Article Review Instructions

You will write **two** article reviews for this course. Each review is worth 15 points. The review should be 1-2 single-spaced pages in a 12-point, Times New Roman font. It is in your best interest to submit your review before it is due so you may check your originality report and correct any spelling and grammatical errors identified by the software program.

The purpose of the review is to provide students knowledge of how research is conducted and reported. The main part of your review needs to include the following information. Please comment on these aspects of the article as part of your review. Provide only the briefest summary of content. What I am interested in is your critique.

Reference. Listed at the top of the paper in APA style.

Introduction. Read the introduction carefully. The introduction should contain:

- A thorough literature review that establishes the nature of the problem to be addressed in the present study (the literature review is specific to the problem)
- The literature review is current (generally, articles within the past 5 years)
- A logical sequence from what we know (the literature review) to what we don't know (the unanswered questions raised by the review and what this study intended to answer
- The purpose of the present study
- The specific hypotheses/research questions to be addressed.
- State the overall purpose of the paper. What was the main theme of the paper?
- What new ideas or information were communicated in the paper?
- Why was it important to publish these ideas?

Methods. The methods section has three subsections. The methods sections should contain:

- The **participants** and the population they are intended to represent (are they described as well in terms of relevant demographic characteristics such as age, gender, ethnicity, education level, income level, etc?).
- The number of participants and how the participants were selected for the study
- A description of the **tools/measures** used and research design employed.
- A detailed description of the procedures of the study including participant instructions and whether incentives were given.

Results. The results section should contain a very thorough summary of results of all analyses. This section should include:

- Specific demographic characteristics of the sample
- A thorough narrative description of the results of all statistical tests that addressed specific hypotheses
- If there are tables and figures, are they also described in the text?
- If there are tables and figures, can they be interpreted "stand alone" (this means that they contain sufficient information in the title and footnotes so that a reader can understand what is being presented without having to go back to the text)?

Discussion. The discussion is where the author "wraps up the research". This section should include:

- A simple and easy to understand summary of what was found
- Where the hypotheses supported or refuted?
- A discussion of how the author's findings compares to those found in prior research
- The limitations of the study

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USING MINDFULNESS MEDITATION TO TEACH BEGINNING THERAPISTS THERAPEUTIC PRESENCE: A QUALITATIVE STUDY

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Some of the more difficult to define aspects of the therapeutic process (empathy, compassion, presence) remain some of the most important. Teaching them presents a challenge for therapist trainees and educators alike. In this study, we examine our beginning practicum students' experience of learning mindfulness meditation as a way to help them develop therapeutic presence. Through thematic analysis of their journal entries a variety of themes emerged, including the effects of meditation practice, the ability to be present, balancing being and doing modes in therapy, and the development of acceptance and compassion for themselves and for their clients. Our findings suggest that mindfulness meditation may be a useful addition to clinical training.

MFT educators train students in a wide range of content and skill areas, including theories and techniques of MFT, mental status assessment and diagnosis, cultural and social issues, and case management. One of the more challenging yet vital skills that educators must teach new therapists is how to effectively form a therapeutic relationship. An effective therapeutic relationship is often difficult to quantify; however, it is estimated that it may account for as much as 30% of outcome variance (Lambert, 1992). Traditionally, teaching new therapists how to develop an effective therapeutic relationship has focused on skills such as reflective listening, joining, or attending (e.g., Young, 2005). However, some suggest that a more ineffable quality—*therapeutic presence*—is the key to an effective therapeutic relationship (Geller & Greenberg, 2002; McDonough-Means, Kreitzer, & Bell, 2004). Therapeutic presence has been defined as having 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" (Geller & Greenberg, 2002, p. 72). Geller and Greenberg suggest that the foundation for presence is the quality of *being* of the therapist and not their skills or activity.

In Gehart and McCollum (2008), we describe a curriculum that we developed for helping students in master's marriage and family therapy programs develop therapeutic presence using *mindfulness*. Mindfulness is a meditation practice that involves bringing the practitioner's awareness fully into the present moment without judging or evaluating that experience (Kabat-Zinn, 1990). Bishop et al. (2004) propose two components of mindfulness: the intentional focus of attention on present experience, especially thoughts, feelings, and physical sensations, while taking a particular orientation toward those experiences, an orientation of curiosity, acceptance, and interested investigation. The practice of mindfulness has been increasingly used by mental health practitioners over the past 20 years to treat a range of mental health disorders, including depression, anxiety, substance abuse, personality disorders, attention deficit disorders, and eating disorders (see Baer, 2003, for a review). More recently, mindfulness has been used as a

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We wish to thank our students who both participated in the mindfulness experience in class and who graciously allowed us to use their class journals for this project.

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preferred mindfulness practice. Students reflect on these experiences in weekly journals and logs. We ask that they reflect on the impact of their practice in their professional work and personal lives. In addition, students learn various mindfulness meditations in class, including eating, movement, compassion, and ice meditations. Class lectures, discussions, and readings provide the theory and practical information to support these experiential activities along with assigned readings (Bodin, 2006; Shafir, 2000). During most class sessions, 15–30 min of the 2½-hr course are dedicated to mindfulness; during this time, students share experiences, questions are answered about practice, and readings are discussed. The rest of the class period is devoted to standard supervision of fieldwork experiences. Mindfulness and contemplative practices are presented using a down-to-earth, practical, and at times humorous style that makes room for the "imperfection" (lack of consistency, difficulty with focus, etc.) that characterizes secular practice and helps students develop realistic expectations for themselves. The curriculum is described in greater detail elsewhere (Gehart & McCollum, 2008).

METHODS

Participants

Using opportunistic sampling, 13 students who participated in our two classes allowed us to use their weekly journal entries as data for this study. The study was approved by the IRBs at both institutions. Our classes were practicum courses at the master's level, designed for students entering the clinical component of training. Students had taken theory and practice courses but were just beginning actual clinical rotations. Thus, they were encountering a variety of issues common to beginning clinicians—anxiety, beginning to use a theoretical model, learning clinic procedures, and so on.

The weekly journals were course requirements and were read by the instructors over the course of the semester and then returned to the students. They were not graded for content, but completion of the journals was required to receive credit for the course. The educational purpose of the journals was to provide an avenue for the students to both communicate and reflect on their experience and to provide some accountability for their weekly practice. Although asked to practice for 5–10 min daily, students were not penalized for not practicing. We asked them simply to report their experience, including when and why they did not practice meditation during a given week. Students were explicitly and frequently encouraged to include both positive and negative experiences, as this is part of mindfulness practice: to accept whatever experience is happening. After the semester was over, those students who were willing to provide their journals to us for research purposes submitted copies of their original journal entries without instructor comments, and these served as data for the study. Thirteen of the 19 students in both classes submitted their journals. Of the 13, seven were men and six were women, ages ranging from 22 to 60. In terms of diversity, one described himself as gay, one identified as Armenian, another Latino, and the remainder as White or Caucasian.

The two instructors each have over 20 years of experience with meditation practices, both maintaining an ongoing practice that involved both mindfulness and yoga. One was a Caucasian male, and the other the daughter of Greek and Austrian immigrants.

Data Collection

In their journals, students were asked to reflect on both the experience of learning mindfulness meditation as well as the effects that they felt it had on their personal lives and their clinical practice. The specific format and structure of the journal assignment was as follows:

Each week you will enter a one-page journal entry reflecting on your mindfulness or contemplative practice for the week. The journal must be typed and should address the following:

- Were you able to practice daily this week? If so, what helped you achieve this goal? If not, what were the impediments?
- Describe your mindfulness or contemplative practice: focus, etc.
- Describe strategies you used for returning to your focus. Were you able to be patient with yourself during the practice?
- Describe any insights you may have gained from observing your mind.

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Table 1
Overview of Themes and Subthemes

Theme	Subthemes
Being present	Attending to inner experience
	Aware of what happens with client
	Acting from awareness
Effects of meditation	Calmer
	Managing inner chatter
	Slowing down
	Boundaries between sessions
Shift in mode	Doing mode balanced by being mode
Compassion and acceptance	Toward self
	Toward client
	Sense of shared humanity

periods of formal practice to create **boundaries** between sessions and when arriving at their clinical sites. This allowed them to set aside thoughts and feelings associated with the previous session or with their lives outside of the clinic and focus their attention on what was happening in the current client session.

The students' experience of presence seems to have formed a foundation for them to **shift their mode of being in the session**. Using Segal, Williams, and Teasdale's (2002) distinction between doing mode of mind and being mode of mind, the students report a gradual shift to more comfort with the being mode. Most started with the notion that therapy is primarily a doing activity but were able to find more and more times when simply being with the client was therapeutic. Being did not become their sole mode in therapy sessions, but they appeared to reach more balance between the two modes. What helped them make this shift was seeing the **positive effects on the clients** of their changed presence. For most students, this came through their interaction with clients in the session, but some actually meditated with their clients and were encouraged when clients found this a useful experience.

Interwoven through all of these experiences, the students reported explicitly experiencing a sense of **compassion** and **acceptance**. This had three components. First, they used the mindfulness practice to come to greater acceptance and compassion for themselves. As they came to accept themselves in the therapist role more, they were also able to accept their clients more. Finally, some students came to a stance of compassion that was consistent with the traditional meditation literature—seeing the commonality between their own struggles and their clients' struggles and recognizing their shared humanity.

In the following sections, we flesh out these categories using the participants' own words.

Being Present

Our participants remarked that their meditation practice helped them be more present with clients. Implied in many of their comments was the notion that this represented a change of some kind, an increase in how present they felt they could be:

> I have been able to be more present in the room with clients and this has helped me join with clients in a more natural way.

Another student summed up his thoughts this way:

> To meditate brings therapeutic presence. I think it's that simple and yet that hard. By that I mean when I meditate I become more present. It takes no thought or technique to develop the presence. All the technique is in quieting the mind. That is the essence of presence I believe. When we quiet the mind and shut down all the background noise

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when describing sessions in which difficult material was discussed or where difficult therapist-client issues had to be raised. One student provided a lengthy and compelling description of how the fruits of mindfulness practice helped in such a situation:

> This client presented with a combination of narcissistic and nearly psychopathic personality traits early in our second session, and became very hostile. He started firing away pointed, personal questions at me about issues that seemed irrelevant to what we were discussing, and I found myself really shaken and defensive by his behavior. However, I was again able to recall an earlier intake, which I wrote about and shared with the class, in which case I was able to hold on for the ride and keep myself centered. This worked for me again in this instance.
>
> This client was nearly bouncing from one side of the couch to the other. His eyes were fixed on me, his breathing shallow and rapid, and his mouth dry. He was having a great deal of difficulty staying in the room, and I am confident his behavior was not drug related. All of his angst was filling me up. He was projecting everything on to me, and I was soaking it up like a sponge, and not by choice! I could feel my insides constricting and my own throat getting dry. I felt as if I had "touched a nerve" inadvertently, and he felt really exposed by my observation.
>
> Like the last time something similar happened, I steeled myself by breathing and remaining focused. Despite the high level of anxiety in the room, I felt confident in a way I didn't expect; it was as if my memory of the last similar encounter rushed up into my consciousness and there I was, all over again, just breathing, maintaining eye contact and a firm position of body language, and a measured, calm voice. The client began to settle down a little, and slumped back onto the couch.
>
> Again, I believe that my ability to draw upon my own peaceful sense inside helped me not only maintain control in the session, but impart something to the client that words alone could not have communicated.

Presence, then, was one important aspect of our students' experience of mindfulness and their developing therapeutic expertise. It involved an ability to consider their own internal experience on a moment-to-moment basis while attending to their clients' needs and experience at the same time. Sometimes, they were able to draw these two strands of data together and bring them into the immediacy of the therapy session in a way that brought issues of importance to their client right into the room (e.g., "I'm wondering if it makes you really uncomfortable to be sitting there, across from me, in a non-perfect state"). Despite the seeming potential for presence to lead to merging with or immersion in the client's world, our students made it clear this was not the case. While staying emotionally connected to their client's experience, they reported not being overwhelmed by it.

Connecting meditation and presence. What are the specific effects or outcomes of contemplative practice that lead to greater presence? Our students identified several. Many of our participants wrote that meditation practice helped them feel **calmer** in general and specifically in their clinical sessions:

> So the meditations have been very helpful in calming me and preparing me for sessions with this client in particular. I try to infuse the session with this sense of calm and it does seem to help the clients control their anxiety.

A sense of calm resulting from meditation practice seems to function as a foundation for therapeutic presence for the students. One wrote:

> I can't say enough about how mindfulness training has helped me develop therapeutic presence. I think a huge aspect to this for me is being calm. Since I have an anxious

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the being mode helpful in understanding what they were describing. Segal et al. describe the "doing mode" as the mode of mind that orients us toward resolving discrepancies between our idea of how things should be and how things actually are. In therapy sessions, this may manifest as pursuit of a predetermined treatment plan despite evidence that it is no longer useful, efforts to quickly move clients' negative affect states to more positive affect states, or other active, goal-directed efforts. The "being mode," on the other hand, could be characterized as simply being present with whatever is occurring in the present without the need to change it. Thus, in therapy, the being mode may manifest as simply being aware and curious about whatever is happening without feeling driven to make it conform to a mental construction of how things "ought to be." It is important to note that both modes of mind are necessary and neither is either good or bad. Planning, intervening, pursuing goals, and so forth are all important skills in therapy. However, it is our impression that our students often come as beginners with the notion that therapy is primarily a "doing" enterprise and need help entering and feeling comfortable in the being mode when it is appropriate. They credited the contemplative practice with helping them do so.

> Ambiguity is difficult for people who like to plan. If I am uncomfortable or a little anxious about a test or an interview, I prepare and plan until my anxiety subsides. This strategy has not been so helpful in the clinic and I am discovering that so much of this process is about being rather than doing. Meditation has encouraged me to be open to going with the process rather than fighting against it.

Another student wrote:

> It is astounding to me how sometimes just backing off in the therapy room ... creates new opportunity for movement. It is almost like for some clients, putting energy in the room becomes an artificial barrier that they have to surmount, in addition to any other challenges they bring with them. Only when I become still enough to feel what is in the room am I able to accurately discern whether or not I should use more or less of my own energy during the session.

Initially, it was somewhat difficult for our participants to trust that the being mode was useful in therapy. In part, this may come from our doing-oriented culture as well as from the fact that most of their coursework focuses on therapy models and techniques—content that points toward action. What seemed to help the students feel more comfortable with the being mode was seeing the **positive effects on clients** when they could set aside a doing orientation and simply be.

> I made time for 10 deep breaths just before going out to greet each client .... I noticed feeling calmer and more focused on the session as we began, and I felt that I was conveying a calming vibe to the client as well. One of my Thursday evening clients presented in the waiting room looking very sad and agitated, and I found myself instantly tapped into what she was experiencing. She commented to me in session that I seemed very serene today, and she expressed that it was helping her relax and be more comfortable about "something unpleasant I have to talk about tonight."

Another student had a similar experience of linking her ability to be in the moment with a change in her client:

> I also had a [good] session with a client who has never been able to be vulnerable and examine her feelings. I think, in being more congruent and having the presence of mind to be able to "stay with her" in terms of feeling states, she finally felt safe enough to enter that realm. I can only describe it as "she softened."

Compassion and Acceptance

Throughout their journals, the students reported that they had found a growing sense of acceptance and compassion as a result of their meditation practice. Acceptance had three

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would not do it otherwise. This pattern of regular practice has been replicated in the four cohorts following the one studied here.

The second surprising finding was that students reported direct links between what they learned or gained in their mindfulness practice and their clinical practice that went beyond the initial link between therapeutic presence and mindfulness. Many reported that through mindfulness practice they learned acceptance of self and others that directly translated to their work with clients in patience, reduced reactivity, and reduced judgment. Although such findings are not altogether surprising, the details and specificity of their reports and the often extremely challenging situations under which they found the impact of their meditation practice useful were unexpected. The students did not report vague claims of "being less stressed" or "more empathetic" but instead claimed that mindfulness was used in highly stressful client-therapist interactions, moments of extreme personal vulnerability, and situations where they would typically react otherwise. Their ability to ground their descriptions of the impact of their mindfulness practice in specific day-to-day experience suggests to us that they were not simply parroting back generalities learned in class.

DISCUSSION

Our students' reports of their experience provide some evidence, at least, that their practice of mindfulness helped them develop qualities similar to what we have termed therapeutic presence. As noted earlier, Geller and Greenberg (2002) describe three components of therapeutic presence—the ability to attend to the client's experience, the ability to attend to one's own experience, and the ability to act therapeutically from the confluence of those attentions. In their descriptions of "being present," our students described those very things and associated them with their practice of mindfulness. In addition, they also reported developing other qualities—compassion and acceptance, for instance—that elsewhere (Gehart & McCollum, 2008) we have argued are also components of therapeutic presence.

There are a number of limitations to this study. First, we were only able to collect data from those students who volunteered to give us their journals after the class was finished. We made this arrangement to preserve the autonomy of our students to participate or not without fear of penalty. However, it could be argued that only those who found the most benefit in the practice would have volunteered to participate. This was not our experience, and the content of the journals we analyzed did not appear to differ markedly from the journals of students who did not participate, but we did not have a systematic way to verify this. In addition, because we were also the class instructors, it is possible that the students simply wrote in their journals what they thought we might want them to experience, thus emphasizing the positive aspects of the practice. To counter this potential, we regularly encouraged our students to report both good and bad aspects of their experience with the meditation practice, and entries from other parts of their journals often included ways in which they struggled with meditating and the frustrations they encountered with the practice. Finally, it is possible that the students were simply repeating in their journals what they had read or been told the effects of mindfulness practice would be. However, as we noted earlier, the ways in which they grounded their descriptions of their experiences in the particularities of their day-to-day clinical work provide some support for the authenticity of their reports.

Implications for Supervision and Training

Although based on a limited number of students' experiences, this study provides support for expanding the scope of supervision to include assigning activities such as mindfulness to directly help students (a) develop therapeutic presence and (b) manage the anxiety that many experience seeing clients for the first time. As discussed above, supervision in family therapy has privileged a doing orientation to therapy: how to conceptualize problems and how to effectively intervene. Arguably, this orientation should remain the primary focus of clinical training. However, student reports in this study indicate that there are other ways that supervisors can be helpful.

By encouraging students to practice mindfulness and related contemplative activities, supervisors are communicating to students that there is another important dimension to effective

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meditating therapists did better on several outcome dimensions than the comparison group. While this study certainly suggests that there are beneficial effects of therapist mindfulness practice, it must be replicated in order for the association to be convincing. Further, we need to experiment with different forms and "dosages" of mindfulness practice. In our study, students varied in the amount and frequency with which they practiced. Some reported significant internal and external obstacles to practice as well. Knowing more about these issues can help us deliver this training component more effectively.

Despite the remaining questions, our students' experience was meaningful to them and moving to us as we watched young, nervous, and often self-preoccupied clinical interns become calmer and more confident beginning-level therapists, in part through their practice of mindfulness. Most impressive was their ability to bring compassion and acceptance to both themselves and their clients and to see the common human longings for happiness and relief from suffering that occupy us all.

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