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Mara Galus
Cultivating Presence: Effects of
Therapist's Mindfulness Meditation
on Therapeutic Presence

ABSTRACT

The purpose of this exploratory study was to gain a deeper understanding of how clinicians' daily mindfulness meditation practice influences the cultivation of therapeutic presence within the relational space of the therapeutic encounter. The study used semi-structured, in-person, and Skype video interviews with 11 clinical social workers with a daily mindfulness meditation practice to gather qualitative data and their reflections on the dynamic interplay between mindfulness meditation and preparing the ground for presence, the process of presence and the experience of in-session therapeutic presence. The findings indicate that all of the clinicians experienced a positive direction of association between daily mindfulness meditation and the cultivation of in-session therapeutic presence. In particular, many of the clinicians described an increased ability to remain grounded, attentive, as well as cognitively and affectively more flexible when confronted with strong client affect, given the influence of their daily mindfulness meditation practice. The intent of this study is to raise awareness of the gap in professional training and graduate social work curricula clinicians are receiving in terms of mindfulness meditation, and to highlight the usefulness of daily mindfulness meditation as a clinical tool for cultivating the clinically useful skill of therapeutic presence.

**CULTIVATING PRESENCE: EFFECTS OF THERAPIST'S MINDFULNESS
MEDITATION ON THERAPEUTIC PRESENCE**

A project based on an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

Common factors research has confirmed the value of personal and interpersonal factors in determining client outcome resulting from the clinical treatment experience. Personal and interpersonal factors consist of client factors, the relationship between client and clinician, and clinician effect (Elkins, 2012). A number of therapist qualities contribute to therapist effect, particularly what is known as “therapeutic presence,” which can be understood as “the attitude or stance toward present experience that the therapist brings to the moment-to-moment therapeutic encounter” (Gehart & McCollum, 2008, p. 178). Meditation and mindfulness practice have been suggested as ways to develop therapeutic presence (Baer, 2003; Davis & Hayes, 2011; Fritz & Mierzwa, 1983; Geller & Greenberg, 2012; Germer, 2005).

Therapeutic presence, meditation, and mindfulness refer to subjective experiences; thus, operational definitions of these terms have yet to emerge in the field (Tannen & Daniels, 2010; Davis & Hayes, 2011). For the purposes of this study, Geller and Greenberg’s (2002) definition of *therapeutic presence* will be used, which includes three components: “an availability and openness to all aspects of the client’s experience, openness to one’s own experience in being with the client, and the capacity to respond to the client from the confluence of this experience” (p. 72). Borrowing from Goleman and Schwartz (1976), *meditation* will be defined as “the intentional self-regulation of attention from moment to moment toward all percepts or mental contents as they spontaneously arise in the field of awareness” (p. 457). *Mindfulness* will be

defined as “a moment-to-moment awareness of one’s experience without judgment” (Davis & Hayes, 2011, p. 198).

Although much has been written on therapeutic presence, there is little empirical research examining the specific factors of therapeutic presence and its influence on the therapeutic relationship from the clinician’s perspective or the dynamic interplay between the phenomena of mindfulness meditation and therapeutic presence. Existing empirical literature provides evidence that the mindfulness and meditation practices of therapists are a positive predictor for the cultivation of therapeutic presence, empathy, compassion (Geller, Greenberg, & Watson, 2010; Germer, 2005; Keane, 2013); enhanced therapeutic alliance (Gockel, Cain, Malove, & James, 2013; Keane, 2013); increased therapist self-efficacy and self-care (Greason & Cashwell, 2009; Shapiro, Brown, & Biegel, 2007); as well as the development of clinical skills that are transferable from the classroom to the therapeutic encounter (Gockel et al., 2013).

Geller, Greenberg and Watson (2010) created a three-component model of therapeutic presence, as well as a method for measuring therapeutic presence, and were able to demonstrate a direct relationship between therapeutic presence and client outcome. The three components of the Geller, Greenberg, and Watson (2010) model of therapeutic presence included preparing the ground for presence, the process of presence, and the experience of presence.

Additionally, neurobiological empirical research found that mindfulness meditation helps develop affective emotion regulation in the brain (Hayes, 2004), and demonstrated mindfulness meditation enables people to have greater cognitive flexibility (Davis & Hayes, 2011). Evidence indicates that mindfulness meditators develop the skill of self-observation that neurologically disengages automatic pathways created from prior learning and enables present-moment input to

be integrated in a new way (Siegel, 2007a), which can prepare the ground for the process of therapeutic presence (Lazar, 2013).

Current literature calls for further research into therapeutic presence, including the mechanisms of how therapeutic presence can be cultivated and integrated into clinical practice. The purpose of this qualitative, exploratory study is to address the need for further research into the concept and curative phenomenon of therapeutic presence and its place in the clinical process. The specific research question is: *How do clinicians' daily mindfulness meditation practices influence therapeutic presence?* Based on the existing research on therapeutic presence, the hypothesis is that a therapist's mindfulness meditation practice is likely to positively influence his or her therapeutic presence.

Eleven licensed clinical social work therapists with a daily mindfulness meditation practice participated in the semi-structured interviews for this study and reflected on their perceptions of the influence, which daily mindfulness meditation practice did or did not have on the cultivation of therapeutic presence in the relational space of the therapeutic encounter.

The study will provide valuable information for individual therapists as well as therapist training programs. Though other studies have examined this phenomenon, there is a lack of qualitative research that examines clinicians' reflections of the influence their mindfulness meditation practice has on the cultivation of therapeutic presence, from the perspective of therapists who are both experienced meditators and experienced clinicians, and who currently have a daily mindfulness meditation practice, as well as an active client base.

The findings of this study can be used to enhance social work practice and clinical training pedagogy at social work educational institutions. The findings can also be used to make a recommendation that mindfulness meditation training become a core social work competency,

focused on the cultivation and transfer of mindfully informed clinical skills from the classroom to the relational therapeutic encounter.

Though this study is inductive, leading to the creation of a framework, the researcher has been informed by mindfulness-informed psychological theories (Geller et al., 2010; Germer, 2005; Kabat-Zinn, 1990; and Walsh & Shapiro, 2006) and mindfulness-informed clinical educational pedagogy theory (Gockel et al., 2013) in designing this study. These theories situate mindfulness and meditation practices as positive predictors of the cultivation of therapeutic presence and identify the experience of therapeutic presence as a valuable therapeutic clinical tool. Finally, neurobiological theory (Davidson et al., 2003; Lazar, 2013; Siegel, 2007a) makes a connection between mindfulness meditation practices and increased cognitive and affective flexibility, which can prepare the ground for the process of therapeutic presence in the relational therapeutic encounter (Geller & Greenberg, 2012; Lazar, 2013).

There are several limitations to this study. There is a sample bias due to the non-probability convenience methods used to recruit participants. A possible bias associated with the study sample is that the interviewees might have been motivated to participate because they believe there is a positive correlation between personal mindfulness meditation practice and therapeutic presence. The researcher acknowledges her bias that mindfulness meditation is a useful practice to enhance therapeutic presence. Clearly, the perspectives examined are those of therapists. Thus, the study is limited in that it will not offer insight into how therapeutic presence influences clients. This may be the topic of subsequent study. The sample used in this study is not a representative sample; thus, the results of the study are not generalizable to the larger population of interest. Instead, the results offer an in-depth examination of the research question.

The following chapters describe the basis for this study and its relationship to the current literature, the methodology used for the study, the demographic and the qualitative findings of the study, and finally, a discussion that makes meaning of the research findings.

CHAPTER II

Literature Review

Therapists can experience a wide spectrum of challenging affective, cognitive and behavioral presentations experienced in the transference, countertransference and the relational space of the therapeutic encounter (Dunn, Callahan, & Swift, 2013). Therapeutic presence is one condition that may enhance the therapist's capacity to remain open and available to all aspects of the client's experience, as well as open to the therapist's own experience, and the intersection of both experiences in the therapeutic encounter (Elkin, 2012). It is unavoidable that therapists will experience strong emotions, thoughts, and sensations with clients during sessions (Dunn et al., 2013). The literature suggests that meditation and other mindfulness practices may aid therapists in cultivating therapeutic presence (Dunn et al., 2013).

In order to understand the cultivation of therapeutic presence, it is essential to look to the literature offered by the psychological, educational, mindfulness-based, and neurobiological communities. The literature review for this study aims to examine the most current articles available from the last 10 years that study the following: how do clinicians' daily mindfulness meditation practices influence therapeutic presence; which mindfulness meditation practices in relation to therapeutic presence have been empirically studied; and whether therapeutic presence is a positive, negative, or neutral predictor of client, session, and therapeutic outcomes. Additionally, the literature review includes one article from the 1980s that reviews historical research reports from this era, tracing the intellectual progression to the present.

In order to explore the research question, the following key content areas are covered in this literature review: 1) mindfulness, meditation, neurobiology, and relational presence; 2) common factors, the therapeutic relationship, and therapeutic presence; 3) clinician meditation, mindfulness practice, and therapeutic presence, and 4) meditation training in beginning therapists, and the implications for further study.

Mindfulness, Meditation, Neurobiology, and Relational Presence

Geller (2013) stated that mindfulness meditation practice is a formal practice of mindfulness, and as such, mindfulness meditation is also ultimately a formal practice of presence.

Geller and Greenberg (2012) theorized that mindfulness meditation practice could help to cultivate therapist's presence in the therapeutic encounter in four important ways. First, mindfulness meditation can help to heighten the sustainability of focused attention that is needed when being present in session with a client. Second, mindfulness meditation practice can enhance self-compassion in the therapist and therefore should lead to greater empathy and compassion with clients. Third, mindfulness meditation can offer a way to reduce stress and enhance well-being and care for the therapist's own self, which allows for the prevention of burnout and greater ability to stay present and connected with clients. Fourth, mindfulness meditation can help generate greater openness and receptivity, as well as grounding in oneself, so the therapist can then experience the depth of relational presence with his or her client (p. 194).

Germer (2005) suggested that mindfulness involves at least three skills: focused attention or concentration, open monitoring or mindfulness per se, and compassionate acceptance. Walsh & Shapiro (2006) noted that the term *meditation* refers to a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater

voluntary control, and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration.

Mindfulness meditation allows for less reactivity and a way of relating to all experiences, positive, negative, and neutral, such that our overall suffering is reduced and our sense of well being increases (Morgan & Morgan, 2005). Mindfulness in deep meditation provides insights into the nature of the mind and the causes of suffering. These insights, such as awareness of how impermanent things really are, help us to become less entangled in our ruminations and thereby foster more mindfulness (Fulton, 2005).

The term mindfulness meditation is typically synonymous with Vipassana, a form of meditation from Theravada Buddhism (Baer, 2003). Vipassana is a Pali word for insight or clear awareness and is a practice designed to gradually develop mindfulness or awareness (Walsh & Shapiro, 2006). In mindfulness meditation, attention is expanded to include as many mental, emotional, and physical experiences that arise, as they occur, from a stance of calmness and neutrality, without elaboration, judgment, censorship, interpretation, attachment, or conclusions (Kabat-Zinn, 1990).

Evidence indicates that mindfulness meditators develop the skill of self-observation that neurologically disengages automatic pathways created from prior learning and enables present moment input to be integrated in a new way (Siegel, 2007a).

Research has demonstrated mindfulness meditation enables people to have greater cognitive flexibility (Davis & Hayes, 2011), and this can promote greater flexibility in conceptualizing the client's issues and increased creativity in responding to his or her needs in the moment (Fulton, 2005).

Siegel (2007b) argued that our ability to become attuned to ourselves draws on the same neural circuitry that enables attunement to others; paying attention to ourselves appears neurologically related to empathic attunement to others.

Practicing attuned presence and mindfulness in relationship with others is profoundly important for therapists, because it is the relational aspect of presence that is often most challenging in therapist's personal lives, and in direct relationship with the client's sometimes insurmountable pain (Geller & Greenberg, 2012).

Further evidence suggests that mindfulness helps develop affective emotion regulation in the brain (Davis & Hayes, 2011). Hoffman, Sawyer, Witt, and Oh's findings (2010) are consistent with evidence that mindfulness meditation leads to increased positive affect and decreased anxiety and negative affect (Davidson et al., 2003). Hence, with sustained mindfulness meditation practice, Geller and Greenberg (2012) suggested that therapists can develop a greater ease and ability to feel the depth of the other's experience, and even one's own resonant pain, and then let it go.

Neuroplasticity—the rewiring that occurs in the brain as a result of experience—now explains how regular mindfulness meditation practice alters the brain's physical structure and the brain's functioning (Lazar, 2013; Siegel, 2007a).

Mindfulness research from a neurobiological perspective has demonstrated that continued mindfulness meditation practice results in cortical thickening (Lazar et al., 2005) and activates parts of the brain, including the anterior insula, the sensory cortex, and the prefrontal cortex. These three areas are involved in paying attention to the breath and to other sensory stimuli, as is typically done during meditation practice (Siegel, 2007b). Furthermore, the prefrontal cortex is

responsible for working memory (Siegel, 2007a), which reflects being able to hold information, such as what clients share in therapy sessions (Geller & Greenberg, 2012).

Mindfulness has a similarity to the psychotherapy construct of intersubjectivity (Benjamin, 1990), which has been theorized to relate to Buddhist psychology and being in the present moment in psychotherapy (Epstein, 2007). Mindfulness and intersubjectivity are similar in that they both enable a sense of connection with others or what Thich Nhat Hanh (1987) calls *interbeing*. Interbeing is a Buddhist notion that states that by living in the present moment, the interdependent nature of all phenomena and people is experienced (Hanh, 1987). Therapeutic presence includes the therapist's present-centered sensory attention in direct relationship to the client's in-the-moment experience, and as such is a relational therapeutic stance (Geller & Greenberg, 2012).

Mindfulness can play a variety of roles in psychotherapy, conceptualized on a continuum from implicit to explicit (Surrey, 2005). At the most implicit end of the continuum is the therapist that practices a form of mindfulness. As mindfulness practice deepens, therapists begin to gain firsthand insight into how our minds create suffering and may practice mindfulness-informed psychotherapy. At the most explicit end of the continuum is mindfulness-based psychotherapy, in which a therapist makes a suggestion, when clinically appropriate, that a client try a specific mindfulness practice in-session or out of session (Pollak, Pedulla, & Segal, 2014).

Geller and Greenberg (2012) noted that as psychotherapists we choose to witness and share human conflict and despair in many of our waking hours. The challenge is to stay receptive, open and present but also not to be so open and enmeshed that we lose ourselves (Geller & Greenberg, 2012). Thus, as therapists we must learn to identify and disentangle from

our own conditioned patterns of thoughts and feelings that arise in the therapeutic relationship (Germer, 2005).

The therapy office can be like a meditation room in which we invite our moment-to-moment experience to become known to us, openly and whole-heartedly through the daily practice of mindfulness meditation, and thus, the cultivation of healing therapeutic presence in the therapeutic encounter (Geller & Greenberg, 2012). As such, therapist's verbal and non-verbal communication of presence is essential, as clients need to experience their therapist as present for presence to be therapeutic (Geller, 2013).

This section focused on the dynamic interplay of mindfulness, meditation, and therapeutic presence. The next section will focus on the evolution of the definition of therapeutic presence and the utility of therapeutic presence in the clinical process.

Common Factors, The Therapeutic Relationship, and Therapeutic Presence

While research supports the efficacy of psychotherapy it also reveals that specific therapeutic techniques have little effect on therapeutic outcome (Drisko, 2004; Elkins, 2012; Norcross & Grencavage, 1989). This discovery suggests that the common factors of psychotherapy techniques are responsible for producing client change (Drisko, 2004, p. 84). Thus, common factors research attempts to define the “common ingredients” that all psychotherapeutic orientations share (Norcross & Grencavage, 1989). Four common factors that contribute to client change have been identified: the client, the therapeutic relationship, technical factors, and expectancy or hope (Drisko, 2004; Tannen & Daniels, 2010). The therapeutic relationship includes therapist effect as well as the interpersonal space between client and clinician. Among the common factors, the therapeutic relationship is second only to client factors in determining therapeutic outcome (Elkins, 2012; Tannen & Daniels, 2010). Common

factors researchers suggest that clinical scientists move away from researching the most effective therapeutic technique or modality and instead work together to decipher the personal and interpersonal factors that make all forms of psychotherapy effective (Elkins, 2012).

The value of presence in the clinical encounter has been expounded upon across theoretical orientations. From psychoanalytic theory to Gestalt and the dialogical approach to existential theory to humanistic theory, much has been written about the diffuse qualities of presence as well as its importance (Geller & Greenberg, 2012). Although the literature is rich with theoretical analysis of therapeutic presence, there are few published empirical studies on the topic.

In an early investigation, Pemberton (1977) studied and interviewed five leading therapists who were specifically selected because of their renowned effectiveness as well as their reported heightened sense of presence. Pemberton delineated three factors that generate presence: commitment, enfolding, and extending. He determined that presence is an intrapersonal phenomenon, the result of both client and therapist being present at the same time. Lastly, Pemberton described a healing quality to the experience of presence that results in a sense of authenticity, centeredness, purpose, clarity, and autonomy. Although Pemberton's study lacked a prescribed qualitative methodology and his sample size was very small, the study has been acknowledged as an important early attempt to examine and define the "ineffable quality" of therapeutic presence (Tannen & Daniels, 2010; Geller & Greenberg, 2012, p. 39).

Phelon (2001) conducted what she called "an intuitive inquiry" into presence by integrating several methodologies in order to identify a "distilled definition" (p. 21). Phelon first carried out a hermeneutic study of writing from a range of disciplines regarding presence (Tannen & Daniels, 2010). She then asked 12 "exemplar" psychotherapists—five males and

seven females, all European-Americans ranging in age from 48 to 70 who had experienced presence as clients in psychotherapy—to review and further distill the categories from the hermeneutic study using “sympathetic resonance” (Phelon, 2001, p. 6). Three categories emerged from the final distilled elements: development and growth, qualities of awareness, and therapeutic alliance (Phelon, 2001). Tannen and Daniels (2010) contended that Phelon’s study “demonstrates an attempt to create methodologies that enable researchers to apply rigor while investigating complex, intangible phenomena” (p. 6). However, sympathetic resonance is not an empirically validated method of research. Phelon does not explain what she means by “exemplar” psychotherapists and there is no racial diversity in her sample.

Building upon the work of Pemberton and Phelon, as well as others, Geller and Greenberg (2012) applied a systematic qualitative methodology to their study of therapeutic presence (Geller & Greenberg, 2012). Seven therapists, picked because they were either authors or known proponents of value of therapeutic presence in their therapy practice, were interviewed about their personal experience of presence including physical, emotional, and cognitive components. Transcriptions of the interviews were analyzed and interpreted through a method of “condensation and categorization” and then reviewed by a panel of veteran therapists (Geller & Greenberg, 2012; Tannen & Daniels, 2010). From the resulting categories, Geller and Greenberg (2012) created a model of therapeutic presence containing three branches: preparing the ground for presence, process of presence, and actual in-session experience of presence (Geller & Greenberg, 2012). In discussing their efforts, Geller and Greenberg (2012) note:

While presence is a holistic subjective experience that loses its essential nature when analyzed in an objective manner, our attempt to articulate such an ineffable quality is

essential in gaining an understanding of and appreciation for the quality that we feel is essential for good therapy (p. 42).

Geller, Greenberg and Watson (2010) went on to conduct a two-part study in which they used Geller and Greenberg's (2012) model of presence to create two versions of a therapeutic presence measure. In the first part of the study, the Therapeutic Presence Inventory—therapist (TPI-T) and client (TPI-C) were analyzed and rated by nine therapists considered experts in the field.

In the second half of the study, “the reliability and validity of the measures were further explored” through a quantitative study (Geller & Greenberg, 2012, p. 44). The TPI-T and the TPI-C were given to therapists and clients participating in “one of two randomized clinical trials on the treatment of depression” (Geller et al., 2010, p. 603). The study consisted of 25 clinical psychologists and 114 clients. Out of the 25 clinicians, eight practiced cognitive behavioral therapy (CBT), four practiced process-experiential therapy (PE), and 13 practiced a combination of PE and client centered (CC) therapy. Therapists and clients were asked to complete the TPI-T (21 items) and TPI-C (3 items) after every third session. Clients also completed the Client Task Specific Measure-Revised to assess session outcome and the Working Alliance Inventory to assess therapeutic alliance. Therapists additionally completed the Relationship Inventory. Both the TPI-T and the TPI-C use a 7-point Likert scale to rate the experience of presence or non-presence in the session. The results of the study indicated that “clients’ experience of the therapist is strongly associated with session outcome and alliance;” however, the “therapists’ experience of themselves is less significant with respect to the therapeutic alliance, process, and outcome” (Geller et al., 2010, p. 607). Thus, the study directly linked therapeutic presence to session outcome. Self-report, the small number of items on the client measure, inclusion of

therapists from only PE, CC, and CBT theoretical backgrounds, and the possibility of shared-method variance were all noted as limitations of the study. Suggestions for further studies included incorporating behavioral observations as well as use of a mixed-model approach (Geller et al., 2010, p. 608).

In both Geller and Greenberg's (2002) qualitative study as well as in Geller et al.'s (2010) quantitative study, the theoretical orientation and years of experience of the "expert" reviewers are noted. However, no further details were provided regarding how the authors delineated who qualifies as an "expert" on the topic of therapeutic presence. Further, although information regarding the gender of both clinicians and clients is provided, there is no mention of racial or sociocultural diversity.

The therapist's presence is an important element of the therapeutic relationship, which accounts for a significant percentage of client change (Elkins, 2012). Pemberton (1977) and Phelon (2001) made important strides in beginning to define therapeutic presence; however, they did not use empirically validated methods of study. By creating a model of therapeutic presence as well as a method for measuring therapeutic presence Geller et al. (2010) were able to demonstrate a direct relationship between therapeutic presence and client outcome.

This section has presented the evolution of the definition of therapeutic presence as well as research that confirms the relevance of therapeutic presence in the clinical process. The following section will focus on practices that have been found to develop or enhance therapeutic presence.

Clinician Meditation, Mindfulness Practice, and Therapeutic Presence

Fritz and Mierzwa (1983) described meditation as "attention training," the effects of which include enhancement of personal variables and behaviors considered important for

“optimum therapeutic functioning” of therapists and which are employed in the present moment to enhance awareness within the therapeutic relationship. Fritz and Mierzwa (1983) noted three general types of meditation: “concentrative meditation, where instruction is given to focus on a particular internal or external precept or mantra; mindfulness meditation which calls for rigorous self- observation without speculative or evaluative elaboration, and integrative meditation that permits the continual integration of emerging experience with some ongoing attentional set” (Fritz & Mierzwa, 1983, p.78).

Fritz and Mierzwa (1983) noted that little systematic attention had been given to the potentially important effects of meditation upon therapists themselves, thus the purpose of their review study was to present anecdotal and research reports, which related meditation to the capacity of therapists to engage in behaviors basic to the therapeutic relationship.

Within the Fritz and Mierzwa (1983) review, Carrington and Ephron (1975) were cited as anecdotally noting the potential contribution of meditation to the professional skills of the psychoanalytically oriented therapist and reporting the following changes in their professional therapeutic work derived from regular meditation practice: increased receptivity to spontaneous perceptions of unconscious conflicts; less sense of threat when confronted with a patient’s negative transference; decreased drowsiness when patient hours followed one another in succession; and the development of certain therapeutic skills, such as empathy, not readily taught by formal educational methods. The Carrington and Ephron (1975) anecdote failed to note the type of meditation method utilized, the length and consistency of individual meditation sessions, and overall years of meditation practice.

Though theoretical hypotheses regarding the potential contribution of meditation to therapist effectiveness formed the basis of few empirical studies in the 1970s, in their review

Fritz and Mierzwa (1983) compiled a list of 26 meditation studies, ranging from 1970 to 1977. These studies had a variety of subject populations and theoretical perspectives that investigated the effects of meditation upon variables associated with counselor and therapist effectiveness. All the studies had significant outcomes, except for one study, which had no main effects (Fritz & Mierzwa, 1983).

Common methodological problems found in the 26 meditation research studies included: the common use of cross-sectional designs, and the comparison of experienced meditators with non-meditators, which failed to control for personality variables and this may have correlated with meditation experience or interest in almost all instances of the studies (Fritz & Mierzwa, 1983). Additionally, the 26 research studies investigated the effects of only one type of meditation style or method (Fritz & Mierzwa, 1983).

Similarly, Dunn et al. (2013) conducted a contemporary review of research studies, and have indicated that newer research has begun to investigate the impact of therapist mindfulness on the therapeutic process. Mindfulness as defined by these researchers “is a trans-theoretical psychotherapy intervention, with both formal techniques, including sitting meditation, yoga, and deep breathing, and informal techniques, which include the mindfulness of daily experience” (Dunn et al., 2013, p. 312).

Dunn et al. (2013) suggested a central component of mindfulness is the development of a moment-to-moment awareness, an ability to direct attention to the present moment, and building capacity for clinically beneficial relationship qualities, such as empathy, openness and acceptance. Dunn et al. (2013) noted that some therapists may find it difficult to incorporate regular formal mindfulness practice into their schedules because many programs require substantial time commitments. To address the issue of time commitment and attrition rates in

regard to maintaining a formal mindfulness practice like a meditation method, Dunn, Callahan, Ivanovic, and Swift (2013) examined, in a quantitative study, whether preparing for a therapy session by engaging in a brief formal mindfulness exercise would have a positive benefit on the subsequent session, and if given the brief formal mindfulness exercise, if therapists would rate themselves as having more therapeutic presence in sessions.

Therapists completed a brief five-week manualized mindfulness training program, which consisted of one training session each week that was 20 minutes long, beginning with didactic instruction of core mindfulness principles, including moment-to-moment awareness, attention, acceptance, non-judging, patience, and non-striving; after this, therapy sessions were randomly assigned so that therapists either completed a five-minute mindfulness meditation exercise immediately prior to the session or engaged in their normal preparation routine. Therapists were given a log to record what activities they had engaged in prior to sessions, as a means to check whether any therapists were completing mindfulness exercises, as preparation for their sessions, that had been assigned to the control group (Dunn, Callahan, Ivanovic, et al., 2013).

At the end of the sessions, clients completed a measure of therapist presence and session effectiveness. At the time, the therapists also completed a self-report measure rating their own presence during the preceding session (Dunn, Callahan, Ivanovic et al., 2013). The therapist presence inventory (Geller et al., 2010) includes two forms, the therapist (TPI-T) and the client (TPI-C), both of which were administered immediately following the sessions. The TPI-C contains three items in which the client rates his or her therapist's level of presence in the preceding session. Reliability and validity for both measures have been previously reported to be adequate (Geller et al., 2010).

Findings indicated that therapists perceived themselves as being more present in the session when they prepared for their sessions when engaging in the formal mindfulness exercise (Dunn, Callahan, Ivanovic et al., 2013). Further, the findings indicated that clients perceived the sessions to be more effective when their therapists engaged in the mindfulness exercise prior to the start of the session (Dunn, Callahan, Ivanovic, et al., 2013).

The participants of the study were 25 trainee therapists who were completing their in-house practicum at one of two psychology department training clinics (Dunn, Callahan, Ivanovic, et al., 2013). Trainees were primarily female and Caucasian, with the other participants identifying as Hispanic, Asian American, and bi/mixed race, and ranging from 22 to 34 years old (Dunn, Callahan, Ivanovic, et al., 2013). Neither of the training clinics required their students to adhere rigidly to one specific theoretical orientation (Dunn, Callahan, Ivanovic, et al., 2013). The results of the study were not generalizable because the formal mindfulness centering exercise was only tested on trainees and not on more experienced therapists. Dunn et al. (2013) noted that there may also be a dose-effect relationship between the length of mindfulness exercise and the amount of improvement in the therapist's therapeutic presence and/or client outcomes.

Dunn, Callahan, Ivanovic, et al. (2013) suggested that their study offers support for the idea that mindfulness practice is a positive predictor of session outcomes, and that there is a positive direction of association for therapist formal mindfulness practice and therapist self-perceptions of their therapeutic presence during sessions. Thus, Dunn, Callahan, Ivanovic, et al. (2013) suggested mindfulness could be used as a convenient in-the-moment tool for therapists to utilize when preparing for an upcoming session. Of particular importance, Dunn, Callahan, Ivanovic, et al. (2013) noted is the need to train beginning therapists, who may experience "inner

chatter” and a reduced ability to remain attentive and therapeutically present in the room when they first embark on seeing clients.

Greason and Cashwell (2009) conducted a quantitative study, utilizing a cross-sectional survey, which investigated the relationship between mindfulness and counseling self-efficacy, and found that counseling self-efficacy was significantly predicted by self-reported mindfulness among masters-level interns and doctoral candidates. In the Greason and Cashwell (2009) study, attention mediated the relationship between mindfulness and self-efficacy, suggesting that mindfulness may contribute to the development of beneficial attentional processes that aid psychotherapists in training. Greason and Cashwell (2009) confirmed this relationship, and found that the students’ ability to sustain attention and to simultaneously attend to multiple points of focus in the counseling process mediated the relationship between mindfulness counseling and self-efficacy among master’s and doctoral students in counseling internships.

Greason and Cashwell (2009) defined counseling *self-efficacy* as a student’s belief or confidence in his or her ability to implement counseling skills successfully with clients in the near future. Greason and Cashwell (2009) stated that the findings of the study were important because counseling self-efficacy is viewed as a critical early marker of helping skills acquisition and has been positively associated with counseling performance among novice trainees.

The limitations of study included use of a cross-sectional survey design and self-report of mindfulness by study participants.

The studies and research reports in this section of the literature review conducted by Carrington and Ephron (1975), Dunn et al. (2013), and Greason and Cashwell (2009) suggest support for the idea that the use of meditation and formal and informal mindfulness practices are

positive predictors for session and therapeutic outcomes, though further studies on “dose effect” is required.

This section has presented practices that have been found to develop or enhance therapeutic presence. The following section will focus on practices that have been found to develop or enhance therapeutic presence in therapists in training.

Meditation Training in Beginning Therapists, and Implications for Future Education

Gehart and McCollum (2010) studied beginning therapists’ experience of learning meditation, in order to learn more about how therapeutic presence is affected by meditation. In their study, two teachers integrated meditation and mindfulness activities into counseling graduate students’ existing practicum experiences. The curriculum consisted of regular meditation practice by students, along with other assigned readings and mindfulness exercises. Students were told to record their experiences in journals, after at least 5–10 minutes of meditation daily (Gehart & McCollum, 2010, p. 347-348). The population studied consisted of 13 students in master’s courses. In this quantitative study, researchers analyzed meditators’ journal entries, and looked for evidence of increased therapeutic presence. Gehart & McCollum (2010) report promising results:

...the students reported being able to attend both to their own experience and that of their client and bring the awareness of both into the moment-by-moment interaction in session (p. 350).

This study had its limitations; only volunteers were required to hand in journals. It is possible that those who ended up participating were those who inherently liked meditation. Participants were not graded, or penalized for not meditating (Gehart & McCollum, 2010, p.

357). While this speaks to students' positive engagement with the study, it also implies that only those who enjoyed meditating partook in the study, possibly skewing results. Also, students meditated for a minimum of 5-10 minutes a day; a study with longer meditation time is implied, as well as one that studies effects on experienced rather than novel meditators. Finally, a mixed-method study is implied, which encourages more concrete data collection along with the helpful anecdotal material provided by this study.

Stefani Schomaker's dissertation, on the impact of meditation and mindfulness on therapeutic alliance in counselor trainees, mirrored many of the results of the above study. However, it was a mixed-methods study, adding new statistically relevant data to our understanding of this issue. She states that while much research confirms the link between meditation and the therapeutic relationship, other investigations have yielded mixed results. To remedy this, she conducted a study of this issue via both quantitative and qualitative outcomes (Schomaker, 2013, p. v). She studied the impact of a six-week mindfulness-training program, including meditation, with counselor trainees. Schomaker found that counselor and client therapeutic alliance, as well as counselor attunement, was enhanced by therapist mediation (Schomaker, 2013, p. vi).

Though Schomaker's mixed-methods study adds validity to her findings, her study was again conducted on volunteers, reflecting a bias that may be present. Further limitations include her small ($n = 9$), homogeneous and nonrandom population (Schomaker, 2013, p. 12). Her study also implies the potential usefulness of meditation training in counselor education.

Shapiro et al. (2007) conducted a study that proposed that a Mindfulness Based Stress Reduction (MBSR) program could help to prepare psychotherapy trainees for the demanding work of being a therapist by developing self-care and the cultivation of mindfulness qualities as

well as reducing stress. Mindfulness Based Stress Reduction is based on the premise that enhancing capacity to be mindful—that is, to attend to present moment experience in a receptive manner—will, over time, reduce the identification with self-focused thoughts and emotions that can lead to poorer mental health (Kabat-Zinn, 1990).

The study had three purposes, which included testing the efficacy of MBSR in enhancing the mental health of therapists in training as measured by a variety of cognitive and affective indicators; examining the process by which MBSR achieved its beneficial effects, and to explore the relation between mindfulness and mental health outcomes.

Study participants were recruited from a master's level counseling program at a small private Jesuit university. The authors used a prospective, non-randomized, cohort-controlled design and found that participants in the MBSR program reported significant improvement in positive affect and self-compassion, as well as a reduction in stress, negative affect, rumination, and state and trait anxiety.

The study was limited by a small sample size, the average weekly time spent in mindfulness by the participants was quite limited, and the effects of practice on psychological outcomes may only appear when some critical time threshold of practice has been met (Shapiro et al., 2007).

Anthony Keane conducted a two-phase study examining the influence of psychotherapists' personal meditation practice on their work. In Phase 1, 40 therapists from a variety of theoretical backgrounds completed a survey measuring mindfulness in session with clients, and empathic capacity. Phase 2 consisted of 12 face-to-face interviews with a subsection of the population (Keane, 2013). Significant associations were found between meditation and mindfulness, and mindfulness and empathy, or therapeutic presence (over 80%). Themes

identified in qualitative responses were increased attention and self-awareness in practice with clients, and increased ability to be present for and attuned to clients (Keane, 2013). The author concluded, “Mindfulness practice could provide a useful adjunct to psychotherapy training and be an important resource in the continuous professional development of therapists” (Keane, 2013).

Though Keane sought to study therapists who have had more meditation experience than the above studies, he did not quantify therapists’ meditation experience. The population, highly diverse in terms of nationality and age range, had 1-35 years of experience meditating. Thus, a study that takes both years of experience with, and specific types of, meditation into account when analyzing results is implied. Finally, only those who indicated an interest in further research after the first quantitative study was completed were interviewed for the subsequent qualitative study. A study is implied that examines quantitative and qualitative results from practitioners whose experience with meditation is defined and quantified. However, Keane’s work and conclusion also support my belief that meditation or mindfulness training should be available to beginning therapists, as it yields great benefit to their practice.

Gockel et al. (2013) used a qualitative study methodology to explore the potential utility of mindfulness training in helping beginning MSW students develop clinical intervention skills. The exploratory study was conducted at a graduate school for social work in a Northeastern state that specializes in training clinical social workers. The study was nested within a broader study assessing the effectiveness of the educational strategies used to help incoming MSW students develop beginning counseling or helping skills (Gockel et al., 2013).

Participants in the study included a random sample of 20 students from classes exposed to mindfulness training. These 20 students were then invited to participate in in-depth interviews

to explore their training experiences. Students ranged in age from 22-58; 15 students were female and five were male; 16 students identified as Caucasian, three as Asian American, and one as African American (Gockel et al., 2013). Twelve students had some previous exposure to one or more mindfulness practices, including meditation. Of this group, six reported that they practiced some form of mindfulness, including meditation, at least a few times per week prior to their enrollment in the foundation practice class.

Gockel et al. (2013) noted that because the transfer of training from the classroom to the field is a key issue in the literature, interviews were conducted two months after students made the transition from the training environment to their practicum placements and initiated their work with clients.

Gockel et al. (2013) stated that the reports of the study provide support for recent suggestions that mindfulness training has a contribution to make to clinical education. Participants in the study reported that mindfulness training enhanced their learning in the classroom and was helpful to their development of counseling skills. The participants also reported that training helped them manage distractions and anxiety, facilitated their ability to attend and respond to the client, and encouraged them to be more self-aware and flexible in their thinking in the classroom and the field (Gockel et al., 2013).

No student reported that the training hindered their learning or skill development in any way, although some students who had previously been exposed to mindfulness training felt that it didn't add to their knowledge, while others reported that it helped them connect their own personal practice of mindfulness and to their role as a social worker (Gockel et al., 2013). Based on those qualitative findings, Gockel et al. (2013) suggested that the integration of mindfulness

training directly into the clinical pedagogy could have specific utility for a variety of students, including those who already have their own personal practice of mindfulness.

Gockel et al. (2013) noted that although students can often demonstrate the mastery of core listening and communications skills following a course of instruction, social work research has shown these skills do not necessarily generalize to their work with clients in field practica, creating a gap in the transfer of training (Kopp & Butterfield, 1986).

Gockel et al. (2013) suggested that mindfulness training may offer a means of filling this gap in the transfer of training, as it provides a methodology for training students in basic skills such as attention and concentration that create a foundation for more complex counseling skills such as active listening and presence. Further, Gockel et al. (2013) suggested that mindfulness training also offers a specific means of cultivating the affective dimension of key therapeutic traits such as empathy and compassion.

Gockel et al. (2013) noted that important to therapeutic success is helping the novice clinician identify and manage negative internal affective reactions to the client, typically called countertransference within the psychodynamic psychotherapy tradition (Gelso & Hayes, 2007). Countertransference is regarded as a key source of ineffective therapist behaviors such as judging, shaming, blaming, neglecting, or rejecting the client, that interfere with the helping relationship and result in poor outcomes (Gelso & Hayes, 2007; Hayes, 2004).

For these reasons, Gockel et al. (2013) stated that mindfulness training holds significant potential for addressing many of the most pressing gaps in the current clinical pedagogy.

Summary of Literature

Although much has been written on therapeutic presence, there is little empirical research examining the specific factors of therapeutic presence and its influence on the therapeutic

relationship and client change from the clinician's perspective or the dynamic interplay between the phenomena of mindfulness meditation and therapeutic presence. Common factors or qualities associated with Geller and Greenberg's (2012) definition of therapeutic presence have been derived from therapist meditation and mindfulness practice, as illustrated in the anecdotal and empirical studies featured within this literature review.

The theoretical framework and design of this qualitative study have been shaped by mindfulness-informed psychological theories (Geller et al., 2010; Germer, 2005; Kabat-Zinn, 1990; Walsh & Shapiro, 2006) and mindfulness-informed clinical educational pedagogy theory (Gockel et al., 2013). These theories situate mindfulness and meditation practices as positive predictors of the cultivation of therapeutic presence as a clinically useful skill. Finally, neurobiological theory (Davidson, 2003; Lazar, 2013; Siegel, 2007a) makes a connection between mindfulness meditation practices and increased cognitive and affective flexibility, which prepare the ground for therapeutic presence in the relational therapeutic encounter.

The existing empirical studies outlined in this review indicate that the mindfulness and meditation practices of therapists indicate a positive direction of association for the cultivation of therapeutic presence, empathy, compassion (Geller et al., 2010; Germer, 2005; Keane, 2013); enhanced therapeutic alliance (Gockel et al., 2013; Keane, 2013); increased therapist self-efficacy and self-care (Greason & Cashwell, 2009; Shapiro et al., 2007); as well as the development of clinical skills that are transferable from the classroom to the therapeutic encounter (Gockel et al., 2013) with clinicians and counseling students.

Geller et al. (2010) created a three-component model of therapeutic presence as well as a method for measuring therapeutic presence and were able to demonstrate a direct relationship between therapeutic presence and client outcome. The three components of the Geller et al.,

(2010) model of therapeutic presence included preparing the ground for presence, the process of presence, and the experience of presence.

Additionally, neurobiological empirical research suggests that mindfulness meditation helps develop affective emotion regulation in the brain (Hayes, 2011) and has demonstrated mindfulness meditation enables people to have greater cognitive flexibility (Davis & Hayes, 2011). Evidence indicates that mindfulness meditators develop the skill of self-observation that neurologically disengages automatic pathways created from prior learning and enables present moment input to be integrated in a new way (Siegel, 2007a).

The scope of current research is limited, leaving gaps in formal education and training schema. In working with a spectrum of challenging emotional, cognitive and behavioral presentations (Dunn et al., 2013) experienced in the relational space of the therapeutic encounter, both beginning and experienced therapists can potentially benefit from enhanced capacity for therapeutic presence.

The study will provide valuable information for individual therapists as well as therapist training programs. Though other studies have examined this phenomenon from other angles, there has been a lack of qualitative research that examines clinicians' reflections of the influence of their mindfulness meditation practice on the cultivation of therapeutic presence, from the perspective of therapists who are both experienced meditators and experienced clinicians, and who currently have a daily mindfulness meditation practice and an active client base.

The findings of this study can be used to enhance social work practice and clinical training pedagogy at social work educational institutions. The findings can also be used to make a recommendation that mindfulness meditation training become a core social work competency,

focused on the cultivation and transfer of mindfully informed clinical skills from the classroom to the relational therapeutic encounter.

In conclusion, current literature calls for further research into therapeutic presence, including the mechanisms of how therapeutic presence can be cultivated and integrated into clinical practice. The purpose of this qualitative, exploratory study is to address the need for further research into the concept and curative phenomenon of therapeutic presence and its place in the clinical process. The specific research question is: *How do clinicians' daily mindfulness meditation practices influence therapeutic presence?* Based on the existing research on therapeutic presence, the hypothesis is that a therapist's mindfulness meditation practice is likely to positively influence his/her therapeutic presence.

CHAPTER III

Methodology

Research Purpose and Question

The purpose of this study was to address the need for further research into the concept and curative phenomenon of therapeutic presence and its place in the clinical process. The specific research question was: *How do clinicians' daily mindfulness meditation practices influence therapeutic presence?* Based on the existing research on therapeutic presence, the researcher hypothesized that a therapist's mindfulness meditation practice is likely to positively influence his or her therapeutic presence.

The researcher hoped the proposed study would add to the body of literature examining therapeutic presence from the perspective of therapists themselves, yielding information which could be harnessed to increase therapy efficacy in the future. The study might yield important themes that could possibly guide practice and influence the direction of future therapist training, and possibly continuing education. The findings may be used to recommend knowledge of and/or access to meditation at therapist training institutions.

Design

The researcher chose a qualitative, inductive, exploratory method to answer this new study question in an open-ended fashion (Engel & Shutt, 2013, p. 520). In order to fully explore this phenomenological territory, the researcher used induction, a process whereby theory is generated from the research findings gleaned during data analysis, allowing for a flexible study

that deepens understanding of the phenomenon without a formal assumption about the actual nature of the relationship between a therapist's mindfulness meditation practice and its influence on cultivating therapeutic presence.

A qualitative study via intensive interviews was most appropriate for the work in order to gain data that is descriptive and nuanced (Engel & Shutt, 2013, p. 549). A qualitative approach allowed study participants the space to describe their experience of therapeutic presence in their own words (Engel & Shutt, 2013, p. 550) and it provided for a subjective, interconnected analysis that quantitative methods could oversimplify.

The researcher created an interview guide containing semi-structured, open-ended questions to gather narrative data from study participants. Interviews were conducted in person and via Skype video chat, due to geographic logistics. The plan was to interview 12 clinical social workers, licensed for two or more years, each of which had a daily mindfulness meditation practice for at least 6 months, and an active client base. Eleven clinical social workers were ultimately interviewed for this study. The last scheduled interviewee dropped out at the last minute, due to an emerging medical crisis.

The researcher recorded the 45-minute interviews on a digital audio recorder; a professional transcriber who signed a confidentiality agreement transcribed the recordings. The researcher took notes of her impressions of the participants in a journal directly following the interviews, which lead to valuable clinical evidence/information and which created an audit trail of the study/thesis process. She then analyzed the narrative data for themes and patterns, which informed the generation of a framework that encapsulated the research findings.

This study used Geller and Greenberg's (2002) definition of *therapeutic presence*, which has three components: "an availability and openness to all aspects of the client's experience,

openness to one's own experience in being with the client, and the capacity to respond to the client from this experience" (p. 72). Borrowing from Goleman and Schwartz (1976), *meditation* is defined as "the systemic and continued focusing of the attention on a single target percept...or persistently holding a specific attentional set toward all percepts or mental contents as they spontaneously arise in the field of awareness" (p. 457). *Mindfulness* is defined as "a moment-to-moment awareness of one's experience without judgment" (Davis & Hayes, 2011, p. 198).

The following sections outline the methodology of this study including the sample, data collection, and analysis, and potential bias inherent in the methodology.

Sample

The study population was comprised of licensed clinical social workers who self-reported a daily personal mindfulness meditation practice. Because it was important that study participants have ample experience to draw on, inclusion criteria for participation were the following: licensed clinical social workers who have been in practice for two or more years; who have a current self-reported daily mindfulness meditation practice of at least six months; who have an active client base; and who have the ability to speak and understand English. Study participants lived or worked in Eastern and Western Massachusetts.

Recruitment

This was an exploratory study designed to gain insight into the relationship between mindfulness meditation practice and therapeutic presence. This study relied on non-probability sampling rather than random selection, which is more practical to implement but is somewhat less desirable because it leads to a non-representative sample; because of this, the study results are not generalizable to the larger population of interest (Engel & Shutt, 2013, p. 123).

The researcher used a snowball sampling technique to find participants, as there was no clear sampling frame for social workers with personal mindfulness meditation practices; however, meditating social workers are an interconnected population (Engel & Shutt, 2013, p. 126).

The researcher was involved in meditation communities in the Boston metropolitan area, as well as Western Massachusetts, and began recruitment by inquiring within her meditation communities, via email and a Facebook posting, to see if any community members were also licensed clinical social workers (Appendix C).

As a candidate seeking a master's degree in social work at Smith College School for Social Work, the researcher completed an internship in social work during the course of this research project. Thus, she asked fellow social workers at her internship location if they might identify social workers with daily mindfulness meditation practices willing to participate in this study.

Once the researcher located licensed clinical social workers with daily mindfulness meditation practices, she then asked them to identify other social workers who also had meditation practices, and so on. The Boston metropolitan area and the towns in and near the Pioneer Valley in Western Massachusetts where research was conducted each have large populations of licensed clinical social workers, as well as numerous meditation communities and centers. Thus, there was strong feasibility that the researcher would be able to access 12 social workers which met the inclusion criteria.

When a contact suggested a prospective study participant, the researcher asked the contact to send an introductory email, cc'ing the researcher's confidential email address. If the prospective participant expressed interest in hearing more about the study, the researcher set up a

phone call to conduct an initial screening and assess if the individual met inclusion criteria. If inclusion criteria were met, prospective study participants were given more information about the study and asked if they were interested in participating. The screening and assessment phone call provided the prospective study participant an opportunity to ask questions about the study.

A possible bias associated with the study sample is that the interviewees might have been motivated to participate because they believed that there is a positive correlation between personal mindfulness meditation practice and therapeutic presence.

Further, the small size of the study sample, 11 interviewees, made it highly unlikely that the sample would be representative of a truly diverse sample. This study will likely produce recommendations for further study of specific mindfulness meditation practices and length of practice, with larger study samples representative of a more diverse population. The researcher did not foresee any ethical issues regarding the study sample.

Ethics and Safeguards

This study was designed and undertaken with approval from the Smith College School for Social Work Human Subjects Review Committee (Appendices D, E, F). Risks and benefits of participation were evaluated according to the ethical principles and guidelines for the protection of human subjects of research.

Four major ethical concerns arose during the design of this study: consent, confidentiality, potential for psychological distress, and potential benefits to study participants. To address these concerns, the researcher built several measures into the study design and carried them out during the recruitment, data collection, analysis, and reporting phases.

If an individual agreed to participate in the study, informed consent and confidentiality were discussed, as well as a description of the study, and potential benefits and risks of participation (Appendix A).

If participants wished to participate with an individual interview, the study participant was emailed a copy of both the informed consent and confidentiality so that he/she could look over the forms before being asked to sign at the beginning of the interview. Potential participants were informed of their right to discontinue participation within the study. The last day to discontinue participation in the study was April 1, 2015. This information was included within the informed consent (Appendix A).

Because prospective study participants were licensed clinicians and long-term meditators, the researcher felt confident that the interviewees would be comfortable answering questions that included both professional jargon as well as references to meditation, mindfulness, and the therapeutic encounter. As a clinician in training, the researcher was aware of non-verbal signs of discomfort or distress and monitored the interviews to avoid participant distress. She informed all participants at the beginning of the interview that they could decline to answer any question, and that they could end the interview for any reason.

The benefits for participants included having an opportunity to talk about their experience and possibly gaining further insight into the influence of their daily mindfulness meditation practice on the cultivation of therapeutic presence during the therapeutic encounter and clinical process. Drawing a connection between these areas may have been beneficial to some participants.

All participants read and signed informed consent forms approved by the Smith College School for Social work before participating in the study (Appendix A). Consent letters were kept

separate from notes and transcripts, and each participant was assigned a code number that was placed on all study materials. To address confidentiality, the researcher kept all consent forms, interview notes, and printed transcriptions in a lockable file drawer during the thesis process, and will continue to do so for three years after, in accordance with federal regulations. After three years the researcher will either destroy the material described above or continue to maintain it in this secure fashion. The electronic data and the audio recording digital files will continue to be stored securely in a locked folder on the researcher's password-protected computer.

The researcher is the only one who has access to the audio digital recordings, with the exception of a professional transcriber who signed a confidentiality agreement before transcribing the interviews (Appendix G).

During data analysis, the researcher chose a pseudonym for all study participants that cannot be connected to the participants' actual names or identifying information. The pseudonym was used to protect the confidentiality of the participants throughout the reporting process.

The researcher collected limited demographic data, including age, as well as which school of social work the study participant attended, years of licensure, and months and/or years of daily mindfulness meditation practice, as well duration and frequency of daily mindfulness meditation practice. This data was only used to describe the sample in the aggregate. The researcher did not connect the demographic data to specific study participants, in accordance with maintaining participant confidentiality. Quotes were used to illustrate the research findings, but these quotes were not connected to the demographic data.

Data Collection Methods

The researcher chose a qualitative, inductive and exploratory design for the collection of raw data, in the form of face-to-face or Skype video chat interviews, with 11 participants

acquired through a non-random snowball sampling technique. The participant inclusion criteria included: social work clinical licensure for two or more years, a daily mindfulness meditation practice of six months or more, an ability to speak fluent English, a willingness to participate, and an active client base.

Data collection took place where it was most convenient for the participant, either at the researcher's office, the participant's office, or at a quiet local coffee shop that afforded privacy and convenience to the participant, yet was conducive to acquiring good quality digital audio recordings. The researcher tested the audio digital equipment prior to each interview to ensure collection of the raw data and the accurate representation of the subject's words, respecting the time and efforts of the subject.

As the Boston metropolitan area and the area in and around the Pioneer Valley are densely concentrated with mindfulness meditation centers and communities, as well as licensed clinicians, and because the researcher used a snowball sampling technique to generate a non-random sample of 12 participants, she believed that there was feasibility for acquiring the 12 participants. At the last minute, one interviewee dropped out due to an emerging medical crisis; thus, 11 participants were ultimately interviewed for this study.

The 45-minute interviews were conducted during the months of March and April 2015. Raw data was collected through use of a standardized, open-ended interview schedule, utilizing pre-written questions that were informed by research of the literature review. The responses given by the participants provided raw data that was recorded through a digital audio recoding device, and transcribed, verbatim, by a professional transcriber who signed a confidentiality form.

The researcher asked the demographic questions at the start of the interview to gather background demographic information while building rapport (Engel & Schutt, 2013, p. 515). This technique tends to “break the ice” and build initial rapport in a relaxing manner, helping the interviewer and interviewee become familiar with each other’s cognitive and conversational styles (per E Kersten, Class 13).

A qualitative study requires presenting questions to the participants in a clear and easily understood fashion. The phrasing of the questions contained some professional jargon, as the participants were licensed clinicians, but efforts were made by the researcher to keep the questions at an eighth-grade level of reading comprehension and to construct the phrasing to optimize accessibility to the participants.

The open-ended and detailed questions for the study were drafted prior to the study and were piloted by two individuals who met the screening criteria for the study, but were not included in the sample, to avoid misinterpretation and improve reliability and validity.

The researcher drafted the 10 open-ended questions in order to encourage the 11 participants to provide more than a “yes” or “no” answer, and to provide a specific opinion about a specific subject (per E Kersten, class 13).

The interview guide was divided into two themes: overview of clinical practice and meditation practice, which included four questions; and the relationship between mindfulness meditation and therapeutic presence, which included six questions (Appendix B). The researcher limited probes to increase the reliability and validity of raw data collected. She asked permission to re-connect with the subject, if she needed to clarify anything in the transcript (per E Kersten, class 13).

There are a number of methodological weaknesses that are important to consider in this study. In conducting a qualitative research study with a non-random sample there is no generalizability. With face-to face interviews, interviewer presence may affect/bias the situation or setting; the interviewer's personality may affect/bias the situation; and the quality of the interaction may have unwanted effects on the responses (Steinberg, 1984, p.107). In addition, face-to-face interviews do not provide anonymity for the participants; embarrassment and potential concern about confidentiality may arise, and the interviews are costly in terms of time for both the participants and the researchers (per E Kersten, class 13).

Data Analysis

The primary data for analysis of the study were transcriptions of the face-to-face interviews. The researcher recorded her subjective feelings and thoughts in a personal journal, after each interview, in order to acknowledge and interpret her subjective experiences (Engel & Shutt, 2013, p. 521) and to create an audit trail. This provided additional relevant information about her biases as well as potentially relevant clinical data (per E Kersten, Class 13).

The overarching goal of the data analysis was to explore what themes emerge from the use of daily mindfulness meditation practice by clinicians, as that practice intersects with the cultivation of therapeutic presence within the therapeutic encounter. The data obtained were subjected to a content/theme analysis. The researcher examined this original material and proceeded to code it for themes, reducing it to its most salient categories. Comparing the responses to each question of the interview guide allowed for salient themes and patterns and complexities to emerge.

Once the interviewees were transcribed, the researcher grouped the responses for each question in order to determine frequency of similar positions and salient themes and patterns in

the narrative. She began the coding process by writing initial comments on the transcribed materials and noting emerging themes particular to the narratives. The coding process also included reading each interview several times, analyzing the content for relevant repeating themes, phrases and sentiments, as well as logging material which did not fit into thematic areas. Quotes from participants that best illustrated high frequency responses or themes are included in the findings chapter.

Discussion

The discussion of the study will present the results of the study in relation to the literature reviewed in order to determine and expand upon the following: the relevance of the findings for social work practice, policy, and education; any salient ethical concerns; generalizability of the results; and the study's limitations.

The researcher did not foresee any ethical concerns within the study. As noted above, due to the use of a snowball sample, the study did not yield generalizable data. The researcher acknowledges her bias that mindfulness meditation is a useful practice to enhance therapeutic presence. She is also aware that the participants, though with a range of mindfulness meditation practices and interests, had an interest and may see value in meditation, given their status as long-time meditators. Clearly, the perspectives examined are those of therapists. Thus, the study is limited in that it will not gain insight into how therapeutic presence influences clients. This may be the topic of subsequent study.

CHAPTER IV

Findings

Introduction

The purpose of this qualitative, exploratory study was to address the need for further research into the concept and curative phenomenon of therapeutic presence and its place in the clinical process. This chapter presents findings from interviews conducted with 11 licensed clinical social work therapists with a daily mindfulness meditation in the greater Boston metropolitan area and Western Massachusetts. The overarching goal of the data analysis was to explore what themes emerge from the use of daily mindfulness meditation practice by clinicians, as that practice intersects with the cultivation of therapeutic presence within the therapeutic encounter.

The data presented in this chapter was collected through eight in-person interviews and three interviews via Skype, due to geographic logistics. All participants answered all interview questions. Each interview was fully transcribed by a professional transcriber, who signed a confidentiality agreement, and then analyzed in an open coding format.

The interview questions were designed to carry out an initial exploration of the influence of clinicians' daily mindfulness meditation on the cultivation of therapeutic presence in the relational space of the therapeutic encounter. The interview guide was divided into two sections: overview of clinical practice and meditation practice, which included four questions; and the relationship between mindfulness meditation and therapeutic presence, which included six

questions. During the study, all participants endorsed the hypothesis that a daily mindfulness meditation practice cultivated therapeutic presence within the relational space of the therapeutic encounter.

This section will explain and describe the main themes and their respective subthemes from the data, using examples from the interviews in the service of maintaining fidelity to the participants' voices. The three main themes this section describes are: preparing the ground for therapeutic presence, the process of presence, and the experience of presence.

This section will focus specifically on reporting themes related to the research question. Themes not related to the research question will be discussed in the following chapter. This chapter begins with an explanation of the demographic findings.

Demographic Data

This study involved 11 licensed clinical social workers with a daily mindfulness meditation practice for six or more months, and clinical licensure with an active client base for two or more years. The amount of mindfulness meditation practice varied for each of the study participants, in terms of number of minutes of mindfulness meditation daily practiced, frequency of daily practice, and the overall years of daily mindfulness meditation practice.

The number of minutes of mindfulness meditation practice ranged from 22 minutes to 120 minutes per day. The average of practice minutes for participants was 50 minutes; the mode was 30 minutes, and the median was 37.5 minutes. Four study participants practiced mindfulness meditation twice daily, once in the morning and then once again in the evening. Seven participants practiced once per day.

The years of participant's daily mindfulness meditation practice ranged from 6 to 34 years. The average number of practice was 13.9 years; the mode was 20 years, and the median

was 12 years of daily practice. All study participants practiced sitting mindfulness meditation daily, described by participants as concentrative and/or open monitoring.

The study participants ranged in age from 36 to 65. The average age for participants was 51.8, with a median age of 54, and a mode age of 44. The years of clinical licensure for study subjects ranged from 3 to 33 years. The average years of clinical licensure was 15.9 years, with a median of 17 years of licensure, and a mode of 20 years of licensure.

All study participants received a master's degree in social work. One participant attended Boston College, three participants attended Boston University, one attended New York University, two participants attended Simmons College, and four attended Smith College School for Social Work. All participants stated that mindfulness and/or meditation training was not a core requirement component of their school's master's degree social work curriculum, nor was mindfulness and/or meditation training offered as an elective.

The participants of the study reported their therapeutic clinical theoretical orientation in the following ways: the psychodynamic four psychologies (ego psychology, object relations, self-psychology, Freudian informed); Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Internal Family Systems (IFS); Accelerated Experiential Dynamic Psychotherapy (AEDP); contextual theory; experiential; mindful space, and Eye Movement Desensitization and Reprocessing (EMDR).

Preparing the Ground For Therapeutic Presence

This section details the ways that the participants in the sample utilized their daily mindfulness meditation and mindfulness practices in daily life, and immediately before a client session, to enhance their capacity for presence in session.

Mindfulness meditation prior to client sessions. Participants described the possible impact of increasing the length of their daily mindfulness meditation, before client sessions, to cultivate therapeutic presence while in session. While all the participants ($N = 11$) agreed that their daily mindfulness meditation practice prepared the ground for presence in session, six participants stated that they could not definitively report that an increase in their mindfulness meditation practice would increase their capacity for presence in session. These six participants could only discern the influence of their mindfulness meditation practice, on preparing the ground for therapeutic presence, in the absence of their practice, because their practice had become internalized, and so much of who they are. One participant stated:

It just becomes a part of who you are. It's hard to isolate; I feel like presence is with me all the time. It's important to be on the cushion, but you don't always need to be on the cushion to be present in a really deep way.

Another participant reported, "You know I can't attribute it to that necessarily, to an increase in length of practice. It's probably more cumulative, just consistent practice over time."

Another participant shared:

I did notice a difference from the 45 minutes in the morning to no sit in the morning. Like my day was different. It sort of set the stage for the day. And I would notice a difference in presence compared to days when I didn't sit, before I established a daily meditation practice.

Two participants reported that their daily mindfulness meditation practice increased their capacity for presence, but were uncertain that an increase in length of meditation practice would increase their capacity for in-session presence. Both participants noted that there were other mindfulness self-care factors involved in cultivating in-session therapeutic presence, including

daily spiritual reading, mindfully walking in nature, yoga, mindfulness retreats and trainings, and meditating with a group. A participant shared:

I sit with this Zen meditation group. We meet once a week and then once a month we do a day of sit, walk, sit, with occasional instruction or teaching by the teacher. It's very helpful, especially the energy to sit with other people that want to be there.

Another participant stated:

Meditation is actually not the most important part of my practice. I think the thing that has the most profound impact for me is spiritual reading for half hour to an hour. I mean, that's for me the best time of the day and it sort of sets a tone that's vicarious throughout the day.

One other participant shared:

Well there's the practice and then there is what I read and what I learned from teachers. And I want to say that those two things are both very important. If I were just doing sitting meditation I think it would deteriorate into some kind of self-focus, and it is anyway, most of the time. I have transitioned to reading a little bit every day after I meditate or before I meditate, and that helps me kind of keep my practice on track with presence.

Three participants stated that an increase in the length of their mindfulness meditation practice increased their capacity for presence in session; said one participant: "it is not even hard to gauge; it's very clear to me that it is a positive force in cultivating presence in session." One clinician emphasized:

When we train clinicians one of the things we talk about is the difference between conscious competence and unconscious competence. I think that I when I am less

frequent with my practice I'm much more likely in a state of unconscious competence, right? I think when I'm doing something more regularly, when I increase my meditation practice, I'm more aware of it. So I'm more consciously able to intervene with patients.

Clinician mindfulness meditation directly before or in between client sessions.

Participants were asked if they practice mindfulness meditation directly before session or in-between clients and its influence on their in-session therapeutic presence.

Two of the participants stated that they did utilize a formal meditation practice between clients to prepare the ground for presence for the next session. Said one participant, "I try to do what I call mindfulness meditation, which is really attending in the present moment without commentary without going to the mind. I do that as much as possible during the day." Another subject stated:

Yes, I do, I clear the mind and I am pretty proficient in knowing when that needs to happen. Like I occasionally, where it screws me up, is the last appointment of the day where sometimes because I'm in such a rush to get home, I actually don't take the minute to mindfully and consciously debrief and meditate, before the last session. And then, I'm like oh it is another person. And I'm in that state where people are not people; they are objects in the field to be dealt with. That means I need to (*breathing noise*) come back to the breath, right? It's always there but we don't always remember that to utilize it to prepare for presence.

The other participants ($n = 9$) emphasized that in a hospital setting in medical social work or in community mental health practice or even in private practice, they did not have a lot of time between clients and patients, yet all clinicians practice some form of "mindful pause moment" between client and patients, in order to prepare the ground for presence before the next client.

Said one participant, “I’ll try to check in with myself and that looks like taking a couple deep breaths or you know sometimes I’ll just stop, close my eyes, feel my feet, and just sort of feel my body anchoring.” Another subject recalled:

Sometimes, at the hospital, in the trauma unit, at the end of an encounter, I would just go into the bathroom and wash my hands. And stand there and wash my hands and wash my hands and just breathe and just focus on that. And it was incredibly helpful. Healing for me. Separating from, you know, really physically separating from the place. And then I could go into the next person with presence.

Bracketing clinical theory. All participants ($N = 11$) reported utilizing an intersection of clinical theories within the clinical process of the therapeutic encounter, yet most ($n = 9$) reported bracketing theory before entering the therapeutic space. Said one participant:

I do think a lot about development and attachment and contextual theory, and, of course systems theory, but I find a lot of clinical language and theory gets in between me and my patients. I believe you learn the theories and then you forget them. You go in the room and you’re a person and you go from moment to moment. And that’s what I do in my work. I try to go from moment to moment and stay present.

Therapist use of mindfulness and meditation during a client session. Participants were asked if they used meditation or mindfulness in session to maintain their therapeutic presence in session. All of the participants ($N = 11$) stated that they use some form of mindful focusing during session to draw their attention back to the present moment. Said one participant: “Definitely; sometimes breath work, particularly when I’m sitting with clients where either I’m experiencing a strong emotion or I’m holding one for them; that’s when I most consciously use it.”

Philosophical commitment to presence in daily life. Participants were asked if their mindfulness meditation practiced enhanced their philosophical commitment to presence in daily life. Most participants ($n = 9$) reported that their mindfulness meditation practice cultivated their philosophical commitment to maintaining present-centered awareness to the suffering and pain of their clients. Said one participant, “You know it all comes back to the Dharma and the idea of suffering and the fact we all have that in common and therefore we can work with and help each other.” Another participant said:

I’m very, very comfortable and aware of the deep vein of sorrow running through the world in a human experience. And I don’t try to get away from that or look on the bright side. Suffering is real. And I sort of think I’ve got a full practice and people keep coming back. So it does to me speak to the need some human beings, at least some human beings have, to be able to have someone who can tolerate this truth. There’s horrible stuff out there. I can tolerate rather than get frustrated by that truth, so that ability to be able to sort of sit with the deep sadness of the world is I think totally about Buddhism and leaning into the places that hurt and scare you. You know, running towards that dog rather than running away from it. That’s how I understand Buddhism, mindfulness meditation and presence. It’s not like there’s a lot of suffering and we should just give up. It’s like yeah there’s a lot of work to do; let’s get busy.

The Process of Therapeutic Presence

This section describes how daily mindfulness meditation influences the process of therapeutic presence: what therapists do, when in presence, in session with a client.

Receptivity. This refers to the therapist’s ability to take in the fullness of the client’s experience (Geller & Greenberg, 2012). Participants were asked if their mindfulness meditation

practice influenced their ability to remain present when confronted with client transference.

Almost all participants ($n = 10$) agreed that their daily mindfulness meditation practice enabled them to remain therapeutically present in session. One participant stated:

I can then be very clear about when a client is reacting to me as if I'm another person in their life. Or as if there's someone they want to be or not be. When they're seeing my strengths or weaknesses and they're reacting to me in the room. That has definitely helped me not to react or project or be triggered as quickly as I may have before.

Another participant stated:

My meditation practice helps me notice that the transference is there; that something is happening with the client or in the relationship. Maybe it's a tone shift. Maybe it's the body language changes or the topic is abruptly. And then the meditation practice helps me to decide what to do with the transference, if it's therapeutically beneficial to bring it up or save it for supervision. The meditation practice, it provides a place of choice.

Inwardly attending. This refers to being in contact with how the experience of taking in the fullness of the client's experience resonates in the therapist's own body (Geller & Greenberg, 2012). Participants were asked if their mindfulness meditation practice influenced their ability to remain present when confronted with their own countertransference. Almost all ($n = 9$) agreed that their daily mindfulness meditation practice enabled them to remain therapeutically present in session when confronted with their own countertransference. One participant stated:

Well, you have to be mindful of it first of all. You have to be present enough and have enough space around yourself and your reactions that you don't either go off in your own story in your head or react to their story. So my meditation practice has really helped in that sense.

Said another participant:

My meditation practice helps me by remaining calm enough to not respond out of anxiety. Either to respond out of anxiety in an attempt to soothe the patient so that it feels better to me or to rise to meet it with aggression or my own response so that it escalates things. So, I'll tend to be curious about it. It's easier to tolerate being curious about it. It's like those principles of being in this present moment and noticing that I'm surviving this present moment even though there's affect. Big feeling. Those are I think things that allow me to stay centered so I can tolerate the stuff.

Extending and contact. This process refers to what therapists engage in during the process of presence when extending themselves and their boundaries to the client and meeting the client and contacting them in an immediate way (Geller & Greenberg, 2012). Participants were asked if their mindfulness meditation practice influenced their ability to cultivate compassion for their clients and self-compassion for themselves, in service to maintaining therapeutic presence in session. Over half of all participants ($n = 6$) agreed that their daily mindfulness meditation practice enabled them to cultivate compassion for their clients and self-compassion for themselves, while remaining therapeutically present in session. One participant stated:

Oh yeah. There have been days when I've said something or made an intervention and I felt like why did I do that? Ugh. And just in realizing that the thing to do is just name the feeling for myself and to just be with it. And if there's a part of me that might be aroused to feel shame or wants to be upset, then I find compassion for myself and that part through my meditation practice, by creating a compassionate space for myself.

Another participant stated:

My daily meditation practice helps with the idea that you can't care for others until you've taken care of your own stuff. So I think that's the building block, it is understanding that I have to care for myself, before I even try to be present in any session for anyone else.

One other participant recalled:

I just remember, you know, sitting with people and I just had this experience of having to breathe to get bigger inside, to hold everything. So what I realized is that in order to hold it all, to witness, which is such a huge part of trauma work, you have to breathe. You can't hold your breath. And you know breathing through meditation practice is what allows you to find compassion for yourself.

Experiencing Presence

This section describes how mindfulness meditation informs the experience of presence: what the therapist experiences when in presence, the actual in-session experience of presence.

Immersion. This involves the therapist being intimately engaged, attentive, and absorbed in the experience of the moment (Geller & Greenberg, 2012). All participants ($N = 11$) agreed that their daily mindfulness meditation practice enabled them become absorbed in the therapeutic encounter, while remaining therapeutically present in session. One participant stated:

So there are definitely more moments where I feel present and longer moments when I feel present now than when I first started. I became a therapist sort of around the same time I started practicing mindfulness meditation, so they sort of go hand in hand.

Another subject said:

I guess what comes to mind, and I alluded to it earlier, is that mental chatter is quieted. I hear more what the client is saying, increased the connection more. Often, clients are verbalizing something, but behind it there's another meaning or other meanings.

Expansion. This is the experience of an expansion of awareness and sensation that is experienced when the therapist is tuned into the many nuances that exist in any given moment with the client, within the self, and within the therapeutic relationship (Geller & Greenberg, 2012).

All participants ($N = 11$) agreed that their daily mindfulness meditation practice enabled them to experience the intersection of the client, the self, and the relationship, with an expansion of awareness. One participant noted:

I'm gonna go back several years to when I was running a group. I find that in a group situation mindfulness meditation really makes a difference, because I'm able to hold space for not just individual clients as they speak or they react but for the whole room. And I find in a group setting that therapists who don't meditate may be much quicker to jump in with their own words, rather than knowing how to hold the space or how to use silence, or how to use presence to hold space. How to do all of those things without having to use words or without taking the clients away from where they are and putting them someplace else. That's a big one. And I have a very strong sense of how to hold a space.

Grounding. This refers to the experience of the therapist being centered, steady and whole, grounded in themselves, while entering the client's experiential world (Geller & Greenberg, 2012). All participants ($N = 11$) agreed that their daily mindfulness meditation

practice enabled them to remain grounded in their therapeutic presence experience while in session. One subject stated:

I can be listening and my eyes are on the client and my body language you know suggests that I'm completely present but my mind has just kind of tuned out a little bit just to protect myself. And so I think the practice has helped me not numb as much as I used to.

Being with and for the client. This is the experience of maintaining an intention to respond in a way that is with and for the client's healing process (Geller & Greenberg, 2012).

Participants were asked if their mindfulness meditation practice influenced their ability to cultivate empathy for their clients. Most of the participants ($n = 8$) agreed that their daily mindfulness meditation practice enabled them to cultivate empathy for their clients while remaining therapeutically present in session. One participant noted:

My meditation practice is what makes it possible to discern between empathy and a projection, right? If I'm being mindful I'm able to stay in a state of reduced anxiety as possible. My chances of being accurately able to imagine what they're thinking or feeling is better than if I'm feeling less anxious or agitated. So mindfulness meditation is designed to keep me in a state of calmness. It's actually I think sort of what Freud might have meant when he talked about evenly suspended attention. I'm thinking that the key is that the more calm I am, the more likely I'm gonna have an accurate ability to imagine to the client's experience.

Summary

This chapter presented the findings from questions posed to 11 licensed clinical social work therapists with a daily mindfulness meditation practice. In most areas, there were a variety of responses that were in agreement with each other. However, the arguments made to support

their responses differed, reflecting the dynamic interplay of mindfulness, meditation, and therapeutic presence. This may be due to participant variation in the length of daily mindfulness meditation practice, the frequency of daily practice, and the overall years of meditating experience mindfulness practice to cultivate and bolster therapeutic presence.

All participants agreed that their formal daily mindfulness meditation practice had a positive direction of association on the cultivation of in-session therapeutic presence, though only a few reported that they could definitively state that increasing the length of their daily meditation practice would increase their in-session experience of presence. Surprisingly, several participants stated that it was in the absence of their daily mindfulness meditation that the influence of their practice on their ability to maintain therapeutic presence became discernable.

Several participants reported that their in-session therapeutic presence was influenced by the quantity of their daily mindfulness meditation practice, as well as the quality of their overall mindfulness practice. These therapists noted that the combination of their daily meditation practice with other formal and informal mindfulness practices such as yoga, spiritual readings, and intensive mindfulness retreat practice bolstered their in-life and in-session therapeutic presence.

All participants agreed their philosophical commitment to maintaining presence in their lives, and within the therapeutic encounter was informed by their daily mindfulness meditation practice. Several participants noticed the interdependent and reciprocal influence of daily mindfulness and meditation practices in cultivating relational connectedness in their personal and professional lives.

Over half of the participants suggested that they utilized mindfulness meditation techniques, immediately prior to sessions, in-between sessions, and during sessions, to return their attention back to the present moment in session.

Most of the subjects reported that their mindfulness meditation assisted with navigating client transference and their own countertransference reactions. Most of the participants reported that their mindfulness meditation practice aided in cultivating compassion and empathy for their clients, and self-compassion for themselves, as therapists.

As an aggregate, the study participants utilized a broad range of clinical theoretical and practice models. All participants agreed that mindfulness and meditation could be a useful in-session clinical intervention, if clinically appropriate given the intersection of client's diagnosis and psychosocial stressors. Several participants stated that they felt that clinical theory could sometimes get in the way of the clinical process and relational experience of the therapeutic encounter, and that their meditation practice assisted them in bracketing preconceived notions of session outcome and use of theory. Further, participants reported that this bracketing, shaped by their mindfulness meditation practice, enabled greater cognitive and affect flexibility, when bearing witness to the pain and suffering of their clients.

The main themes that emerged from the qualitative data in this study exploring how clinicians' daily mindfulness meditation influence the cultivation of therapeutic presence are: preparing the ground for presence, the process of presence, and the experience of presence.

The implications of these findings for social work practice and education follow in the next chapter. The following chapter also contains a further discussion of the main themes and the reviewed literature, and an outline of study bias and limitations, as well as recommendations for future research.

CHAPTER V

Discussion

The purpose of this research study was to explore the concept and curative phenomenon of therapeutic presence and its place in the clinical process. Specifically, how do clinicians' daily mindfulness meditation practices influence the cultivation of therapeutic presence in the relational space of the therapeutic encounter? The framework outlined in this discussion arose through analysis of qualitative data collected during eight in-person interviews and three interviews conducted by Skype, with 11 clinical social work therapists. These 11 therapists identified as maintaining a daily mindfulness meditation practice, for at least six months, and as licensed independent clinical social workers, with an active client base, for at least two years. Further, the 11 participant therapists identified their formal daily mindfulness meditation practice as a concentrative and/or open monitoring sitting meditation practice.

This chapter opens with an exploration of the salient findings inducted from the subject narratives in the context of the literature reviewed. This will be followed by limitations in study data and design, implications for clinical practice and education, as well as areas for further clinical research. A summary concludes this chapter.

Salient Themes in Relation to the Literature

The findings verify the dynamic interplay of daily mindfulness meditation and the cultivation of therapeutic presence within the relational space of the therapeutic encounter. Study participants, however, each had slightly different interpretations of the interconnectedness of

meditation, mindfulness and presence based on their personal experiences of in-session therapeutic presence.

The major findings of this research project are: All participants ($N = 11$) agreed that their daily mindfulness meditation practice had a positive influence on the cultivation of in-session therapeutic presence, enabling greater cognitive and affect flexibility, when bearing witness to and holding space for the pain and suffering of their clients. Most of the subjects ($n = 9$) reported that their mindfulness meditation assisted with navigating client transference and their own countertransference reactions. Most of the participants ($n = 9$) reported that their mindfulness meditation practice aided in cultivating compassion and empathy for their clients, and self-compassion for themselves, as therapists. All participants ($N = 11$) suggested that they utilized mindfulness meditation techniques, immediately prior to sessions, in-between sessions, and during sessions, to return their attention back to the present moment-centeredness, in service of cultivating and maintaining therapeutic presence.

These main findings are generally supported in the existing empirical and theoretical literature, which were outlined in the literature review.

The following sections highlight how the three themes/domains from this study compare with the existing empirical and theoretical literature on the connection between daily mindfulness meditation practice and the cultivation of therapeutic presence. Preparing the ground for presence is considered first, followed by the process of presence, and finally, experiencing presence.

Preparing the Ground for Presence

Findings indicate that all participants ($N = 11$) agreed that their daily mindfulness meditation practice prepared the ground for presence in session, however six study participants

stated that they could not definitively report that an increase in their mindfulness meditation practice would correlate to an increase in their capacity for presence in session.

These findings are contrary to the findings in Dunn, Callahan, Ivanovic et al. (2013), which suggested that there may be a dose-effect relationship between the length of therapist mindfulness practice and an increase in therapeutic presence.

Findings indicate that two of the participants of the study utilized a formal meditation practice between client sessions to prepare the ground for presence for the next session. The other study participants ($n = 9$) emphasized that in a hospital setting, in medical social work, or in community mental health practice or even in private practice, that they did not have a lot of time between clients and patients, yet all found practicing some form of “mindful pause moment” between client and patients was useful in preparing the ground for presence before the next client or patient. These findings are consistent with the findings of the Dunn, Callahan, Ivanovic et al. (2013) study, which showed that therapists perceived themselves as being more present in the session when they prepared for their sessions by engaging in a formal or informal mindfulness exercise directly before a session.

Also, consistent with the findings of this study, Dunn, Callahan, Ivanovic et al. (2013) suggested that mindfulness can be used as a convenient in-the-moment tool for therapists to utilize when preparing for an upcoming client session.

Findings indicate that all of the participants ($N = 11$) stated that they use some form of mindful meditative focusing during session to draw their attention back to the present moment and to maintain therapeutic presence. These findings support the study findings of Gockel et al. (2013), which stated that participants in that study reported detailed instances in which they

credit their in-session mindfulness practice for helping them improve their in-session skills, often significantly, including therapeutic presence and attentiveness.

Findings indicate that all participants ($N = 11$) reported utilizing an intersection of clinical theories within the clinical process of the therapeutic encounter, yet most ($n = 9$) reported bracketing theory before entering the therapeutic space. These nine participants stated their meditation practice assisted them in bracketing both preconceived notions of session outcome and an over use of clinical theory as a clinical skill and intervention. These findings are consistent with an empirical research study conducted by (Davis & Hayes, 2011), which demonstrated mindfulness meditation enables people to have greater cognitive flexibility (Davis & Hayes, 2011). Cognitive flexibility can promote greater flexibility in conceptualizing the client's issues and increase creativity in responding to the client's needs in the moment (Fulton, 2005).

The findings indicate that most participants ($n = 9$) reported that their mindfulness meditation practice cultivated their philosophical commitment to maintaining personal self-care, in service of maintaining present-centered awareness in session and in their personal lives. These findings support the findings of Shapiro et al. (2007), which showed that an MBSR program helped to prepare psychotherapy trainees for the demanding work of being a therapist by developing self-care and the cultivation of mindfulness qualities.

Further, the findings of Shapiro et al. (2007) demonstrated that mindfulness practice helps therapists in training to reduce stress, tension, and anxiety, in part through the development of affect regulation.

Process of Presence

The findings indicate that almost all participants ($n = 10$) agreed that their daily mindfulness meditation practice enabled them to remain therapeutically present in session when confronted with strong client transference. These findings support the Fritz and Mierzwa (1983) review study, the purpose of which was to present anecdotal and research reports, which related meditation to the capacity of therapists to engage in behaviors basic to the therapeutic relationship. Within the Fritz and Mierzwa (1983) review, Carrington and Ephron (1975) were cited as anecdotally noting the potential contribution of meditation to the professional skills of the psychoanalytically oriented therapist, and reporting the following changes in their professional therapeutic work derived from regular meditation practice: increased receptivity to spontaneous perceptions of unconscious conflicts and less sense of threat when confronted with a patient's negative transference.

The findings indicate that almost all participants ($n = 9$) agreed that their daily mindfulness meditation practice enabled them to remain therapeutically present in session when confronted with their own countertransference. These findings support Gehart and McCollum's (2008) study, which showed that participants' mindfulness practice was useful in highly stressful client-therapist interactions, moments of personal vulnerability, and situations where they would typically react otherwise. The findings of this study also support the findings of Gockel et al. (2013), which stated that important to therapeutic success is helping the novice clinician identify and manage negative internal affective reactions to the client, typically called countertransference. Further empirical evidence reviewed in the literature suggested that mindfulness helps develop affective emotion regulation in the brain (Davis & Hayes, 2011).

Findings indicate that over half of all participants ($n = 6$) agreed that their daily mindfulness meditation practice enabled them to cultivate compassion for their clients and self-compassion for themselves, while remaining therapeutically present in session. These results support the findings of McCollum and Gehart (2010), which showed that mindfulness training fosters the clinician's ability to embody core affective traits such as empathy, warmth, and greater acceptance and compassion toward self and other in the helping relationship. The findings of Gehart and McCollum (2008) also suggested that student's mindfulness practice helped them develop qualities that are reflective of therapeutic presence, such as the ability to attend to both the client's and their own experience, and to respond from a confluence of both.

Experience of Presence

Findings indicate that all participants ($N = 11$) agreed that their daily mindfulness meditation practice enabled them to become absorbed, attentive, and engaged in the therapeutic encounter, while remaining therapeutically present in session. These results support the findings of Gockel et al. (2013), which showed that mindfulness training helped beginning MSW students develop clinical intervention skills.

Participants in the Gockel et al. (2013) study reported that mindfulness training enhanced their learning in the classroom and was helpful to their development of counseling skills. The participants also reported that mindfulness training helped them manage distractions and anxiety, facilitated their ability to attend and respond to the client, and encouraged them to be more self-aware and flexible in their thinking in the classroom and the field (Gockel et al., 2013).

Findings indicate that all of the participants ($N = 11$) agreed that their daily mindfulness meditation practice enabled them to experience the intersection of the client, the self, and the therapeutic relationship, with an expansion of awareness. These findings support Greason and

Cashwell's (2009) study, which investigated the relationship between mindfulness and counseling self-efficacy, and found that counseling self-efficacy was significantly predicted by self-reported mindfulness among masters-level interns and doctoral candidates.

In the Greason and Cashwell (2009) study, attention mediated the relationship between mindfulness and self-efficacy, suggesting that mindfulness may contribute to the development of beneficial attentional processes that aid psychotherapists-in-training. Greason and Cashwell (2009) confirmed this relationship, and found that the students' ability to sustain attention and to simultaneously attend to multiple points of focus in the counseling process mediated the relationship between mindfulness counseling and self-efficacy among master's and doctoral students in counseling internships.

Findings indicate that all of the participants ($N = 11$) agreed that their daily mindfulness meditation practice enabled them to remain centered, open, and steady in their therapeutic presence experience while in session. These findings are consistent with empirical evidence reviewed in the literature, which indicated that mindfulness meditators develop the skill of self-observation that neurologically disengages automatic pathways created from prior learning and enables present moment input to be integrated in a new way (Siegel, 2007a).

Findings indicate that most of the participants ($n = 8$) agreed that their daily mindfulness meditation practice enabled them to cultivate empathy for their clients while remaining therapeutically present in session. These findings support Siegel's (2007b) argument that our ability to become attuned to ourselves draws on the same neural circuitry that enables attunement to others; paying attention to ourselves, appears neurologically related to empathic attunement to others.

These findings also support the findings of Geller and Greenberg (2002), which suggested that practicing attuned presence and mindfulness in relationship with others is profoundly important for therapists, because it is the relational aspect of presence that is often most challenging in therapist's personal lives, and in direct relationship with the clients sometimes insurmountable pain.

Limitations in Study Data and Design

There are several limitations to this study. The study was conducted with a small sample size ($N = 11$). Each participant maintained a daily mindfulness meditation practice and has been a licensed and practicing independent clinical social work therapist, for more than two years, which accurately reflected the criteria for the target population.

Also, participants self-reported the length their daily mindfulness meditation practice, though all participants endorsed a daily sitting mindfulness meditation practice.

Although the findings confirm what was found in the literature, the small sample size does not allow the findings to be highly generalizable, as a non-probability snowball sampling method was used to recruit subjects for this study. Instead, the findings provide an in-depth examination of the research question.

A possible bias associated with the study sample is that the interviewees might have been motivated to participate because they believe that there is a positive correlation between personal mindfulness meditation practice and therapeutic presence. The researcher is also aware that the participants, though with a range of mindfulness meditation practices and interests, will have an interest and see value in meditation, given their status as long time meditators.

The validity of the theory generated from this inductive study is limited by the nature of the sample such that it may be particular to the sample. All study participants self-selected for the interviews.

The researcher acknowledges her bias that mindfulness meditation is a useful practice to enhance therapeutic presence. However, she remained mindful of this bias and ensured that the 10 interview questions were in an open form, without leading or judgmental language. She created an interview guide for the study that she piloted with individuals who met the screening criteria and were not included in the study. Because the study was exploratory, the questions were intentionally vague so that participants could identify their own meanings and associations with the research questions. The interview guide prompted responses that were tied to the research question. Given the practical nature of the findings and recommendations, they stand as good social work practice and consistent with the field.

Implications for Practice and Social Work Education

The findings in this study verified the positive direction of association between clinicians' daily mindfulness meditation practice and the cultivation of therapeutic practice in the relational space of the therapeutic encounter. The dynamic interplay of mindfulness, mediation, and therapeutic presence was evident throughout the empirical and theoretical literature and the participant responses. Participants, however, each had slightly different interpretations of that link based on their personal understanding of their mindfulness meditation practice and its influence on cultivating their experience of therapeutic presence, including preparing the ground for therapeutic presence, the process of therapeutic presence, and the experience of therapeutic presence.

This study contributes to the empirical clinical research related to the intersection of mindfulness, meditation, and therapeutic presence. The findings of this study can be used to enhance social work practice and clinical training pedagogy at social work educational institutions. The findings can also be used to make a recommendation that mindfulness meditation training become a core social work competency, focused on the cultivation and transfer of mindfully informed clinical skills from the classroom to the relational therapeutic encounter.

Mindfulness training is thought to foster the clinician's ability to embody core affective traits such as empathy, warmth, and compassion in the helping relationship (Gehart & McCollum, 2008).

The data in this study suggest that mindfulness meditation practice is useful in cultivating self-care, self-efficacy, and clinical skills (Dunn et al., 2013; Gockel et al., 2013; Greason & Cashwell, 2011; Geller et al., 2010) useful in the therapeutic encounter for therapists in general, and therapists in training, in particular.

Shapiro et al. (2007) reviewed in the literature stated that mindfulness meditation provided a well-researched stress management technique that enabled clinicians to better handle the challenges commonly experienced in early years of training, by reducing stress, tension, and anxiety and increasing self-care, in part through the development of affect regulation.

Advocates of mindfulness training argue that mindfulness training fosters the development of many of the skills and characteristics that are pivotal to the therapeutic effectiveness (Gehart & McCollum, 2008; Morgan & Morgan, 2005), making mindfulness of value as a pedagogical strategy for clinical instruction.

Although based on a limited number of clinicians' experience, this study provides support for the scope of clinical training to include assigning mindfulness meditation activities to directly help experienced therapists and clinical social work students in training to: (a) develop therapeutic presence (as a learning goal) and (b) manage the anxiety that many experience seeing clients for the first time and sitting with clients whom they experience a strong countertransference (Gockel et al., 2013).

Given that the findings of this study confirm that mindfulness meditation is a means to develop mindfulness and therapeutic presence, both social work education and continuing education programs could beneficially offer mindfulness meditation training (Geller & Greenberg, 2012; Gockel et al., 2013; Fulton, 2005).

Areas of Further Clinical Research

Although the findings of this study provided qualitative empirical data to support the positive direction of association between a daily mindfulness meditation practice and the cultivation of therapeutic presence, and other useful clinical skills, including emotional regulation, cognitive flexibility, and the affective qualities of compassion and empathy (Pollak et al., 2013), additional studies are needed.

In the reviewed literature, Dunn, Callahan, Ivanovic et al. (2013) demonstrated that therapist mindfulness meditation practice is associated with better client outcomes, in terms of the client's increased experience of the therapist's presence. This study could be replicated in order for the association to be more convincingly demonstrated.

Further, there is a need to experiment with a specific quantified "dosage" of mindfulness meditation practice, in relation to the cultivation of theoretical presence. In the current study, while each clinician practiced sitting mindfulness meditation each day, the range of daily

practice, that is the dose of sitting mindfulness meditation, varied from 22 minutes to 2 hours per day, with an overall average of 50 minutes per day. Dunn, Callahan, Ivanovic et al. (2013) noted that there might be a dose-effect relationship between the length of mindfulness exercise and the amount of improvement in the therapist's therapeutic presence and/or client outcomes. Also, different research designs that do not rely on participant self-report measures of daily mindfulness meditation need to be used.

Quality of practice time is potentially as relevant to outcomes as quantity thereof (Dunn, Callahan, Ivanovic et al., 2013). This issue also deserves consideration in future research. More research is needed to better understand how the benefits of mindfulness meditation practice accumulate over time and influence the cultivation of therapeutic presence over time. Research in neuroplasticity may help explain the relationship between length and quality of meditation practice (Walsh & Shapiro, 2006).

Research might also explore whether the use of formal versus informal mindfulness practices produce differing outcomes in the cultivation of therapeutic presence.

Summary

This study provides valuable information about the concept and curative phenomenon of therapeutic presence and its place in the clinical process, confirming the researcher's hypothesis that a therapist's mindfulness meditation practice is likely to positively influence his/her therapeutic presence.

Given that the therapeutic relationship is an emotionally intimate, potentially conflictual, and inherently interpersonal, therapist's trait presence cultivated through mindfulness and meditation may aid their ability to develop and sustain clinically useful affective qualities like empathy and compassion, clinically necessary cognitive skills such as attention and non-

judgment, as well as an efficacious therapy process and therapeutically healing relationships with clients.

The study also supports the empirical literature, which suggests that mindfulness training can bolster a clinician's perception of clinical efficacy and support an intention for personal self-care, as a preventive measure against professional burnout, especially for therapists in training (Shapiro et al., 2007). The findings of this study can be used to enhance social work practice and clinical training pedagogy at social work educational institutions.

Although the findings confirm what was found in the literature, the small sample size does not allow the findings to be highly generalizable, as a non-probability snowball sampling method was used to recruit subjects for this study. Instead, the findings offer an in-depth examination of the research question.

This study examines two aspects of the participants' lives: daily mindfulness meditation and therapeutic presence. It is the researcher's hope that the information presented in this study will be of use to both experienced and novice meditators, as well as experienced clinicians and therapists in training, in cultivating therapeutic presence, in the challenging, surprising, and beautiful space of the relational therapeutic encounter.

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Appendix A: Informed Consent Form



**Consent to Participate in a Research Study Smith College
School for Social Work • Northampton, MA**

.....
Title of Study: Cultivating Presence: Effects of Therapist’s Daily Meditation Practice on
Therapeutic Presence

Investigator(s): Mara Galus, cell: X.XXX.XXX.XXXX, Smith College School for Social Work

.....

Introduction

- You are being asked to be in a research study of the effects of therapist’s daily mindfulness meditation practice on therapeutic presence and the relational space of the therapeutic encounter.
- You were selected as a possible participant because you have been a licensed and practicing clinical social worker for one or more years, and because you have a current daily meditation practice, for at least six months or more.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn about the effects of therapist’s daily mindfulness meditation practice on therapeutic presence and the relational space of the therapeutic encounter.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you will be interviewed by the researcher for 45 minutes. The interview will be audio recorded.

Risks/Discomforts of Being in this Study:

- The study has no reasonable foreseeable (or expected) risks, but I will be asking you to discuss moments from the therapeutic clinical encounter and process, which may evoke discomfort. Feel free to decline to answer any question, or even end the interview early if the interview causes you any discomfort.

Benefits of Being in the Study

- The benefits of participation are having an opportunity to talk about your experience and possibly gaining further insight into the influence of daily mindfulness meditation practice on therapeutic presence.
- The benefits to social work/society are: to provide information for further research. The proposed study will add to the body of literature examining therapeutic presence from the perspective of therapists themselves, yielding information which may be harnessed to increase therapy efficacy in the future. The results of the study may influence the direction of future therapist training and possibly continuing education, as the findings may be used to recommend knowledge of and/or access to meditation at therapist training institutions.

Confidentiality

Your participation will be kept confidential. The researcher will be the only person who will know about your participation. The interview will take place either at the researcher's office, at your office, a quiet local coffee shop or at another public place of your choice that affords privacy, yet is conducive to acquiring good quality audio recordings.

In addition, the records of this study will be kept strictly confidential. I will be the only one who will have access to the audio recording, with the exception of a potential transcriber, who will sign a confidentiality agreement. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time up to April 1, 2015 without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You

must notify me of your decision to withdraw by email or phone by April 1, 2015. After that date, your information will be part of the thesis and final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Mara Galus at maragalus@gmail.com or by telephone at X.XXX.XXX.XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....
Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

.....
[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

Appendix B: Interview Guide

Demographic Questions

- What is your current age?
- How many years have you been a licensed independent clinical social worker?
- Which school of social work did you receive your master's degree from?
- Did you receive any type of mindfulness meditation training through your school of social work while you were working towards acquiring your master's degree in social work?

Overview of clinical practice and meditation practice

- How many months or years have you had a mindfulness meditation practice?
- How many times a day do you practice mindfulness meditation and for how long do you practice each time?
- How would you describe your current mindfulness meditation practice?
- Do you practice mindfulness meditation in-between clients? While in session? Immediately before a session?
- How would you describe your clinical theoretical orientation?

The relationship between mindfulness meditation and therapeutic presence

- How do you notice a difference in relational moment-to-moment experience of the therapeutic encounter, given an increase in the length of your daily mindfulness meditation practice?
- How does your mindfulness meditation practice influence your ability to tolerate client negative and positive transference?
- How does your mindfulness meditation practice influence your ability to tolerate or modulate your in-session countertransference affect?
- How does your mindfulness meditation practice assist with therapist "inner chatter"?
- How does your mindfulness meditation practice assist you with cultivating empathy for your client?
- How does your mindfulness meditation practice assist you with cultivating compassion for your client? For you, in your role as therapist?
- Are there other ways that your mindfulness meditation cultivates or enhances your openness and availability, your therapeutic presence, within the therapeutic encounter?

Appendix C: Recruitment Email and Facebook Post



Greetings!

My name is Mara Galus, and I am a graduate student at Smith College School for Social Work. I am currently conducting a research study to fulfill the thesis requirement of my graduate program. This study, titled: *Cultivating Presence: Effects of Therapist's Daily Meditation Practice on Therapeutic Presence* will explore the impact of therapist's daily mindfulness meditation practice on therapeutic presence and the relational space of the therapeutic encounter. Participation in the study is confidential.

As part of the study, you would be asked to participate in a 45-minute interview in-person that will be audio recorded. In order to be part of the study you must:

- be a licensed clinical social worker currently in practice, for two years or more
- have a current daily mindfulness meditation practice, for six months or more
- be able to complete the interview in English

Your participation in the study will be kept confidential. You will not be monetarily compensated for participating in this study. The results of the study may be published or used in presentations, though individual identities will be disguised. Participants have the right to withdraw from the study at any time.

If you are interested in participating in this study you may contact me by email or by phone at maragalus@gmail.com or X.XXX.XXX.XXXX. If someone you know would be interested in being interviewed for this study, please forward this message to them.

Thank you for your time and consideration and I look forward to hearing from you!

Appendix D: Human Subjects Review Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 11, 2015

Marianne Galus

Dear Mara,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Tessa Hutchinson, Research Advisor

Appendix E: Research Project Change of Protocol Form – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Cultivating Presence: Effects of Therapist’s Meditation Practice on Therapeutic Presence
Mara Galus
Tess Hutchinson

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

- 1) **Interviews will be conducted in person, as well as by Skype, utilizing a laptop computer.**
- 2) **For interviews conducted by phone, participants will be sent an informed consent letter by mail, as well as provided with a postage paid and self-addressed envelope to return the informed consent letter, with a “wet” signature”, to the researcher.**

[DESCRIBE ALL PROTOCOL CHANGES BEING PROPOSED IN NUMERIC SEQUENCE;
BE BRIEF AND SPECIFIC]

.....

I understand that these proposed changes in protocol will be reviewed by the Committee.
 I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
 I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Mara Galus

Name of Researcher (PLEASE PRINT): Mara Galus **Date:** March, 16, 2015

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO:
Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

******Include your Research Advisor/Doctoral Committee Chair in the ‘cc’. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.******

.....

Appendix F: Email approval from L. Wyman, HSR protocol change

Dear Mara,

Congratulations! Approval of your amended Research Application is confirmed in the attached letter from Dr. Elaine Kersten, Co-Chair of the Human Subjects Review Committee.

As this approval letter will be included in your thesis, for security purposes we have not included your address information.

Your Research Adviser Tessa Hutchinson has received a copy as well.

Do contact me with any questions.

Best wishes in your research.

Laurie

--

Laura H. Wyman
Administrative Assistant/Research Sequence
Smith College School for Social Work
Lilly Hall
Northampton, MA 01063
[\(413\) 585-7974](tel:4135857974)

Appendix G: Transcriber Confidentiality Form

Volunteer or Professional Transcriber's Assurance of Research Confidentiality

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, - *insert name of researcher* - shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

PLEDGE

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, - *insert name of researcher* - for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

Christy Sanders-Wilson

Signature

4/17/15

Date

Insert name of researcher

Date