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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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means of developing the therapeutic relationship (Hick & Bien, 2008). Our curriculum invites students to participate in a range of mindfulness practices to increase their ability to be more fully in the present moment, which may increase their ability to be more fully present with clients. Our students kept weekly journals of their experiences with mindfulness. Although several general themes emerged from the students' journals—the actual experience of meditation, effects on the students' general well-being, structure of the class, and obstacles to practice—this article describes the qualitative analysis of sections of their journals that describe how practicing mindfulness affected their work as therapists, the primary goal of the mindfulness curriculum.

BACKGROUND

In recent years, numerous therapists have been exploring the theoretical and practical connections between mindfulness and the therapeutic relationship (Hick & Bien, 2008), including applications in family therapy (Gehart & McCollum, 2008; Lysack, 2008), psychoanalytic therapy (Safran & Reading, 2008), substance abuse treatment (Marlatt, Bowen, Chawla, & Witkiewitz, 2008), counseling (Schure, Christopher, & Christopher, 2008), and Acceptance and Commitment Therapy, a cognitive-behavioral approach (Wilson & Sandoz, 2008).

For decades, therapy educators have used mindfulness to teach new therapists empathy (Shapiro & Izett, 2008; Walsh, 2009). Lesh (1970) found that counseling psychology students demonstrated increased empathy after a meditation intervention in comparison to their wait-listed peers. Similarly, in a randomized controlled study with medical students, Shapiro, Schwartz, and Bonner (1998) found a significant increase in empathy with students who went through a Mindfulness Based Stress Reduction (MBSR; Kabat-Zinn, 1990) training program, while Shapiro and Brown (2007, as cited in Shapiro & Izett, 2008) reported similar findings with counseling psychology students. Shapiro and Izett suggest three means by which mindfulness may facilitate empathy: (a) reducing stress, which is correlated with increased empathy, (b) increasing self-compassion, which many consider a prerequisite for other-empathy, and (c) loosening our identification with our personal subjective experience and thereby being better able to perceive and accept the experience of others without judgment or defense.

More recently, mindfulness has been explored as one of the few well-defined techniques for cultivating therapeutic presence (Bien, 2008; Gehart & McCollum, 2008). Similarly, mindfulness has also been used in medicine to cultivate *healing presence* in physicians (Epstein, 2003a, 2003b; McDonough-Means et al., 2004). When students practice mindfulness, they increase their capacity to focus their awareness in the present moment, creating a sense of "being present" that is difficult to quantify but readily perceptible to others by the quality of listening, attitude of receptivity, and open style of engagement (Epstein, 2003b). More a quality of being than of doing (Hick, 2008), many describe therapeutic presence as the key component to developing an effective therapeutic relationship.

Various approaches have been used to teach mindfulness to therapists. Kramer, Meleo-Meyer, and Turner (2008) have developed an Interpersonal Mindfulness Program (IMP), a 6-week curriculum that they use in university medical centers and private practice settings to teach medical professionals and therapists mindfulness. IMP introduces a four-part process to mindfulness in professional settings: pause, relax, listen deeply, and speak the truth.

In an academic counseling program, Schure et al. (2008) report offering a three-unit course that teaches mindfulness using meditation, yoga, and qigong. Of these three approaches, students reported increased awareness and acceptance of emotions and personal issues only with meditation. Specifically, students reported that mindfulness practices increased their comfort with silence, made them more attentive to therapy practice, and expanded their view of the therapy to include physical and spiritual dimensions.

Unlike IMP or the three-unit course described by Schure et al. (2008), we (Gehart & McCollum, 2008) integrate the teaching of mindfulness into existing practicum experiences using assigned readings, in-class mindfulness exercises, journals/logs, and regular mindfulness practice by students. Students are asked to complete 5–10 min of mindfulness practice daily using breath focus, mantra (religious, spiritual, or nonspiritual), walking meditation, or another

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.

- Describe any differences in your daily life that may have resulted from this practice.
- Describe any differences in your professional practice that may have resulted from this practice.
- Describe new insights, practices, or experiences related to developing therapeutic presence.

For this study, only the responses focusing on the students' clinical practice were used.

Data Analysis

Data analysis consisted of a process of thematic analysis from a social constructionist framework (Denzin & Lincoln, 1994). Braun and Clarke (2006) describe thematic analysis as "a method for identifying, analyzing and reporting patterns (themes) within data" (p. 79). In our case, the first author assembled and entered the data into qualitative data management software. Before analysis, all identifying information was removed. He then read and reread the entries to familiarize himself with the breadth of the data. Since the journal entries were rather wide-ranging in their focus, the initial coding simply identified general domains that passages within entries referred to.

General domains included such things as (a) the actual experience of meditation, (b) effects on the students' general well-being, (c) comments about the structure of the class, (d) obstacles to practice, and so forth. One general domain—**the effects of meditation on the students' clinical practice**—was then used as data for this study; due to space limitations, the other domains are not covered in this article. All passages that were coded in the clinical domain were assembled and again read and reread with an eye toward identifying recurring patterns or themes. When a set of codes had been developed that appeared to contain most of the content of the data set, these codes were examined for similarities and larger themes were constructed from the more specific codes. Both authors conferred during the course of the data analysis and, when the first author had developed a preliminary set of final themes, the second author reviewed the entire data set and the results of the first author's analysis to refine the themes. The final set of themes, along with their component parts, comprises the findings of this study. Although a traditional participant check of the themes was not conducted with the group of participants used in the study, the results were shared with the next year's cohort. After completing the same assignment, these students were asked whether the results matched their experience or not. The following year's cohort agreed strongly with the overall findings in this study even though the analysis did not include their own journal entries.

RESULTS

Our students described a rich and varied set of experiences arising from their mindfulness practice that they felt influenced their work as new therapists (see Table 1 for a list of themes and subthemes, printed in bold in the text). In short, they said that mindfulness helped them **be present** in their sessions. "Being present" had a number of dimensions. The students reported being able to **attend to their inner experience** during sessions as well as **being aware of what was happening with the clients** in front of them. They were further able to take their awareness of these two domains and **bring them together in the therapist-client interaction**; that is, 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. While they reported being present, the students also made it clear that this was not a process of becoming absorbed. They described instances where they were able to remain present with intense or difficult material in sessions without becoming "infected" with it; that is, in contact but not overwhelmed, a theme we called **Centered.**

The students credited several "effects" of their mindfulness practice with their ability to be present as therapists. They felt that formal practice of meditation helped them be **calmer** in general and specifically in their therapy sessions. They also felt that it helped them become more aware of their **inner chatter** and either decrease or disconnect from it. Meditation also helped them **slow down** their perceived inner pace or sense of hurry. Finally, some of them used brief

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

and mind chatter. . . we become aware of our surroundings. . . and in the therapeutic environment; we become more present for our clients. . . powerful stuff.

Components of presence. The students described several aspects of their experience that further illustrate the qualities of presence they were experiencing. One aspect was **becoming more aware of their inner experience** as something that could be observed and attended to. One student noted:

> Knowing all of this about my experience has really been a challenge for me. I am learning what pieces of my experience are because I'm new in the clinic and what pieces are reflections of my personality .... I am learning to be ok with my automatic emotional response, but to keep the haze and the fog from being a permanent fixture in my life, I need to learn how to separate that and process it. The mindfulness experiences are invaluable at helping me do that because they give me the "blank slate" mind that I need to be able to work through the difficulties that I am experiencing either personally or professionally.

Another student wrote:

> The space created for therapy by slowing down and being more aware of the current state of how I think and feel allows me to be more receptive to where my clients are.

Coupled with more internal awareness or focus, the students also described being aware of what was going on around them, specifically being **aware of their clients during therapy sessions.** One noted that after meditating regularly for several days, she felt an increased sense of well-being that carried over to her clinical site where she worked with public school students:

> I arrived [at my clinical site] in a good mood each day and felt much more present for the students. I noticed small subtle things they would say and do. I acknowledged these, which led to great therapeutic movement.

Another student observed:

> At my fieldwork placement, I am starting to spend a few minutes focusing and getting ready for the session. In the sessions, I think it does improve my ability to attend to the clients.

By keeping these two areas of experience (attention to self and attention to client) in focus, students were sometimes able to bring the confluence of the two into the moment-to-moment flow of the session. Elsewhere (Gehart & McCollum, 2008) we have proposed that this is a primary aspect of therapeutic presence, and while it certainly may take time to develop in a therapist's career, our students were beginning to make some strides in that direction and crediting those strides to their mindfulness practice:

> One of my male clients had just woken up and had "bed head." When he demonstrated shame for looking the way he did, I was able to bring it to light, instead of simply telling him that I didn't care how he looked. I was able to say, "I'm wondering if it makes you really uncomfortable to be sitting there, across from me, in a non-perfect state." Then I was able to hear his answer without fixing. We were then not only able to process his difficulty trusting women with who he really is, but our therapeutic relationship along those lines as well. The conversation flowed and I was not nervous in bringing so much unspoken truth to light.

While they reported being more present as one "product," as it were, of their mindfulness practice, the students also made it clear that **presence was not without boundaries** nor was it a state of complete absorption in their clients' world. They made this distinction most clearly

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

running commentary in my head at all times, I think I tend to "jump in" to save the client so as to alleviate my own anxiety.

In addition to promoting a sense of calm, the students also felt that their meditation experience helped them become more aware of their **"inner chatter"** and be less affected by it. Again, the students linked this effect of meditation to their ability to be present with their clients:

> I noticed that that negative running commentary, which held me in the bonds of fear, drastically diminished this week. This allowed me the freedom of bringing me into the sessions, which allows me more presence with [my clients].

Another student noted:

> My "internal clutter" seems to be more in check when I'm in therapy sessions.

In addition to helping them feel calmer and less involved in their inner monologues, the students credited meditation practice with helping them **slow down** a sense of internal rush or hurry. This allowed them to attend more completely to what was happening in the present rather than rushing ahead toward some typically undefined goal. One student described it this way:

> Additionally, the space created for therapy by slowing down and being more aware of the current state of how I think and feel allows me to be more receptive to where my clients are.

Another student gave this example:

> I think I was so excited to have a new client that I raced through the paperwork (my supervisor said) but I did end up slowing down when my client started telling her story. During her story, I was able to follow details and absorb what she was saying. So, overall I think my meditation was helpful in being present once I slowed the pace down.

Finally, our participants described how they used brief periods of formal meditation practice to create **boundaries around therapy sessions**. One student made the following observation:

> The mindfulness practice has helped me to center myself between each session. Since I have a variety of clients and all of my slots filled, it has become increasingly important for me to leave each client in their time slot and not take them with me into the next session. When I've had some particularly bad or tough nights, inevitably I take some of the last sessions into the next sessions. I am hoping that this will decrease with time, but my meditative breathing and prayer have really helped me not to take all of my baggage from the last session into the next session.

Another student described how he used a brief period of formal practice as a preparation for his clinical internship:

> I try to get to my traineeship a few minutes early. I park my car and practice 5 minutes of mindfulness before I walk into the clinic. It really seems to clear my mind and keep me present.

A Balance of Doing and Being

As they noted their ability to be present in the session and linked this to the effects of their meditation practice, our students also described finding themselves being able to **shift modes of mind** while in session with their clients. Although our students did not necessarily use this language, we found Segal and colleagues' (2002) distinction between the doing mode of mind and

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

related components. First, students described feeling acceptance and compassion for themselves as a result of their practice:

> I have guarded against comparing myself to others since I began my work in the clinic. However after a challenging session and several discouraging conversations I began to doubt myself last week. As I entered this week, I knew I did not want to go down that road because it was . . . miserable. At the very least I felt I owed it to my clients to get this tendency to be overly self-critical under control. By adding the element of prayer to my meditation it was easier to connect with my true self and the gifts I possess. I entered the clinic with a greater sense of patience for my progress and compassion for my struggles.

In addition to feeling compassion for themselves, the students also noted that they felt more compassionate and accepting of their clients.

> At my fieldwork site, the clients are struggling to function on a very basic level. What they don't need are heavy judgments about material wealth and success. The meditation is helping to guide me toward a non-judgmental acceptance of them and myself.

Finally, the students linked these two aspects of compassion and acceptance, feeling that self-compassion provided a basis for compassion and acceptance for their clients.

> I might have read this in *The Zen of Listening* [class text], but the book was stating that to be an effective therapist, one must be comfortable with the positive and negative traits that encompass oneself. How else can we convey to clients that their tears, anger and feelings are OK to have in session, if we don't accept these qualities in ourselves? I think I can understand why this practice is going to make us better therapists.

Sometimes the experience of compassion and acceptance became an experience of the common humanity between the students and their clients—the recognition that we all struggle regardless of which side of the desk we sit on.

> Interestingly, this week my client's experience closely mirrored my own. She is recognizing that she is being kinder to herself and, in general, more forgiving of herself. This has given her freedom to enjoy situations and relationships she normally struggles with .... Listening to her put to words some of what I am struggling with, and to see the problem from a distance, was powerful.

Our students used their practice of mindfulness meditation and other contemplative practices in a variety of ways as they negotiated the often challenging waters of early clinical training. They reported feeling present in the therapy room with clients, finding ways to abandon a task-oriented doing mode of mind when that was not what was needed in favor of simply being with clients, and the recognition that compassion added to their effectiveness as therapists—compassion for themselves and for their clients.

RESEARCHERS' REFLECTIONS ON THE FINDINGS

Two findings were most surprising in the analysis of the data: (a) that students reported being fairly regular with their practice, and (b) that they reported detailed instances in which they credit their mindfulness practice for helping them improve their in-session skills, often significantly. Although most students reported having 1 or 2 weeks during which it was difficult to keep up with their daily practice of mindfulness, most reported meeting or exceeding this goal most weeks of the semester. Such regular practice is difficult to achieve and was likely facilitated by the weekly discussions, group support, and "assignment" of a class activity. In fact, one of the two classes "asked" the instructor to "require" mindfulness for the second semester of the class to increase their incentive to practice; many stated that they probably

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

therapy: the therapist's way of being in the room. Supervisors can add mindfulness activities as a specific and concrete means to help students develop a quality of being that can be useful in therapy. These activities also provide a highly efficient and well-researched stress management technique that enables students to better handle the challenges commonly experienced in the early years of training.

Suggestion for Implementation

Supervisor's personal practice. We believe that integrating mindfulness into the supervisory process requires that the supervisor regularly practice mindfulness. The supervisor's personal experience with the challenges of mindfulness and contemplative practices is considered prerequisite to effectively teaching the practice (Kabat-Zinn, 1990); while mindfulness meditation instructions are relatively straightforward, the supervisor's personal experience with the practice will help guide students to set realistic expectations for what mindfulness can do and prepare for the ups and downs that characterize regular practice. Supervisors who maintain their own practice can help students when they experience common meditation struggles, such as difficulty focusing, difficulty with a schedule, falling asleep, and variable quality of practice.

Benefits of group process. The group learning experience is the preferred and most researched method for teaching mindfulness and likely contributed to our students' willingness to practice regularly enough to experience noticeable effects. Supervision groups offer an ideal context for learning mindfulness because they make it possible to share this otherwise solitary experience.

Requiring practice. In general, we have found it most effective to "require" a minimum of mindfulness practice, although we do not have a penalty for not completing the minimum. The requirement involves all members of the class in the learning process and discussion, and many students anecdotally report that this "class requirement" helps them take self-care seriously. In fact, most subsequent classes have asked for it to be required in the second semester of the course so that they feel pressure to keep up their practice.

Down-to-earth style. We believe it is especially important in course settings to present mindfulness using a down-to-earth and practical approach that from the start honors the "imperfection" (lack of consistency, difficulty with focus, etc.) that characterizes secular practice. We use humor and stories of our own struggles to help students develop realistic expectations, and more importantly, accept their own inconsistent practice.

Ethical issues. Instructors need to be careful as to how they present mindfulness and contemplative practices so that the reasons for doing so are clearly linked to academic learning goals, namely developing therapeutic presence. In most educational contexts, issues of religion and spirituality need to be carefully handled to avoid students feeling as though they are being forced into a religious practice.

CONCLUDING REFLECTIONS

While mental health training programs have regularly emphasized skill training and theoretical models of intervention in formal teaching, it is harder to teach the less behavioral skills of empathy, connection, and presence. Yet these factors play a vital role in successful therapy. We decided to teach our beginning clinical interns mindfulness meditation in an active and overt effort to help them develop the quality of therapeutic presence. We believed that mindfulness practice, with its emphasis on nonjudgmental attention to the present moment, would give students a laboratory in which to explore what being present really means. Our students embraced this challenge and reported that their practice of mindfulness helped them to engage more fully in their therapeutic encounters. Their experience suggests that mindfulness practice may be a worthwhile endeavor for other beginning therapists.

Many questions remain, of course. First and foremost, we need to demonstrate that therapist mindfulness practice is associated with better client outcomes. One such study already exists (Grepmair et al., 2007). Grepmair and colleagues compared the client outcomes of a group of therapists randomly assigned to practice mindfulness in the Zen tradition to the client outcomes of a randomly assigned group of nonmeditating therapists. The clients of the

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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