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Effects of pre-session centering for therapists on session presence and effectiveness

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Abstract
The present study tested whether engaging in a mindfulness centering exercise 5 minutes before a session could have a positive impact on therapy, in particular on the therapists’ ability to remain present in session and on session outcomes. Results indicated that therapists perceived themselves as being more present in session when they prepared for their sessions by engaging in a mindfulness centering exercise ($d = .45$), while clients perceived their therapists as being highly present regardless of whether their therapist completed the mindfulness centering exercise. Clients did, however, perceive the sessions as being more effective when their therapists engaged in the mindfulness centering exercise prior to the start of the session ($d = .52$).

Keywords: therapist training; psychotherapy outcomes; mindfulness; therapeutic presence; randomized controlled adjunctive-instruction design

In recent years a burgeoning amount of empirical research has focused on the use of mindfulness in the field of psychology. In particular, research on mindfulness has demonstrated the positive effects of using mindfulness as an intervention for clients experiencing a variety of clinical conditions (Cullen, 2011). Furthermore, recent research has suggested that therapists’ practice of mindfulness may be beneficial to therapists’ personal well-being, while also helping them develop important therapeutic skills and attributes, such as empathy and compassion (Aggs & Bambling, 2010; Bruce, Shapiro, Constantino, & Manber, 2010; Davis & Hayes, 2011). For example, Shapiro, Brown, and Biegel (2007) found that therapists who engaged in an 8-week mindfulness-based stress-reduction program showed significant decreases in stress, negative affect, rumination, and state and trait anxiety, and significant increases in positive affect and self-compassion. It is hypothesized that cultivating a non-judgmental, compassionate attitude for oneself through mindfulness will in turn promote a sense of acceptance and compassion for others (Kristeller & Johnson, 2005; Ryan, Safran, Doran, & Muran, 2012). Therapists’ ability to remain attentive during sessions has been identified as another important factor in therapy (Greason & Cashwell, 2009). A major focus of mindfulness is developing moment-to-moment awareness and the ability to direct attention to the present moment. McCollum and Gehart (2010) found that therapists believed they were more present during sessions, were more comfortable with silences, and were more attentive and responsive to clients after participating in mindfulness training. Others have similarly found positive results associated with mindfulness training for therapists (Greason & Cashwell, 2009; Moore, 2008; Schure, Christopher, & Christopher, 2008; Shapiro, Astin, Bishop, & Cordova, 2005).

Although research has demonstrated that therapists who practice mindfulness report improvements in their own well-being and therapeutic skills, few studies have examined whether these self-perceived benefits translate to actual improvements in therapeutic outcomes. In particular, there is a lack of research investigating whether therapists’ use of mindfulness leads to improved therapy outcomes from the clients’ perspective. This topic is of particular importance when considering attrition rates in psychotherapy and the need to train beginning therapists in effective ways to establish strong therapeutic relationships with their clients.
In the first contemporary study that examined the relationship between therapist mindfulness and client outcome, Stanley et al. (2006) measured levels of mindful awareness for 23 trainee therapists in a psychology department training clinic. They conducted an archival review of the outcome data for all of the clients seen by those 23 therapists. While therapist mindfulness was not related to clients’ ratings of their own improvement, it was negatively correlated with clients’ symptom reduction at termination. These results appear to indicate that therapist mindfulness might actually have a negative impact on treatment outcomes. One limitation of the study that should be considered is that they did not assess for mindfulness levels while the therapists were seeing the clients whose outcome data were used in the study. Thus, it cannot be assumed that therapists’ levels of mindfulness at the time of the assessment were the same as when the therapists were seeing the clients. Another limitation is that therapists were not trained in mindfulness during the study nor were they instructed to practice mindfulness exercises. The researchers relied on a self-report measure of awareness and attention to assess for mindfulness, which could be problematic since self-reports of mindfulness may not reflect true levels of mindfulness (Grossman, 2008). As Davis and Hayes (2011) point out in their review of the mindfulness literature, mindfulness practice may be a better predictor of treatment outcomes than self-reports of mindfulness.

Grepmaier et al. (2007) conducted a randomized, double-blind, controlled study examining the influence of therapist mindfulness on client outcomes. For this study trainee therapists were randomly assigned to a 9-week daily Zen meditation group or a control group (no meditation). Compared to clients seen by the therapists in the control group, clients who were seen by the therapists who practiced daily Zen meditation reported a greater understanding of their problems, an increased problem-solving capacity, and a greater reduction of symptoms by the end of their treatment. A strength of this study was the promotion of mindfulness in therapists through daily meditation practice rather than relying solely on self-report measures. Additionally, the study’s randomized, double-blind, controlled design adds to the strength of the findings. The use of randomization and control conditions is significantly lacking in the existing mindfulness literature. The results of this study support the use of mindfulness practice to improve therapeutic outcomes; however, therapists in the study were asked to complete a relatively intense mindfulness training program, which included 1 hour of training each morning for 9 weeks. The applicability of such time-consuming practice in the schedules of graduate students may be a limitation of the study.

Ryan et al. (2012) investigated the association between therapist pre-training, dispositional levels of mindfulness and therapist self-affiliation (or friendliness towards the self), the therapeutic alliance, and treatment outcome. Results of the study indicated that therapists with higher levels of trait mindfulness were found to report higher levels of positive self-affiliation. Therapist mindfulness was also positively correlated with therapist ratings of the working alliance. On patients’ ratings of working alliance, therapist mindfulness was associated only with the Act with Awareness subscale, suggesting that therapists’ sustained attentiveness and focus may positively impact patients’ perceptions of the working alliance. There was no significant relationship between therapist mindfulness and symptom improvement; however, therapist mindfulness was associated with patient-rated improvements in interpersonal functioning. This study offers partial support for the hypothesis that therapist mindfulness has a positive impact on therapeutic outcomes.

Due to the limited research and contradictory findings, further research is needed to understand whether therapists’ mindfulness actually influences therapeutic outcomes. Furthermore, no existing research has examined whether completing a mindfulness exercise immediately preceding a session would lead to improved client outcomes. While several studies have demonstrated the benefits of therapists completing a mindfulness training program, it is unclear whether therapists continue to utilize mindfulness practice after the program ends. Training therapists to use a brief mindfulness exercise as a part of their preparation routine for upcoming sessions would provide them with an accessible tool in order to maintain the benefits that were gained from the training program. Additionally, completing mindfulness practice immediately before a session, as opposed to hours or days before meeting with a client, may have a more potent effect on therapeutic outcomes.

The purpose of the current study was to test whether engaging in a mindfulness centering exercise 5 minutes before a session could have a positive impact on therapy, in particular on the therapists’ ability to remain present in session and on session outcomes. We hypothesized that therapists who completed the mindfulness centering exercise before a session would be rated (by self and client) as having more presence in session and clients would rate sessions as more effective, as compared to sessions when the therapist did not complete the mindfulness centering exercise. The results of this study have important implications regarding whether the practice of mindfulness can be used as an effective session preparation tool for therapists.
Method

Participants

Participants were 25 trainee therapists who were completing their in-house practicum at one of two psychology department training clinics. Nineteen of the trainees were graduate students enrolled in one of three APA-accredited, scientist-practitioner doctoral programs in psychology (Clinical Psychology, Clinical Health Psychology and Behavioral Medicine (accredited as Clinical), and Counseling Psychology) at a large university in the West South Central Division of the United States. The remaining six trainees were graduates students enrolled in either a Clinical Psychology master’s program or an APA-accredited doctoral program in Clinical-Community Psychology at a large University in the Pacific Northwest Division of the United States. All of the training programs espouse a scientist-practitioner model of training and neither training clinic requires their students to adhere rigidly to one specific theoretical orientation. Students from each program normally begin their practicum at the end of their first year or beginning of their second year in training, following successful completion of pre-practicum training and competency attainment (to include instruction and supervision in the areas of basic clinical skills, ethics, and psychopathology). While the master’s students typically complete only one semester of training in the department clinic, the doctoral students see clients in the clinic over several consecutive semesters.

Trainees were primarily female (68%) and Caucasian (72%; Hispanic n = 2; Asian-American n = 1; Bi/multi-racial or other n = 4). The average age was 26.28 (SD = 2.75), ranging from 22 to 34 years old. They reported an average of 2.75 (SD = 0.83) years of training in their respective programs and an average of 2.48 (SD = 1.69) years of clinical experience. Almost all of the trainees endorsed either a cognitive-behavioral (42.9%) or integrative (42.9%) theoretical orientation, with the remaining identifying with a dynamic (4.8%), client-centered (4.8%), or other (4.8%) orientation.

Client participants (n = 89) were those adults who were seen for at least one individual therapy session during the study time period. Given that the clients were secondary participants, and were unaware of the purposes or nature of the study, no demographic data were obtained from these specific clients. In general, clients seen in the clinic are often female (63.5%), diverse (full clinic demographics reveal 77.2% are Caucasian, 7.9% Latino/Hispanic, 7.2% biracial, 4.8% African-American, 1.4% Asian, and less than 1% each Asian-American, Native-American, Pacific Islander, African, and “other” ethnicity) and include a wide age range (18–73 years; M = 30.25, SD = 10.08). Clients seen in these clinics present with a wide variety of clinical concerns and diagnoses; the most common diagnoses for both clinics fall among the mood and anxiety disorder categories. Both of the psychology department training clinics for this study are similar in that they serve students from their respective universities as well as individuals from their larger communities and both operate on a low-cost sliding-scale fee system. All participants in this study were treated in accordance with the American Psychological Association’s (APA) code of ethics (APA, 2002) and approval was obtained from each university’s Institutional Review Board (IRB) and training clinic prior to collecting any data.

Procedures

Early in the fall 2011 semester, graduate students who were completing their practicum in either of the training clinics were recruited for study participation. Those students who agreed to participate engaged in a brief 5-week manualized mindfulness training program (a copy of the training manual can be obtained by contacting the authors). The goal of the program was to provide an introduction to some of the basic principles of mindfulness as well as provide guided practice of mindfulness exercises. The five training sessions were each 20 minutes long, beginning with didactic instruction of core mindfulness principles, including moment-to-moment awareness, attention, acceptance, non-judging, patience, and non-striving. Participants then completed a 5-minute guided mindfulness exercise. Participating trainees were also instructed to complete daily formal (home practice with the guided exercises from the training sessions) and informal mindfulness practices (e.g., being present while brushing teeth) on their own between the training sessions. During each session therapists were asked to discuss the previous week’s homework along with any positive or negative aspects they had experienced with it. Results from a test of the effectiveness of this program (Swift, Callahan, Dunn, & Ivanovic) are available from the corresponding author.

Data collection occurred over a period of 2 weeks in the larger clinic and 3 weeks in the smaller clinic. Immediately prior to every adult individual therapy session during the weeks of data collection, participating therapists drew a slip of paper that instructed them to engage in either a mindfulness centering exercise (n = 68) or a control activity (n = 64). Per routine clinic procedures, therapists then gave their clients the Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996). If the therapist had drawn a
paper slip that instructed him or her to engage in the mindfulness centering exercise, he or she went directly to the therapy room and listened to a 5-minute centering audio recording while the client completed the OQ-45.2. The centering exercise can be found in Eifert and Forsyth’s (2005) Acceptance & commitment therapy for anxiety disorders. If the therapist had drawn a paper slip that instructed her or him to engage in the distraction activity, she or he was instructed to chat with other therapists, check email, or use the restroom while the client completed the OQ-45.2. Prior to the start of the study, participating therapists were asked what activities they usually engage in while their clients complete the OQ-45.2; these were the three most common responses. Therapists were also 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. No therapists reported that they had completed mindfulness exercises before sessions that were assigned to the control group. Sessions then proceeded as usual. At the end of these sessions, clients completed a measure of therapist presence and session effectiveness. At the same time, therapists also completed a self-report measure rating their own presence during the preceding session. Therapists were instructed to complete measures and have their clients complete measures after every session during the 2-week period of data collection.

**Measures**

**Therapist Presence Inventory – Therapist and Client Forms.** The Therapist Presence Inventory (Geller, Greenberg, & Watson, 2010) includes two forms, the therapist (TPI-T) and the client (TPI-C), both of which were administered immediately following sessions. Both forms are self-report questionnaires with 7-point Likert-style scaled responses. The TPI-T consists of 21 items on which the therapist rates his or her own level of presence in the preceding session. 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 versions of the measure have previously been reported to be adequate (Geller et al., 2010), with internal consistencies ranging from .82 (TPI-C) to .94 (TPI-T). The TPI-C has been found to predict client scores on the client version of the Working Alliance Inventory (Horvath & Greenberg, 1989) and a rating of session effectiveness (CTSC-R; Watson, Schein, & McMullen, 2010). Within the current sample, internal consistency was found to be .94 for the TPI-T and .72 for the TPI-C.

**Session Rating Scale.** Session effectiveness was assessed following each session with the four-item, visual analogue Session Rating Scale (SRS; Johnson, Miller, & Duncan, 2000). The SRS is used to measure session-specific therapeutic alliance and effectiveness. The four items include a rating of the relationship (“I felt heard, understood, and respected”), goals and topics (“we worked on and talked about what I wanted to work on and talk about”), approach or method (“the therapist’s approach is a good fit for me”), and the overall session (“overall, today’s session was right for me”). To indicate their response, clients are instructed to place a hash mark on a 10-cm line with bi-polar anchor descriptions to indicate how well their experience in the preceding session fits with the anchored descriptors. Using a millimeter for scale measurement, scores on each item range from 0 to 100. A total score is computed by simply summing the item scores. Internal consistency of .88 has been previously reported (Duncan et al., 2003). Duncan and colleagues reported initial test-retest reliability to be .70, with lower test-retest reliability (.64) found over the course of multiple administrations, demonstrating the measure’s sensitivity to measure change. Duncan et al. also reported that the SRS adequately predicted treatment outcomes. The SRS and the Helping Alliance Questionnaire-II (HAQ-II; Luborsky et al., 1996) have been found to be moderately correlated (.48). With our sample an internal consistency of .83 was found for the four items.

**Data Analysis**

We were interested in examining whether our therapists were more present (as rated by themselves and their clients) and more effective (as rated by the clients) in sessions that were preceded by the mindfulness centering exercise compared to those preceded by the control activities. Since we were interested specifically in session-level impacts, randomization occurred at the session, not therapist or client, level. Randomization at the session level allowed for a comparison of conditions for the same clients and therapists, thus reducing the potential issues with internal validity that might have occurred if clients or therapists actually differed between conditions (e.g., clients with most severe symptoms seen by therapists assigned to one condition). Because the sessions were nested within clients (some clients were seen for multiple sessions during the study) and the clients were nested within therapists (some therapists conducted multiple sessions with multiple clients during the study), the data obtained from the sessions were not independent. Given the non-independence of the data, hierarchical
linear modeling, compared to an independent samples t-test or an ANOVA, provides a more appropriate method for data analysis (Adelson & Owen, 2012; Kenny & Hoyt, 2009). In this study we were not interested in examining whether a set of client and/or therapist variables were able to predict therapist presence or session effectiveness. Instead we were only interested in testing whether differences in session presence and effectiveness existed between the sessions that were preceded by therapist centering and those preceded by some other activity. Thus, clients and therapists were included at Levels 2 and 3 and condition (centering or control) was entered at Level 1 in order to account for the nested nature of the data, but no client or therapist predictors were included in any of the models.

**Results**

We were first interested in examining whether therapists perceived themselves as being more present using the 21-item TPI-T in sessions that were preceded by the centering exercise. Therapists failed to complete the TPI-T for six sessions that were preceded by centering and three sessions that were preceded by another activity. On average, therapists rated their level of presence as $M = 120.63$ (SD = 19.05) for sessions that were preceded by the centering exercise ($n = 62$). In contrast, therapists rated their level of presence as $M = 111.93$ (SD = 19.48) for sessions that were preceded by a control activity ($n = 61$). Using HLM, the adjusted difference between groups, 9.96, 95% CI [0.04, 19.88], was found to be significant, $t(22.40) = 2.08, p < .05$, $d = .45$. These results indicate that therapists perceived themselves as being more present in session when they prepared for their sessions by engaging in a mindfulness centering exercise.

We were next interested in testing whether clients rated their therapists as being more present using the three-item TPI-C in sessions that were preceded by the centering exercise. Although all clients were asked to complete the TPI-C following sessions, a few indicated that they were pressed for time due to other obligations ($n = 4$ for centering condition, $n = 9$ for control condition; see Figure 1). On average, clients rated their therapists’ level of presence as $M = 19.78$ (SD = 1.74) for sessions that were preceded by the centering exercise ($n = 64$). In contrast, clients rated their therapists’ level of presence as $M = 19.44$ (SD = 1.66) for sessions that were preceded by a control activity ($n = 55$). Using HLM, the adjusted difference between groups, 0.30, 95% CI [.77, 1.38], was not significant, $t(14.47) = .60, p = .56, d = .20$, thus indicating that clients perceived their therapists as being highly present in session, regardless of whether their therapists engaged in pre-session centering or another activity.

Last, we were interested in examining whether clients rated the sessions as more effective using the SRS in sessions that followed the therapist centering exercise. Clients failed to complete the SRS for four sessions that were preceded by centering and 11 sessions that were preceded by another activity. On average, clients rated the quality of the session as $M = 381.66$ (SD = 26.01) for sessions that were preceded by the centering exercise ($n = 64$). In contrast, clients rated the quality of the session as $M = 363.64$ (SD = 40.87) for sessions that were preceded by a control activity ($n = 53$). Using HLM, the adjusted difference between groups, 13.48, 95% CI [3.46, 23.50], was found to be significant, $t(260.43) = 2.65, p < .01, d = .52$, thus indicating that clients perceived the sessions as being more effective when their therapists engaged in the centering exercise prior to the start of the session.

**Discussion**

The purpose of this study was to test whether engaging in a mindfulness centering exercise 5 minutes before a session could have a positive impact on therapy, in particular on therapists’ ability to remain present in session and on session outcomes. Although clients perceived their therapists as being highly present regardless of whether their therapists completed the mindfulness centering exercise, therapists perceived themselves as being more present in session when they prepared for their sessions by engaging in a mindfulness centering exercise. In addition, clients did perceive the sessions as being more effective when their therapists engaged in the centering exercise prior to the start of the session.

Mindfulness training has been found to impact therapeutic skills and attributes, and some existing evidence had demonstrated that it also has an influence on therapy outcomes (Aggs & Bambling, 2010; Bruce et al., 2010; Ryan et al., 2012). This study offers support for the idea that mindfulness practice is a positive predictor of session outcomes. Furthermore, in this study we show that mindfulness can also be used as a convenient, in-the-moment tool for therapists to utilize when preparing for an upcoming session.

Similar to the findings of McCollum and Gehart (2010), our results indicated a positive relationship between therapist mindfulness and therapists’ self-perceptions of their therapeutic presence during sessions. Our findings combined with previous research offer support for the use of training in mindfulness as a means to increase therapists’ feelings of
The use of mindfulness may be particularly beneficial for beginning therapists who may experience "inner chatter" and a reduced ability to remain attentive and present in the room when they first embark on seeing clients. Future research may wish to focus specifically on this possibility.

Unexpectedly, our results indicated that therapists' completion of the mindfulness centering exercise before a session did not significantly predict clients' perceptions of therapeutic presence during sessions. The null finding could potentially be attributed to the ceiling effect associated with the measure that was used to assess clients' perceptions of therapeutic presence. The average rating of clients was 19.78 out of 21.

A unique strength of the present study was that we examined the effect of a brief mindfulness centering exercise immediately prior to a session, while in other studies therapists were only asked to engage in mindfulness practice during the training period. Our results indicated that clients seen by therapists who completed the mindfulness centering exercise prior to the session rated their session as significantly more effective than clients seen by therapists in the control group. Our results suggest that even a brief mindfulness centering exercise can have a positive impact on clients' perceptions of treatment. The brief mindfulness training program and the 5-minute mindfulness exercises used in this study suggest that therapists can conveniently integrate mindfulness practice into their training in order to improve therapeutic outcomes.

A second unique strength of this study can be found in the study design. In this study we chose to randomize sessions rather than clients or therapists to conditions. Previous studies of mindfulness have randomized therapists to either engage or not engage in mindfulness practices throughout the duration of the study (e.g., Grepmair et al., 2007). These previous studies have thus demonstrated that a client's outcomes can be improved if he or she is assigned to a therapist who practices mindfulness. With our design we demonstrate that even a single therapist can see session improvements (client rat-
ings of effectiveness and therapist presence) for the sessions that she or he precedes with a mindful centering exercise compared to the sessions that she or he does not precede with mindful centering. In turn, with our design, we demonstrate the same client will experience a more positive session if his or her therapist prepares for it by practicing centering compared to some other pre-session activity.

Although our design allowed us to make between-condition comparisons within the same therapists rather than between therapist conditions, because randomization occurred at the session level rather than the therapist level we cannot be sure that therapists had an even distribution of sessions across conditions. In other words, it could be possible that a particular therapist ended up having more sessions randomized to one of the conditions over the other. However, this is not likely given the randomization process. A further potential limitation is that therapists were not blind to the purpose of the study or their random assignment, which could have potentially affected their presence ratings. It would be helpful for future studies to investigate in-session processes of the therapists’ presence by using ratings from a blind observer. In addition, the generalizability of our results should be considered. Since the mindfulness centering exercise was only tested with trainee therapists, further research is needed to investigate whether mindfulness practice before a session could be beneficial for experienced therapists.

Although the present study offers some promising findings for the use of mindfulness by therapists to improve session outcomes, additional research is warranted. In particular, the current study provides a solid foundation upon which to build an inquiry into whether therapists’ usage of pre-session centering is significantly related to end of treatment client outcomes (i.e., symptomology, subjective well-being, working alliance, and/or satisfaction with service provisions). Further, it might also be interesting to examine whether therapist factors, such as theoretical orientation, or patient characteristics might moderate the effect found here. It is also possible that there may be a dose-effect relationship between the length of the mindfulness exercise and the amount of improvement in therapeutic presence and/or client outcomes and this possibility should be explored. Alternatively, future research could capture additional baseline data to extend this line of inquiry so that the direction of study effects can be established (via contrasting the impact of the control activity and the centering activity with baseline “usual preparation”). A different line of inquiry to extend this research would be to more closely examine the impact of mindfulness on the process of psychotherapy, perhaps using observer-rated analyses of recordings, or measuring immediate effects on the therapist and/or client.

Existing research has established that therapists’ use of mindfulness can positively impact their personal well-being as well as their perceptions of their own therapeutic skills and attributes. The present study offers preliminary evidence that practicing a brief mindfulness exercise immediately before a session can also improve session outcomes from the clients’ perspective. It is recommended that graduate programs in psychology offer training in mindfulness to students and encourage students to engage in mindfulness exercises as a means to prepare for their upcoming sessions.

References


