

1 Cultivating Therapeutic Relationships

The Role of Mindfulness

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This chapter introduces what mindfulness is, how it is cultivated, and why it is important to the relationship between clients and therapists, group counselors, community workers, and other mental health professionals. The more in-depth discussion and overview of empirical research on how the therapeutic relationship is vital in contributing to client progress and clinical outcome is reserved for Chapter 2. This book is necessary for two primary reasons. First, as Chapter 2 indicates, the therapeutic relationship is crucial for effective therapy or group work. In fact, some clinicians have found that it is more important than the type of intervention that is followed. Second, mindfulness has the potential to play a central role in enhancing the therapeutic relationship.

Defining mindfulness is a paradoxical undertaking, especially if one intends to use just words. For one thing, mindfulness really must be experienced to be understood. Further, mindfulness can be considered a preconceptual and presymbolic notion. It is an embodied state of being that cannot be accurately described using language. I have found that as my mindfulness practice develops, word-based definitions seem to capture less and less of its essence. Having said this, one must note

that numerous researchers have delved into defining mindfulness and in the process have helped clarify and concretize it, especially, perhaps, for people that do not practice it. It is defined by some as having a spiritual quality and by others within a strictly scientific orientation. Still others combine the two, seeking scientific evidence for what are essentially traditional spiritual practices. Most see it as a way of living or being in the world, rather than a set of techniques—a path that is cultivated through experience rather than absorbed from a book. So, while the theory in this book may be helpful in formulating mindfulness and its uses for the therapeutic relationship, ultimately you may need to “sit quietly and breathe” and perhaps engage some of the exercises contained in the book.

Practitioners such as psychotherapists, social workers, psychiatrists, family therapists, and other mental health professionals, as well as medical doctors, are showing extraordinary interest in mindfulness as it affects practice, both for themselves and their clients. There is unparalleled interest in mindfulness-based interventions and approaches for a range of issues such as addictions, suicide, depression, trauma, and HIV/AIDS, to name a few. As the chapters in this book indicate, there is mounting interest in mindfulness practice as training through which the professional can cultivate empathy and compassion or develop a sense of presence or listening skills. Mindfulness can have an impact on how practitioners relate to their clients. This is often referred to as the therapeutic relationship (for an in-depth examination of the therapeutic relationship see Chapter 2). Beyond directly affecting client–therapist interaction, mindfulness can alter how practitioners cope with stressful events in their lives both at work and at home. Because of this, many employers of mental health professionals see mindfulness as a potential means for reducing worker turnover or so-called burnout (Wheat, 2005).

Anecdotal evidence from delivering a mindfulness-based group intervention called radical mindfulness training (an adapted version of mindfulness-based stress reduction [MBSR]) leads me to conclude that a key ingredient for positive outcome lies in the relationship that develops between the facilitator and the clients, or what we are calling the therapeutic relationship in this book. The research that is examined in this book highlights the centrality of the therapeutic relationship as a primary factor contributing to positive client outcome. When it comes to exploring how mindfulness might contribute to the therapeutic relationship, there is a gap in the existing literature—a gap this book aims to address.

MINDFULNESS IN A THERAPEUTIC CONTEXT

Mindfulness has been described as focusing attention, being aware, intentionality, being nonjudgmental, acceptance, and compassion. Mark Lau and his team at the Centre for Addiction and Mental Health in Toronto collated definitions from Kabat-Zinn (1990), Shapiro, Schwartz, and Bonner (1998), and Segal, Williams, and Teasdale (2002), who describe mindfulness as a nonlaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is. The present-centered awareness or way of paying attention is cultivated, sustained, and integrated into everything that one does, including one's therapy or community work. At the base of mindfulness is an ongoing meditation practice or other exercises that propel deep inquiry. Many elements contained within mindfulness can be traced back to centuries-old meditative traditions.

Within the client–therapist relationship, mindfulness is a way of paying attention with empathy, presence, and deep listening that can be cultivated, sustained, and integrated into our work as therapists through the ongoing discipline of meditation practice. Mindfulness can be thought of as a kind of shift from a “doing mode” to a “being mode.” We tend to spend much of our time as “human doings,” running from one activity to another—living our lives as though on a perpetual treadmill. This way of living distracts us from our lives. The being mode places the therapist directly in the here-and-now encounter with the client. Mindfulness meditation is an example of an activity that exemplifies the being mode. It is a nonjudgmental moment-to-moment awareness.

Larry Rosenberg (1998, p. 15), a meditation teacher, likens mindfulness to a mirror simply reflecting what is there. He emphasizes the present moment and the nonjudgmental aspect of mindfulness. Mindfulness is an innate human capacity to deliberately pay full attention to where we are, to our actual experience, and to learn from it. This can be contrasted with living on automatic pilot and going through our day without really being there. We can drive to work or take a shower and not be there for it. Everyone is familiar with the experience of driving somewhere and suddenly realizing that they were hardly aware of driving, not even knowing in that instant where they are.

Thich Nhat Hanh, a Vietnamese Zen monk, poet, and peacemaker summarized the essence of mindfulness in a radio interview:

Mindfulness is a part of living. When you are mindful, you are fully alive, you are fully present. You can get in touch with the wonders of life that can nourish you and heal you. And you are stronger, you are more solid in order to handle the suffering inside of you and around you. When you are mindful, you can recognize, embrace and handle the pain, the sorrow in you and around you. . . . And if you continue with concentration and insight, you'll be able to transform the suffering inside and help transform the suffering around you. (transcript available at speakingoffaith.publicradio.org/programs/thichnhathanh/transcript.shtml)

The practice of mindfulness involves both formal and informal meditation practices and nonmeditation-based exercises. Formal mindfulness, most often referred to as meditation, involves intense introspection whereby one sustains one's attention on an object (breath, body sensations) or on whatever arises in each moment (called choiceless awareness). Informal mindfulness is the application of mindful attention in everyday life. Mindful eating and mindful walking are examples of informal mindfulness practices. In fact any daily activity can be the object of informal mindfulness practice. In my mindfulness classes I engage people early on with informal practice, asking them to mindfully undertake one activity each day between classes and report on the experience. The list of activities they report is endless: mindfully brushing the teeth, mindful driving behind a slow car, mindful ironing, and so forth.

Nonmeditation-based mindfulness exercises are specifically used in dialectical behavior therapy (DBT; Linehan, 1993) and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999; see below). Therapists and therapist trainers could use some of these exercises to cultivate mindfulness for their therapeutic relationships. ACT involves 41 exercises, nine of which are of the formal or informal mindfulness type. The remainder are not meditation based. For example, ACT begins with an exercise called "your suffering inventory" whereby the client lists and ranks painful and difficult issues in his or her life. Another exercise displays how difficult it is to suppress our thoughts. It asks participants to get a clear picture of a yellow jeep in their minds and then try as hard as they can not to think even one single thought about a yellow jeep. DBT involves extensive questionnaires and exercises to assist clients in better regulating emotions, increase their sense of personal identity, and sharpen their judgment and observation skills. Other practices involve paying attention to environmental elements such as music or aromas (Baer, 2006).

Whether meditation based or not, mindfulness is an ongoing disci-

pline and practice that refines our capacity for paying attention, and it is this that provides the potential for effective therapeutic relationships. One often begins mindfulness training by simplifying and narrowing one's focus of attention to something, for example the breath or a particular activity. Intentionally observing something like the breath, a feature of life that is almost always taken for granted, one begins to train the mind in mindfulness. By simply feeling the sensations of the breath entering and leaving the body one can practice being in the present moment. It sounds like a simple exercise, but trying it reveals how difficult it actually is to do. The mind will wander off, thinking about what happened yesterday or planning the afternoon.

Mindfulness is a nonstriving activity. It isn't about getting anywhere or attaining any special state of mind—even relaxation or stress relief. This presents an interesting paradox for practitioners offering mindfulness courses for stress reduction or symptom management. People come to the course with expectations and the desire for results and are told, usually in the first session, to put aside those goals and just let things be, resting in awareness, observing the mind, body, and world unfolding in the present moment. It can also be a challenge for people in our results-oriented society.

MINDFULNESS APPLICATIONS AND PRACTICES

Most mindfulness research has been conducted within the area of mindfulness-based interventions. Although this book is not directly concerned with mindfulness-based interventions and their effectiveness, they provide a useful context for the discussion of mindfulness as a way of cultivating a positive therapeutic relationship and for teaching how to do this.

Mindfulness has been used in wide variety of clinical and therapeutic settings, having been shown to be effective with chronic pain (Kabat-Zinn, 1984, 1990; Kabat-Zinn, Lipworth, Burney, & Sellers, 1987), stress (Shapiro, Schwartz, & Bonner, 1998), depressive relapse (Segal et al., 2002; Teasdale et al., 2000), disordered eating (Kristeller & Hallett, 1999), cancer (Monti et al., 2006; Carlson, Ursuliak, Goodey, Angen, & Speca, 2001), and suicidal behavior (Linehan, Armstrong, Suarez, Allman, & Heard, 1991; Williams, Duggan, Crane, & Fennell, 2006). In their overview of mindfulness-based interventions, Salmon, Santorelli, and Kabat-Zinn (1998) documented 240 programs. Baer (2003, 2006) provides a review of mindfulness-based interventions.

The first of the mindfulness-based interventions was MBSR (Kabat-

Zinn, 1990). The core program of MBSR consists of eight weekly 2- to 3-hour classes and one daylong class. It includes formal guided instruction in mindfulness meditation and mindful body movement or yoga practices, exercises to enhance awareness in everyday life, daily assignments lasting from 45 minutes to an hour that are largely meditations, and methods for improving communication. The program emphasizes being present with sensations within the body, and then expanding this to emotions and thoughts. MBSR aims to help people develop an ongoing meditation practice. Participants are provided with two CDs, each containing four or five guided meditations.

More recently, mindfulness-based cognitive therapy (MBCT) was developed as a treatment approach to reduce relapse and recurrence of depression (Segal et al., 2002). Two controlled clinical trials demonstrated that MBCT can reduce the likelihood of relapse by between 40 and 50% in people who have suffered three or more previous episodes of depression (Kenny & Williams, 2007; Ma & Teasdale, 2004; Teasdale et al., 2000). MBCT is based on MBSR, but integrates several elements of cognitive therapy such as client education and emphasis on the role of negative thoughts, and on how rumination, avoidance, suppression, and the struggle with unhelpful cognitions and emotions can perpetuate distress rather than resolve it (Williams et al., 2006, p. 202). That said, MBCT does differ substantially from cognitive therapy. MBCT emphasizes the acceptance of thoughts as thoughts rather than strategies to change the content of thinking. Instead of learning to replace negative thoughts with positive thoughts, MBCT focuses on noticing the effects of negative thoughts on the body in terms of body sensations. Mark Williams and his team at the University of Oxford are exploring the use of MBCT with suicidal individuals (Williams et al., 2006).

The practices contained in mindfulness-based interventions include a variety of exercises or meditations for building awareness and compassion. MBSR and MBCT emphasize formal guided meditations combined with informal mindful living exercises. ACT and DBT emphasize nonmeditation based activities and exercises but include some meditation.

OPERATIONAL DEFINITIONS AND MEASURES OF MINDFULNESS

Researchers, primarily within psychology, have recently endeavored to specify their definitions of mindfulness. This has occurred at two levels. First, discussions have been tightened and clarified. Secondly, at least

eight quantitative measures of mindfulness have been developed and tested. Surprisingly, at least to me, there is little critique of this trend toward instrumentalizing mindfulness. In other social science research areas, positivist and instrumentalist approaches would be critiqued.

With these cautions in mind, I next review the attempts at defining and measuring mindfulness. Dimidjian and Linehan have worked toward precision in refining their definition of mindfulness as involving three qualities and three activities (2003, p. 166). The three qualities include (1) observing, noticing, bringing awareness; (2) describing, labeling, and noting; and (3) participating. The accompanying activities are (1) nonjudgmentally, with acceptance, allowing; (2) in the present moment, with beginner's mind; and (3) effectively. This is a complex definition that captures the key components of mindfulness. In a similar attempt to operationalize mindfulness, Bishop et. al. (2004, p. 230) see mindfulness as comprising two main components. The first component is metacognitive skills, which involve sustained self-regulated attention, attention switching, and the inhibition of elaborative processing. The second component is one's orientation to the present moment experience. This includes the maintenance of an attitude of curiosity, acceptance of one's experience, and an openness to observe what comes up in the field of awareness.

Shapiro, Carlson, Astin, and Freedman (2006, p. 374) build on Kabat-Zinn's definition of mindfulness as paying attention in a particular way: "on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4). They posit three components (axioms) of mindfulness: (1) intention, (2) attention, and (3) attitude (IAA) as follows:

1. "On purpose" or intention.
2. "Paying attention" or attention.
3. "In a particular way" or attitude (mindfulness qualities).

Building on these components, Shapiro et al. (2006, p. 377) propose a model of the mechanisms of mindfulness, whereby intentionally (I) attending (A) with openness and nonjudgmentalness (A) leads to a significant shift in perspective, which they have termed *reperceiving*. This shift enables people to stand back and simply witness the drama of their lives rather than being immersed in it.

Unlike cognitive therapy's emphasis on "cognitive errors" and "distorted interpretations," mindfulness teaches the practice of observing thoughts without getting entangled in them, approaching them as

though they were leaves floating down a stream. It is not about replacing negative thoughts with positive ones, but rather accepting one's ongoing flow of thoughts, sensations, and emotions.

In order to further untangle the impact of the components of mindfulness, several groups have developed scales or measures of mindfulness. At present eight mindfulness measures have been developed. Seven are based on self-reporting of particular trait-like constructs, and one measures mindfulness as a state-like construct. The trait-based measures include the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003), the Freiburg Mindfulness Inventory (FMI; Buchheld, Grossman, & Walach, 2001), the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004), the Cognitive and Affective Mindfulness Scale (CAMS; Feldman, Hayes, Kumar, & Greeson, 2004), the Mindfulness Questionnaire (MQ; Chadwick, Hember, Mead, Lilley, & Dagnan, 2005), the Revised Cognitive and Affective Mindfulness Scale (CAMS-R; Feldman et al., 2004), and the Philadelphia Mindfulness Scale (PHLMS; Cardaciotto, 2005).

The scales tend to measure different aspects of mindfulness and take different approaches. Brown and Ryan's (2003) thoroughly tested MAAS emphasizes measuring attention and awareness but neglects other important aspects of mindfulness such as compassion, nonjudgmental attitude, openness to new experiences, insightful understanding, and nonstriving. The KIMS scale, in contrast, measures qualities and skills taught in DBT. Using a consensus approach, Bishop, Lau, Shapiro, Carlson, Anderson, and Carmody (2004) and 10 colleagues, primarily in Toronto and Calgary, developed the Toronto Mindfulness Scale (TMS; Bishop et al., 2004). This scale takes a different approach and measures mindfulness as a state-like phenomenon (as opposed to a trait-like quality) that is evoked and maintained by regulating attention. Studies have shown that the TMS is a reliable and valid measure useful in investigations of the mediating role of mindful awareness in mindfulness-based interventions (Lau et al., 2006).

RESEARCH ON THE THERAPEUTIC RELATIONSHIP

A key research finding in the past 20 years is that different therapies produce similar positive therapeutic outcomes (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliott, 1986). As Lambert and Simon indicate in Chapter 2 of this volume, another key finding is that very little of the variance in therapeutic outcomes is

due to the treatment model that is used (Lambert, 1992; Lambert & Barley, 2001). This has led researchers to look for elements common to different therapeutic approaches and an analysis of the relationship that forms between therapist and client. Bohart, Elliott, Greenberg, and Watson (2002, p. 96) found that overall, empathy accounts for as much and probably more outcome variance than do specific interventions. Fulton (2005, p. 57) reports that on average 30% of treatment outcome may be attributable to “common factors” that are present in most successful treatment relationships.

The two studies most often cited when discussing the impact of the therapeutic relationship on outcome are both meta-analytic studies (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Horvath and Symonds (1991) found that the therapeutic relationship accounted for moderate amounts of outcome variance, with an average effect size of 0.26. They consider this to be a conservative estimate since any correlations in the 24 studies that were computed but not reported, or were reported but not significant, were treated as zero correlations. Martin et al. (2000) conducted a meta-analysis of 79 studies and found an average effect size of 0.22.

Early explorations of the therapeutic relationship focused solely on the therapist (client-centered) or the client (psychodynamic) as arbiters of the relationship. In the 1970s explorations of the therapeutic relationship focused on the collaborative and interactive elements in the relationship (Bordin, 1979; Luborsky, 1976). Current research is building on the work of Luborsky and Bordin, and there appears to be some agreement that the collaborative work of therapist and client against the client's pain and suffering is central (Bordin, 1979). Researchers are examining different components of the therapeutic relationship, such as the affective relationship between the participants (e.g., warmth, support), specific activities of client and therapist (e.g., self-observation, exploration), negative contributions (e.g., hostility), the sense of partnership or collaboration, and so forth (Bachelor & Horvath, 1999).

While research necessarily isolates variables such as client characteristics and therapist characteristics and treats them as though they were static, independent entities, they are actually best thought of as continuously interacting aspects of an immensely complex interpersonal reality. Miller and Rollnick (2002) suggest, for example, that the trait of denial in alcoholics so often identified by therapists is actually a function of the interpersonal context. Alcoholics are often lectured to by concerned family and friends, and even by therapists of the old school, who hold that their denial must be vigorously confronted. In-

stead, however, it seems that such treatment actually *elicits* denial, since, like everyone else, alcoholics don't particularly enjoy being lectured to or told what to do. And in fact, they respond better to empathy than to harsh confrontation, as do other human beings.

Summarizing thousands of studies across 60 years, Lambert and Ogles (2004) concluded that variables measuring the effect of the therapeutic relationship consistently correlate more highly with client outcome than specialized therapy techniques. They specify that more successful therapists are more understanding, accepting, empathic, warm, and supportive. Further, they found that therapists who develop positive therapeutic relationships engage less often in negative behaviors such as blaming, ignoring, neglecting, rejecting, or pushing a technique-based agenda when clients are resistant (Lambert & Ogles, 2004).

This is where mindfulness enters the picture. In my own work I have seen mindfulness contribute to the development of the different components of the therapeutic relationship, such as empathy, deep listening, and compassion. Although the research on mindfulness and the therapeutic relationship is in its very early stages, preliminary findings support my anecdotal evidence.

RESEARCH ON MINDFULNESS AND THE CLIENT-THERAPIST RELATIONSHIP

Recently there have been numerous studies on the efficacy of mindfulness interventions for addressing various client difficulties. There is little research examining the impact of mindfulness as training for the therapist and even less on how mindfulness might have an impact on the therapeutic relationship or client outcome via the therapeutic relationship. The focus of mindfulness research has been on the development and testing of "brand-name" mindfulness-based interventions such as MBSR, MBCT, and ACT. The thrust has been to provide evidence that specific mindfulness-based therapeutic techniques are correlated positively with outcome. Further, while MBSR is advertised as a generic approach, recent incarnations of mindfulness-based intervention are oriented more toward manualized approaches to the treatment of specific disorders. This is the case with MBCT, which was explicitly developed for the treatment of depression relapse. As Lambert and Simon suggest in Chapter 2, the emphasis within the mindfulness research may be misplaced. They argue that if research on mindfulness as an intervention strategy follows the trajectory of research on other psy-

chotherapy techniques, then ultimately it will reveal that the intervention plays only a small role in positive outcome—the larger share of outcome being attributable to common factors such as the therapeutic relationship.

In other psychotherapy treatments, Norcross (2002, p. 5) found, specific techniques account for only 5–15% of the outcome variance. The remainder is attributed to circumstances outside the control of therapy or relationship factors. If the same holds true for mindfulness-based interventions, and there is little reason to doubt this, then we may be missing an important piece of the outcome puzzle. In addition, if mindfulness is viewed as a way of being in the world rather than an instrumental set of methods, then perhaps relationship is even more important. After all, relationships are mostly about the way we are with another person or persons. Mindfulness guides us in how to be deeply present with ourselves and others. In my mind, mindfulness is about cultivating, sustaining, and integrating a way of paying attention to the ebb and flow of emotions, thoughts, and perceptions within all human beings. This kind of awareness can enable us as therapists, community workers, or group counselors to be present in a therapeutic relationship in a different way—a way that is more about being with clients than about being a detached expert.

Discussions about mindfulness-based interventions generally examine what is being taught to clients, but what about the therapists themselves? Most, if not all, discussions about mindfulness-based interventions strongly suggest that the people who teach the programs should practice mindfulness themselves, in a “practice what you preach” model. However, thus far there is little evidence on this aspect of the practice.

In one of the few studies of mindfulness and the therapeutic relationship, Wexler (2006) used a correlational design to examine the relationship between therapist mindfulness and the quality of the therapeutic alliance. Therapist mindfulness was measured using the MAAS (Brown & Ryan, 2003), and the therapeutic alliance was measured using dyadic ratings from the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Data from a sample of 19 therapist–client dyads revealed significant positive correlations between both client and therapist perception of the alliance and therapist mindfulness, both in and out of therapy.

Grepmaier et al. (2007a, 2007b) performed what is perhaps the first controlled large-scale study of the effects of mindfulness in psychotherapists in training on treatment results. They examined the therapeutic treatment course and results of 124 inpatients using a randomized, double-blind controlled study. They compared the outcomes for 18 different therapists, nine of whom undertook a 9-week meditation course and

nine who did not meditate at all. They found that compared to the group with nonmeditating therapists ($n = 61$), the inpatients of the mediators ($n = 63$) was significantly higher using a variety of scales. Furthermore they found that the inpatients of the mediators showed greater symptom reduction, better assessments of their progress in overcoming their difficulties, greater rate of change, and higher subjectively perceived results.

A few other studies have directly examined the impact of mindfulness practices on the cultivation of empathy within practitioners (Aiken, 2006; Shapiro et al., 1998; Wang, 2006). Shapiro et al. (1998) assessed the efficacy of a short-term mindfulness-based intervention in enhancing the doctor–patient relationship through the cultivation of empathy. Using the 42-item Empathy Construct Rating Scale (ECRS) to provide a measure of empathy, the 200 medical students who received mindfulness training showed significant increased levels of empathy, with an alpha coefficient of .89.

In another study, Wang (2006) measured the impact of mindfulness meditation on specific relationship variables such as psychotherapists' levels of awareness or attention and empathy. Two groups of psychotherapists (meditators versus nonmeditators) were compared using measures of awareness or attention, and empathy. Eight meditating psychotherapists also participated in semistructured interviews. The study found no significant differences between meditating psychotherapists and nonmeditating psychotherapists on the attention or awareness levels. However, meditating psychotherapists scored significantly higher levels of empathy than nonmeditating psychotherapists. Qualitative data also supported enhanced levels of attention and awareness, empathy, nonjudgmental acceptance, love, and compassion.

Qualitative interviews (Aiken, 2006) with six psychotherapy practitioners with extensive mindfulness practice (over 10 years) found that mindfulness contributes to a therapist's ability to achieve a felt sense of the client's inner experience; communicate his or her awareness of that felt sense; be more present to the pain and suffering of the client; and help clients become better able to be present to and give language to their bodily feelings and sensations. Aiken (2006) examined how mindfulness practice may have noticeable effects on a therapist's ability to cultivate an empathic orientation.

While containing obvious limitations, this research is promising, illustrating the potential effects of practitioner mindfulness on the therapeutic relationship. It is important to note that a study by Stratton (2005) did not support a correlation between therapist mindfulness and general client outcomes. The study measured mindfulness of the therapist using the MAAS and the Mindfulness/Mindlessness Scale (MMS),

and this was correlated with client outcome scores as measured by the Outcome Questionnaire 45 (OQ-45). While this study did not directly measure the impact of mindfulness on the therapeutic relationship or its variables, it does highlight the need for further study.

Future research is needed to explore the impacts and effects of mindfulness on therapists and the therapeutic relationship, and then ultimately on client outcome.

CONCLUSION

Teasdale, Segal, and Williams (2003, p. 158) maintain that the way in which mindfulness training is delivered may be as important as the content of what is delivered. Others (Bien, 2006; Epstein, 1995; Linehan, 1993) have recognized that mindfulness, while generally conceptualized as an intervention, should also be examined as a therapeutic strategy—as attitudes and behaviors that a therapist demonstrates as opposed to skills that are taught to clients. As we will see in Chapter 2, what the therapist communicates has a lot to do with the therapeutic relationship.

Bishop et al. (2004) report that in a mindful state, practitioners are better able to observe thoughts, feelings, and sensations dispassionately and without attachment. This dispassionate state of self-observation, according to Bishop et al., may introduce a delay between one's perception and response. Mindfulness may therefore enable practitioners to respond to situations more reflectively.

Thomas Bien (2006, p. 217), in his book *Mindful Therapy*, observes that to him “mindful therapy is therapy in which the therapist produces true presence and deep listening. It is not technique driven.” This insight reflects the importance Bien attaches to the role of mindfulness in cultivating presence and listening within the client–therapist relationship. But he also sees the role of mindfulness in another light. His book is as much about the therapeutic relationship as it is about how therapists can use mindfulness to take better care of themselves. This aspect of mindfulness as self-care has the potential to positively affect the therapist and in turn the therapeutic relationship.

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