nearest to the description that best fits your experience.

#### Attention

- I felt bored, distracted, or uninterested.  
- I felt alert, attentive, and curious.

#### Attitude

- I felt critical or judgmental.  
- I felt open and accepting.

#### Authenticity

- I felt inauthentic or insincere.  
- I felt authentic and sincere.

#### Connection

- I felt disconnected or out of sync with my client.  
- I felt connected and in sync with my client.
Appendix G

Supervisor Questionnaire
**Supervisor Questionnaire**

Name: ____________________________  Date: ________________

**Supervisee Name:** __________________________

**Instructions:** Please reflect on the demonstrated competencies of the supervisee listed above and respond to the questions below by highlighting your response.

1. This supervisee demonstrated the reflective capacity to consider his/her own material (emotions, motives, attitudes, culture, values, etc.) as it related to his/her clinical work

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
   Not at all | A little | Moderately | Quite a bit | Very Much |

2. This supervisee demonstrated an ability to empathetically listen in his/her clinical work

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
   Not at all | A little | Moderately | Quite a bit | Very Much |

3. This supervisee demonstrated an ability to attend to affect in his/her clinical work

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
   Not at all | A little | Moderately | Quite a bit | Very Much |

4. This supervisee demonstrated an ability to utilize the therapeutic relationship in a helpful way

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
   Not at all | A little | Moderately | Quite a bit | Very Much |

5. This supervisee practiced self-care

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>
   Not at all | A little | Moderately | Quite a bit | Very Much |
Appendix H

Student Questionnaire
Student Questionnaire

Code: ____________________________ Date: ________________

Training (circle one): Mindfulness Video

**Instructions:** Please reflect on the training and respond to the questions below by circling your response

1. This training helped me develop the reflective capacity to consider my own material (emotions, motives, attitudes, culture, values, etc.) as it relates to my clinical work
   
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a: all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

2. This training helped me develop an ability to empathetically listen in my clinical work
   
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a: all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

3. This training helped me develop an ability to attend to affect in my clinical work
   
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a: all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

4. This training helped me develop an ability to utilize the therapeutic relationship in a helpful way
   
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a: all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

5. This training helped me practice self-care
   
<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a: all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

**Comments:** On the reverse side of this page, please provide any additional information about the training you feel would be important for us to know. We value your feedback!
Appendix I

Mindfulness Questionnaire
Mindfulness Questionnaire

**Code:** ________________________________  **Date:** __________________

**Instructions:** We are interested in your experience of these trainings. Please read each statement below and circle your response.

1. This week I practiced mindfulness

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1 – 2 days</td>
<td>3 – 4 days</td>
<td>5 – 6 days</td>
<td>Every day</td>
</tr>
</tbody>
</table>

2. This week I practiced mindfulness immediately before I conducted therapy with my pseudoclients

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Once</td>
<td>Twice</td>
<td>Three times</td>
<td>More than three times</td>
</tr>
</tbody>
</table>

3. I believe these trainings are helping my clinical work

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

4. This week my stress level was

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low</td>
<td>Low</td>
<td>Average</td>
<td>High</td>
<td>Very high</td>
</tr>
</tbody>
</table>

5. I shared what I am learning in these trainings with my fellow students who are not in the mindfulness trainings

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>
Appendix J

Video Questionnaire
Mindfulness Training

Video Questionnaire

Code: __________________________ Date: ______________

**Instructions:** We are interested in your experience of these trainings. Please read each statement below and circle your response.

1. This week I reflected on the therapy videos

<table>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>1 – 2 days</td>
<td>3 – 4 days</td>
<td>5 – 6 days</td>
<td>Every day</td>
</tr>
</tbody>
</table>

2. This week I reflected on the therapy videos immediately before I conducted therapy with my pseudoclients

<table>
<thead>
<tr>
<th></th>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Once</td>
<td>Twice</td>
<td>Three times</td>
<td>More than three times</td>
</tr>
</tbody>
</table>

3. I believe these trainings are helping my clinical work

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>

4. This week I felt stressed

<table>
<thead>
<tr>
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<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Very low</td>
<td>Low</td>
<td>Average</td>
<td>High</td>
<td>Very high</td>
</tr>
</tbody>
</table>

5. I shared what I am learning in these trainings with my fellow students who are not in the video trainings

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<th></th>
<th>0</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a bit</td>
<td>Very Much</td>
</tr>
</tbody>
</table>
Appendix K

Informed Consent
Prospective Research Participant: Read this consent form carefully and ask any questions that may help you decide if you want to participate in this research.

RESEARCH PARTICIPANTS INFORMED CONSENT FORM

You are being asked to participate in a study designed to investigate the effects of types of clinical training on therapeutic effectiveness. Your participation includes attending regularly scheduled Clinical Foundations class time (10, 40-minute sessions) during which you will participate in trainings relevant to your clinical work. You will be asked to answer questions related to the trainings (taking approximately 1 minute each week) and related to your pseudoclient therapy sessions (taking approximately 30 seconds each week). In addition, your pseudoclients and Clinical Foundations teacher's assistants will answer questions related to your therapeutic effectiveness.

The data collected in the study will not be used to evaluate your therapeutic effectiveness outside the confines of this research. The data gathered will not affect your course grade. The researchers conducting this study will inspect data obtained in this study, but the records and identities obtained will be treated as confidential information in so far as permitted by law. The results of the study may be published for scientific purposes but will not give your name or include any identifiable references to you. There are no known risks associated with your participation in this study.

For your investment of time and participation in this study, you will receive relevant information to your clinical training. There is no financial compensation for your participation in this research. You are free to choose whether or not to participate in this study, and there will be no penalty or loss of benefits to which you are otherwise entitled if you choose not to participate or to terminate participation during the study.

The principal researcher, Joel Simons, MA, who can be contacted at jsimons10@georgefox.edu, will answer any further questions you may have about this study or your rights as a participant. Alternatively, Dr. Carlos Taloya and Dr. Wayne Adams are supervising this research and can be contacted should you have concerns related to this study (503-554-2370).

By signing below, you acknowledge that you have read and understand this consent form, and that you volunteer to participate in this research. You understand that you will receive a copy of this form if you request it. Also, if you check the box below you will receive a summary of the results of this investigation. You voluntarily choose to participate, but you understand that your consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. You further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws.

[] I am requesting a summary of the results of this study when it is completed. It can be sent to my email address, which is: ________________________________

Participant Name (printed): ________________________________ Date: ______________

Principal Researcher Signature: ________________________________ Date: ______________
Appendix L

Mindfulness Trainings
Exercise 1

Breath and Body

1. Assume a comfortable seated position. Keep your spine straight and let your shoulders drop.
2. Close your eyes if it feels comfortable.
3. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.
4. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.
5. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.
6. If your mind wanders away from the breath a thousand times, then your “job” is simply to bring it back to the breath every time, no matter what it becomes preoccupied with.
7. Try expanding the field of your awareness “around” your breathing and “around” your belly to include a sense of your body as a whole as you are sitting.
8. Maintain this awareness of the body sitting and breathing, and when the mind wanders, bring it back to sitting and breathing.
Exercise 2

Breath and Sound

1. Assume a comfortable seated position. Keep your spine straight and let your shoulders drop.

2. Close your eyes if it feels comfortable.

3. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.

4. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.

5. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

6. If your mind wanders away from the breath a thousand times, then your “job” is simply to bring it back to the breath every time, no matter what it becomes preoccupied with.

7. Try just listening to sound. This does not mean listening for sounds, rather just hearing what is here to be heard, moment by moment, without judging or thinking about them. Just hearing them as pure sound. And hearing the silences within and between sounds as well.
Exercise 3

Breath and Thought

1. Assume a comfortable seated position. Keep your spine straight and let your shoulders drop.

2. Close your eyes if it feels comfortable.

3. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.

4. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.

5. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

6. Try shifting your awareness to the process of thinking itself. Let go of the breath and just watch thoughts come into and leave the field of your perception.

7. Try to perceive them as “events” in your mind.

8. Note their content and their charge while, if possible, not being drawn into thinking about them, or thinking the next thought, but just maintaining the “frame” through which you are observing the process of thought.

9. Note than an individual thought does not last long. It is impermanent. If it comes, it will go. Be aware of this.

10. Note how some thoughts keep coming back.
11. Note thoughts about the past and thoughts about the future.

12. Note thoughts as they come and go.

13. If you get lost in all this, just go back to your breathing.

Exercise 4

Breath and Feelings

1. Assume a comfortable seated position. Keep your spine straight and let your shoulders drop.

2. Close your eyes if it feels comfortable.

3. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.

4. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.

5. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

6. Try shifting your awareness to your feelings and mood. Let go of the breath and just watch feelings come into and leave the field of your perception.

7. Try to perceive them as “events” in your mind.
8. Note their content and their charge while, if possible, not being drawn into thinking about them, or feeling the next feeling, but just maintaining the “frame” through which you are observing the process of feeling.

9. Note than an individual feeling is impermanent. If it comes, it will go. Be aware of this.

10. Note how some feelings keep coming back.

11. Note feelings about the past and feelings about the future.

12. Note feelings and moods as they come and go.

13. If you get lost in all this, just go back to your breathing.

Exercise 5

Dyad Breath, Thoughts, and Feelings with Focus on Self

1. Partner yourself in dyads. If there is an uneven number create a triad.

2. Assume a comfortable seated position across from your partner. Keep your spine straight and let your shoulders drop.

3. Close your eyes if it feels comfortable.

4. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.

5. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.
6. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

7. Try shifting your awareness to the process of thinking and feeling. Let go of the breath and just watch thoughts and feelings come into and leave the field of your perception.

8. Try to perceive them as “events” in your mind.

9. Note their content and their charge while, if possible, not being drawn into thinking about them, or thinking the next thought, or feeling the next feeling, but just maintaining the “frame” through which you are observing the process of thought and feeling.

10. Note than an individual thought or feeling does not last long. It is impermanent. If it comes, it will go. Be aware of this.

11. Note how some thoughts and feelings keep coming back.

12. Note feelings about the past and feelings about the future.

13. Note what feelings are associated with different thought contents.

14. Note thoughts, feelings, and moods as they come and go.

15. If you get lost in all this, just go back to your breathing.

Exercise 6

Dyad Breath, Thoughts, and Feelings with Focus on Partner

1. Partner yourself in dyads. If there is an uneven number create a triad.

2. Assume a comfortable seated position across from your partner. Keep your spine straight and let your shoulders drop.
3. Keep your eyes open if it feels comfortable.

4. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.

5. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.

6. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.

7. Try shifting your awareness to your partner. Let go of the breath and just watch thoughts and feelings about your partner come into and leave the field of your perception.

8. Try to perceive them as “events” in your mind.

9. Note their content and their charge while, if possible, not being drawn into thinking about them, or thinking the next thought, or feeling the next feeling, but just maintaining the “frame” through which you are observing the process of thought and feeling.

10. Note than an individual thought or feeling does not last long. It is impermanent. If it comes, it will go. Be aware of this.

11. Note how some thoughts and feelings about your partner keep coming back.

12. Note thoughts and feelings about the past and thoughts and feelings about the future.

13. Note what feelings are associated with different thought contents.

14. Note thoughts, feelings, and moods as they come and go.

15. If you get lost in all this, just go back to your breathing.
Exercise 7

Dyad Breath, Thoughts, and Feelings with Focus on Partner

1. Partner yourself in dyads. If there is an uneven number create a triad.
2. Assume a comfortable seated position across from your partner. Keep your spine straight and let your shoulders drop.
3. Keep your eyes open if it feels comfortable.
4. Bring your attention to your belly, feeling it rise or expand gently on the inbreath and fall or recede on the outbreath.
5. Keep the focus on your breathing, “being with” each inbreath for its full duration and with each outbreath for its full duration, as if you were riding the waves of your own breathing.
6. Every time you notice that your mind has wandered off the breath, notice what it was that took you away and then gently bring your attention back to your belly and the feeling of the breath coming in and out.
7. Try shifting your awareness to your partner. Let go of the breath and just watch thoughts and feelings about your partner come into and leave the field of your perception.
8. Try to perceive them as “events” in your mind.
9. Note their content and their charge while, if possible, not being drawn into thinking about them, or thinking the next thought, or feeling the next feeling, but just maintaining the “frame” through which you are observing the process of thought and feeling.
10. Note than an individual thought or feeling does not last long. It is impermanent. If it comes, it will go. Be aware of this.
11. Note how some thoughts and feelings about your partner keep coming back.

12. Note thoughts and feelings about the past and thoughts and feelings about the future.

13. Note what feelings are associated with different thought contents.

14. Note thoughts, feelings, and moods as they come and go.

15. If you get lost in all this, just go back to your breathing.