Measuring The Effects Of A Mindfulness Intervention On Counselors’-In-Training Dispositions, Strength Of The Therapeutic Relationship, And Client Outcomes

Therese Louise Newton
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MEASURING THE EFFECTS OF A MINDFULNESS INTERVENTION ON COUNSELORS’-IN-TRAINING DISPOSITIONS, STRENGTH OF THE THERAPEUTIC RELATIONSHIP, AND CLIENT OUTCOMES

by

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DEDICATION

This is for you Amy. Words cannot begin to express the great joy I feel for having had you in my life. I will forever hold your energy and spirit in my heart. Until we meet again, sweet friend.
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ABSTRACT

Using a multiple baseline single case research design, the present study sought to measure the effects of a mindfulness intervention on counselors’-in-training facilitative dispositions of: (a) empathetic understanding, (b) level of regard, (c) unconditionality of regard, and (d) congruence (as observed through weekly in-session engagement with clients), and client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]). In addition, the investigation examined the influence of counselors-in-training participation in a brief mindfulness intervention on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]). More specifically, this study analyzed the effect of mindfulness education and engagement in mindfulness activities on the in-session occurrences of counselor-in-training expressions of additive empathetic understanding, subtractive empathetic understanding, positive regard, negative regard, the unconditionality of their regard, congruence, and incongruence, as well as the effect of counselor-in-training engagement in mindfulness education and mindfulness activities on client outcomes. The results support mindfulness as effective in increasing the dispositions of additive empathy and positive regard, while also demonstrating effectiveness in enhancing client outcomes. A discussion of the study procedures, results, limitations, and implications are provided.
TABLE OF CONTENTS

Dedication ........................................................................................................................................ iii
Acknowledgements......................................................................................................................... iv
Abstract ............................................................................................................................................. vii
List of Tables ...................................................................................................................................... x
List of Figures ................................................................................................................................... xi
Chapter One: INTRODUCTION ................................................................................................. 1
Chapter Two: LITERATURE REVIEW ......................................................................................... 33
Chapter Three: METHOD ............................................................................................................. 65
Chapter Four: RESULTS ............................................................................................................. 101
Chapter Five: DISCUSSION ........................................................................................................ 146
References ....................................................................................................................................... 173
Appendix A: UNIVERSITY OF SOUTH CAROLINA IRB APPROVAL........................................ 189
Appendix B: INFORMED CONSENT - COUNSELOR-IN-TRAINING ...................................... 190
Appendix C: INFORMED CONSENT - CLIENTS ......................................................................... 193
Appendix D: GENERAL DEMOGRAPHIC SURVEY - CIT ......................................................... 196
Appendix E: GENERAL DEMOGRAPHIC SURVEY - CLIENTS ................................................ 198
Appendix F: OPERATIONAL DEFINITIONS AND CLARIFIERS - DISPOSITIONS ................. 200
Appendix G: CIT DISPOSITIONAL DATA - COLLECTION FORM ............................................... 204
Appendix H: INTERVENTION FIDELITY CHECKLIST - INTERVENTION ONE ..207
Appendix I: INTERVENTION FIDELITY CHECKLIST - INTERVENTION TWO...209
Appendix J: INTERVENTION FIDELITY CHECKLIST - INTERVENTION THREE
.........................................................................................................................211
Appendix K: INTERVENTION FIDELITY CHECKLIST - INTERVENTION FOUR
.........................................................................................................................213
Appendix L: DAILY MINDFULNESS ACTIVITY LOG........................................215
Appendix M: PERSONAL GROWTH INITIATIVE SCALE - II.........................219
Appendix N: BARRETT-LENNARD RELATIONSHIP INVENTORY-OS-40.........220
Appendix O: POST-INTERVENTION FOLLOW-UP QUESTIONNAIRE...........222
LIST OF TABLES

Table 4.1 Counseling session attendance by semester and counselor-in-training ........104

Table 4.2 Total client-reported scores on the Outcomes Questionnaire-45.2 for Betsy’s clients at each administration.................................................................128

Table 4.3 Total client-reported scores on the Outcomes Questionnaire-45.2 for Amelia’s clients at each administration.................................................................129

Table 4.4 Total client-reported scores on the Outcomes Questionnaire-45.2 for Cora’s clients at each administration.................................................................131

Table 4.5 Total scores reported by Betsy’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration.................................................................134

Table 4.6 Total scores reported by Amelia’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration.................................................................136

Table 4.7 Total scores reported by Cora’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration.................................................................139

Table 4.8 Interobserver agreement data for baseline and intervention phases of the study.................................................................................................................142
LIST OF FIGURES

Figure 4.1 Total occurrences of Empathetic Understanding for each participant during baseline and intervention .......................................................... 110

Figure 4.2 Total occurrences of Regard for each participant during baseline and intervention ................................................................. 115

Figure 4.3 Total occurrences of Congruence for each participant during baseline and intervention .............................................................. 119

Figure 4.4 Total client-reported scores on the Personal Growth Initiative Scale-II across baseline and intervention phases of the study ........................................ 123

Figure 4.5 Total scores reported by Betsy’s clients on the Outcomes Questionnaire-45.2 at each administration ......................................................... 128

Figure 4.6 Total scores reported by Amelia’s clients on the Outcomes Questionnaire-45.2 at each administration ......................................................... 130

Figure 4.7 Total scores reported by Cora’s clients on the Outcomes Questionnaire-45.2 at each administration ......................................................... 131

Figure 4.8 Total scores reported by Betsy’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration ............................................. 135

Figure 4.9 Total scores reported by Amelia’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration ............................................. 137

Figure 4.10 Total scores reported by Cora’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration ............................................. 139
CHAPTER ONE: INTRODUCTION

The purpose of this research study is to contribute to the current knowledge surrounding the use of mindfulness to cultivate counselor dispositions. Specifically, the presented investigation analyzed the effect of participation in a brief mindfulness training intervention had on counselors’-in-training facilitative dispositions of: (a) empathetic understanding, (b) level of regard, (c) unconditionality of regard, and (d) congruence (as observed through weekly in-session engagement with clients). In addition, the investigation examined the effects of counselors-in-training participation in a brief mindfulness intervention on client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]) and the influence of counselor-in-training engagement with mindfulness on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]).

Overall, psychotherapy has been found to be an effective form of treatment to improve most client’s outcomes (Lambert, 2013; Lambert & Ogles, 2004; Wampold, 2001, 2007), with the strength of the therapeutic alliance accounting for the largest portion of intra-therapeutic outcome variance (30%; Norcross & Lambert, 2011). Rogers (1957) outlined what he believed to be the “necessary and sufficient conditions” of a strong therapeutic alliance: (a) counselor empathy, (b) unconditional positive regard, and
(c) counselor congruence. While Rogers put forth his “conditions” as change producing mechanisms (e.g., positive client outcomes) of the therapeutic process rather than personal attributes held by the clinician, Barrett-Lennard (1962) contends that it is the client’s perception of the therapeutic alliance that informs change. Further, as perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another, the conditions of empathetic understanding, congruence, level of regard, and unconditionality of regard are better understood as counselor attributes or dispositions (Barrett-Lennard, 1962). With this, exploring effective methods of cultivating such dispositional qualities in counselors is warranted. However, research conducted on effective means of dispositional cultivation, or framing the aforementioned constructs as dispositions rather than behaviors or skills, is sparse.

The American Counseling Association (ACA, 2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) each identify the cultivation of counselor professional dispositions as important to the creation of a strong and unified counselor professional identity; which has long been promoted as integral to the recognition of counseling as an equal and reputable mental health profession. While CACREP accredited training programs are required to assess and evaluate students for professional dispositions as a component of student progress and gatekeeping (Section 4, Standard B, G), the question exists of whether counselor training programs proactively attend to the cultivation of students’ cognitive and dispositional development, in addition to technical counseling skill development (Greason & Cashwell, 2009; Greason & Welfare, 2013). However, as the counselor is responsible for implementing treatments and obtaining positive outcomes, it is logical to view the
counselor, more specifically the person of the counselor (McConnaughy, 1987), as a form of treatment that also requires attention and facilitative cultivation.

McConnaughy (1987) describes the individual personality characteristics, character, and interpersonal style of the counselor to comprise what she refers to as the person of the counselor. It is this personhood that transcends theory and therapeutic technique to create effective therapeutic relationships and enhance positive client change. She goes on to state that while clinical techniques can be learned and used to enhance practice, it is the person of the counselor that selects the technique based on past experiences and personality. Therefore, techniques are but reflections of the counselor’s immediate state, well-being, and awareness: “the therapist as a person is the instrument of primary influence in the therapy enterprise” (McConnaughy, 1987, p. 303).

McConnaughy’s assertion is further supported throughout many of the prominent theories within counseling and psychotherapy literature. Carl Rogers described the person-centered clinician to be “congruent, genuine, integrated person” (1957, p. 97) who possesses ample awareness of self so that they may be free to fully experience the present moment and create an environment of warmth, acceptance, and congruence conducive to client change. Though quite different in approach to client change, Jung (1933), Erikson (1950), Freud (1912), and Whitaker (1974) each emphasized the importance of the clinician’s personality, well-being, personal development, and disposition as a cornerstone for successful therapeutic growth. Further, with the rising acceptance of therapy as generally integrative in nature (Norcross & Goldfried, 2006; Norcross, 2005), addressing the commonalities across theoretical approaches has found that the counselor’s ability to create an effective therapeutic alliance far outweighs the technique
or approach taken (Lambert, 1992; Messer & Wampold, 2002; Norcross & Lambert, 2011).

As stated earlier, it is the client’s perception of the therapeutic alliance that is said to inform change, and perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another (Barrett-Lennard, 1962), attending to the dispositional cultivation of the person of the counselor is logical. In recent years, the exploration of mindfulness, or the intentional practice of bringing one’s awareness into the present moment and accepting one’s thoughts and feelings in that moment without judgment or evaluation (Kabat-Zinn, 2013), as a means of enhancing counseling skills self-efficacy and cultivating various facilitative dispositions has seen promising results. Additionally, as both the mind attitudinal foundations of mindfulness (e.g. non-judging, patience, acceptance, letting-go, etc.) and the heart attitudinal foundations (e.g. non-harming, kindness, compassion, empathetic joy, etc.) as described by Kabat-Zinn (2013), parallel the professional values of counseling (ACA, 2014), mindfulness appears to be a complimentary practice to counseling. Therefore, this study used mindfulness practices as a training intervention, measuring the effects of mindfulness on counselor-in-training dispositions, client perception of the therapeutic relationship, and client outcomes.

**Statement of the Problem**

The strength of the therapeutic alliance has been found to account for the largest portion of intra-therapeutic outcome variance (30%; Norcross & Lambert, 2011). Counseling technique (15%), client expectations (15%), and extra-therapeutic factors (40%) account for the remaining outcome variance (Lambert, 1992; Norcross & Lambert,
With a significant percentage of outcome variance attributed to a manipulatable factor such as the therapeutic alliance, it is logical that the specific factors leading to cultivation of an effective alliance be explored. As the counselor is an integral member of the therapeutic alliance; with 5%-18% of variance in client outcome attributed to the individual counselor (Baldwin, Wampold, & Imel, 2007; Crits-Christoph & Mintz, 1991; Lutz, Martinovich, Lyons, Leon, & Stiles, 2007; Norcross & Lambert, 2011; Owen, Duncan, Reese, Anker, & Sparks, 2014), identifying counselor training interventions that are proven to cultivate facilitative dispositions for the benefit of greater client outcome is beneficial to the advancement of the counseling profession.

Mindfulness has been found to be effective in enhancing counseling skills self-efficacy (Buser, Buser, Peterson, & Seraydarian, 2012) and various counselor dispositions (Campbell & Christopher, 2012; Christopher, Christopher, Dunnagan & Shure, 2006; Duffy, Guiffrida, Araneda, Tetenov, & Fitzgibbons, 2017). Mindfulness as a training intervention often includes activities informed by Kabat-Zinn’s Mindfulness-Based Stress Reduction (MBSR; 2013) such as sitting meditation to encourage attention to breathing while remaining open to experienced sensations, thoughts, and emotions; a body scan encouraging an individual to attend to physical sensations and tension in each part of the body; hatha yoga using gentle stretches and postures to encourage mind-body awareness; loving-kindness meditation to encourage compassion toward others as well as love and compassion toward self. Additional practices done outside of formal practice may include journaling, mindful activities, or sitting with difficult thoughts.

Counseling students who engaged in mindfulness practice reported increased awareness and acceptance of self and others, increased patience, focus/attention,
empathy, compassion, emotional stability, and decreased levels of judgment (Campbell & Christopher, 2012). Additionally, a positive relationship has been found between counselor mindfulness and empathy (Greason & Cashwell, 2009), counselor mindfulness and client perception of the therapeutic alliance (Greason & Welfare, 2013), and mindfulness and moral reasoning (Shapiro, Jazaieri, & Goldin, 2012).

However, gaps exist in the literature related to methods of cultivating counselor dispositions. First, many studies focused on mindfulness and constructs such as empathy, congruence, and client outcomes are correlational (Greason & Cashwell, 2009; Greason & Welfare, 2013), therefore a causal relationship cannot be determined. Second, while several qualitative studies (Campbell & Christopher, 2012; Christopher et al., 2006; Duffy et al., 2017) have offered rich descriptions of the experiences of counselors-in-training who have engaged in mindfulness practice, they are retrospective by nature and do not account for observable in-session behavior or client outcome as a result of their mindfulness practice. This study measured the effect of a mindfulness intervention on the dispositions of empathetic understanding, level of regard, unconditionality of regard, and congruence to determine if a causal relationship exists between mindfulness and counselor dispositions. Additionally, this study sought to further validate previous findings related to strength of the therapeutic relationship as predictive of positive therapeutic outcome through assessment of client change, and client perception of counselor empathy, regard, unconditionality of regard, and congruence.

**Significance of the Study**

This study measured the effect of a brief mindfulness training intervention on dispositions of counselors-in-training and client outcomes, while concurrently assessing
for client perception of the therapeutic relationship as an influential factor for client outcomes. Several implications exist for counselor training programs, professional gatekeeping, and ethical standards.

Results of this study contribute to the current knowledge surrounding the use of mindfulness to cultivate counselor dispositions. Counselors enter a therapeutic relationship with not only their learned skills and therapeutic techniques, but with personal dispositional qualities that may be inseparable from their counselor role. Through attention to the impact of such dispositional qualities on the therapeutic relationship and client outcome, counselor training programs may improve gatekeeping procedures through more accurate assessment of dispositions while also developing training interventions specific to cultivation of specific dispositions proven to be effective in enhancing client outcome.

Attention to cultivation of facilitative dispositions necessary to build a strong therapeutic alliance is often missing from counselor training curriculums (Greason & Cashwell, 2009; Greason & Welfare, 2013). While counselor training programs continue to produce well-skilled and technically-competent clinicians, the absence of training interventions specific to cultivation of the person of the counselor may be representative of the profession’s move toward incorporation of manualized treatment procedures in counseling (Miller, Hubble, Chow, & Seidel, 2013). However, as the clinician is responsible for implementing treatment and obtaining positive outcomes, it is logical to consider the clinician, more specifically the person of the counselor, as the filter through which all learned skills and techniques flow. Therefore, an argument may be asserted that
it would be beneficial to the profession and client outcome to view the counselor as a form of treatment requiring appropriate dispositional cultivation.

**Theoretical Framework**

This study is grounded in four concepts: (a) mindfulness, (b) counselor dispositions, (c) the therapeutic relationship, and (d) client outcomes.

**Mindfulness**

Mindfulness is defined as the intentional practice of bringing one’s awareness into the present moment and accepting one’s thoughts and feelings in that moment without judgment or evaluation (Kabat-Zinn, 2013). According to Kabat-Zinn (2013), the cultivation of mindfulness leads to calmness, relaxation, and increased insight into oneself. As multiple descriptions of mindfulness exist in the literature, Bishop et al. (2004) proposed use of a single operational definition inclusive of common themes found across definitions: (a) self-regulation of attention to present moment thoughts, feelings, and sensations, and (b) an orientation of curiosity, openness, and acceptance of these experiences. Simply phrased, mindfulness is the expansion of one’s awareness to encompass all present moment experiences while also choosing not to over-identify with any one, but instead accepting them simply as present; allowing an individual to become aware of the space between observation of thought, emotion or sensation, and response. Bishop et al. (2004) proposes that it is within that space that a person may choose how they wish to respond instead of reacting in a habitual or automatic manner; becoming more reflective and intentional as opposed to reactive or reflexive.

Jon Kabat-Zinn was instrumental in gaining acceptance of mindfulness as an effective form of treatment through his work studying the effects of mindfulness in the
treatment of chronic pain and other medical disorders (1982, 2013). Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2013), originally developed under the name Stress Reduction and Relaxation Program, has since laid the foundation for the emergence of other mindfulness-based interventions such as Dialectical Behavioral Therapy (Linehan, 1993), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999). To date, mindfulness practices have been used as the foundation for treatment of a variety of mental health and medical disorders (Grossman, Niemann, Schmidt, & Walach, 2004) and as a method of cultivating counseling self-efficacy (Buser et al., 2012) and various counselor attitudes and dispositions (Campbell & Christopher, 2012; Christopher et al., 2006; Duffy et al., 2017).

**Counselor Dispositions**

Counselor professional dispositions have been broadly defined in recent literature as core values, attitudes, and beliefs, as well as in terms of emotional stability, ethical behavior, and adaptability (Garner, Freeman, & Lee, 2016; Lambie, Mullen, Swank, & Blount, 2015; Spurgeon, Gibbons, & Cochran, 2012; Swank, Lambie, & Witta, 2012). The American Counseling Association (ACA, 2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) state that importance of cultivating counselor professional dispositions. CACREP accredited training programs are required to assess and evaluate their students for professional dispositions as a component of student progress and gatekeeping. While CACREP has included a definition of professional dispositions in their most recent Standards (2016), “the commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors
that influence the counselor's professional growth and interactions with clients and colleagues” (p. 43), a unified set of specific dispositions has yet to be introduced.

Governing bodies of other related professions, such as teaching and school psychology, have begun taking steps to define the characteristics essential to their respective professions. The *Council for the Accreditation of Educator Preparation* (CAEP) has adopted the definition of dispositions put forth by the *Council of Chief State School Officers* (CCSSO) in the Interstate Teacher Assessment and Support Consortium (InTASC) Model Core Teaching Standards as “the habits of professional action and moral commitments that underlie and educator’s performance” (CCSSOO, 2011, p. 6). InTASC further outlines specific dispositional criteria to be used when evaluating teacher candidates during their training. The *National Association of School Psychologists* (NASP) requires graduate programs to evaluate students’ level of “professional work characteristics needed for effective practice as school psychologists, including respect for human diversity and social justice, communication skills, effective interpersonal skills, responsibility, adaptability, initiative, dependability, and technology skills” (NASP, 2010, p. 16).

While several variations of assessments evaluating counselor dispositions and characteristics exist (Frame & Stevens-Smith, 1995; Garner et al., 2016; Lambie et al., 2015; McAdams, Foster, & Ward, 2007; Spurgeon et al., 2012), neither ACA nor CACREP has identified or offered an agreed upon set of dispositional criteria that are central to the development of a unified professional identity. This study will interpret Rogers’ (1957) conditions necessary for the formation of a strong therapeutic alliance;
counselor empathy, unconditional positive regard, and congruence, as counselor attributes, or dispositions, as proposed by Barrett-Lennard (1962, 2015).

**The Therapeutic Relationship**

The therapeutic alliance continues to be cited as the strongest predictor of positive client outcome (Lambert et al., 2001; Lambert & Hill, 1994; Miller et al., 2013). The therapeutic alliance, therapeutic relationship, and working alliance are all phrases used to describe the interpersonal and dynamic engagement between counselor and client (Horvath & Luborsky, 1993; Miller et al., 2013). Carl Rogers (1957) placed great emphasis on the therapeutic relationship, asserting that if certain conditions were met, the relationship would be sufficient to make positive change in the client. These “necessary and sufficient” (Rogers, 1957; p.95) conditions include the counselor’s ability to be empathetic, offer the client unconditional positive regard, and remain in a state of congruence. However, it is the client’s perception of the therapeutic relationship, rather than the counselor’s, that more accurately informs therapeutic change (Bachelor, 1995; Barrett-Lennard, 1962; Gurman, 1977). As perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another, attention must be paid toward the appropriate cultivation of the counselor’s facilitative dispositions. This study will use the *Barrett-Lennard Relationship Inventory* (BLRI; Barrett-Lennard, 1962) to measure client perception of the therapeutic relationship.

**Client Outcomes**

Client outcomes, or change, is generally viewed in relation to counselor techniques, processes and interactions, and client behavior (Lambert & Hill, 1994). Client behavior may be further described in terms of a client’s reported symptomology and
distress level across the areas of: individual functioning, relational functioning, and social functioning (Lambert & Hill, 1994). Client behavior may also be described in terms of a personal growth initiative and adaptability to change (Robitschek, 1998; Robitschek et al., 2012). Personal growth is believed to be a way of addressing all aspects of life: individual, relational, and social, from the perspective that as change is inevitable and an individual must possess the skills needed to grow and adapt to change. Further, as change occurs across all aspects of life, and individuals are presented with various forms of challenges and obstacles throughout the life cycle, those possessing a higher self-efficacy surrounding intentional personal growth and ability to make change will be better able to cope and adapt (Bandura, 1977; Robitschek, 1998).

Studies assessing for client outcomes resulting from direct counselor engagement in mindfulness activities are rare. This study measured client outcome as a change over time in personal growth initiative using the *Personal Growth Initiative Scale-II* (Robitschek et al., 2012) and a change in reported symptomology using the *Outcomes Questionnaire-45.2* (Lambert et al., 1996).

**Operational Definitions of Terms**

Several terms were used throughout this study when discussing the constructs being explored. To ensure clarity and understanding, the constructs are briefly defined.

**Mindfulness**

Mindfulness is defined as the intentional expansion of one’s awareness to encompass all present moment experiences while consciously choosing not to over-identify with any one, but instead accepting them simply as present; thus allowing an individual to become increasingly aware of the space between initial observation of
thought, emotion or sensation, and intentional response (Kabat-Zinn, 2013; Bishop et al., 2004).

**Counselor Dispositions**

Counselor dispositions are defined as “the commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors that influence the counselor's professional growth and interactions with clients and colleagues” (CACREP, 2016, p. 43). This study will specifically investigate the following counselor dispositions: (a) empathic understanding, (b) level of regard, (c) unconditionality of regard, and (d) congruence.

**Empathic Understanding.** Empathetic understanding, or empathy, is defined as the extent to which one desires to know and experience the process and content of another’s awareness. Further, it the ability to sense the immediate quality and intensity of another’s experience while being able to recognize the context of the feeling or thought (i.e. what/whom the feeling is directed toward or the conditions that produced the feeling). Empathetic understanding is demonstrated through experiential recognition of perceptions or feelings that another has directly expressed, as well as through the sensing and inferring of that which another has implied or indirectly expressed. Empathetic understanding is diminished when one projects perception of another’s experience that has originated within oneself and one’s own experiences (Barrett-Lennard, 1962, 2015).

**Level of regard.** Level of regard is defined as the affective aspects, both positive and negative, of one’s response to another. Positive aspects may include indicators of leaning into another’s experience, warmth, respect, affection, and appreciation. Negative
aspects may include indicators of pulling away from another, impatience, dislike, rejection, and contempt (Barrett-Lennard, 1962, 2015).

**Unconditionality of regard.** Unconditionality of regard is defined as the degree of variability, or constancy, that exists in one’s affective response to another. Conditionality exists when one’s communication of experience is tailored to obtain desired affective responses from another (Barrett-Lennard, 1962, 2015).

**Congruence.** Congruence is defined as consistency between present experience, awareness, and response. Congruence is enhanced when an individual is psychologically unthreatened, therefore allowing openness to awareness of another’s experience while also responding to their experience with honesty, directness, and sincerity. Incongruence is demonstrated through discomfort, tension, anxiety, and inconsistency between what one says and what is implied through expression, gesture, or tone of voice (Barrett-Lennard, 1962, 2015).

**The Therapeutic Relationship**

The therapeutic relationship is defined as the interpersonal and dynamic engagement between counselor and client (Horvath & Luborsky, 1993; Miller et al., 2013). While development of a strong therapeutic relationship is contingent upon the presence of counselor empathy, unconditional positive regard, and congruence (Rogers, 1957), it is the client’s perception of the presence of these constructs that is predictive of positive outcome (Bachelor, 1995; Barrett-Lennard, 1962; Gurman, 1977).

**Client Outcome**

Client outcome will be defined as a change over time in client’s personal growth initiative, as measured by the *Personal Growth Initiative Scale-II* (Robitschek et al.,
2012) and a change in reported symptomology using the *Outcomes Questionnaire-45.2* (Lambert et al., 1996).

**Counselor-In-Training**

For the purpose of this study, a counselor-in-training was defined as a student who is “engaged in formal graduate-level counselor education” (ACA, 2014, p. 21) and who has advanced through to practicum experience.

**Practicum**

Practicum is defined as a “distinctly defined, supervised clinical experience in which the student develops basic counseling skills and integrates professional knowledge” (CACREP, 2016, p. 43). Practicum is completed prior to internship.

**Research Questions & Hypotheses**

The purpose of this study was to measure the effect of a counselors’-in-training participation in a mindfulness intervention on the observable dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence, and client outcome. Additionally, clients’ perception of the degree to which these facilitative dispositions exist within their counselor was also measured. The following research questions were used to guide the study:

**Primary Research Questions & Hypotheses**

Research Question 1

Does counselors-in-training participation in a brief mindfulness intervention affect their dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as demonstrated through in-session engagement with clients)?

Hypothesis 1
Counselors-in-training dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as demonstrated through in-session engagement with clients) will demonstrate a measurable increase after introduction of the mindfulness intervention.

Research Question 2

Does counselors-in-training participation in a brief mindfulness intervention affect client outcomes (as measured by the *Personal Growth Initiative Scale-II*; [Robitschek et al., 2012] and the *Outcomes Questionnaire-45.2*; [Lambert et al., 1996])?

Hypothesis 2

Client outcomes (as measured by the *Personal Growth Initiative Scale-II*; [Robitschek et al., 2012] will increase after introduction of the mindfulness intervention with scores from the *Outcomes Questionnaire-45.2*; [Lambert et al., 1996]) showing a positive trend as client perception of the therapeutic alliance (as measured by the *Barrett-Lennard Relationship Inventory Form OS-40*; [Barrett-Lennard, 1962]) increases.

Research Question 3

Is the strength of the therapeutic alliance, as determined by client perception of the presence of counselor (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as measured by the *Barrett-Lennard Relationship Inventory Form OS-40*; [Barrett-Lennard, 1962]) influenced by counselor-in-training participation in a brief mindfulness intervention?

Hypothesis 3

The strength of the therapeutic alliance, as determined by client perception of the presence of counselor (a) empathetic understanding, (b) regard, (c) unconditionality of
regard, and (d) congruence (as measured by the *Barrett-Lennard Relationship Inventory Form OS-40;* [Barrett-Lennard, 1962]) will be positively influenced by counselor-in-training participation in a brief mindfulness intervention.

**Research Design**

This study used a concurrent multiple baseline across-participants single-case research design (SCRD; Gast, 2010; Kazdin, 2011) to measure the effect of a brief mindfulness training intervention on: (a) counselor-in-training dispositions, (b) client perception of the therapeutic relationship, and (c) client reported outcome. The multiple baseline across participants SCRD has been described as an A-B design that is replicated across participants, where each participant is able to serve as their own control (Gast, 2010; Kazdin, 2011; Ray, 2015). This control is possible as each participant is exposed to both a control condition (A) and an intervention (B). While results from a single A-B design are not sufficient to infer a causal relationship as threats to internal validity, particularly the impact of extraneous variables on outcome, cannot be ruled out (Kazdin, 2011), the implementation of a second A phase following the intervention may strengthen the inference of intervention effectiveness (Foster, 2010; Gast, 2010). However, as many counseling interventions strive to offer long term change and are effects are “functionally irreversible” (Gast & Ledford, 2010, p. 284), implementing an A phase post-intervention proves challenging due to the high potential for carryover effect, or the effect of an intervention on another phase (Ray, 2015). In situations such as this, replication of the experiment across-participants using a multiple baseline increases rigor and reduces threats to internal validity (Gast & Ledford, 2010, Kazdin, 2011). Replication across participants supports the potential to develop “more robust inferences about the
functional nature” of treatments and outcome (Lenz, 2015). Multiple baseline is considered a rigorous experimental design that is fully able to make meaningful contribution to evidence-based outcomes research (Gast, 2010; Lenz, 2015; Ray, 2015).

Multiple baseline designs may run concurrently or nonconcurrently across participants. Concurrent multiple baselines are characterized by participants beginning baseline phase simultaneously and matriculating through to the intervention phase at a staggered rate, as determined by baseline stability and demonstration of observable treatment effect in subjects who have previously begun the intervention (Christ, 2007; Gast & Ledford, 210; Heppner, Wampold, & Kivlighan, 2008; Kazdin, 2011). Further, incorporating components of randomization into single case research, such as the random assignment of client-participants to counselors-in-training, serves to increase internal validity and experimental control (Kratochwill & Leven, 2010; Watson & Workman, 1981).

Use of concurrent multiple baseline across-participants SCRD was appropriate for this study as it will allow for isolation of intervention effect on the dependent variables. Additionally, when utilizing across participant multiple baseline design, Gast & Ledford (2010) view the identification of participants who exhibit “similar learning histories and who emit the same target behavior at similar frequencies under similar pre-intervention conditions” (p.313) as an ideal, or even conservative, approach to the research design. As participants will be counselors-in-training who have progressed through their counselor training program at the same rate and who are at similar places in their counseling professional development, they are an ideal sample for inclusion and analysis of treatment effectiveness using an across participants concurrent multiple baseline SCRD.
In addition to the continuous data collection related to counselor-in-training dispositions, client data related to treatment outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012]) will also be collected on a continuous basis following each counseling session. Further probing for additional client-report data related to symptom distress and perception of the therapeutic alliance occurred at predetermined points throughout the study; (a) baseline session one, (b) intervention week one, (c) fall semester end, (d) spring semester start, and (e) termination session. Client data was collected using the Barrett-Lennard Relationship Inventory Form OS-40 (Barrett-Lennard, 1962) to assess the strength of the therapeutic relationship and the Outcomes Questionnaire-45.2 (Lambert et al., 1996) as a supplemental measure of treatment outcomes. Probing for client data at selective times was appropriate to reduce the impact of continued measurement and enhance internal validity (Christ, 2007).

Research Method

Population and Sampling

The target populations for this study was current counselors-in-training and their clients. Using purposive sampling (Heppner et al., 2008), study participants included three counselors-in-training enrolled in a practicum course in which they saw a minimum of two clients in a university-based clinic. Potential counselors-in-training included students matriculating through Marriage, Couples, and Family Counseling and School Counseling tracks of a CACREP-accredited graduate counseling program. While the minimum sample size required in SCRD is one, and analysis of data occurs at the individual level, when implementing a multiple baseline design the inclusion of at least three participants is required to demonstrate experimental control and reduce threats to
internal validity (Gast & Ledford, 2010; Lenz, 2015). Clients included a minimum of six undergraduate students enrolled in courses within the Counseling minor academic program. All clients were required to be currently enrolled at the university at time of participation and over the age of 18.

_Incentives._ Counselors-in-training received a $25 gift card for their participation in this investigation. Counselors-in-training also received credit toward their required practicum and internship hours for time spent engaging in counseling activities and for time spent participating in the mindfulness intervention. Counselors-in-training each received weekly supervision as required by their enrollment in the practicum course. Weekly supervision was offered by second-year Counselor Education & Supervision doctoral students in group, triadic, and individual formats. Supervising doctoral students each received weekly supervision of their supervision practice by a counselor education program faculty member. Additionally, two fully licensed, second-year counselor education doctoral students served as on-site clinical supervisors to participating counselors-in-training; providing supplemental weekly supervision. Should recruitment efforts produce more than three volunteer counselors-in-training, potential participants were informed that a random sample will be identified through use of a computer-generated selection tool (Heppner et al., 2008) and only those participants selected would receive the intervention. To encourage session attendance and reduce the potential for client attrition, participating undergraduate students received extra credit in their courses.
Instrumentation

Observers

In addition to the primary researcher, two first-year doctoral students in the Counselor Education and Supervision program were trained to observe and collect data related to participant dispositions and engagement in counseling sessions. Using guidelines put forth by Ayers & Gast (2010), the independent observers were trained by the researcher to identify and record instances of dispositional expressions under investigation. Trainings occurred over a two-week period and included the use of fictitious, or role-played, counseling session videos for practice coding. Independent observers did not begin recording baseline data until an IOA of 80% was consistently met or exceeded during training. Observer training also included review of procedures for completing and storing data and documentation to ensure confidentiality of participant data and experimental control. Operational definitions and behavioral clarifiers for each disposition were included with all CIT Dispositional Data-Collection Forms for continued reference. Follow up training occurred as needed throughout the duration of the study.

Counselor-in-Training (CIT) Dispositional Data-Collection Form

The CIT Dispositional Data-Collection Form (see Appendix G) was created by the researcher using recommended SCRD data-collection form templates (Gast & Ledford, 2010). The forms are organized by observation periods, disposition, and clarifying information related to the disposition expression observed (e.g. verbal, nonverbal, positive, negative) Observers used tick marks (|) to record each instance of the disposition during the individual time period. Tick marks were then tallied after each
segment and then all tallies were added together to offer a session total for each disposition.

**Demographic Survey**

The *General Demographic Survey* (see Appendix D and E) is a self-report questionnaire created by the researcher to collect participants’ demographic information (e.g., gender, age, ethnicity, level of education, counselor prior exposure to mindfulness, client prior exposure to counseling, etc.). This demographic information was completed prior to initial counseling session and collected by the researcher. Counselors-in-training and clients were each assigned a unique identifier in lieu of name to protect their confidentiality. Unique identifiers were used for all documentation and reporting (e.g. video recordings, disposition data-collection forms, client report assessments).

**Personal Growth Initiative Scale-II**

The Personal Growth Initiative Scale-II (PGIS-II) is a 16-item assessment of personal growth assessed through four subscales of: (a) Intentional Behavior, (b) Using Resources, (c) Planfulness, and (d) Readiness for Change. Individual items on the *PGIS-II* use a six-point Likert scale ranging from 0 (Disagree Strongly) to 5 (Agree Strongly), with a final score ranging from 0-80. Psychometrics for the *PGIS-II* show a Cronbach’s alpha of .92 (Shigemoto, Low, Borowa, & Robitschek, 2016) and a test-retest reliability of .90-.94 when administered at intervals of one to six week (Robitschek et al., 2012). As the *PGIS-II* will be administered at one-week intervals, the high test-retest reliability of this instrument makes it an appropriate choice for this investigation.
Barrett-Lennard Relationship Inventory OS-40

The Barrett-Lennard Relationship Inventory (BLRI), in its original form, is a 64-item assessment containing four subscales that align with Rogers’ (1957) facilitative conditions of empathetic understanding, level of regard, unconditionality, and congruence (Barrett-Lennard, 1962). The BLRI measures the client’s perception, consider most impactful to the relationship (Rogers, 1957), of the facilitative conditions within the therapeutic relationship. Clients use a six-point interval scale to respond to questions based on their level of agreement; -3 to +3 with use 0 not offered as a potential response. Each subscale may be scored independently to assess specific facets of the relationship or combined to obtain a total score for the relationship.

Several variations of the BLRI have been created for use across settings and populations. This study will utilize the abbreviated Barrett-Lennard Relationship Inventory Form OS-40 (BLRI-OS-40) containing a total of 40 questions, or 10 questions for each of the four subscales. Reliability coefficients for the subscales of the BLRI-OS-40 include .91 for empathic understanding, .87 for level of regard, .82 for unconditionality, and .88 for congruence.

Outcomes Questionnaire - 45.2

The Outcomes Questionnaire – 45.2 (OQ-45.2) is a 45-item self-report outcomes assessment used to measure change in client symptomology over time (Lambert et al., 1996). Individual items on the OQ-45 use a five-point Likert scale ranging from 0 (Never) to 4 (Always), with a final score ranging from 0-180. Research indicates that scores demonstrating a change of 14-points or more is indicative of significant client change (Vermeersch, Lambert, & Burlingame, 2000). Psychometrics for the OQ-45.2
show a test-retest reliability of .84 and a Cronbach’s alpha of .93 (Mueller, Lambert, & Burlingame, 1998).

**Daily Mindfulness Activity Log**

The *Daily Mindfulness Activity Log* (see appendix L) is a self-report instrument created by the researcher to collect information related to counselor-in-training engagement and experiences associated with their mindfulness practices during the intervention phase of this study. Information collected included details related to specific mindfulness activities practiced each week, duration of practice, and context of the practice (i.e. time of day, reason for specific activity selection, etc.). While data obtained was reviewed for across participant themes related to specific mindfulness activities practiced, *Daily Mindfulness Activity Logs* were designed to serve as a method for counselors-in-training to remain accountable for their engagement in mindfulness activities while participating in the intervention.

**Post-Intervention Follow-Up Questionnaire**

The *Post-Intervention Follow-Up Questionnaire* (see Appendix O) is a self-report instrument created by the researcher to capture counselor-in-training thoughts and opinions related to the mindfulness intervention. Data collected was used to assess for the social validity (Kazdin, 2011) of the intervention. The questionnaire was sent to counselors-in-training following completion of data collection.

**Data Collection**

Data collection was continuous (Gast, 2010) and began during the first encounter between the counselor-in-training and client. All 50-minute counseling sessions were held in a university counseling training clinic, and each session was video recorded using
an IRB-approved portable recording camera that was placed in the counseling clinic rooms during sessions. Following each session, video recordings were reviewed by a member of a team of trained observers and, using the *CIT Dispositional Data-Collection Form*, observers tallied the frequency, or occurrences, of dispositional expressions being investigated. Each 50-minute counseling session recording was broken down into five 10-minute observation periods; with periods one, three, and five reviewed by observers for occurrences of dispositional expressions and then tallied to obtain an individual segment frequency count and a total frequency count. Periods two and four, where observations did not occur, allowed for observers to record observations and tally the completed period before moving onto the next (Kazdin, 2011). Frequency recording was used when measuring the occurrences of empathetic understanding and regard as these dispositional expressions, as operationally defined for this study, proved to have identifiable beginning and end points (Kazdin, 2011). Congruence was measured using whole interval recording as the dispositional expressions for congruence/incongruence often accompanies expressions or statements associated with empathetic understanding and regard; therefore, discrete measurement of congruence/incongruence is challenging. Whole interval recording (Kazdin, 2011) allows for the measurement of behaviors that occur at a high rate or those with variation in duration, such as congruence/incongruence. If a counselor-in-training presented as congruent, based on the operational definitions used in this study, an occurrence of congruence (+) was marked for that observation period. Similarly, if a counselor-in-training presented as incongruent, based on the operational definitions used in this study, an occurrence of incongruence (-) was marked for that observation period. As with empathetic understanding and regard, occurrences were then
tallied to offer a total count. Completed observation forms were then collected by the researcher and data points were visually graphed, using Microsoft Excel, for continuous pattern analysis. Furthermore, in an effort to reduce the potential for recording bias, each independent observer remained blinded to participant phases and phase change occurrences.

Client report data was also collected after each counseling session. Following the conclusion of the counseling sessions, clients were given an envelope containing the assessments required for them to complete. Upon completion of the assessments, clients were asked to return the completed assessments to the original envelope and seal the envelope before handing it to their counselor-in-training. Once the packet was handed to the counselor-in-training, the counselor-in-training delivered the sealed envelope to the researcher. The researcher then recorded and graphed client responses for continuous visual analysis.

**Procedures**

**Baseline**

Baseline, or the control condition, refers to the period of time prior to introduction of an intervention (Kazdin, 2011; Ray, 2015). During the baseline phase repeated measurements of the dependent variables (e.g. counselors’-in-training empathy, level of regard, unconditionality of regard, and congruence) were collected to establish a pattern of behavior that may predict future behavior if an intervention was not being introduced (Gast, 2010). Using video recordings, baseline data collection began during the first encounter between counselor-in-training and client. Stabilization of baseline data related to the target behaviors was established through visual analysis using no fewer than five
Data points prior to moving into the intervention phase (Gast, 2010; Kazdin, 2011; Lentz, 2015; Ray, 2015). Once stabilization of baseline data for the first participant occurred, the participant was able to transition into the intervention phase. Baseline data continued to be collected for the remaining participants until both stabilization of individual baseline data was present and clear indication of treatment effect, using no fewer than three data points, had occurred in prior participants. Once both criterion had been met, the next participant was able to enter into the intervention phase of the study. This pattern continued until all participants had entered into the intervention phase of the study. Baselines of differing lengths is needed to accurately evaluate for threats to internal validity (Gast & Ledford, 2010).

**Intervention**

Upon progression to the intervention phase, counselors-in-training individually participated in a brief mindfulness intervention. Counselors-in-training continued seeing their clients for 50-minute counseling sessions throughout the intervention phase. The mindfulness intervention, created by the researcher, is informed by Kabat-Zinn’s Mindfulness-Based Stress Reduction (2013) and traditional mindful meditation teachings and practices (Thera, 1962/1996). The intervention consisted of two stages: (a) guided practice and (b) independent practice. During the initial stage, guided practice, counselors-in-training individually attended four 75-minute mindfulness sessions over the course of two weeks. The guided mindfulness sessions were held within the University counseling clinic and led by the primary researcher who has practiced mindfulness for several years and has received training in mindfulness practices.
Counselors-in-training were required to engage in both formal and informal mindfulness practices outside of the scheduled intervention sessions and log their experiences using the *Daily Mindfulness Activity Logs*, which they returned to the researcher prior to each intervention session. All guided sessions followed the same format (see Appendix H-K): (a) introduction and welcome, (b) opening practice (e.g. breathing exercise), (c) follow-up and processing of mindfulness experiences and/or questions, (d) psychoeducation (e.g. foundations and tenets of mindfulness, attitudinal qualities), (e) guided meditations and processing of experience, (f) brief closing practice (e.g. breathing meditation), and (g) review of homework expectation.

At the conclusion of the guided practice phase, counselors-in-training entered into the independent practice phase of the intervention. During this phase, counselors-in-training did not attend intervention sessions but were asked to continue logging their mindfulness activities using the *Daily Mindfulness Activity Logs*. Logs were handed in weekly to the researcher for review. Counselors-in-training remained in the independent practice phase of the intervention until the conclusion of the investigation. Continuous data collection during the independent practice phase of the intervention allowed for analysis of the lasting effect of a brief mindfulness intervention on counselor-in-training dispositions.

**Client Report Data**

Client data was collected continuously throughout this investigation. Clients completed the *Personal Growth Initiative Scale-II* (PGIS-II; Robitschek et al., 2012) following each counseling session. The continuous collection of data related to client personal growth, a key indicator of positive treatment outcome (Robitschek et al., 2012),
allows for an assessment of a causal relationship between the mindfulness intervention, counselor dispositions, and client outcome. In addition to administration of the PGIS-II, clients also completed the Barrett-Lennard Relationship Inventory Form OS-40 (Barrett-Lennard, 1962) to assess their perception of the strength of the therapeutic relationship and the Outcomes Questionnaire-45.2 (Lambert et al., 1996) to measure changes in client distress and symptomology.

Data Analysis

Both counselor-in-training and client data was visually analyzed using graphical displays of data points created using Microsoft Excel. Analysis included documentation of baseline pattern, examination of data within phases to assess for patterns, comparison of data between phases to assess for intervention effect, and integration of data across phases to determine if there is a minimum of three demonstrations of effect (Kratchowill et al., 2010). Additionally, the following variables will be considered when analyzing between and within group data: (a) level, or mean of each phase; (b) trend, or slope of data; (c) variability between each data point in phases; (d) immediacy, or time between intervention and effect; (e) overlap, or proportion of data that overlaps phases; and (f) consistency of data patterns across phases for replication and credibility (Hott et al., 2015; Kratochwill et al., 2010).

Interobserver agreement (IOA), or the accuracy of agreement between observers, aids in enhancing credibility to findings (Hott et al, 2015). IOA will be assessed though a simple frequency ratio to determine agreement between observations (Kazdin, 2011). Frequency ratio is computed by dividing the smaller total by the larger total and then multiplying this number by 100 to form a percentage. This percentage indicates the
consistency of which the target behavior was observed. It is recommended that IOA data be assessed in 20-33% of observations, with a minimum of 80% IOA as a recommended cut-off to ensure validity of results (Ayers & Gast, 2010; Kazdin, 2011).

Treatment integrity, or intervention fidelity, refers to the degree to which the procedures described for the intervention phase were implemented across participants (Gast, 2010). Differences in intervention implementation may result in variability of outcome and loss of reliability in results (Kazdin, 2011). To determine the degree of integrity for which the intervention was implemented, a random selection of 25% of video recorded intervention sessions were reviewed by an outside observer using the Intervention Fidelity Checklists for each intervention session (see Appendix H-K). To determine the percentage of treatment integrity, the number of observed events were divided by the number of planned events and then this number was multiplied by 100.

**Ethical Considerations**

The following measures were taken to ensure this research study was conducted in accordance with ethical standards and to ensure the protection of participant confidentiality:

1. Participant names were not used during data collection, analysis, or reporting.

   Participants were assigned a unique number code as their identifier and the researcher maintained an electronic code key that was encrypted and password-protected as required by the ACA Code of Ethics (2014).

2. Participation in this study was voluntary and though incentives were offered for completing the study, early withdrawal did not negatively impact academic standing.
3. All participants were informed of their rights and an explanation of research was approved by the IRB at the University of South Carolina.

4. Client completed assessments were collected and sealed in prelabeled envelopes following each collection time. The researcher collected and stored the completed assessments in a locked cabinet in Wardlaw 140.

5. Permission to use the instruments was obtained from the authors when required and appropriate licenses were obtained.

6. The study was conducted with the permission and approval of dissertation co-chairs, committee members, and IRB of the University of South Carolina.

**Potential Limitation of the Study**

Several limitations exist within this study. First includes the use of self-report measures as the primary method of client data collection. While this method is common, the potential for malingering, untruthful, or distorted answers was present; potentially impacting results. Also, through observer ratings of client dispositions, what may be considered internal processes, there was an increased chance of inaccurate scoring. Precautions to reduce inaccurate measurement included thorough training of observers by the primary researcher to identify dispositions using the operational definitions and behavioral clarifiers for each disposition under investigation. Additionally, while precautions were taken to reduce the effect of history and maturation, these threats to internal validity exist. Perhaps the largest limitation due to chosen research design is the question of generalizability of results to other settings or populations (Heppner et al., 2008).
Chapter Summary

Chapter One introduced the constructs (counselor dispositions, mindfulness, therapeutic relationship, and client outcome) investigated in this study. The research design (multiple baseline single case research) was explained, and potential limitations and ethical considerations were identified. Chapter Two reviews relevant literature related to the constructs investigated. Chapter Three will present the methodology used in the study. Chapter Four will present the results of the study. Chapter Five will discuss the results of the study in relation to implications and future research.
CHAPTER TWO: LITERATURE REVIEW

Chapter Two presents a thorough review of literature relevant to the constructs of this investigation: (a) mindfulness, (b) counselor dispositions, (c) the therapeutic relationship, and (d) client outcomes. Additionally, the use of single case research designs in counseling research is explored.

Mindfulness

Mindfulness has been practiced for over 2,500 years, often as a means of alleviating suffering rooted in psychological distress (Fulton & Siegel, 2005). Buddhism holds mindfulness, or the practice of intentional attention toward an object, as the heart of Buddhist meditation, teaching that mindfulness is the practice of fully knowing the mind, so as to be able to shape the mind, so as to be able to free the mind (Thera, 1965/1996). Within this Buddhist doctrine, the mind acts as the starting point, focal point, and culminating point of all experiences, believing that “if the mind is comprehended, all things are comprehended” (Thera, 1965, p. 21). Buddhist meditation encourages individuals to intentionally attend to all mental processes, without attachment or judgement, and with the awareness of the impermanence of all experiences. The orientation toward impermanence, as all situations and phenomena in life are subject to change, removes mental attachment and is believed to alleviate suffering (Lee, 2017). Like many current psychotherapeutic theories, mindfulness meditation holds that attaching oneself to distorted thoughts and false beliefs, or core values, leads to suffering
(Fulton & Siegel, 2005) and that through the practice of intentional attention one may begin to fully know the mind and gain the power to begin shaping it.

**Mindfulness in Counseling**

Interest in infusing mindfulness into counseling and counselor preparation has grown steadily in recent years (Brown, Marquis, & Guiffrida, 2013; Germer, 2005; Lee, 2017). To date, mindfulness-based interventions have been used in the treatment of a variety of mental health and medical disorders (Grossman, Niemann, Schmidt, & Walach, 2004); proving to be effective in treating a wide array of conditions, including chronic pain (Kabat-Zinn, 1982), anxiety (Miller, Fletcher, & Kabat-Zinn, 1998), depression (Lenz, Hall, & Smith, 2016; Smith et al., 2008), and insomnia (Cincotta, Gehrman, Gooneratne, & Baime, 2011; Ong & Sholtes, 2010). Following Kabat-Zinn’s introduction of Mindfulness-Based Stress Reduction (MBSR), there has been an emergence of other mindfulness-based therapies such as Dialectical Behavioral Therapy (Linehan, 1993), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999).

In addition to use of mindfulness as a clinical intervention, there has been increasing interest in use of mindfulness in counselor preparation programs as a means of enhancing counseling skills self-efficacy (Buser, Buser, Peterson, & Seraydarian, 2012) and various facilitative dispositions (Campbell & Christopher, 2012; Christopher, Christopher, Dunnagan & Shure, 2006; Duffy, Guiffrida, Araneda, Tetenov, & Fitzgibbons, 2017). Additionally, theorists have posited that mindfulness exists as a common thread throughout all schools of psychotherapy (Germer, 2005). This section
will provide an overview of mindfulness constructs, processes, and research regarding the relationship between mindfulness and counselor dispositions.

Current Definitions of Mindfulness

**Foundational definition.** While mindfulness has been widely practiced for over 2,500 years, it has largely been considered an Eastern philosophy. Jon Kabat-Zinn was one of the first theorists to bring mindfulness to modern medicine and formulate a working definition. Kabat-Zinn defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (1994, p. 4). This perspective of mindfulness encourages present-moment awareness and an attitude of acceptance. Germer (2005) expanded on Kabat-Zinn’s definition by highlighting the interdependence of awareness and acceptance in mindfulness, and that presence of one does not indicate presence of the other. Kabat-Zinn’s foundational definition serves as the building blocks for Mindfulness-Based Stress Reduction.

**Mindfulness-Based Stress Reduction.** Mindfulness-Based Stress Reduction (MBSR) was originally developed under the name Stress Reduction and Relaxation Program for the treatment of chronic pain (Kabat-Zinn, 1982, 2013). MBSR is a systemic training program in mindfulness using meditative practices grounded in Buddhist traditions. Like the Eastern philosophies, Kabat-Zinn puts forth the belief that by knowing the mind one may be able to embrace well-being and greater self-understanding, thereby achieving a form of mental liberation and healing (2013). MBSR aligns with seven attitudinal foundations of mindfulness practice:

- Non-judging: paying attention to moment-to-moment thoughts and experiences while refraining from placing evaluation on them (e.g. good/bad, right/wrong,
like/dislike). This encourages an individual to practice seeing things as they are rather than through a lens distorted by past experience or opinion;

- Patience: believed to be a form of wisdom, it is the practice of allowing things, experiences, or thoughts to come to fruition in their own time;

- Beginner’s Mind: the practice of viewing and experiencing phenomena as if for the first time by setting aside opinion, evaluation, and prior experience; allowing an individual to embrace the impermanence of a moment by knowing that each moment will differ from the one before and the one ahead;

- Trust: an integral foundation for meditative practice, it is the development of trust in self and one’s feelings while maintaining an awareness that mistakes are unavoidable;

- Non-Striving: described as “being”, it is the practice of allowing experiences and sensations to find a natural flow by staying in the present-moment, without striving or pushing through;

- Acceptance: a willingness to see things as they are in the present-moment, allowing clarity of thought and decision-making;

- Letting Go: a form of acceptance, letting go of attachment to thought, experience, sensation, or emotion while inviting awareness of them without judgement.

In addition to the seven attitudinal foundations of mindfulness practice, Kabat-Zinn (2013) also describes the cultivation of orientations toward non-harming, generosity, gratitude, forbearance, forgiveness, kindness, compassion, empathetic joy, and equanimity as fundamental to mindfulness meditation practice.
**Operationally Defining Mindfulness.** As the integration of mindfulness into mental health interventions became increasingly popular, an operational definition was proposed by Bishop and colleagues (2004). This proposed definition defined mindfulness as having two distinct mechanisms: (a) self-regulation of sustained attention to present moment thoughts, feelings, and sensations, and (b) an orientation of curiosity, openness, and acceptance of these experiences (Bishop et al., 2004). Otherwise stated, mindfulness may be defined as the expansion of one’s awareness to encompass all present moment experiences while choosing not to over-identify with any one, but instead accepting them simply as present; allowing an individual to become aware of the space between observation of thought, emotion or sensation, and response. Bishop et al. (2004) proposes that it is within that space that a person may choose how they wish to respond instead of reacting in a habitual manner; thereby becoming more reflective and intentional as opposed to reactive or automatic.

In addition to the aforementioned definitions, Carmody and Baer (2008) have identified five-factors as constant throughout mindfulness interventions: (a) observing (attending to/noticing internal and external stimuli), (b) describing (mentally labeling those stimuli with words), (c) acting with awareness (responding intentionally vs reactivity), (d) nonjudgement of inner experiences (refraining from evaluating sensations, thoughts, or emotions), and (e) non reactivity to inner experience (allowing feelings to come and go without rumination). These factors are helpful in understanding the multifaceted and holistic nature of mindfulness as both a clinical and counselor training intervention.
This study has synthesized the definitions put forth by Kabat-Zinn and Bishop to define mindfulness as the intentional expansion of one’s awareness to encompass all present moment experiences while consciously choosing not to over-identify with any one, but instead accepting them simply as present; thus allowing an individual to become increasingly aware of the space between initial observation of thought, emotion or sensation, and intentional response.

**Mindfulness Practices**

Mindfulness meditation practices, both formal and informal, are designed to promote an orientation toward awareness and openness of present-moment experiences. The meditative practices themselves are the platform from which cultivation of the attitudinal qualities of the mind and heart within mindfulness occurs (Kabat-Zinn, 2003, 2013). Formal practices generally include guided sitting or walking meditation, prolonged body scans, awareness of breath, and yoga. During practice, individuals are encouraged to observe thoughts, emotions, and sensations from an orientation of curiosity, or beginner’s mind, acknowledging judgments and attachment without analysis or striving toward attainment of non-judgment and letting go. While initially this may appear paradoxical, it is through trust, non-striving, acceptance, and awareness that change will naturally occur (Kabat-Zinn, 2013).

Informal mindfulness practices are often described as the infusion of mindfulness into daily tasks, such as chores, errands, eating, and communication. Germer (2005) describes the informal practice of everyday mindfulness as instrumental in enhancing awareness of habitual thought or behavior patterns, thereby increasing the possibility of choosing how to engage or respond in a more intentional manner. Intentionality in
mindfulness is believed to be a key function in understanding the processes of mindfulness (Shapiro, Carlson, Astin, & Freedman, 2006) as well as the dynamic force toward growth and healing (Kabat-Zinn, 2013).

**Mechanisms of Change**

Over the past 30 years, mindfulness-based interventions have been proven effective in the treatment of a broad spectrum of medical, psychological, and emotional conditions. However, the question of how mindfulness works continues to be explored.

**Reperceiving.** Shapiro and colleagues (2006) proposed that mindfulness may be more fully understood as comprised of three interwoven components: (a) intention, (b) attention, and (c) attitude (IAA). This assertion parallels Kabat-Zinn’s definition of “paying attention (attention) in a particular way (attitude): on purpose (intention), in the present moment, and non-judgmentally” (1994, p. 4). Shapiro (2006) went on to introduce a “meta-mechanism of action” (p. 374) called reperceiving. Reperceiving occurs through intentionally (I - intention) attending (A - attention) with openness and non-judgment (A - attitude), leading to a significant shift in perspective. This shift allows a person to distance themselves from their thoughts, emotions, or sensations so that they may perceive them from a more objective perspective. Shapiro et al.’s phenomenon is closely related to the *participant observer* (Germer, 2005), *decentering* (Safran & Segal, 1990), and *deautomatization* (Deikman, 1982; Safran & Segal, 1990). Kabat-Zinn (2013) discusses this phenomenon as a change in the relationship one has with the thought, emotion, or sensation. Rather than embodying the sensation (e.g. pain), an individual may continue to feel the pain but is now able to observe their pain as a single part of a larger self; thereby gaining control over their sensations, thoughts, and feelings.
While reperceiving does create distance and offer clarity, it does not equate to detachment or dissociation (Shapiro et al., 2006). Instead, Shapiro and colleagues describe reperceiving as:

allowing one to deeply experience each event of the mind and body without identifying with or clinging to it.... Through this process we are actually able to connect more intimately with our moment-to-moment experience, allowing it to rise and fall naturally with a sense of non-attachment. We experience what is instead of a commentary or story about what is. (p. 379)

Reperceiving may then lead to additional mechanisms of change: (a) self-regulation and self-management, (b) emotional, cognitive, and behavioral flexibility, (c) values clarification, and (d) exposure.

**Empirical Research**

Mindfulness has been suggested as an effective method of cultivating the appropriate skills and dispositions needed to be an effective counselor (Campbell & Christopher, 2012; Christopher & Maris, 2010; Fulton, 2005; Germer, 2005; Kabat-Zinn, 2003). Additionally, as both the mind attitudinal foundations of mindfulness (e.g. non-judging, patience, acceptance, letting-go, etc.) and the heart attitudinal foundations (e.g. non-harming, kindness, compassion, empathetic joy, etc.) as described by Kabat-Zinn (2013), parallel the professional values of counseling (ACA, 2014), mindfulness appears to be a complimentary practice to counseling. Fulton (2005) describes counselor mindfulness a practice of “presence independently of the content of the moment” (p. 59). To remain attentive and present, despite experiences of boredom or anxiety, is described as “a gift” to offer to every client. Moreover, mindfulness practice has been described as
a means of enhancing affect tolerance when faced with strong emotions or challenging situations, increasing empathy, acceptance, and compassion, reinforces equanimity, and promotes self-discovery in counselors (Fulton, 2005). This section will review relevant empirical literature pertinent to counselor mindfulness, dispositions, and client outcome.

Counselor Mindfulness and Dispositional Qualities

Christopher and Maris (2010) conducted a meta-analysis of themes derived from five qualitative research studies conducted over a span of nine years related to the experiences of counseling students who participated in a mindfulness course. The goal of the analysis was to offer a narrative summary of student outcomes through analysis of themes derived from participants’ reported experiences. The authors described the course as an elective course that had been integrated into a counselor training curriculum. The course, described as loosely based around Kabat-Zinn’s (2013) Mindfulness-Based Stress Reduction curriculum, met twice weekly for 2.5hrs each time over the course of 15 weeks. Christopher and Maris stated that the original goals for the course included offering counseling students’ self-care techniques and educating them on the growing field of mind/body medicine and ways in which contemplative practice may be integrated into behavioral and mental health practice. The classes were structured so that the first 75-90 minutes was dedicated to learning and practicing contemplative activities such as, meditation, yoga, the body scan, and qigong. While the second half of class was dedicated to instruction of how mindfulness has been integrated into a variety of disciplines (e.g. religious studies, psychology, medicine, anthropology, etc.). In addition to in-class practice, students were also expected to engage in contemplative practice four times throughout the week for no less than 45 minutes each time.
Results of the qualitative meta-analysis indicated that students reported that engagement in the mindfulness course influenced their personal well-being as well as their counseling skills. The authors noted the most common meta-theme to be a sense of increased awareness and acceptance that spanned across emotional, physical, mental, and professional facets of their lives. With this increased sense of awareness and acceptance, students reported that they were able to develop in their ability to show compassion toward self and others. Through greater compassion, students felt better able to express themselves in a more authentic manner in their interactions with others as they had an increased ability to accept themselves and others as they are, with compassion, and without projection of personal expectation or beliefs regarding who/what the other should be/do. Furthermore, Christopher and Maris reported that by challenging students to sit with discomfort and unpleasant emotional or physical sensation, students were able to overcome their “habitual, instant, unconscious movement away from discomfort” (p. 117). The authors inferred that this exercise allowed students to experience the temporary nature of distress through awareness and acceptance; thereby reducing instances of experiential avoidance and increasing their capacity to sit with clients in a calm and focused manner during times of difficulty or distress. Related to this finding is a reported reduction in emotional reactivity to stimuli and increased cognitive flexibility. Additional themes included enhanced attention, focus, and compassion, as well as reduced anxiety, reactivity, feelings of incompetence, and the need to control the counseling session.

The findings are important as they suggest that counseling students experienced a broad array of personal and professional benefits from having participated in the 15-week mindfulness course. Additionally, Christopher and Maris have demonstrated that
integration of mindfulness training into pre-existing counseling curricula is both feasible and sustainable. However, the authors’ choice to engage in nearly exclusive qualitative analysis when investigating the effects of students’ participation in the mindfulness course over the nine-year time span, while offering rich information detailing counseling student experiences and immediate outcomes following engagement in mindfulness practice, has hindered the inference of a causal relationships between mindfulness and the counselor dispositions and skills mentioned. Additionally, the qualitative investigations reported and analyzed are retrospective in nature and only report on the experiences and perception of the counselors-in-training, neglecting to account for client perception of counselor dispositions or how counselor engagement in mindfulness practice impacted the therapeutic relationship or client outcomes.

Fulton (2016) conducted a correlational study to investigate the relationship between: (a) counselor-in-training mindfulness and client perception of counselor empathy; (b) counselor-in-training mindfulness and counselor attributes of self-compassion, affect, and ambiguity tolerance; and (c) counselor-in-training mindfulness and self-compassion, and session depth as rated by both the client and the counselor. Using a convenience sample of 55 client-counselor trainee dyads from a CACREP-accredited counseling program, Fulton sought to obtain information to begin filling the gap in counseling literature related to client perception of counselor and session qualities, using counselor mindfulness as a potentially influential variable. Counselors-in-training (CIT) represented clinical mental health (49.1%), couples and family (21.8%), school (18.2%), and dual track (10.9%). The CIT sample included 48 (87.3%) women and 7 (12.7%) men, with a mean age of 32. Participants identified as European American
(78.3%), Hispanic/Latino (12.7%), and Biracial/Multiracial (9.0%). With regard to prior mindfulness training and exposure, 64.2% reported having engaged in infrequent (less than once weekly) yoga practice, meditation, and prayer, while 39.6% reported exposure to mindfulness through yoga, counseling, or books. Client participants were predominantly women (87.3%), with a mean age of 36.4 years. Clients identified as European American (61.8%), Hispanic/Latino/a (27.2%), African American (5.5%), and Biracial/Multiracial (5.5%).

CITs completed the Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006) to assess for level of mindfulness, Self-Compassion Scale (SCS; Neff, 2003) to measure degree of self-compassion, Session Evaluation Questionnaire-Form 5 (SEQ; Stiles & Snow, 1984) to assess perception of session quality, Acceptance and Action Questionnaire - II (AAQ-II; Bond et al., 2011) to measure psychological flexibility and experiential avoidance, and Multiple Stimulus Types Ambiguity Tolerance Scale-II (MSTATS; McClain, 2009) to measure ambiguity intolerance. Clients completed the SEQ and the Barrett-Lennard Relationship Inventory-Client Form (BLRI; Barrett-Lennard, 1962) to assess for client perception of counselor empathy, regard, unconditionality, and congruence. While clients completed the full BLRI, only the empathy scale was utilized in this study. CIT and client data were collected following the third session, with a mean collection point of session six.

Using multiple linear regression analyses, findings indicated that a significant relationship exists between counselor mindfulness and client-perceived empathy ($r = .35$, $p = .01$). Further, while overall mindfulness accounted for 14.9% of the total variance, the only facet of counselor mindfulness that was significantly predictive of client-perceived
empathy was the non-judging subscale of the FFMQ \((b = .32, p = .03)\). Demonstrating that a relationship exists between counselor mindfulness and client perception of empathy is valuable as non-judging is both a foundational tenet and attitudinal quality of mindfulness practice (Kabat-Zinn, 2013). Next, through use of Pearson product-moment correlations, counselor mindfulness \((r = .37, p = .007)\) and self-compassion \((r = .37, p = .006)\) were found to be predictive of CIT perception of session depth, though neither counselor mindfulness and self-compassion were significantly predictive of client perception of session depth. Finally, overall mindfulness \((r = -.50, p < .001)\) and self-compassion \((r = -.65, p < .001)\) each had a significant negative relationship with psychological flexibility and experiential avoidance among CITs. Fulton’s findings quantitatively support the qualitative findings reported by Christopher & Maris (2010), while also beginning to bridge the gap between counselor report constructs and client perceptions of counselor attributes and session quality.

**Counselor Mindfulness and Client Outcome**

Grepmair et al. (2007) investigated the effect of counselor mindfulness on client outcomes using 18 psychotherapists-in-training (PiTs) and 124 patients seeking treatment at an inpatient facility in Germany. Using a randomized, double-blind, controlled study, the researchers sought to investigate the effects of PiT participation in a nine-week Zen meditation exercise, practiced prior to seeing patients, on patient-reported treatment outcome. PiTs were randomly assigned to one of two groups: (a) Zen meditation group \((n = 9; \text{MED})\), and (b) control group, withheld meditative practice \((n = 9; \text{noMED})\). PiTs were 100% women, of similar age \((\text{MED}: M = 29.3, \text{noMED}: M = 30.4)\), and in their second of three required years of internship practice post academic coursework. Both
PiTs and the clients were blinded to their conditions in that clients were not informed of PiT training and PiTs each completed meditation training at different times; MED group immediately before therapy sessions, noMED control group at a later time, details of which were not disclosed by the authors.

To assess for client outcomes, the researchers administered the Session Questionnaire for General and Differential Individual Psychotherapy (STEP), a 12-item German questionnaire that uses a 7-point Likert scale to assess for common factors within the therapeutic process: clarification, problem solving, and relationship perspectives. The Questionnaire of Changes in Experience and Behavior (VEV) is a 42-item German questionnaire assessing client perceived changes in experience and behavior between relaxation and tension, stoicism and insecurity, and optimism and pessimism. The third instrument, the Symptom Checklist (SCL-90-R), is a 90-item questionnaire that uses a 5-point Likert scale to assess client perception of physical and psychological symptoms across nine subscales of somatization, insecurity in social contact, obsession/compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. PiTs offered weekly treatment to clients in accordance with reported standard inpatient practices: two 50-minute individual sessions, five 60-minute group therapy sessions, two 60-minute Gestalt group sessions, five 60-minute psychoanalytic group sessions, and two 30-minute progressive muscle relaxation and sports/gymnastic groups.

Grepmair and colleagues (2007) reported that compared to the noMED group ($n = 61$), patients of MED group clinicians ($n = 63$) reported significantly higher scores on two of the three STEP subscales of clarification and problem-solving perspectives ($p <$
Additionally, overall VEV scores of patients of MED group clinicians (MED: 224.9 +/- 34.9; \( p < 0.01 \)) showed they perceived significant changes as compared to that those of noMED patients (noMED: 209.3 +/- 23.8; \( p < 0.01 \)). With regard to symptom reduction, patients of MED group clinicians showed greater symptom reduction on eight of the nine SCL-90-R scales: somatization, insecurity in social contact, obsessiveness, anxiety, anger/hostility, depression, and psychoticism \( (p < 0.01) \), and phobic anxiety \( (p = 0.048) \). Paranoid thinking was the only subscale that was not reflective of significant between group difference \( (p = 0.16) \).

Empirical support of the causal relationship between counselor mindfulness and positive client outcomes is just emerging in the literature. Grepmair’s findings are significant as the results are empirical proof that counselor mindfulness has the potential to positively influence the treatment outcomes for their clients. Additional investigations are necessary to continue exploring this causal relationship and the details related to mindfulness mechanisms for change in counselors that may lead to positive client growth.

**Counselor Dispositions**

Counselor professional dispositions have been broadly defined in recent literature as core values, attitudes, and beliefs, as well as in terms of emotional stability, ethical behavior, and adaptability (Garner, Freeman, & Lee, 2016; Lambie, Mullen, Swank, & Blount, 2015; Spurgeon, Gibbons, & Cochran, 2012; Swank, Lambie, & Witta, 2012). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) defines counselor professional dispositions as “the commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors that influence the
counselor’s professional growth and interactions with clients and colleagues” (p. 43). The American Counseling Association (ACA, 2014) and CACREP (2016) have each identified the cultivation of counselor professional dispositions as important to the creation of a strong and unified counselor professional identity. CACREP accredited counselor training programs are required to continually assess and evaluate students for professional dispositions as a component of student progress and gatekeeping (Section 4, Standard B, G). However, researchers have raised the question of how well counselor training programs proactively attend to students’ emotional or dispositional cultivation, in addition to their counseling skill development (Aponte et al., 2009; Fulton, 2005; Greason & Cashwell, 2009; Greason & Welfare, 2013; Miller et al., 2013; Roach & Young, 2007). While counselor training programs continues to produce well-skilled and technically-competent clinicians, the absence of training interventions specific to cultivation of the person-of-the-counselor may be representative of a current focus on achieving clinical effectiveness through use of theoretically-bound interventions (Fulton, 2005; Miller, et al., 2013). However, as clinicians are tasked with implementing clinical interventions to achieve positive outcome, the clinician, more specifically the person of the counselor (McConnaughy, 1987), may be viewed as a form of treatment intervention that requires appropriate and facilitative cultivation so as to effectively serve the role of counselor.

**Person of the Counselor**

The individual personality characteristics, character, and interpersonal style of the counselor are said to comprise the person of the counselor (Haber, 1994; McConnaughy, 1987). It is this personhood that transcends theory and therapeutic technique to create
effective therapeutic relationships and enhance positive client change. While clinical
techniques and interventions can be learned and used to enhance practice, it the person of
the counselor that selects each technique based on past experiences and personality
(Aponte et al., 2009; Haber, 1994; McConnaughey, 1987). Therefore, techniques may be viewed as reflections of the counselor’s immediate state, well-being, and awareness: “the therapist as a person is the instrument of primary influence in the therapy enterprise” (McConnaughey, 1987, p. 303).

The person of the counselor is discussed throughout many of the prominent theories within counseling and psychotherapy literature. Carl Rogers described the person-centered clinician to be “congruent, genuine, integrated person” (1957, p. 97) who possesses ample awareness of self so that they may be free to fully experience the present moment and create an environment of warmth, acceptance, and congruence conducive to client change. Though diverse in their approach to client change, Jung (1933), Erikson (1950), Freud (1912), and Whitaker (1974) each emphasized the importance of the clinician’s personality, well-being, personal development, and disposition as a cornerstone for successful therapeutic growth. Furthermore, as therapies becomes less purist and more integrative in nature (Norcross & Goldfried, 2006; Norcross, 2005), it may be imperative that counselor training programs attend more heavily to the dispositional qualities of a counselor that prove conducive to the formation of an effective therapeutic alliance (Lambert, 1992; Messer & Wampold, 2002; Norcross & Lambert, 2011).
Rogers’ Facilitative Conditions as Counselor Attributes

Rogers’ facilitative conditions of counselor empathy, unconditional positive regard, and congruence are often interpreted as change producing mechanisms (e.g., positive client outcomes) of the therapeutic process rather than personal attributes held by the clinician. In an effort to expand on Rogers’ work, Barrett-Lennard (1962) posited that as it is the client’s perception of the therapeutic alliance that most accurately informs change, and perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another, the conditions of empathetic understanding, level of regard, unconditionality of regard, and congruence are better understood as attributes, or dispositions, embodied by the clinician.

Client perception. Therapy and therapeutic growth is often described from the perspective of the counselor (Bohart & Byock, 2005). However, as noted earlier, it is the client’s perception of the therapeutic alliance that is said to most accurately inform change (Bachelor, 1995; Barrett-Lennard, 1962; Gurman, 1977), with perception being guided by the interaction of an individual’s personality characteristics and personal attributes with those of another (Barrett-Lennard, 1962). Failing to account for the client’s perception and feedback has been found to lead to an overestimation of clinician effectiveness as well as distortion of client improvement and deterioration (Walfish, McAlister, O’Donnell, & Lambert, 2012).

Barrett-Lennard’s Relationship Variables

Empathic understanding. Empathetic understanding is defined as the extent to which one desires to know and experience the process and content of another’s awareness. Further, it the ability to sense the immediate quality and intensity of another’s
experience while being able to recognize the context of the feeling or thought (i.e. what/whom the feeling is directed toward or the conditions that produced the feeling). Empathetic understanding is demonstrated through experiential recognition of perceptions or feelings that another has directly expressed, as well as through the sensing and inferring of that which another has implied or indirectly expressed. Empathetic understanding is diminished when one projects perception of another’s experience that has originated within oneself and one’s own experiences (Barrett-Lennard, 1962, 2015).

**Level of regard.** Level of regard is defined as the affective aspects, both positive and negative, of one’s response to another. Positive aspects may include indicators of leaning into another’s experience, warmth, respect, affection, and appreciation. Negative aspects may include indicators of pulling away from another, impatience, dislike, rejection, and contempt (Barrett-Lennard, 1962, 2015).

**Unconditionality of regard.** Unconditionality of regard is defined as the degree of variability, or constancy, that exists in one’s affective response to another. Conditionality exists when one’s communication of experience is tailored to obtain desired affective responses from another (Barrett-Lennard, 1962, 2015).

**Congruence.** Congruence is defined as consistency between present experience, awareness, and response. Congruence is enhanced when an individual is psychologically unthreatened, therefore allowing openness to awareness of another’s experience while also responding to their experience with honesty, directness, and sincerity. Incongruence is demonstrated through discomfort, tension, anxiety, and inconsistency between what one says and what is implied through expression, gesture, or tone of voice (Barrett-Lennard, 1962, 2015).
Empirical Research

The individual therapist has a significant effect on the therapeutic alliance, which in turn has been found to have a significant impact on client outcome, with an estimated 5%-18% of the variance within client outcomes attributed to the individual therapist’s qualities and characteristics (Baldwin, Wampold, & Imel, 2007; Crits-Christoph & Mintz, 1991; Lutz, Martinovich, Lyons, Leon, & Stiles, 2007; Norcross & Lambert, 2011; Owen, Duncan, Reese, Anker, & Sparks, 2014). In a study of treatment outcomes from 25 clinicians and data from 1,141 clients at a University counseling center, Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) found the individual counselor effect on client outcome was unrelated to therapist gender, theoretical orientation, professional experience, and overall social skills. However, client outcome was significantly correlated with such facilitative interpersonal skills as: verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus attention.

Researchers used a Hierarchical Linear Modeling to assess for predictive strength of therapist degree of facilitative interpersonal skills (FIS) on client outcome and further investigate the specific therapist variables that may influence outcome. FIS is described as counselor qualities that are likely influence the therapeutic process and relationship, exclusionary of basic demographic characteristics (e.g. age, level of training, and gender). The counselors ($N = 25$) participating in the study included licensed doctoral therapists ($n = 17$), postdoctoral therapists ($n = 2$), predoctoral therapists ($n = 3$), and graduate trainees ($n = 3$). Client data included completed outcomes assessments from 1,141 clients at a University counseling center. Those included had attended a minimum of three
therapy sessions ($M = 9.09$ sessions) and whose therapist agreed to participate. Client mean age was 23.0 years with a range of 18-56 years. Clients identified as predominantly women (62.8%) and Caucasian (85.5%).

Client data included completed *Outcomes Questionnaires* (OQ-45; Lambert et al., 1996); client completion of the OQ-45 was reported to be standard protocol, therefore ample data was available. The OQ-45 is a 45-item self-report outcomes assessment used to measure change in client distress over time. The OQ-45 contains three subscales: (a) symptom distress, (b) interpersonal relationships, and (c) social role performance. Individual items use a five-point Likert scale ranging from 0 (Never) to 4 (Always), with a final score ranging from 0-180, with higher scores indicates higher degrees of distress.

Counselors completed the *Social Skills Inventory* (SSI; Riggio, 1986) following completion of treatment with clients in the study. The SSI is a 90-item self-report assessment of perceived social skills and is scored using a 5-point Likert scale. The SSI assesses for skills in expressivity, sensitivity, and control in verbal (social) and nonverbal (emotional) domains of interaction. In addition to the SSI, counselors were also assessed using the *Facilitative Interpersonal Skills Performance Task* (FIS; Anderson et al., 2009). The FIS is designed so that an observer may assess counselor elicited responses that are reflective of their ability to perceive, understand, and communicate a range of interpersonal messages, as well as assess their ability to persuade others who are experiencing challenging circumstances to apply suggested solutions and abandon maladaptive patterns of engagement. To accomplish this, eight segments of pre-recorded video tape, showing four common challenges to the therapeutic process, were reenacted by hired actors to who had been trained to embody the client challenges presented in each
video recording. The common challenges demonstrated in the recordings included; (a) a confrontational or angry client, (b) a passive or withdrawn client, (c) a confused or dependent client, and (d) a controlling or blaming client. Demonstrations included portrayal of clients as exhibiting self-focused, negative, self-effacing behavior; as well as clients exhibiting highly other-focused, friendly, high dependency behavior. Counselors were prompted to respond to the pre-recorded reenactments at designated moments as if they were the actual therapist sitting with the client/actor. Scoring of counselor FIS included a 5-point Likert scale assessing 10 specific FIS items of verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus. Two independent observers scored each therapist-actor engagement, their scores were summed and totaled to obtain a final score. Interrater reliability was reported to be acceptable at $r > 0.70$.

Analysis of the data was depicted through three models using HLM. The first model demonstrated no difference among counselors at the onset of treatment and initial administration of the OQ-45, though significant differences existed in terms of average treatment outcome. Findings from the second model showed counselor demographics including sex, theoretical orientation, and percentage of total time spent engaging in direct counseling activities were not predictive of outcomes across counselors. However, counselor age was predictive of client outcome; with older counselors obtaining better treatment outcomes. Finally, findings from the third model examining FIS scores, SSI scores, and age as predictive of outcome demonstrated that once FIS was introduced as a predictive variable, counselor age was no longer predictive of outcome. FIS alone was the predictor of variance in client outcome across counselors. Essentially, counselors with
higher facilitative interpersonal skills had clients who achieved greater treatment outcome ($r = .47$).

The findings from Anderson and colleagues (2009) is significant in that while therapist effect is a known predictor of client outcome, little is known about the underlying qualities and attributes leading to therapist effect. Furthermore, the authors asserted this study serve as further support of the notion that the person of the therapist is instrumental to successful psychotherapy treatment outcome and client growth.

The Therapeutic Relationship

The therapeutic relationship has been described as the “totality of the interpersonal field” (Hill & Knox, 2009) and, the interpersonal and dynamic engagement between a counselor and client, thus (Horvath & Luborsky, 1993; Miller et al., 2013), and the feelings and attitudes held by the client and counselor and the manner in which they are expressed (Gelso & Carter, 1985). While each brief definition is unique, they all succeed in encompassing the full verbal, nonverbal, and behavioral interactions within a therapeutic encounter (Horvath & Luborsky, 1993; Miller et al., 2013).

The strength of the therapeutic relationship is widely considered to be a robust predictor of therapeutic outcome and effectiveness (Luborsky, 1994; Miller et al., 2013; Norcross & Lambert, 2011; Orlinsky, Rønnestad, & Willutzki, 2004). The strength of the therapeutic relationship, considered the foundation of the common factors approach in psychotherapy (Grencavage & Norcross, 1990; Rosenzweig, 1936), has been found to account for the largest portion of intra-therapeutic outcome variance; 30% (Norcross & Lambert, 2011). Counseling technique (15%), client expectations (15%), and extra-therapeutic factors (40%) account for the remaining outcome variance (Lambert, 1992;
Historically, how the therapeutic relationship is conceptualized and what factors are believed to be most influential to the cultivation of a strong and effective therapeutic alliance vary by psychotherapy theory. However, as therapies becomes less purist and more integrative in nature (Norcross & Goldfried, 2006; Norcross, 2005), a reliance on attending to the common factors found to exist throughout most forms of therapy has become increasingly favored (Messer & Wampold, 2002; Norcross & Lambert, 2011). This section will provide an overview of the therapeutic relationship, factors that influence the therapeutic relationship, and research regarding the relationship between the therapeutic relationship and client outcomes.

Major Theoretical Conceptualizations of the Therapeutic Relationship

**Psychoanalytic Perspective.** Freud (1912) initially began discussing the unique nature of the relationship between client and analyst, stating the importance of the client’s transference to the nature of the work. Later expanding on Freud’s work, Greenson (1965) introduced the term *working alliance* as a way to describe the interaction between a client, a client’s transference, and the analyst’s interpretation of the transference. Greenson, like Freud, held that analysts were to remain in a neutral and unattached state with their clients so that an environment conducive to increased transference reactions could develop (1965). Within classic psychoanalytic theory there is controversy over whether the alliance is a relationship. The alliance-as-transference perspective puts forth that clients enter into psychotherapy carrying remnants of past unresolved interpersonal relations, and that the thoughts and feeling associated with the unresolved relationships are then unconsciously projected, or transferred, onto the analyst (Gelso & Carter, 1985). This creates a relationship that is not grounded in present reality, but one that is a
misrepresentation and falsification of the clinician and the client-analyst interaction, therefore the alliance is functional (i.e. working alliance) and not relational in nature (Gelso & Carter, 1985). The role of countertransference, or the projection of the analyst’s thoughts and feeling associated with the unresolved relationships onto clients, is also a key feature of the psychoanalytically-grounded working alliance. Greenson (1965) states the importance of analysts’ awareness of countertransference so that the analyst may restrain it so as not to impact client transference as interpersonal reciprocity and analyst attachment are believed to be counterproductive to client progress.

Though grounded in the psychoanalytic perspective, Bordin (1979, 1994) diverted from the traditional etiology in favor of offering a more pan-theoretical perspective of the working alliance, drawing on practicalities of client-counselor interactions. Bordin (1979) asserted that the working alliance, of which he considered to be the key agent of client change, was comprised of three factors: (a) agreement between the client and counselor on the goals of treatment, (b) definition and clarity in implementing the tasks assigned to client and counselor in pursuing those goals, and (c) the quality of the bond. Further distancing his conceptualization of the working alliance from the more traditional psychoanalytic working alliance, was Bordin’s notion that a bond, or relationship, of influence exists between client and clinician. This bond is described as the way in which clients perceive and respond emotionally to the counselor that transcend their formal roles as client and counselor (Bordin, 1994; Orlinsky & Rønnestad, 2000). The generic terms used in Bordin’s conceptualization of the working alliance allow for generalizability and integration with different theoretical orientations (Bordin, 1979; Horvath & Greenberg, 1989).
**Person-Centered Perspective.** Carl Rogers (1946) is revered as the father of person-centered psychotherapy. Unlike other therapeutic mediums of the time who valued the clinician as the expert in the room, Rogers approached therapy believing the client to be the expert on their life. The person-centered counselor’s role is to cultivate an environment conducive to guiding the client through the process of deeply and reflectively exploring thoughts, feelings, and patterns of behavior. Rogers’ Person-Centered Therapy places great emphasis on the therapeutic relationship, asserting that if certain conditions were met, the relationship would be sufficient to make positive change within the client. These six “necessary and sufficient” (Rogers, 1957; p.95) conditions include the client and counselor engaging a form of psychological contact, a state of incongruence within the client, the counselor’s ability to be empathetic, the counselor’s ability to offer the client unconditional positive regard, counselor congruence or genuineness, and a minimal degree of client perception of therapist’s offering of the facilitative conditions (e.g., empathy, unconditional positive regard, and congruence). If conditions are met, the client will move toward a state of self-actualization and personality growth (1946, 1957, 1961/1989). While Rogers communicated an understanding of the importance of client perception of the counselor-offered facilitative conditions to positive outcome, his seminal writings seemed to convey uncertainty in how to conceptualize or realize the presence of this condition (1957). Rogers stated that as therapist attitudes were not able to be directly perceived, the counselor should regard this condition as “met” if they believed the client perceived a minimum degree of at least one of the conditions (1957). It was his student, Barrett-Lennard, who expanded on this condition, believing that it was the client’s experience of the therapist response that was
the most influential factor in a therapeutic relationship and therefore critical to achieving positive client outcomes (1962, 2015). Furthermore, while Rogers put forth his “conditions” as change producing mechanisms (e.g., positive client outcomes) of the therapeutic process rather than personal attributes held by the clinician, Barrett-Lennard contends that as it is the client’s perception of the therapeutic alliance that informs change, and perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another, the conditions of empathetic understanding, congruence, level of regard, and unconditionality of regard are better understood as attributes, or dispositions, embodied by the clinician (Barrett-Lennard, 1962).

**Empirical Research**

**The Therapeutic Relationship & Client Outcome**

Norcross and Wampold (2011) reported the conclusions and recommendations of the second Task Force on Evidence-Based Therapy Relationships; updating and reaffirming prior assertions made by the original Task Force in 2001 (Norcross, 2001). After analyzing more than a dozen meta-analyses, the Task Force offered conclusions related to specific relationship elements that proved to be *demonstrably effective* and others deemed *probably effective* to obtain positive client outcome. A third category was presented as *promising* based on available outcome studies, though lacked sufficient empirical evidence needed to support a judgment regarding outcome effectiveness. Recommendations for training, practice, research, and policy were also presented by the authors on behalf of the Task Force.
Through analysis of multiple meta-analyses, conclusions drawn from Task Force include the reaffirmation of the effectiveness and value of the therapeutic relationship in client outcomes, asserting the leverage of the relationship in both treatment success and failure. Furthermore, practice guidelines should thoroughly and explicitly address therapist behaviors and qualities that promote the cultivation of the therapeutic relationship. Elements of the relationship that have shown to be *demonstrably effective* include: (a) alliance in individual and youth psychotherapy, (b) alliance in family therapy, (c) cohesion in group therapy, (d) empathy, and (e) collecting client feedback. Included as *probably effective* includes: (a) goal consensus, (b) collaboration, and (c) positive regard. Finally, elements that have shown *promising* yet inconclusive evidence of effectiveness include: (a) congruence/genuineness, (b) repairing alliance ruptures, and (c) managing countertransference. Within recommendations for future research, Norcross and Wampold (2011) emphasize the need to move beyond correlational research designs when investigating counselor relationship behaviors and counselor contributions to client outcome; encouraging researchers to become familiar with methodologies that will allow for the exploration of complexities inherent to counselor variables, client variables, and outcome.

**Client Outcomes**

Counseling has been found to be an effective form of treatment to improve most client’s outcomes (Lambert, 2013; Lambert & Ogles, 2004; Smith & Glass, 1977; Wampold, 2001, 2007). Empirically demonstrating the effectiveness of counseling and psychotherapy gained momentum following the publication of a study questioning the differences in client outcomes between those who sought treatment for symptom
reduction and those who did not seek treatment, going so far as to assert that 75% of neurotic patients showed improvement without treatment (Eysenck, 1952). While the study was shown to be flawed in a variety of ways, the drive to prove the effectiveness of counseling had begun. Nearly 25 years after Eysenck’s critique of the effectiveness of psychotherapy, Smith & Glass (1977) published a meta-analysis of 375 published evaluations of counseling and psychotherapy. Results demonstrated that individuals who sought treatment were better off than 75% of those who did not seek treatment regardless of therapeutic modality (Smith & Glass, 1977). This early finding supported later discoveries that demonstrate the superiority of the therapeutic relationship over specific intervention or technique in predicting outcome.

Client outcomes, or change, is often evaluated from a multi-faceted perspective. Lambert and colleagues (1996) identified three facets, or domains, of client change as indicative of outcomes: (a) intrapersonal discomfort or symptomatic distress, (b) interpersonal functioning, and (c) social role performance. Each domain assesses for degree of functioning and are considered to be valid indicators of therapeutic growth (Lambert et al., 1996; Lambert & Hill, 1994). Client outcomes may also be evaluated through assessment of a client’s intentionality regarding personal growth and change. Personal growth is believed to be a way of approaching life and all aspects of life, (e.g. career, relationships, life stage) rather than just a singular treatment outcome (Robitschek, 1998; Robitschek et al., 2012). Personal growth may occur through the natural life cycle and developmental process, environmentally, or through intentionality (Prochaska & DiClemente, 1986). Counseling is believed to be essential to the process of personal growth as counseling offers the opportunity to enhance a client’s self-efficacy.
surrounding change and adaptability; capacity for change and adaptability are viewed as critical to coping and healthy development (Bandura, 1977, Robitschek, 1998).

As positive client growth is largely considered to be the goal of counseling, research related to client outcomes has been fully integrated throughout Chapter Two. Analyses of empirical studies demonstrating current knowledge related to the nature of the relationship between the constructs of this study and client outcomes was outlined and discussed.

**Single Case Research Design in Counseling Research**

Historically, there has been a lack of single case research studies published in counseling journals. In an analysis of 20 peer-review counseling journals associated with the American Counseling Association (ACA), Woo, Lu, Kuo, and Choi (2016) found only seven empirical articles in five journals between 2003 and 2014. Woo and colleague’s findings reflected prior frequency analyses done showing only two instances of single-case studies published, comprising 1% of all articles, in the Journal of Counseling and Development (JCD) between 1990 and 2001 (Bangert & Baumberger, 2005). This low occurrence of single-case research was described as both “unexpected” and “problematic” (Bangert & Baumberger, 2005, p. 483) due to the amount of time counselors spend offering individualized therapies to clients while lacking the empirical evidence demonstrating intervention efficacy with specific or specialized populations, instead relying more heavily on group designs that fail to account for unique characteristics of individuals that extend beyond the general clinical populations represented. Bangert and Baumberger (2005) also note that the applied nature of single-case design in counseling research lends itself well to a scientist-practitioner model of
counselor training and practice, adding that counseling professionals may benefit from increased knowledge of single-case research to better evaluate current practices and outcomes.

In an effort to highlight the applicability and increasing use of single-case research within counselor education and counseling research, in October of 2015 the Journal of Counseling & Development (JCD) published a special issue dedicated to single case research. The issue contains both conceptual articles outlining single case practice and procedures, as well as empirical articles demonstrating use of the designs. While this is a productive step toward the integration of single case research into the counseling literature, it should be noted that single case research is a complex methodology and researchers should carefully attend to their training regarding many of the nuances within the analysis and reporting of single case research. Through proper training and consultation with established single case methodologists, counseling researchers will be better able to use the design with fidelity while also being better equipped to competently critique existing literature in which the designs were used.

While counselor educators are required to be trained in diverse methodologies, single case research design is often left out of counselor and counselor educator curriculums (Woo et al., 2016), despite the evidence in support of the complimentary nature of single case research to counseling applications (Bangert & Baumberger, 2005; Foster, 2010; Gast, 2010; Heppner et al., 2008; Lenz, 2015; Lundervold & Belwood, 2000). The inherent “goodness of fit” (Lenz, 2015, p. 388) between single-case research design and the counseling profession has begun to enter the counseling literature; highlighting the characteristics of counseling and single case research that both honor the
uniqueness of an individual while attending to detailed and nuanced changes over time (Foster, 2010; Heppner et al., 2008; Lenz, 2015; Lundervold & Belwood, 2000). Therefore, a single case research design is complimentary to the purpose of this investigation as it will allow for detailed analysis of the complexities of the interpersonal engagement between counselor and client throughout the proposed intervention while also demonstrating applicability of the design to the overall counseling profession.

Chapter Summary

Chapter Two reviewed relevant literature pertinent to the constructs (counselor dispositions, mindfulness, therapeutic relationship, and client outcome) to be investigated in this study. Chapter Three will present the methodology used in the study. Chapter Four will present the results of the study. Chapter Five will discuss the results of the study in relation to implications and future research.
CHAPTER THREE: METHOD

Chapter Three presents details of the selected research design, method, and procedures for the investigation. More specifically, the following areas are reviewed in this chapter: (a) research design, (b) research questions and hypotheses, (c) population and sampling procedures, (d) instrumentation, (e) data collection methods, (f) intervention procedures, (g) methods of data analysis, (h) ethical considerations, and (i) limitations to the study. The purpose of this research study was to contribute to the current knowledge surrounding the use of mindfulness to cultivate counselor dispositions. Specifically, this investigation analyzed the effect of participation in a brief mindfulness intervention had on counselors’-in-training facilitative dispositions of: (a) empathy, (b) level of regard, (c) unconditionality of regard, and (d) congruence (as observed through weekly in-session engagement with clients). In addition, the investigation examined the effects of counselors-in-training participation in a brief mindfulness intervention on client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]) and the influence of counselor-in-training engagement with mindfulness on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]).

A multiple baseline, across participants, single case research design (Gast, 2010; Kazdin, 2011) was used to investigate the research questions. Use of multiple baseline
SCRD is appropriate for this study as it allowed for isolation of intervention effect on the dependent variables (dispositions) while also replicating results across participants to increase validity of the results (Gast, 2010; Heppner et al., 2008; Kazdin, 2011).

**Research Design**

This study used a concurrent multiple baseline across-participants single-case research design (SCRD; Gast, 2010; Kazdin, 2011) to measure the effect of a brief mindfulness training intervention on: (a) counselor-in-training dispositions, (b) client perception of the therapeutic relationship, and (c) client reported outcome. The multiple baseline across participants SCRD has been described as an A-B design that is replicated across a minimum of three participants. When utilizing a multiple baseline design, each participant serves as their own control as each are exposed to both a control condition (A) and an intervention (B) (Gast, 2010; Kazdin, 2011; Ray, 2015). Replication of treatment effect is required to demonstrate experimental control and allow for inference of a causal relationship between independent and dependent variables by reducing threats to internal validity (Kazdin, 2011). While three demonstrations of a treatment effect using only one subject may be produced through other SCRDs (e.g. A-B-A-B), a multiple baseline design is preferable when the effect of treatment is “functionally irreversible” (Gast & Ledford, 2010, p. 284), as is the general goal of counseling interventions. The implementation of an A phase post-intervention proves challenging due to the high potential for carryover effect, or the lasting effect of the intervention on subsequent phases (Ray, 2015). In situations such as this, replication of the experiment across-participants using a multiple baseline increases rigor and reduces threats to internal validity (Gast & Ledford, 2010, Kazdin, 2011). During both baseline (A) and
intervention (B) phases, there is continuous collection of data related to the identified
dependent variable(s), often referred to as target behaviors (Gast, 2010; Kazdin, 2011). It
is during analysis of a participant’s data, continuously collected before, during, and after
the intervention, when isolation of treatment effect and causal relationships may be
discovered (Lenz, 2015). Replication across participants supports the potential to develop
“more robust inferences about the functional nature” of treatments and outcome (Lenz,
2015). Multiple baseline designs are rigorous experimental designs that are fully able to
make meaningful contribution to evidence-based outcomes research (Gast, 2010; Lenz,
2015; Ray, 2015).

Multiple baseline designs may run concurrently or nonconcurrently across
participants. Concurrent multiple baselines are characterized by participants beginning
baseline phase simultaneously and matriculating through to the intervention phase at a
staggered rate, as determined by baseline stability and demonstration of observable
treatment effect in subjects who have previously begun the intervention (Christ, 2007;
Gast & Ledford, 210; Heppner, Wampold, & Kivlighan, 2008; Kazdin, 2011). As
participant matriculation from baseline to intervention phase is dependent upon
individual baseline stability and the observation of a treatment effect in prior participants,
utilizing multiple baseline designs can be challenging due to the unpredictable nature of
stable baseline attainment, with lengthy extensions of participant baselines having the
potential to create negative experiences in participants due to boredom and fatigue (Gast
& Ledford, 2010). However, as multiple baseline designs are able to isolate the
intervention effect on dependent variables, while also replicating results across
participants, use of a concurrent multiple baseline design is appropriate for this investigation.

Incorporating components of randomization into single case research, such as the random assignment of client-participants to counselors-in-training, serves to increase internal validity and experimental control (Kratochwill & Leven, 2010; Watson & Workman, 1981). Additionally, when utilizing across participant multiple baseline design, Gast & Ledford (2010) view the identification of participants who exhibit “similar learning histories and who emit the same target behavior at similar frequencies under similar pre-intervention conditions” (p.313) as an ideal, or even conservative, approach to the research design. As participants will be counselors-in-training who have progressed through their counselor training program at the same rate and who are at similar places in their counseling professional development, they are an ideal sample for inclusion and analysis of treatment effectiveness.

**Research Questions & Research Hypothesis**

The purpose of this study was to measure the effect of a counselors’-in-training participation in a mindfulness intervention on the observable dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence, and client outcome. Additionally, clients’ perception of the degree to which these facilitative dispositions exist within their counselor was also measured. The following research questions were used to guide the study:

**Primary Research Questions & Hypotheses**

Research Question 1
Does counselors-in-training participation in a brief mindfulness intervention affect their dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as demonstrated through in-session engagement with clients)?

Hypothesis 1
Counselors-in-training dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as demonstrated through in-session engagement with clients) will demonstrate a measurable increase after introduction of the mindfulness intervention.

Research Question 2
Does counselors-in-training participation in a brief mindfulness intervention affect client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996])?

Hypothesis 2
Client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] will increase after introduction of the mindfulness intervention with scores from the Outcomes Questionnaire-45.2; [Lambert et al., 1996]) showing a positive trend as client perception of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962]) increases.

Research Question 3
Is the strength of the therapeutic alliance, as determined by client perception of the presence of counselor (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as measured by the Barrett-Lennard Relationship Inventory
Hypothesis 3

The strength of the therapeutic alliance, as determined by client perception of the presence of counselor (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962]) will be positively influenced by counselor-in-training participation in a brief mindfulness intervention.

**Dependent and Independent Variables**

**Independent Variables**

Mindfulness as a training intervention will serve as the independent variable for this study. Mindfulness was selected as the independent variable as a relationship between mindfulness and counselor empathy, acceptance, nonjudgment, congruence, and positive client perception of the therapeutic relationship has been reported in previous literature (Campbell & Christopher, 2012; Greason & Cashwell, 2009; Greason & Welfare, 2013).

**Dependent Variables**

The primary dependent variables to be investigated in this study are counselors’-in-training dispositions and client outcomes. Specific dispositions being investigated include: (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence. These dispositions were selected as they are reflective of Rogers’ facilitative conditions (1957) reframed as counselor attributes (Barrett-Lennard, 1962), and have been found to be effective elements of successful therapeutic relationships (Norcross &
Wampold, 2011). Furthermore, as it is the client’s perception of the therapeutic relationship that is said to inform outcome, and perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another (Barrett-Lennard, 1962), client outcomes will be investigated in relation to counselor-in-training dispositions. Finally, as the therapeutic relationship has been cited as the strongest predictor of positive client outcome (Lambert et al., 2001; Lambert & Hill, 1994; Luborsky, 1994; Miller et al., 2013; Norcross & Lambert, 2011; Orlinsky, Rønnestad, & Willutzki, 2004), client perception of the therapeutic alliance (Barrett-Lennard, 1962, 2015) will serve as a secondary dependent variable.

Population and Sampling Procedures

Population and Sample

The target populations for this study was current counselors-in-training and their clients. The counselors-in-training were entering the clinical experience portion of their training. A counselor-in-training is defined as a student who is “engaged in formal graduate-level counselor education” (ACA, 2014, p. 21). The sample for this study was three counselors-in-training enrolled in a practicum course at a large University in the Southeast, each counselor-in-training saw a minimum of two clients weekly in a university-based clinic. Potential counselors-in-training included students matriculating through Marriage, Couples, and Family Counseling and School Counseling tracks of a CACREP-accredited graduate counseling program at a large University in the Southeast.

Counselors-in-training are an appropriate population for this study as the purpose of the investigation is to add to the current literature (Campbell & Christopher, 2012; Christopher, Christopher, Dunnagan & Shure, 2006; Duffy, Guiffrida, Araneda, Tetenov,
& Fitzgibbons, 2017) regarding mindfulness as a means of cultivating counselor dispositions during graduate training. While the minimum sample size required in SCRD is one, and analysis of data occurs at the individual level, when implementing a multiple baseline design the inclusion of at least three participants is required to demonstrate experimental control and reduce threats to internal validity (Gast & Ledford, 2010; Kazdin, 2011).

The clients were undergraduate students currently enrolled in courses within a Counseling minor academic program at a large University in the Southeast. While the minimum sample size would be three clients, one client per counselor-in-training, nine clients were recruited to protect against threats to internal validity such as client-participant attrition. All clients were required to be currently enrolled at the university at time of participation and over the age of 18.

**Sampling Procedure**

**Counselors-In-Training.** The researcher attended the counselors-in-training practicum classes to recruit prospective counselor-in-training participants; offering details of the study, presenting informed consent forms, and a sign-up sheet for interested participants. Counselors-in-training were informed that their participation in the research study was voluntary, though hours accrued through participation in counseling activities and time spent participating in the intervention would count toward completion of their required practicum hours. Counselors-in-training each received weekly supervision as required by their enrollment in the practicum course. Weekly supervision was offered by second-year Counselor Education & Supervision doctoral students in group, triadic, and individual formats. Supervising doctoral students each received weekly supervision of
their supervision practice by a counselor education program faculty member. Additionally, two fully licensed, second-year counselor education doctoral students served as on-site clinical supervisors to participating counselors-in-training; providing supplemental weekly supervision. Using the random sample selection tool in Microsoft Excel, a random sample was identified from the counselors-in-training who volunteered (Heppner et al., 2008) and only the participants that were selected received the intervention. Participants also received a $25 gift card for their participation.

**Clients.** Participants volunteering to serve as clients for the counselors-in-training were undergraduate students currently enrolled in a Counseling minor academic program at a large University in the Southeast. The researcher attended Counseling minor classes to recruit prospective participants; offering details of the study, presenting informed consent forms, and a sign-up sheet for interested participants. Students were informed that their participation in the research study was completely voluntary, though extra course credit would be awarded to those who begin and successfully complete the requirements of the study. Students were informed that early withdrawal would not negatively impact their academic standing, though extra credit points will be awarded only to those who completed the investigation. In addition, students were informed that while the course instructor would be informed of who participated, so that extra credit may be awarded, their instructor would have no knowledge of the details surrounding the content or disclosures made during counseling sessions. A minimum of nine students were recruited to serve as randomly assigned clients to the counselors-in-training. Using the random sample selection tool in Microsoft Excel, a random sample was identified from the students who volunteered (Heppner et al., 2008) and only the participants that
were selected received counseling through the participating counselors-in-training. Those who were not selected through random selection were offered appropriate counseling services referrals.

**Instrumentation**

**Observers**

In addition to the primary researcher, two first-year doctoral students in the Counselor Education and Supervision program were trained to independently observe and record data related to participant dispositions and engagement in counseling sessions. The researcher attended first-year doctoral classes to recruit prospective observers; offering details of the study, details related to their role as observer, and a sign-up sheet for interested individuals. Students were informed that their participation as observers would be voluntary, though credit will be offered toward completion of course requirements outlining students’ required engagement in a research project. The two independent researchers for this study identified as White/non-Hispanic cisgender females. Each observer participated in this study during their first year of doctoral studies and each had earned their master’s degrees from CACREP-accredited clinical mental health counseling programs.

**Observer training.** Using guidelines put forth by Ayers & Gast (2010), the independent observers were trained by the researcher to identify and record instances of dispositional expressions under investigation. Trainings occurred over a two-week period and included the use of fictitious, or role-played, counseling session videos for practice coding. Independent observers did not begin recording baseline data until an IOA of 80% was consistently met or exceeded during training. Observer training also included review
of procedures for completing and storing data and documentation to ensure confidentiality of participant data and experimental control. Operational definitions and behavioral clarifiers for each disposition were included with all CIT Dispositional Data-Collection Forms for continued reference. Follow up training occurred as needed throughout the duration of the study.

**Counselor-in-Training (CIT) Dispositional Data-Collection Form**

The CIT Dispositional Data-Collection Form (see Appendix G) was created by the researcher using recommended SCRD data-collection form templates (Gast & Ledford, 2010). The forms are organized by observation periods, disposition, and clarifying information related to the disposition expression observed (e.g. verbal, nonverbal, positive, negative) Observers used tick marks (|) to record each instance of the disposition during the individual time period. Tick marks were then tallied after each segment and then all tallies were added together to offer a session total for each disposition.

**Demographic Survey**

The General Demographic Survey (see Appendix D and E) is a self-report questionnaire created by the researcher to collect participants’ demographic information (e.g., gender, age, ethnicity, level of education, counselor prior exposure to mindfulness, client prior exposure to counseling, etc.). This demographic information was completed prior to initial counseling session and collected by the researcher. Counselors-in-training and clients were each assigned a unique identifier in lieu of name to protect their confidentiality. Unique identifiers were used for all documentation and reporting (e.g. video recordings, disposition data-collection forms, client report assessments).
Personal Growth Initiative Scale-II

The Personal Growth Initiative Scale-II (PGIS-II) is a 16-item assessment containing four subscales that measure the multidimensional nature of personal growth initiative (PGI; Robitschek, 1998; Robitschek et al., 2012): (a) Intentional Behavior, (b) Using Resources, (c) Planfulness, and (d) Readiness for Change. Individual items on the PGIS-II use a six-point Likert scale ranging from 0 (Disagree Strongly) to 5 (Agree Strongly), with a final score ranging from 0-80.

Personal Growth Initiative (PGI) is used to describe the active and intentional engagement in the process of personal growth and change (Robitschek, 1998). Individuals possessing high levels of PGI are viewed as better able to adapt to changes through the intentional identification of areas for personal growth and the ability and initiative to take action toward making change that will lead to personal growth (Robitschek, 1998; Robitschek et al., 2012). Rather than approaching client outcome from a perspective of short-term symptom relief, Robitschek (1998) believes that personal growth is a way of approaching life and all dynamic aspects of life (e.g. career, relationships, life stage). Further, as change occurs throughout the life cycle, and individuals are presented with various forms of challenges and obstacles, self-efficacy surrounding personal growth and change is believed to be important to coping, adaptability, and healthy personality development (Bandura, 1977; Robitschek, 1998; Robitschek et al., 2012).

Psychometric properties of the PGIS-II. The populations included during the development and norming of the PGIS-II were comprised exclusively of college students. Psychometrics for the PGIS-II show a Cronbach’s alpha of .92 (Shigemoto, Low,
Borowa, & Robitschek, 2016) and an overall test-retest reliability of .62 - .82 when administered at intervals of one to six weeks (Robitschek et al., 2012). Estimate of reliability at one-week intervals was reported as .82; as this study administered the PGIS-II weekly, the strength of this score was important. Mean internal consistency coefficients by subscale were reported as: .93 for overall scores, .85 for readiness for change, .90 for planfulness, .83 for using resources, and .86 for intentional behavior.

Subscales of the PGIS-II have also been found to significantly correlate with various measures of psychological functioning. Weigold, Porfeli, and Weigold (2013) found that higher positive affect, as measured by the Positive and Negative Affect Schedule (PANAS), was significantly correlated with the subscales of readiness for change (.72), planfulness (.88), and intentional behavior (.85). They also found strong correlations between the subscales and negative affect (-.62), depression (-.86), anxiety (-.72), and stress (-.62). Measures of depression, anxiety, and stress were obtained using the Depression Anxiety Stress Scales (DASS). The only subscale that did not demonstrate significant correlations was using resources, with a correlation value of .20.

Barrett-Lennard Relationship Inventory OS-40

The Barrett-Lennard Relationship Inventory (BLRI), in its original form, is a 64-item assessment containing four subscales that align with Rogers’ (1957) facilitative conditions of empathetic understanding, level of regard, unconditionality, and congruence (Barrett-Lennard, 1962). The BLRI measures the client’s perception of the facilitative conditions within the therapeutic relationship. Clients use a six-point interval scale to respond to questions based on their level of agreement; -3 to +3 with use of 0 not offered as a potential response. Each subscale may be scored independently to assess specific
facets of the relationship or combined to obtain a total score for the relationship. Several variations of the BLRI have been created for use across settings and populations, including children, groups, couples, and families (Barrett-Lennard, 2015). This study used the abbreviated Barrett-Lennard Relationship Inventory Form OS-40 (BLRI-OS-40) containing a total of 40 questions, or 10 questions for each of the four subscales.

Theoretically, the BLRI was created using Carl Rogers’ (1957) person-centered, or humanistic, approach to psychotherapy. Created under the supervision of Carl Rogers, Barrett-Lennard (1962) crafted the instrument to assess the quality of the therapeutic relationship using Rogers’ facilitative conditions of empathy, unconditional positive regard, and congruence. However, while Rogers acknowledged the importance of client perception of the presence of the facilitative conditions, Barrett-Lennard (1962) asserted that the client’s perception of the therapeutic relationship was more important than the counselor’s perception of their delivery of these conditions. Furthermore, Barrett-Lennard expressed his belief that perception of the facilitative conditions was guided by the interaction of an individual’s personality characteristics and personal attributes with those of another; thereby Rogers’ facilitative conditions may be more accurately described as counselor attributes, or dispositions, rather than conditions. This study collected data related to the client’s perception of the therapeutic relationship using the BLRI-OS-40 (Barrett-Lennard, 1962) at predetermined points throughout the duration of the investigation: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session.

Subscales. Barrett-Lennard (1962) describes empathetic understanding as “experiencing the process and content of another’s awareness in all its aspects” (p. 3). As
such, the empathetic understanding subscale is concerned with measuring the client’s perception of the counselor’s ability to remain fully present and capable of sensing the affective qualities of their experience while being able to recognize the context from which the affective quality and intensity was produced (Barrett-Lennard, 1962, 2015). Examples of questions used to measure empathetic understanding include: “___ usually senses or realizes what I am feeling” and “___’s own attitudes get in the way of understanding me” (Barrett-Lennard, 2015, pp. 115-116).

The level of regard subscale is concerned with assessing the reactions of one to another (i.e. counselor to client) using a continuum of positive to negative (Barrett-Lennard, 1962). Examples of questions used to measure level of regard include: “I know I am valued and appreciated by ___” and “I feel that ___ disapproves of me” (Barrett-Lennard, 2015, pp. 115-116). In contrast, the unconditionality of regard subscale is concerned with assessing for the degree of variability or consistency of one’s affective responses to another, using questions such as “___’s interest in me depends on my words and actions (how I perform)” and “I don’t think anything I say or do really changes the way ___ feels toward me” (Barrett-Lennard, 2015, pp. 115-116). Finally, the congruence subscale assesses the degree to which one is perceived to be integrated in their awareness, experience, and communication (Barrett-Lennard, 1962). Barrett-Lennard describes congruence to have direct implications on the variables of empathetic understanding, level of regard, and unconditionality of regard as congruence implies that one is unthreatened by the experiences or affective responses of another. Therefore, a congruent individual is better able to enter a relationship fully open and without psychological defenses that may impede their capacity to offer empathetic understanding and
unconditionality of regard (Barrett-Lennard, 1962, 2015). Examples of questions
designed to assess for congruence include: “I feel that ___ puts on a role with me” and
“Sometimes ___ is not at all comfortable but we go on, outwardly ignoring it” (Barrett-
Lennard, 2015, pp. 115-116).

**Psychometric properties of the Barrett-Lennard Relationship Inventory.** The
shorter 40-item BLRI has been found to have consistent reliability and validity with the
longer 64-item BLRI (Barrett-Lennard, 2015). A review of 24 studies assessing the
reliability of the BLRI, Gurman (1977) reported mean internal consistency coefficients of
.91 for overall scores, .84 for empathetic understanding, .91 for level of regard, .74 for
unconditionality of regard, and .88 for congruence. Test-retest reliability was reported as
.90 for overall scores, .83 for empathetic understanding, .83 for level of regard, .80 for
unconditionality of regard, and .85 for congruence (Gurman, 1977). Reliability
coefficients for the subscales of the *BLRI-OS-40* include .91 for empathic understanding,
.87 for level of regard, .82 for unconditionality, and .88 for congruence (Barrett-Lennard,
2015). Gurman (1977) concluded that “substantial, if not overwhelming evidence” (p. 523)
exists supporting the psychometric properties of the BLRI and the link between
client perception of the therapeutic relationship and client outcomes.

When determining validity of the scale, Barrett-Lennard (1962, 2015) described a
formal procedure in which five expert judges, considered to be experts in person-centered
counseling, were asked to first categorize each item of the assessment as either positive,
negative, or neutral. Second, judges assigned a score of 1 through 5 to items based on
their perception of the strength or importance of the item to the therapeutic variables. The
results of this procedure showed unanimous decisions by all five judges on all but four
items; three of which were removed from the scale and one which remained as only one judge differed from the others in the categorization of the item. Barrett-Lennard asserts that this process, along with the prevalence of studies that have used the BLRI to assess for the predictive strength of the therapeutic relationship on client outcome and the hundreds of doctoral dissertations that have included the measure, substantial support for the validity of the instrument has been demonstrated (2015).

Outcomes Questionnaire - 45

The Outcomes Questionnaire – 45.2 (OQ-45.2) is a 45-item self-report outcomes assessment used to measure change in client distress over time (Lambert et al., 1996). The OQ-45.2 is a well-established and frequently used assessment of client change and was included as a supplemental measure to further analyze the effect had on client outcome by counselor-in-training participation in a brief mindfulness intervention. The OQ-45.2 contains three subscales: (a) symptom distress, (b) interpersonal relationships, and (c) social role performance. Individual items on the OQ-45.2 use a five-point Likert scale ranging from 0 (Never) to 4 (Always), with a final score ranging from 0-180, with higher scores indicates higher degrees of distress. In addition to repeated findings that the OQ-45.2 is a psychometrically sound outcomes measure, it has also been found able to detect changes across all three subscales when used with a University population (Talley & Clark, 2006). Overall item sensitivity to change (Vermeesh et al., 2000; Vermeersch et al., 2004) and overall effectiveness with the present population (Talley & Clark, 2006; Vermeersch et al., 2004) are important as administration of the OQ-45.2 occurred at relatively close intervals throughout the study: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session.
Psychometric properties of the Outcomes Questionnaire - 45.2. The OQ-45.2 is a 45-item self-report outcomes assessment used to measure change in client symptomology over time (Lambert et al., 1996). Individual items on the OQ-45 use a five-point Likert scale ranging from 0 (Never) to 4 (Always), with a final score ranging from 0-180. Research indicates that scores demonstrating a change of 14-points or more is indicative of significant client change (Vermeersch, Lambert, & Burlingame, 2000).

The OQ-45.2 is designed for multiple administrations, with a reported overall test-retest reliability of .84 (Lambert et al., 1996) and a Cronbach’s alpha of .94 (Boswell, White, Sims, Harrist, & Romans, 2013). Test-retest reliability for symptom distress, interpersonal relationships, and social role performance were reported at .78, .80, and .82, respectively (Lambert et al., 1996). Boswell and colleagues (2013) reported the internal consistency reliability for symptom distress, interpersonal relationships, and social role performance to be .93, .78, and .70, respectively. These findings are comparable to Lambert and colleagues (1996) reported internal consistency reliability of .91, .74, and .71, respectively. Regarding concurrent validity, Total Scores for the OQ-45.2 were found to have significant concurrent validity with the following tests: the Symptom Checklist 90-Revised (.73), the Beck Depression Inventory (.80), the State-Trait Anxiety Inventory (.64 for state anxiety; .80 for trait anxiety), the Zung Self Rating Depression Scale (.88), the Zung Self Rating Anxiety Scale (.80), and the Taylor Manifest Anxiety Scale (.86) (Lambert et al., 1996).

Daily Mindfulness Activity Log

The Daily Mindfulness Activity Log (see Appendix L) is a self-report instrument created by the researcher to collect information related to counselor-in-training
engagement and experiences associated with their mindfulness practices during the intervention phase of this study. Information collected included details related to specific mindfulness activities practiced each week, duration of practice, and context of the practice (i.e. time of day, reason for specific activity selection, etc.). While data obtained was reviewed for across participant themes related to specific mindfulness activities practiced, *Daily Mindfulness Activity Logs* were designed to serve as a method for counselors-in-training to remain accountable for their engagement in mindfulness activities while participating in the intervention.

**Post-Intervention Follow-Up Questionnaire**

The *Post-Intervention Follow-Up Questionnaire* (see Appendix O) is a self-report instrument created by the researcher to capture counselor-in-training thoughts and opinions related to the mindfulness intervention. Data collected was used to assess for the social validity (Kazdin, 2011) of the intervention. The questionnaire was sent to counselors-in-training following completion of data collection.

**Data Collection**

Data collection was continuous (Gast, 2010) and began during the first encounter between the counselor-in-training and client. All 50-minute counseling sessions were held in a university counseling training clinic, and each session was video recorded using an IRB-approved portable recording camera that was placed in the counseling clinic rooms during sessions. Following each session, video recordings were reviewed by a member of a team of trained observers and, using the *CIT Dispositional Data-Collection Form*, observers tallied the frequency, or occurrences, of dispositional expressions being investigated. Each 50-minute counseling session recording was broken down into five 10-
minute observation periods; with periods one, three, and five reviewed by observers for occurrences of dispositional expressions and then tallied to obtain an individual segment frequency count and a total frequency count. Periods two and four, where observations did not occur, allowed for observers to record observations and tally the completed period before moving onto the next (Kazdin, 2011). Frequency recording was used when measuring the occurrences of empathetic understanding and regard as these dispositional expressions, as operationally defined for this study, proved to have identifiable beginning and end points (Kazdin, 2011). Congruence was measured using whole interval recording as the dispositional expressions for congruence/incongruence often accompanies expressions or statements associated with empathetic understanding and regard; therefore, discrete measurement of congruence/incongruence is challenging. Whole interval recording (Kazdin, 2011) allows for the measurement of behaviors that occur at a high rate or those with variation in duration, such as congruence/incongruence. If a counselor-in-training presented as congruent, based on the operational definitions used in this study, an occurrence of congruence (+) was marked for that observation period. Similarly, if a counselor-in-training presented as incongruent, based on the operational definitions used in this study, an occurrence of incongruence (-) was marked for that observation period. As with empathetic understanding and regard, occurrences were then tallied to offer a total count. Completed observation forms were then collected by the researcher and data points were visually graphed, using Microsoft Excel, for continuous pattern analysis. Furthermore, in an effort to reduce the potential for recording bias, each independent observer remained blinded to participant phases and phase change occurrences.
Client report data was also collected after each counseling session. Following the conclusion of the counseling sessions, clients were given an envelope containing the assessments required for them to complete. During completion of the assessments, counselors-in-training left the counseling room until the clients indicated they had completed the packet. Upon completion of the assessments, clients were asked to return the completed assessments to the original envelope and seal the envelope before handing it to their counselor-in-training. Once the packet was handed to the counselor-in-training, the counselor-in-training delivered the sealed envelope to the researcher. The researcher then recorded and graphed client responses for continuous visual analysis.

**Graphing of Data**

Use of line graphs to record collected data is the most commonly used method of displaying single case data (Gast & Spriggs, 2010). Line graphs offer clear and concise visual analysis of the frequency, or rate, of target behavior occurrence or nonoccurrence, allowing for easier pattern analysis throughout baseline and intervention phases. Further, line graphs are both easily constructed through common computer programs and easily interpreted by most readers due to familiarity with the graphical display of data (Gast & Spriggs, 2010). Data collected from recorded counseling sessions and client report assessments was graphed continuously throughout the investigation for analysis of baseline stability, phase changes, and treatment effects.

**Operational Definitions and Clarifiers**

To ensure clarity, understanding, and agreement when recording counselor-in-training dispositional data, the following definitions and clarifiers were used during data collection and recording. Operational definitions align with those offered by Barrett-
Lennard (1962, 2015) and clarifiers, while created by the researcher, are informed by Barrett-Lennard (2015) and Lambie and colleagues (2015). A table containing the below information may also be viewed in Appendix F.

**Empathic understanding.** Empathetic understanding, or empathy, is defined as the extent to which one desires to know and experience the process and content of another’s awareness. Further, it the ability to sense the immediate quality and intensity of another’s experience while being able to recognize the context of the feeling or thought (i.e. what/whom the feeling is directed toward or the conditions that produced the feeling). Empathetic understanding is demonstrated through experiential recognition of perceptions or feelings that another has directly expressed, as well as through the sensing and inferring of that which another has implied or indirectly expressed. Empathetic understanding is diminished when one projects perception of another’s experience that has originated within oneself and one’s own experiences (Barrett-Lennard, 1962, 2015).

**Clarifiers.** Additive (+) empathy: (a) CIT accurately reflects client's directly expressed or verbalized feelings. Demonstrated through reflection of feeling (e.g., “I hear you saying you are angry…”); (b) CIT accurately infers client's indirectly expressed or nonverbalized feeling. Demonstrated through an inference of feeling (e.g., “I am sensing you are angry…”); (c) CIT accurately interprets and/or reframes client's feelings, experiences, beliefs, etc. Demonstrated through paraphrases and/or reflection of meaning using client's frame of reference, without projection of bias or assumption from counselor; (d)CIT asks exploratory questions that seek to elicit deeper meaning behind client stories, experiences, or feelings (e.g., "What does…mean to you?", "What sense do you make of…?", "What value do you place on…?")
Subtractive (-) empathy: (a) CIT offers superficial responses, demonstrates an inability to recognize the deeper context of the client's thoughts and/or feelings; (b) CIT projects feelings, thoughts, beliefs, or experiences onto client's feelings, thoughts, beliefs, or experiences. Demonstrated through bias and/or assumptions related to client's feelings, thoughts, experiences, or beliefs (e.g., inaccurate reflection of feeling, inaccurate inference of feelings or thoughts, inaccurate interpretations or reframes, or inaccurate reflection of meaning).

**Level of regard.** Level of regard is defined as the affective aspects, both positive and negative, of one’s response to another. Positive aspects may include indicators of leaning into another’s experience, warmth, respect, affection, and appreciation. Negative aspects may include indicators of pulling away from another, impatience, dislike, rejection, and contempt (Barrett-Lennard, 1962, 2015).

**Clarifiers.** Positive (+) regard: (a) verbal or nonverbal validation of client's positive and negative feelings, thoughts, experiences; (b) verbal or nonverbal expressions of warmth, concern, or caring toward client following disclosures (e.g., vocal tone, facial expressions, patience); (c) verbal or nonverbal expressions of respect, appreciation, or gratitude toward client, client's disclosures, client's experiences (e.g., vocal tone, facial expressions); (d) CIT appears nonjudgmental and refrains from evaluative statements about client's experiences or following client disclosures; (e) CIT's demeanor is one of openness and acceptance during client disclosures, interactions, or communication (e.g. leaning in, body position (e.g., open posture, mirroring client), eye contact, and vocal tone (e.g., warmth, curiosity, compassionate).
Negative (-) regard: (a) verbal or nonverbal validation of only positive or only negative feelings, thoughts, experiences (e.g., selective attention). As demonstrated by repeated minimization or nonattention to certain feelings, thoughts, or experiences; (b) verbal or nonverbal expressions of impatience, disrespect, disregard, or rejection toward client, client's disclosures, or client's experiences (e.g. facial expressions, lack of eye contact, administrative vocal tone, fidgeting, foot/finger tapping, interruptions); (c) CIT makes judgmental or evaluative statements about client's experiences or following client disclosures; (e) CIT's demeanor is one of discomfort, tension, or defense during client disclosures, interactions, or communication (e.g. leaning away from client, arm crossing).

**Unconditionality of regard.** Unconditionality of regard is defined as the degree of variability, or constancy, that exists in one’s affective response to another. Conditionality exists when one’s communication of experience is tailored to obtain desired affective responses from another (Barrett-Lennard, 1962, 2015). Conditionality of regard is demonstrated through variability in occurrences of positive aspects and negative aspects of level of regard. For example, counselors who demonstrate considerably more occurrences of positive regard than negative regard while have a higher degree of unconditionality than a counselor who demonstrates a higher occurrence of negative regard.

**Congruence.** Congruence is defined as consistency between present experience, awareness, and response. Congruence is enhanced when an individual is psychologically unthreatened, therefore allowing openness to awareness of another’s experience while also responding to their experience with honesty, directness, and sincerity. Incongruence is demonstrated through discomfort, tension, anxiety, and inconsistency between what
one says and what is implied through expression, gesture, or tone of voice (Barrett-Lennard, 1962, 2015).

**Clarifiers.** Congruence (+): (a) there is consistency between CIT’s spoken word and nonverbal gesture or expression; (b) CIT appears able to freely communicate in an honest and sincere manner, without appearing apprehensive or as if measuring words/responses; (c) CIT appears relaxed and genuine in interactions with client, does not appear to present with a façade or as if playing a role.

Incongruence (-): (a) there is inconsistency between CIT’s spoken word and nonverbal gesture or expression; (b) CIT appears to struggle to freely communicate in an honest and sincere manner, showing apprehension or a careful measuring of words/responses; (c) CIT appears to present with a façade or as if playing a role.

**Procedure**

**Baseline**

Baseline, or the control condition, refers to the period of time prior to introduction of an intervention (Kazdin, 2011; Ray, 2015). During the baseline phase repeated measurements of the dependent variables (e.g. counselors’-in-training empathy, level of regard, unconditionality of regard, and congruence) were collected to establish a pattern of behavior that may predict future behavior if an intervention was not being introduced (Gast, 2010). Using video recordings, baseline data collection began during the first encounter between counselor-in-training and client. Stabilization of baseline data related to the target behaviors was established through visual analysis using no fewer than five data points prior to moving into the intervention phase (Gast, 2010; Kazdin, 2011; Lentz, 2015; Ray, 2015). While this investigation was examining the effect of a mindfulness
intervention on multiple target behaviors, stability of baseline for each individual disposition was not required. Instead, a single disposition, empathy, was selected to determine baseline stability, treatment effect, and phase changes for all participants. While empathy served as the determinant target behavior, each target behavior was observed and recorded continuously. Additionally, the independent observers remained blind to role of empathy in determining stability, treatment effect, and phase changes.

During baseline, counselors-in-training did not participate in mindfulness-related activities. Counselors-in-training met individually with their clients for weekly 50-minute counseling sessions. Throughout the investigation, clients remained blinded to the phase their counselor-in-training was in. Other than select instances requiring rescheduling of a session, counseling sessions were regularly scheduled and occurred at the same time, on the same day of the week, and were held in the same clinic room. The regularity and consistency of counseling sessions was in place to further reduce the impact of confounding variables on dispositional expressions of counselors-in-training. Counselors-in-training engaged in regular clinical supervision each week as is required of their practicum course. Additionally, as hours accrued through participation in this study were able to be counted toward total required practicum hours, counselors-in-training also received supplemental on-site supervision as is required of a University practicum site. This on-site supervision continued through the duration of the investigation.

Once stabilization of baseline data for the first participant occurred, the participant was able to transition into the intervention phase. Baseline data continued to be collected for the remaining participants until both stabilization of individual baseline data was present and clear indication of treatment effect, using no fewer than three data
points, had occurred in prior participants. Once both criterion had been met, the next participant was able to enter into the intervention phase of the study. This pattern continued until all participants had entered into the intervention phase of the study. Baselines of differing lengths is needed to accurately evaluate for threats to internal validity (Gast & Ledford, 2010).

**Intervention**

Upon progression to the intervention phase, counselors-in-training individually participated in a brief mindfulness intervention. Counselors-in-training continued seeing their clients for 50-minute counseling sessions throughout the intervention phase. The mindfulness intervention, created by the researcher, is informed by Kabat-Zinn’s Mindfulness-Based Stress Reduction (2013) and traditional mindful meditation teachings and practices (Thera, 1962/1996). The intervention consisted of two stages: (a) guided practice and (b) independent practice. During the initial stage, guided practice, counselors-in-training individually attended four 75-minute mindfulness sessions over the course of two weeks. The guided mindfulness sessions were held within the University counseling clinic and led by the primary researcher who has practiced mindfulness for several years and has received training in mindfulness practices.

All guided sessions followed the same format (see Appendix H-K): (a) introduction and welcome, (b) opening practice (e.g. breathing exercise), (c) follow-up and processing of mindfulness experiences and/or questions, (d) psychoeducation (e.g. foundations and tenets of mindfulness, attitudinal qualities), (e) guided meditations and processing of experience, (f) brief closing practice (e.g. breathing meditation), and (g) review of homework expectation. Counselors-in-training were then given a *Daily*
Mindfulness Activity Log (see Appendix L) and a reference sheet outlining the topics and homework for each intervention session. As the meditations conducted during the intervention session were expected to be practiced between intervention sessions, audio recordings of the guided meditations practiced during that intervention session were then sent electronically to the counselor-in-training for their continued practice. During the guided practice phase of the intervention, counselors-in-training returned their Daily Mindfulness Activity Logs to the researcher at the beginning of each intervention session.

Counselors-in-training were required to engage in both formal and informal mindfulness practices outside of the scheduled intervention sessions. Engaging in mindfulness practices outside of formal meetings is considered fundamental to the cultivation of mindfulness and the adoption of a regular contemplative practice (Kabat-Zinn, 2013). While activities described in the intervention are informed by both traditional contemplative practice (Thera, 1962/1996) and the Mindfulness Based Stress Reduction program (MBSR; Kabat-Zinn, 2013; Santorelli, 2014; Santorelli, Meleo-Meye, & Koerbel, 2017), as with other studies who have implemented interventions using MBSR-informed meditative practices (Bohecker & Horn, 2016; Buser et al., 2012; Christopher & Maris, 2010; Jain et al., 2007; Shapiro, Schwartz, & Bonner, 1998), key differences exist with regard to practice duration, program or intervention length, participant engagement, and method of delivery.

At the conclusion of the guided practice phase, counselors-in-training entered into the independent practice phase of the intervention. During this phase, counselors-in-training did not attend guided intervention sessions but were asked to continue logging their mindfulness activities using the Daily Mindfulness Activity Logs. Logs were
returned to the researcher at the beginning of each week for review. Counselors-in-training remained in the independent practice phase of the intervention until the conclusion of the investigation. Continuous data collection during the independent practice phase of the intervention allowed for analysis of the continued effect of a brief mindfulness intervention on counselor-in-training dispositions.

**Client Report Data**

Client data was collected continuously throughout this investigation. Clients completed the *Personal Growth Initiative Scale-II* (PGIS-II; Robitschek et al., 2012) following each counseling session. The continuous collection of data related to client personal growth, a key indicator of positive treatment outcome (Robitschek et al., 2012), allows for an assessment of a causal relationship between the mindfulness intervention, counselor dispositions, and client outcome. In addition to administration of the *PGIS-II*, clients also completed the *Barrett-Lennard Relationship Inventory Form OS-40* (Barrett-Lennard, 1962) to assess their perception of the strength of the therapeutic relationship and the *Outcomes Questionnaire-45.2* (Lambert et al., 1996) to measure changes in client distress and symptomology. Probing for client data at selective times is appropriate to reduce the impact of continued measurement (Christ, 2007).

**Data Analysis**

Both counselor-in-training disposition data and client-reported *PGIS-II* scores were visually analyzed using graphical displays of data points created using Microsoft Excel. Analysis included documentation of baseline pattern, examination of data within phases to assess for patterns, comparison of data between phases to assess for intervention effect, and integration of data across phases to determine if there is a
minimum of three demonstrations of effect (Kratchowill et al., 2010). Additionally, the following variables were considered during data analysis: (a) level, or mean of each phase; (b) trend, or slope of data; (c) variability between each data point in phases; (d) immediacy, or time between intervention and effect; (e) overlap, or proportion of data that overlaps phases; and (f) consistency of data patterns across phases for replication and credibility (Hott et al., 2015; Kratochwill et al., 2010). Finally, as is standard with graphical display of multiple baseline data, vertical comparison was used when reviewing data for effect. Vertical comparison of multiple baseline data involves stacking the graphical display of participant data to allow for the simultaneous assessment of change, and absence of change, across participants and phases (Horner, Swaminathan, Sugai, & Smolkowski, 2012).

Level refers to the magnitude of data, and changes in data, as indicated by the ordinate scale value (Gast & Spriggs, 2010; Kazdin, 2011). Level of data is often determined through calculation of the within phase mean or median data points. While calculating the mean value of data points is common, the median is considered a more reliable value for determining level stability and level change as it is less influenced by outliers. Assessing for a change in level between phases is important for determining treatment effect. For this investigation, level was determined by identifying the median value for data points within phases and then comparing the median values across phases to determine the magnitude of change across time.

The trend of data refers to the slope or angle of data points. Data trends are important when assessing for the projected path of data, particularly during baseline and before introduction of the independent variable. Determining trend may be done visually
but can be challenging when data is highly variable. A second method of assessing data trends is through the split-middle method (White & Haring, 1980), though it should be noted that the split-middle method offers an estimate, not a guaranteed projection, of the data trend. To obtain an estimation of the trend in data using the split-middle method, you must first split the data path (e.g. baseline) in half and then locate the “mid-date”, or the middle data point when counting left to right, for each half; drawing a vertical line through each (|). Once the “mid-date” has been identified, locate the “mid-rate” for each half by calculating the median data points; drawing a horizontal line (-) through the values. Finally, connect the two data intersections (+) using a straight line to obtain an estimate of trend. The split-middle method was used in this study when determining an estimation of data trend.

Along with level and trend, variability of data is also analyzed when determining the degree of stability within phases. To determine stability of data, a stability envelope was calculated by first determining the trend of the data using the split-middle method. Then, using the median values obtained through the split-middle method, a parameter of +/- 25% of the median values was created. If 80% of data points fell within the stability envelope, the data was determined to be stable (Gast & Spriggs, 2010).

When analyzing between-phase data for an effect, immediacy of change, percent of overlapping/nonoverlapping data, and consistency of data patterns are all considered. Immediacy of change in data level, trend, and/or variability is analyzed to determine strength of the treatment effect. The more immediate the change when comparing the last three data points of one phase with the first three data points following introduction of an intervention, the stronger the inference is for a causal relationship (Kratochwill et al.,
Analyzing between phase data points for the amount of overlapping data is also used when determining strength of a treatment effect. The less overlapping data following the introduction of an intervention, the stronger the inference is for a causal relationship (Kratochwill et al., 2010). Finally, the consistency of data patterns across similar phases (e.g. intervention phase) is also used when making inferences related to the strength of an intervention effect. The more similar data patterns are across participants following the introduction of an intervention, the stronger the effect (Kratochwill et al., 2010).

**Interobserver Agreement**

Interobserver agreement (IOA), or the accuracy of measurement agreement between observers, aids in enhancing credibility to findings (Hott et al., 2015). IOA will be assessed through a simple frequency ratio to determine agreement between observations (Kazdin, 2011). Frequency ratio is computed by dividing the smaller total by the larger total and then multiplying this number by 100 to form a percentage. This percentage indicates the consistency of which the target behavior was observed. It is recommended that IOA data be assessed in 20-33% of observations, with a minimum of 80% IOA as a recommended cut-off to ensure validity of results (Ayers & Gast, 2010; Kazdin, 2011).

Properly implemented study procedures such as, thorough observer training, clearly defined target behaviors, and a systematic method of collecting and recording data are intended to produce a single, or agreed upon, outcome; particularly when multiple observers are responsible for recording and data collection (Ayers & Gast, 2010; Hott, Limberg, Ohrt, & Schmit, 2015). When proper procedures have been implemented and
variability between observations is low, there is believed to be a high level of IOA (Ayers & Gast, 2010; Hott et al., 2015; Kazdin, 2011). A high percentage of IOA increases the credibility of the findings and validity of outcome. When low IOA is assessed due to large discrepancies between observer recordings, confidence in established study protocols is lowered and the validity of subsequent findings are diminished (Ayers & Gast, 2010).

**Treatment Integrity**

Treatment integrity, or intervention fidelity, refers to the degree to which the procedures described for the intervention phase were implemented across participants (Gast, 2010). Differences in intervention implementation may result in variability of outcome and loss of reliability in results (Kazdin, 2011). To determine the degree of integrity for which the intervention was implemented, a random selection of 25% of video recorded intervention sessions were reviewed by an outside observer using the Intervention Fidelity Checklists for each intervention session (see Appendix H-K). To determine the percentage of treatment integrity, the number of observed events will be divided by the number of planned events and then this number will by multiplied by 100.

**Social Validity**

Social validity refers to the social importance and acceptability of the purpose of the study, the intervention, and the outcomes of the intervention (Kazdin, 2011). The social significance of the purpose of the study is assessed to determine if the dependent variables being studied are valuable and relevant. The social validity of the intervention refers to how accepted and well-liked that intervention was by the participants. An intervention with high social validity is more likely to be completed with fidelity and
replicated following completion of the study. The social validity of the intervention does not assess for intervention effectiveness (Kazdin, 2011). Social validity of the intervention outcomes refers to significance of change produced. Social validity of the outcomes is often assessed through social/peer comparison, subjective evaluation obtained from the participant or a stakeholder, or researcher evaluation.

The social validity of the dependent variables and the need to examine such counselor variables has been discussed throughout Chapters One and Two. The social validity of the intervention was assessed by asking participants to complete a short, self-report questionnaire, *Post-Intervention Follow-Up Questionnaire*. This questionnaire attempted to capture participants’ thoughts and opinions related to their participation in the intervention and was sent following the completion of data collection. Social validity of the results will be determined through analysis of the findings. However, as studies using direct observation to measure the dispositions under investigation have not been done, determining what is considered a meaningful change following introduction of the intervention may be challenging.

**Ethical Considerations**

The following measures were taken to ensure this research study was conducted in accordance with ethical standards and to ensure the protection of participant confidentiality:

1. Participant names were not used during data collection and analysis. Participants were assigned a unique number code as their identifier and the researcher maintained an electronic code key that was encrypted and password-protected as required by the ACA Code of Ethics (2014).
2. Participation in this study was voluntary and though incentives were offered for completing the study, early withdrawal did not negatively impact academic standing.

3. All participants were informed of their rights and an explanation of research was approved by the IRB at the South Carolina.

4. Client completed assessments were collected and sealed in prelabeled envelopes following each collection time. The researcher collected and stored the completed assessments in a locked cabinet in Wardlaw 140.

5. Permission to use the instruments was obtained from the authors when required and appropriate licenses were obtained.

6. The study was conducted with the permission and approval of dissertation co-chairs, committee members, and IRB of the University of South Carolina.

Chapter Summary

Chapter Three presented the research methods to be used for the study measuring the effect of counselors-in-training participation in a four-week mindfulness intervention on their facilitative dispositions of: (a) empathy, (b) regard, (c) unconditionality, and (d) congruence (as observed through weekly in-session engagement with clients), client outcomes (as measured by the Personal Growth Initiative Scale-II [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]), and the influence of counselor-in-training engagement with mindfulness on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]). The methodology outlined in chapter three included: (a) research design, (b) research questions and hypotheses, (c) population and
sampling procedures, (d) instrumentation, (e) data collection methods, (f) intervention procedure, and (g) methods of data analysis. Additionally, the dependent and independent variable were presented, and the ethical considerations and the limitations for the study were reviewed. Chapter Four will present the results of the study. Chapter Five will discuss the results of the study in relation to implications and future research.
CHAPTER FOUR: RESULTS

Chapter Four presents the results of the investigation, addressing each research question individually. The purpose of this research study was to contribute to the current knowledge surrounding the use of mindfulness to cultivate counselor dispositions. This investigation used a concurrent multiple baseline, across participants, single case research design to examine the effects of counselors-in-training participation in a brief mindfulness intervention on the facilitative dispositions of: (a) empathy, (b) level of regard, (c) unconditionality of regard, and (d) congruence (as observed through weekly in-session engagement with clients). In addition, the investigation examined the effects of counselors-in-training participation in a brief mindfulness intervention on client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]), and the influence of counselor-in-training engagement with mindfulness on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]).

Population and Sample

The population for this study was current counselors-in-training and their clients. The counselors-in-training were enrolled in a CACREP-accredited graduate counseling program at a large university in the Southeast. During recruitment, five counselors-in-training volunteered to participate in the study. The three counselors-in-training who
were chosen were randomly selected using the random sort function available in Microsoft Excel. The sample for this study was comprised of three (N = 3) counselors-in-training who were enrolled in the Marriage, Couples, and Family Counseling (n = 2) and School Counseling (n = 1) tracks and entering the clinical experience portion of their training. All three counselors-in-training remained active in the study from start through completion, for a total of 14 weeks of data collection. As stated, two counselors-in-training were enrolled in the Marriage, Couples, and Family Counseling track and one was enrolled in the School Counseling track. All three counselors-in-training identified as White/non-Hispanic, cisgender females, with a mean age of 30 years (range = 23 to 43).

Regarding past exposure to mindfulness, or experience engaging in mindfulness activities, all participants reported some prior experience with meditation practices through their individual participation in yoga classes. One participant also reported learning meditation through self-guided learning and reading books on the topic.

The clients were currently enrolled undergraduate students, over the age of 18, and enrolled in an Introduction to Counseling course within the Counseling minor program at a large University in the Southeast. Total sample size for this study was nine clients. During recruitment, 12 undergraduate students volunteered to participate as clients in this study. The nine clients who were chosen were randomly selected using the random sample selection tool available in Microsoft Excel. All nine clients participated during Fall 2017 semester (weeks 1-7), however three clients were unable to continue into the Spring 2018 semester (weeks 8-14) due to graduation (n =1), lack of scheduling availability (n =1), and referral for additional services (n=1). The remaining six clients remained in the study through data collection completion.
Of the total client sample \( (N = 9) \), the majority identified as cisgender females \( (n = 8) \) with one participant identifying as “other”. One participant identified as biracial (Asian American and Native American), while the remaining eight participants identified as Caucasian/White (non-Hispanic). The mean age for the sample was 20.7 years (range = 19 to 23). All clients were currently enrolled undergraduates, four were seniors, four were juniors, and one was a sophomore. One client-participant reported receiving concurrent counseling through the University’s counseling center, the remaining eight reported that they were not currently receiving counseling services, though one did disclose monthly medication monitoring with a psychiatrist. One client-participant reported that they had never before received individual, couples, or family counseling services, while the remaining eight participants reported having received counseling services in the past.

Data collection consisted of 14 weeks of scheduled counseling sessions separated by a five-week University break. Seven weeks of data collection occurred during the second half of the Fall 2017 semester and the remaining seven weeks of data collection occurred during the beginning half of the Spring 2018 semester. A total of 101 counseling sessions were scheduled between the three counselor-in-training participants. Of the total scheduled sessions, clients attended 94, for a session adherence rate of 93%. All scheduled counseling and intervention sessions were held within a University counseling clinic. Counseling sessions were scheduled in advance and held on the same day of the week, at the same time of day, and within the same clinic room. Exceptions to this, while infrequent, included instances where the client or counselor-in-training required a reschedule. Rescheduled appointments were conducted during the same week.
so that session attendance remained consistent across clients and across counselors-in-training. This ensured session attendance regularity for participants and similarity in number of sessions between counselors-in-training. See Table 4.1 for a full breakdown of session attendance by semester and counselor-in-training.

Table 4.1 Counseling session attendance by semester and counselor-in-training.

<table>
<thead>
<tr>
<th></th>
<th>Fall 2017</th>
<th></th>
<th>Spring 2018</th>
<th></th>
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<tbody>
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<td></td>
<td>Scheduled</td>
<td>Attended</td>
<td>%</td>
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<tr>
<td>Betsy</td>
<td>21</td>
<td>19</td>
<td>90.5%</td>
<td>12</td>
</tr>
<tr>
<td>Amelia</td>
<td>21</td>
<td>19</td>
<td>90.5%</td>
<td>12</td>
</tr>
<tr>
<td>Cora</td>
<td>21</td>
<td>20</td>
<td>95.2%</td>
<td>14</td>
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**Research Question Results**

The results of this investigation are outlined below. During discussion of the results, counselor-in-training participant names have been replaced with pseudonyms that differed from the unique identifiers used during data collection as an additional measure to ensure confidentiality of participant identity. Clients of each counselor-in-training are then identified using the prefix CL, followed by the first letter of their counselor-in-training’s pseudonym, and then identified with a number. For example, Amelia’s three clients are identified as: CL-A-1, CL-A-2, and CL-A-3, whereas Cora’s three clients are identified as: CL-C-1, CL-C-2, and CL-C-3.
Research Question One

To answer the question “Does counselors-in-training participation in a brief mindfulness intervention affect their dispositions of (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as demonstrated through in-session engagement with clients)?” instances of in-session dispositional expressions were observed and tallied by observers, using the provided operational definitions and clarifiers. The mindfulness intervention was introduced to counselors-in-training at a staggered rate, dependent upon baseline stability and evidence of a treatment effect in prior participants who have begun the intervention phase. As this investigation was investigating the effect of an intervention on multiple dispositions, and achieving simultaneous stability across all dispositions was unlikely, baseline stability and treatment effort were both determined through analysis of additive empathetic understanding data points.

Intervention sessions for all participants occurred at a rate of four guided, or in-person, sessions over a two-week period. The two independent observers were blinded to phase changes across participants to reduce the potential for observer bias during the data recording process. Primary dependent variable data were plotted for visual inspection and data was continuously analyzed for level, trend, variability, immediacy of the effect, overlap, and consistency of data patterns across and within phases (Kratochwill et al., 2010).

Empathetic Understanding. During baseline, Betsy’s in-session occurrences of additive empathetic understanding, or additive empathy, had a level of 5.5 and were trending slightly upward, with split-middle median values of 5 and 6, respectively. Of the
counselors-in-training, Betsy had the shortest baseline phase, eight sessions, and the longest overall intervention (guided practice and independent practice) phase. While the first half of baseline had high variability, Betsy’s baseline stabilized between data points four and eight, allowing her to transition into the intervention phase. Following introduction of the intervention, there was an immediate upward trend in Betsy’s occurrences of additive empathy. Using the last three data points as comparison for determining effect, there was in immediate increase in level and the degree of slope in the upward trend. While Betsy’s occurrences of additive empathy fell slightly following the third intervention data point, there was an overall increase in level from baseline \((Mdn = 5.5)\) to intervention \((Mdn = 7.5)\). Further, the stability of data showed a 20-percentage point increase from baseline, where 75\% of data points fell within the stability envelope, to intervention, with 95.5\% of data points falling within the stability envelope. Regarding non-overlapping data between phases, four out of the 22 data points \((18.2\%)\) recorded during Betsy’s intervention phase exceeded her highest baseline data point, which occurred only one time. However, 11 out of the 22 data points \((50\%)\) recorded during Betsy’s intervention phase exceeded her second highest baseline data point which was recorded more frequently.

Regarding Betsy’s in-session occurrences of subtractive empathetic understanding, or subtractive empathy, there was an immediate and significant reduction in observed occurrences following introduction of the intervention. At baseline, her median rate of subtractive empathy was 7, with split-middle median values of 7.5 and 7, respectively. Her intervention median rate of subtractive empathy was 2, with split-middle median values of 2 and 1, respectively; demonstrating a five-point change in
level. Further, Betsy’s percentage of non-overlapping data between phases for occurrences of subtractive empathy 95.5% as 21 of her 22 intervention phase data points fell below the lowest data point recorded during baseline phase.

Following demonstration of treatment effect in Betsy’s data, Amelia’s was transitioned into the intervention phase. During Amelia’s baseline phase, totaling 13 counseling sessions, the median occurrence, or level, of in-session additive empathy was 2. While her baseline data did demonstrate an upward trend during baseline, with split-middle median values of 1 and 3.5, respectively; the first half of her baseline phase, data points one to six, showed higher variability than her second half of baseline, points, eight to thirteen. Amelia’s overall baseline variability for additive empathetic understanding was the highest of the three counselors-in-training, with only 23.1% of her data falling in the stability envelope created around the trend line. Following introduction of the intervention, there was an immediate increase in Amelia’s occurrences of additive empathy. Though recorded occurrences fell during the initial session following the University break, occurrences quickly returned to a point of stabilization, with 87.5% of intervention data points falling within the stability envelope; a 64.4-percentage point increase from baseline. There was also an overall increase in level from baseline ($Mdn = 2$) to intervention ($Mdn = 5$). Further, four out of the sixteen data points (25%) recorded during Amelia’s intervention phase exceeded her highest baseline data point, which occurred only one time. However, nine out of the sixteen data points (56.3%) recorded during Amelia’s intervention phase exceeded her second highest baseline data point which was recorded more frequently.
Regarding Amelia’s in-session occurrences of subtractive empathetic understanding, or subtractive empathy, there was significant decrease in recorded observations throughout baseline, with split-middle median values of 8 and 3, respectively. Following the introduction of the intervention, when comparing the median values for the final three baseline data points with the first three intervention data points, an immediate change in data was not observed. However, if the median value of the final five baseline data points is compared with the median value of the first five intervention data points, a change in level is observed. Overall, there was a decrease in Amelia’s phase levels from baseline ($Mdn = 5$) to intervention ($Mdn = 2$); demonstrating a three-point level change. Finally, three of the sixteen data points (18.8%) recorded during Amelia’s intervention phase fell below the lowest recorded baseline data point.

Due to the break in the University schedule, Cora did not transition into the intervention phase until the Spring semester. Upon returning from the University break, counseling sessions resumed, and additional baseline data was recorded for Cora prior to her entering intervention. Cora remained in baseline significantly longer than the other two participants, with 26 total counseling sessions, and had a shorter intervention phase, totaling 8 sessions. Also, due to recording errors, two of Cora’s sessions were unable to be coded by observers. The first recording error occurred during baseline and the second during intervention.

Cora’s in-session occurrences of additive empathetic understanding, or additive empathy, had a level of 7 and were trending slightly downward, with split-middle median values of 8 and 7, respectively. Cora’s overall baseline stability for additive empathetic understanding was the highest of the three counselors-in-training, with 84% of her data
falling within the stability envelope created around the trend line. Following introduction
of the intervention, there was an immediate increase in Cora’s occurrences of additive
empathy. Her data appeared to stabilize at a higher level than her baseline data, with an
intervention level of 9; two-data points higher than her overall baseline level.
Additionally, while Cora’s baseline data has a slight downward trend, her intervention
data points changed to demonstrate an upward trend, with split-middle median values of
8 and 9, respectively. Further, six of the seven (85.7%) data points recorded during
intervention phase fell within the stability envelope. None of Cora’s intervention data
points exceeded the highest recorded data points during intervention. However, two of
the seven (28.6%) intervention data points do exceed the two highest recorded baseline
data points, each recorded only one time during the first 25% of Cora’s baseline.

Regarding Cora’s in-session occurrences of subtractive empathetic understanding,
using the median values of the last three baseline data points and the first three
intervention data points, there was an immediate change in observed occurrences
following introduction of the intervention. At baseline, her median rate of subtractive
empathy was 5 and showed a downward trend, with split-middle median values of 6 and
4, respectively. Her intervention median rate of subtractive empathy was 4,
demonstrating a one-point change across phase levels. Following intervention, there was
also a change in data trend, as Cora’s data appeared to stabilize or flatten, with split-
middle median values of 3 and 3. None of Cora’s intervention data points fell below the
lowest recorded baseline data point.

Across participants, an immediate effect was observed in the occurrences of
additive empathetic understanding following the introduction of the intervention. Further,
Figure 4.1 Total occurrences of *Empathetic Understanding* for each participant during baseline and intervention. Dotted connector lines denote a lack of data due to recording error. Shaded areas denote a lapse in data collection due to semester break.
across participants, phase levels showed an increase and variability in data reflective of occurrences of additive empathetic understanding reduced following the introduction of the intervention. Further, changes in phase levels were observed across participant’s data reflecting occurrences of subtractive empathetic understanding; with change evident in the first three data points of Betsy and Cora’s graphs, and within the first five data points of Amelia’s graph, following introduction of the intervention. Empathetic understanding data, both additive and subtractive, for each counselor in training may be reviewed in Figure 4.1.

**Level and Unconditionality of Regard.** During baseline, Betsy’s in-session occurrences of positive regard had a level of 6 and a flat to slightly upward trend, with split-middle median values of 5.5 and 6, respectively. Using the median values of the last three baseline data points and the first three intervention data points to determine latency of treatment effect, an immediate increase in level is observable. However, Betsy’s data point levels did not exceed her levels from baseline until her fifth intervention data point. A total of six of the 22 data points (27.3%). recorded during Betsy’s intervention phase exceeded her highest baseline data point. Betsy’s data trend following the introduction of the intervention showed a flattening, or stabilizing, of in-session occurrences of positive regard, with split-middle median values of 7 and 7, respectively. Additionally, there was a one-point increase in overall phase levels between baseline ($Mdn = 6$) and intervention ($Mdn = 7$), with stability of data showing an 11-percentage point increase from baseline, where 75% of data points fell within the stability envelope, to intervention, with 86.4% of data points falling within the stability envelope.
Regarding Betsy’s in-session occurrences of negative regard, her median rate during baseline was 3, with split-middle median values of 3.5 and 2.5, respectively. Her intervention median rate of negative regard was 1, with split-middle median values of 2 and 0, respectively; demonstrating a two-point change in level and an increase in the slope of the downward trending data. Following introduction of the intervention, there was an immediate change noted when comparing the median values of the last three baseline data points ($Mdn = 2$) and the first three intervention data points ($Mdn = 1$). However, her data show an increase in the frequency of occurrence at the third intervention point and remained above the phase median level until the sixth intervention data point, falling below the phase median level at the seventh intervention data point. Betsy’s percentage of non-overlapping data between phases for occurrences of negative regard was 31.8% as seven of her 22 intervention phase data points fell below the lowest data point recorded during baseline phase.

During Amelia’s baseline phase, the median occurrence of in-session positive regard was 3 and showed an upward trend, with split-middle median values of 1 and 4, respectively. Similar to her data reflective of additive empathetic understanding, Amelia’s overall baseline variability for positive regard was the highest of the three counselors-in-training, with 53% of her data falling in the stability envelope created around the trend line. Following introduction of the intervention, there was an immediate increase in Amelia’s occurrences of positive regard, though her rate did not exceed her highest baseline data point until intervention data point five. Amelia’s recorded occurrences of positive regard fell during the initial session following the University break, they quickly returned to a point of stabilization, with 93.8% of intervention data points falling within
the stability envelope; a 40.8-percentage point increase from baseline. There was also an overall increase in level from baseline ($Mdn = 3$) to intervention ($Mdn = 5.5$), with intervention phase split-middle median values of 5 and 6. Further, four out of the sixteen data points (25%) recorded during Amelia’s intervention phase exceeded her highest baseline data point, which occurred only one time. However, eight of the sixteen data points (50%) recorded during Amelia’s intervention phase exceeded her second highest baseline data point, also recorded only one time, and 14 of the 16 data points (87.5%) exceeded her third highest baseline data point which was recorded more frequently.

Regarding Amelia’s in-session occurrences of negative regard there was significant decrease in recorded observations throughout baseline, with split-middle median values of 6.5 and 4, respectively. Directly following the introduction of the intervention, an increase in the data is observed. However, the subsequent data points demonstrated a continued decrease in occurrences of in-session negative regard, with the third intervention data point reflecting a rate the fell below the lowest recorded baseline data point. Using the median comparisons of the last three baseline data points with the first three intervention data points, a one-point change in level was observed. A delayed change is the rate of occurrences of negative regard is observable following the University break. Overall, there was a decrease in Amelia’s phase levels from baseline ($Mdn = 5$) to intervention ($Mdn = 2.5$); demonstrating a 2.5-point level change. Finally, eight of the sixteen data points (50%) recorded during Amelia’s intervention phase fell below the lowest recorded baseline data point.

Cora’s in-session occurrences of in-session positive regard had a baseline level of 5 and were trending upward, with split-middle median values of 3 and 6, respectively.
Following introduction of the intervention there was an immediate increase in Cora’s occurrences of positive regard. Her data appeared to stabilize at a higher level than her baseline data, with split-middle median values of 7 and 8, respectively. Additionally, there was a three-point increase in overall phase levels between baseline (Mdn = 5) and intervention (Mdn = 8), with stability of data showing an 36-percentage point increase from baseline, where 64% of data points fell within the stability envelope, to intervention, with 100% of data points falling within the stability envelope. Finally, only one of Cora’s seven intervention data points (14.3%) exceeded the highest recorded baseline data point.

Regarding Cora’s in-session occurrences of negative regard, there was a significant and immediate change in observed occurrences following introduction of the intervention. At baseline, her median rate of negative regard was 4 and showed a downward trend, with split-middle median values of 6 and 4, respectively. Her intervention median rate of negative regard was 2, demonstrating a two-point change across phase levels. Following intervention, there was also a change in data trend, as Cora’s data appeared to stabilize or flatten, with split-middle median values of 2 and 2. Finally, two of the seven intervention data points (28.6%) fell below the lowest recorded baseline data point.

Across participants, an immediate effect was observed in the frequency of observed occurrences of positive regard following introduction of the intervention. Further, across participants, phase levels showed an increase between baseline and intervention, while variability in data reflective of occurrences of positive regard decreased. Further, changes in phase levels were observed across participant’s data reflecting occurrences of negative regard; with change evident in the first three data
Figure 4.2 Total occurrences of *Regard* for each participant during baseline and intervention. Dotted connector lines denote a lack of data due to recording error. Shaded areas denote a lapse in data collection due to semester break.
points following introduction of the intervention. Finally, un/conditionality of regard was assessed through comparing the rates of positive and negative regard. As occurrences of positive regard increased across participants and occurrences of negative regard decreased, a shift in conditionality of regard appears to have taken place as rates of occurrence for both positive and negative regard appeared to stabilize or continue on a decreasing (negative regard) or increasing (positive regard) path following introduction of the intervention. See Figure 4.2 for graphs of participant data related to occurrences of regard.

**Congruence.** As noted in Chapter Three, while frequency recording was used to measure the rate of occurrence for empathetic understanding and regard, congruence was measured using whole interval recording. Whole interval recording (Kazdin, 2011) allows for the measurement of behaviors that occur at a high rate, those with variability in duration, and those with less discrete beginning- and end-points; such as congruence/incongruence. If a counselor-in-training presented as congruent, based on the operational definitions used in this study, an occurrence of congruence (+) was marked for that observation period. Similarly, if a counselor-in-training presented as incongruent, based on the operational definitions used in this study, an occurrence of incongruence (-) was marked for that observation period. As there were a total of three 10-minute observation periods per 50-minute session, data ranges for in/congruence are 0 to 3.

Betsy’s baseline data for in-session occurrences of congruence had a level of 2 and a slightly upward trend, with split-middle median values of 2 and 2.5, respectively. Following introduction of the intervention, there was an immediate change in Betsy’s data using a comparison of the last three baseline data points and the first three
intervention data points. However, a more notable delayed change occurred at the sixth intervention data point where a stabilization of Betsy’s data begins to occur. Additionally, there was a one-point increase in overall phase levels between baseline \((Mdn = 2)\) and intervention \((Mdn = 3)\). During intervention, Betsy’s data trend flattened, with split-middle median values of 3 and 3.

Regarding Betsy’s in-session occurrences of incongruence, her median rate during baseline was 1, with split-middle median values of 1 and 0.5, respectively. Her intervention median rate of incongruence was 0, with split-middle median values of 0 and 0; demonstrating a stabilization of data as well as a one-point change in level. Similar to Betsy’s data reflective of congruence, following the introduction of the intervention, there was an immediate change in her data using a comparison of the last three baseline data points and the first three intervention data points. However, a more notable delayed change occurred at the sixth intervention data point where a stabilization of Betsy’s data begins to occur. Overall, Betsy’s data demonstrated the most stability and least amount of variability among the participants for data related to both congruence and incongruence.

During Amelia’s baseline phase, the median occurrence of in-session congruence was 1 and showed a slight upward trend, with split-middle median values of 1 and 1.5, respectively. Directly following the introduction of the intervention, a decrease in the data is observed. Using a comparison of means, an immediate decrease in congruence occurred. Amelia’s third intervention data point shows an increase, though data again falls. However, a delayed change is observable in intervention data points 6 through 16, demonstrating a stabilization of data. Overall, there was a one-point increase in phase
levels between baseline ($Mdn = 2$) and intervention ($Mdn = 3$), with intervention split-middle median values of 3 and 3.

Regarding Amelia’s in-session occurrences of incongruence, her median rate during baseline was 2, with split-middle median values of 2 and 1.5, respectively. Her intervention median rate of incongruence was 0.5, with split-middle median values of 1 and 0, respectively. Similar to Amelia’s data reflective of congruence, directly following the introduction of the intervention, an increase in the data is observed. Using a comparison of means, an immediate increase in incongruence occurred. Amelia’s third intervention data point shows a decrease, though data again rises. A more notable delayed change is observable following intervention data point six as Amelia’s data begins to stabilize and her trend flattens. Overall, there was a 1.5-point decrease in phase levels between baseline ($Mdn = 2$) and intervention ($Mdn = 0.5$), with intervention split-middle median values of 1 and 0. Finally, between the participants, Amelia’s data related to in/congruence demonstrated the most variability across phases.

Cora’s baseline data for in-session occurrences of congruence had a level of 2 and a slightly upward trend, with split-middle median values of 2 and 3, respectively. Following introduction of the intervention, no immediate change in Cora’s data was observed when using a comparison of the last three baseline data points and the first three intervention data points. There was a one-point increase in overall phase levels between baseline ($Mdn = 2$) and intervention ($Mdn = 3$). Further, during intervention, Cora’s data trend flattened, with split-middle median values of 3 and 3.

Regarding Cora’s in-session occurrences of incongruence, her median rate during baseline was 1 and showed a downward trend, with split-middle median values of 1 and
Figure 4.3 Total occurrences of Congruence for each participant during baseline and intervention. Dotted connector lines denote a lack of data due to recording error. Shaded areas denote a lapse in data collection due to semester break.
0, respectively. Her intervention median rate of incongruence was 0, with split-middle median values of 0 and 0; demonstrating a stabilization of data as well as a one-point change in level. Similar to data for congruence, following the introduction of the intervention, there was not an immediate change in Cora’s data using a comparison of the last three baseline data points and the first three intervention data points. However, a notable delayed change occurred at the third intervention data point where a stabilization of data occurs. Across participants, Cora’s data demonstrated the most change in stability following introduction of the intervention for both congruence and incongruence.

Unlike the prior dispositions being investigated, an immediate effect was not recorded in all participants regarding the frequency of in/congruence following introduction of the intervention. While Betsy’s data was demonstrative of a positive and immediate change, Cora’s data did not show a change, and Amelia’s data showed an immediate but negative change. Despite the inconsistency in the latency of effect across participants, all phase levels showed an increase between baseline and intervention for congruence and a decrease for incongruence. Further, following intervention, data for Betsy and Cora showed stabilization while Amelia’s data was approaching stabilization. See Figure 4.3. for graphs of participant data related to occurrences of congruence.

Research Question Two

To answer the question “Does counselors-in-training participation in a brief mindfulness intervention affect client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996])?" two methods of obtaining client-report data were used. First, in an effort to draw causal conclusions related to the effect on client outcomes when clients
are receiving treatment from a counselor-in-training who is concurrently participating in a mindfulness intervention, the *Personal Growth Initiative Scale-II* (PGIS-II) was administered to clients following all counseling sessions. This continuous collection of PGIS-II scores allows for analysis of client outcomes across phases. Second, in an effort to supplement findings related to client outcome, an additional measure of outcome, the *Outcomes Questionnaire-45.2* (OQ-45.2), was administered at pre-determined points in time: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session.

The two assessments measure client outcomes from different, yet complimentary, perspectives. While the PGIS-II measures outcome from the perspective of personal growth and a client’s willingness and ability to make positive change, the OQ-45.2 measures client outcome from the perspective of a change in distress and symptomology. While a causal relationship between the intervention and scores obtained from the OQ-45.2 is not able to be made as data collection was not continuous (e.g. occurring after each counseling session), trends in scores following each administration are helpful in making relational inferences that may inform future research studies. Presentation of results from the two outcomes measures will be presented separately and by individual CIT.

**PGIS-II.** As mentioned, the PGIS-II was completed by clients following all counseling sessions. Data is displayed graphically as this investigation attempted to make causal inferences between the intervention and client outcome data obtained from the PGIS-II. To determine effect, data was analyzed using the six features of visual analysis outlined by Kratochwill and colleagues (2010): (a) level, (b) trend, (c) variability, (d)
immediacy of effect, (e) overlap, and (f) consistency. While visual inspection of data points was the primary method of within and between phase analysis, use of a calculated stability envelope (Gast & Spriggs, 2010) was used for confirmation of visual analysis. Use of the stability envelope was helpful during analysis of study results to mediate the potential for subjectivity and reduce ambiguity that often accompany visual inspection of graphically-presented data. All client-reported outcome data may be viewed in Figure 4.4

**Betsy.** CL-B-1 completed the *PGIS-II* 11 times; three occurred during baseline, two occurred during the first phase of intervention (guided practice), and the remaining six occurred during the second phase of intervention (independent practice). Baseline data showed a median value of 48 with a flat trend. Following Betsy’s transition into the intervention phase, CL-B-1’s data showed a small increase, with the median value of 49.5 for the first three intervention data points, indicating a small but immediate change. While data showed a minimal increase in the median, or level, of scores across phases, with intervention phase level of 51.5, there was a large percentage of nonoverlapping data with scores obtained weeks six-thirteen measuring consistently higher than the highest recorded baseline data point.

CL-B-2 completed the *PGIS-II* a total of 14 times; three times during baseline, twice during guided practice phase of intervention, and the remaining nine administrations occurring during the independent practice phase of intervention. Baseline data showed a median value of 59 and an upward slope. Upon Betsy’s transition into the intervention phase of the study, an initial increase in scores was observed, with a median value of 67 for the first three intervention data points. Between phase median scores, or level, indicate an upward trend in client growth as measured by the *PGIS-II*; with an
Figure 4.4 Total client-reported scores on the Personal Growth Initiative Scale-II across baseline and intervention phases of the study. Dotted connector lines denote a lack of client report data due to a missed session. Shaded areas denote a lapse in data collection due to semester break.
intervention phase median value of 68, for a nine-point increase over baseline. Further, with the exception of data point seven, there is an absence of overlapping data between baseline and intervention phases.

CL-B-3 had the least amount of data available for analysis; with two data points during baseline, one during the guided practice phase of intervention, and two during independent practice phase of intervention. The low number of data points available for inspection limits the extent to which a prediction of data trend and stability can be made. However, a steep downward slope is visible between the first and second administrations of the PGIS-II. Scores significantly increased following Betsy’s transition into the intervention phase of the study and stabilized at a level that exceeded baseline measurements, allowing for the absence of overlapping data. However, as data collection was not consistent due to inconsistent session attendance, an assessment of effect is challenging to ascertain.

Amelia. CL-A-1 completed the PGIS-II 12 times, having missed only one counseling session during baseline where data was unable to be collected. Of the 12 administrations, four occurred during baseline, two occurred during the first phase of intervention (guided practice), and the remaining six occurred during the second phase of intervention (independent practice). Baseline data had a median value of 58.5 and exhibited a slight downward trend. Following Amelia’s transition into the intervention phase of the study, an immediate increase in PGIS-II scores was observed, however, a decrease in scores occurred at the next administration. Following the break in data collection, an upward trend was observed in CL-A-1’s scores. A comparison of the level, or median scores, between the baseline ($Mdn = 58.5$) and intervention ($Mdn = 67.5$)
phases shows an increase in scores and a projected upward trend; indicating positive client growth occurred. However, overlap of data between phases was high, with only two data points (25%) exceeding the highest score recorded during baseline phase.

CL-A-2 completed the *PGIS-II* a total of seven times, of which five were collected during baseline and two during the first phase of intervention. An upward trend is observed during baseline, a trend which steadily continued into intervention phase. While there are no overlapping data points between phases, the low number of data points available from CL-A-2 during intervention phase limits the extent of analysis when determining effect of intervention.

CL-A-3 completed the *PGIS-II* a total of 11 times; four during baseline phase, two during the guided intervention phase of the intervention, and the remaining five during the independent practice phase of the intervention. Baseline scores data had a median value of 50 with a slight downward trend. Following Amelia’s transition into intervention phase, an immediate increase in scores and an overall upward trend was observed, with an intervention phase median score of 61. While scores fell slightly over subsequent administrations, throughout intervention scores remained higher than the highest data point recorded during baseline phase, allowing for the absence of overlapping data points.

*Cora.* CL-C-1 completed the *PGIS-II* a total of 14 times; 10 data points were collected during baseline, two during the guided practice phase of intervention, and two during the independent practice phase of intervention. Baseline data shows a median value of 59.5 with a steady upward trend. Following Cora’s transition into the intervention phase of the study, *PGIS-II* scores reported by CL-C-1 showed an immediate
increase. Further, a comparison of the level, or median scores, between the baseline ($Mdn = 59.5$) and intervention ($Mdn = 73$) phases shows an increase in scores and a continued projected upward trend; indicating positive client growth occurred. Finally, CL-C-1’s scores continued to increase through the remainder of the study, with no overlapping data recorded during intervention phase.

CL-C-2 completed the *PGIS-II* a total of 13 times; nine administrations occurred during baseline, two during the guided practice phase of intervention, and two during the independent practice phase of intervention. With the exception of data collected during week two, a consistent upward trend in scores was observed throughout baseline and median score of 63 was recorded. Following Cora’s transition into the intervention, CL-C-2’s scores continued to increase. Intervention scores consistently exceeded baseline scores recorded, allowing for an absence of overlapping data between phases.

CL-C-3 completed the *PGIS-II* seven times, all of which occurred during baseline phase. As CL-C-3 terminated at the end of Fall semester, there is a lack of between phase data points available for analysis and comparison. Therefore, conclusions may not be drawn related to the effectiveness of the intervention on her *PGIS-II* scores.

**OQ-45.2.** As mentioned, probing for client-report data related to changes in symptomology and distress occurred at selected points in time: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session. Of the nine client participants that began the study, three terminated at the conclusion of the Fall 2017 semester and therefore received the *Outcomes Questionnaire-45.2* (OQ-45.2) between two (CL-C-3) and three (CL-A-2, CL-B-3) times, depending on where their counselor-in-training was within phases of the study. The
remaining six clients who completed the study received all five administrations of the assessment. While a causal relationship is not able to be determined as data collection related to this aspect of client outcomes was not continuous (e.g. occurring after each counseling session), trends in data following each administration are helpful in making relational inferences that may inform future research studies.

Results related to OQ-45.2 data will be presented and discussed by individual CIT as score analysis and comparisons will be made in relation to the individual CIT’s movement within phases of the study. An overview of client-reported scores may be viewed in Table 4.2 (Betsy), Table 4.3 (Amelia), and Table 4.4 (Cora). Additionally, a graphical display of total assessment scores across clients for each CIT may be viewed in Figure 4.5 (Betsy), Figure 4.6 (Amelia), and Figure 4.7 (Cora).

**Betsy.** At initial administration of the OQ-45.2, following baseline session one, the mean total score across clients was 64.3 (range = 51 to 83). Following the second administration at week four (intervention session one), mean of total assessment scores showed a slight decrease to 60.3 (range = 51 to 77). At final administration of the OQ-45.2, which occurred during weeks 13 and 14 (final termination) for CL-B-1 and CL-B-2 and during week seven (semester end/termination) for CL-B-3, the mean for total scores was: 49.7 (range = 33 to 66). Further, the mean for total change in scores from initial administration to final administration was: 14.7 (range = -1 to -26); with the degree of change reported by CL-B-2 (-26points) and CL-B-3 (-17) considered to be clinically significant.

**Amelia.** At initial administration of the OQ-45.2, following baseline session one, the mean total score across clients was 53 (range = 50 to 56). Following the second
administration at week six (intervention session one), mean of total assessment scores was 44.3 (range = 37 to 59). Interestingly, total scores for CL-A-1 showed a clinically significant change, with a decrease of 16 points, and total scores reported by CL-A-2 were approaching a significant change, with a decrease of 13 points. However, total scores

Table 4.2 Total client-reported scores on the Outcomes Questionnaire-45.2 for Betsy’s clients at each administration.

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<th></th>
<th>Baseline Session One</th>
<th>Intervention Session One</th>
<th>Semester End/ Termination</th>
<th>Semester Start</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL-B-1</td>
<td>51</td>
<td>53</td>
<td>46</td>
<td>46</td>
<td>50</td>
<td>-1</td>
</tr>
<tr>
<td>CL-B-2</td>
<td>59</td>
<td>51</td>
<td>41</td>
<td>24</td>
<td>33</td>
<td>-26**</td>
</tr>
<tr>
<td>CL-B-3*</td>
<td>83</td>
<td>77</td>
<td>66</td>
<td>-</td>
<td>-</td>
<td>-17**</td>
</tr>
</tbody>
</table>

*Termination occurred at end of Fall 2017 semester

**Clinically significant change > 14pts

Figure 4.5 Total scores reported by Betsy’s clients on the Outcomes Questionnaire-45.2 at each administration.
reported by CL-A-3 showed a slight increase of three points. CL-A-3’s scores showed another increase of six points at the next administration during week seven (*semester end/termination*). Following the semester break, total scores reported by CL-A-3 showed a consistent decrease, with *final termination* scores totaling three points lower than initial administration (baseline session one) scores. At final administration of the *OQ-45.2*, which occurred during week 13 (*final termination*) for CL-A-1 and CL-A-3 and during week seven (*semester end/termination*) for CL-A-2, the mean for total scores was: 37 (range = 28 to 53). Further, the mean for total change in scores from initial administration to final administration was: 37 (range = -28 to -53); with the degree of change reported by CL-A-1 and CL-A-2, both reporting a 22-point decrease between initial and final administration, considered to be clinically significant.

Table 4.3 Total client-reported scores on the *Outcomes Questionnaire-45.2* for Amelia’s clients at each administration.

<table>
<thead>
<tr>
<th></th>
<th>Baseline Session One</th>
<th>Intervention Session One</th>
<th>Semester End/Termination</th>
<th>Semester Start</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL-A-1</td>
<td>53</td>
<td>37</td>
<td>41</td>
<td>43</td>
<td>30</td>
<td>-23**</td>
</tr>
<tr>
<td>CL-A-2*</td>
<td>50</td>
<td>37</td>
<td>28</td>
<td>-</td>
<td>-</td>
<td>-22**</td>
</tr>
<tr>
<td>CL-A-3</td>
<td>56</td>
<td>59</td>
<td>65</td>
<td>59</td>
<td>53</td>
<td>-3</td>
</tr>
</tbody>
</table>

* Termination occurred at end of Fall 2017 semester
**Clinically significant change > 14pts
Figure 4.6 Total scores reported by Amelia’s clients on the Outcomes Questionnaire-45.2 at each administration.

Cora. At initial administration of the OQ-45.2, following baseline session one, the mean total score across clients was 78.3 (range = 73 to 83). As Cora did not enter the intervention phase of this study until week 10, following Fall semester end only two (CL-C-1 and CL-C-2) of the three clients completed the OQ-45.2 following intervention session one at week 11. CL-C-3 terminated at the end of week seven, semester end/termination. The mean scores for baseline session one, excluding CL-C-3 as they did not complete the forms following Cora’s transition to the intervention phase, remained fairly similar to the mean scores presented above. The mean scores for CL-C-1 and CL-C-2 following administration at intervention session one was 60.5 (range = 46 to 75). At final administration of the OQ-45.2, which occurred during week 14 (final termination) for CL-C-1 and CL-C-2, respectively, and during week seven (semester end/termination) for CL-C-3 the mean for total scores was: 60 (range = 45 to 68). Further, the mean for total change in scores from initial administration to final administration was: 18.3 (range
= -11 to -28); with the degree of change reported by CL-C-1 (-16 points) and CL-C-2 (-28) considered to be clinically significant.

Table 4.4 Total client-reported scores on the *Outcomes Questionnaire-45.2* for Cora’s clients at each administration.

<table>
<thead>
<tr>
<th></th>
<th>Baseline Session One</th>
<th>Semester End/ Termination</th>
<th>Semester Start</th>
<th>Intervention Session One</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL-C-1</td>
<td>83</td>
<td>73</td>
<td>79</td>
<td>75</td>
<td>67</td>
<td>-16**</td>
</tr>
<tr>
<td>CL-C-2</td>
<td>73</td>
<td>59</td>
<td>68</td>
<td>46</td>
<td>45</td>
<td>-28**</td>
</tr>
<tr>
<td>CL-C-3*</td>
<td>79</td>
<td>68</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-11</td>
</tr>
</tbody>
</table>

* Termination occurred at end of Fall 2017 semester
** Clinically significant change > 14pts

Figure 4.7 Total scores reported by Cora’s clients on the *Outcomes Questionnaire-45.2* at each administration.
Research Question Three

To answer the question “Is the strength of the therapeutic alliance, as determined by client perception of the presence of counselor (a) empathetic understanding, (b) regard, (c) unconditionality of regard, and (d) congruence (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962]) influenced by counselor-in-training participation in a brief mindfulness intervention?” probing for client-report data related to client perception of the therapeutic alliance occurred at selected points in time: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session. Of the nine client participants that began the study, three terminated at the conclusion of the Fall 2017 semester and therefore received the Barrett-Lennard Relationship Inventory Form OS-40 (BLRI-OS-40) between two (CL-C-3) and three (CL-A-2, CL-B-3) times, depending on where their counselor-in-training was within phases of the study. The remaining six clients who completed the study received all five administrations of the assessment. While a causal relationship is not able to be determined as data collection related to the therapeutic relationship was not continuous (e.g. occurring after each counseling session), preliminary analysis of trends in data following each administration are helpful in making relational inferences that may inform future research studies.

Results related to BLRI-OS-40 client-report data will be presented and discussed by individual CIT as score analysis and comparisons will be made in relation to the CIT’s movement within phases of the study. A full breakdown of client-reported scores, including subscales, may be viewed in Table 4.5 (Betsy), Table 4.6 (Amelia), and Table 4.7 (Cora). Additionally, a graphical display of total assessment scores across clients for
each CIT may be viewed in Figure 4.8 (Betsy), Figure 4.9 (Amelia), and Figure 4.10 (Cora).

**Betsy.** At initial administration of the *BLRI-OS-40*, following *baseline session one*, the mean total score across clients was 70, with total assessments scores ranging from +47 to +86. Within the total score, the mean subscale scores were 21 for empathetic understanding (range = +15 to +24), 20 for level of regard (range = +16 to +24), 16 for unconditionality of regard (range = +9 to +22), and 13 for congruence (range = +7 to +16). Betsy entered the intervention phase at the end of week three, with clients completing the *BLRI-OS-40* during week four. There was an overall increase in total scores following *intervention session one* and an increase in all subscale scores across clients except for the empathetic understanding subscale score reported by CL-B-3, which decreased by two points. Mean of total scores were 81 (range = +59 to +101), 23.3 for empathetic understanding (range = +19 to +29), 22.3 for level of regard (range = +16 to +29), 20.3 for unconditionality of regard (range = +15 to +27), and 15 for congruence (range = +9 to +20). At final administration of the *BLRI-OS-40*, which occurred during weeks 13 and 14 (*final termination*) for CL-B-1 and CL-B-2, respectively, and during week seven (*semester end/termination*) for CL-B-3, the mean for total change in scores from initial administration to final administration were: 28 (range = +13 to +39), 5.7 for empathetic understanding (range = +1 to +10), 6.3 for level of regard (range = +4 to +9), 6.3 for unconditionality of regard (range = +2 to +9), and 9.7 for congruence (range = +6 to +12). Scores reported by Betsy’s clients show a consistent upward trend from initial administration through final administration, except for the small drop in scores reported by CL-B-1 at *semester end/termination*. The total change across all scores remained
Table 4.5 Total scores reported by Betsy’s clients on the *Barrett-Lennard Relationship Inventory-OS-40* at each administration.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Baseline Session One</th>
<th>Intervention Session One</th>
<th>Semester End/Termination</th>
<th>Semester Start</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CL-B-1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathetic Understanding</td>
<td>15</td>
<td>19</td>
<td>15</td>
<td>24</td>
<td>25</td>
<td>+10</td>
</tr>
<tr>
<td>Regard</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>21</td>
<td>25</td>
<td>+9</td>
</tr>
<tr>
<td>Unconditionality of Regard</td>
<td>9</td>
<td>15</td>
<td>10</td>
<td>13</td>
<td>18</td>
<td>+9</td>
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<td>+11</td>
</tr>
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<td><strong>Total</strong></td>
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<td><strong>59</strong></td>
<td><strong>53</strong></td>
<td><strong>75</strong></td>
<td><strong>86</strong></td>
<td><strong>+39</strong></td>
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<tr>
<td><strong>CL-B-2</strong></td>
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<td></td>
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<tr>
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<td>29</td>
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<td>30</td>
<td>30</td>
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<tr>
<td>Regard</td>
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<td>29</td>
<td>30</td>
<td>30</td>
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<td>+6</td>
</tr>
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<td>16</td>
<td>23</td>
<td>22</td>
<td>28</td>
<td>+12</td>
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<td><strong>118</strong></td>
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<td></td>
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<td>Empathetic Understanding</td>
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<td>22</td>
<td>25</td>
<td>-</td>
<td>-</td>
<td>+1</td>
</tr>
<tr>
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<td>24</td>
<td>-</td>
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<td>19</td>
<td>-</td>
<td>-</td>
<td>+2</td>
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<td>Congruence</td>
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<td>20</td>
<td>22</td>
<td>-</td>
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<td>+6</td>
</tr>
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<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td><strong>83</strong></td>
<td><strong>90</strong></td>
<td>-</td>
<td>-</td>
<td><strong>+13</strong></td>
</tr>
</tbody>
</table>

* Termination occurred at end of Fall 2017 semester
Figure 4.8 Total scores reported by Betsy’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration.

relatively small, with the largest change reported in client’s perception of Betsy’s congruence.

Amelia. At initial administration of the BLRI-OS-40, following baseline session one, the mean total score across clients was 43.7. However, there was large variability across Amelia’s clients with total assessments scores ranging from +2 to +83. Within the total score, the mean subscale scores were 14.7 for empathetic understanding (range = +5 to +24), 17.3 for level of regard (range = +10 to +28), 6.7 for unconditionality of regard (range = -5 to +15), and 5 for congruence (range = -8 to +21). There was a notable increase in scores following intervention session one which occurred at week 6; mean of total scores was 80.3 (range = +59 to +105), 23.7 for empathetic understanding (range = +23 to +25), 23.7 for level of regard (range = +17 to +30), 17 for unconditionality of regard (range = +6 to +27), and 16 for congruence (range = +1 to +24). Interestingly, all subscales scores were higher during this second administration except for the
Table 4.6 Total scores reported by Amelia’s clients on the *Barrett-Lennard Relationship Inventory-OS-40* at each administration.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Baseline Session One</th>
<th>Intervention Session One</th>
<th>Semester End/Termination</th>
<th>Semester Start</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Empathetic Understanding</td>
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<td>25</td>
<td>26</td>
<td>28</td>
<td>30</td>
<td>+6</td>
</tr>
<tr>
<td>Regard</td>
<td>28</td>
<td>30</td>
<td>23</td>
<td>29</td>
<td>29</td>
<td>+1</td>
</tr>
<tr>
<td>Unconditionality of Regard</td>
<td>10</td>
<td>27</td>
<td>27</td>
<td>26</td>
<td>28</td>
<td>+18</td>
</tr>
<tr>
<td>Congruence</td>
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<td>23</td>
<td>23</td>
<td>27</td>
<td>26</td>
<td>+5</td>
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<td><strong>105</strong></td>
<td><strong>99</strong></td>
<td><strong>110</strong></td>
<td><strong>113</strong></td>
<td><strong>+30</strong></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
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<td>5</td>
<td>23</td>
<td>27</td>
<td>-</td>
<td>-</td>
<td>+22</td>
</tr>
<tr>
<td>Regard</td>
<td>10</td>
<td>17</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td>+10</td>
</tr>
<tr>
<td>Unconditionality of Regard</td>
<td>-5</td>
<td>18</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>+24</td>
</tr>
<tr>
<td>Congruence</td>
<td>-8</td>
<td>1</td>
<td>9</td>
<td>-</td>
<td>-</td>
<td>+10</td>
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<tr>
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<td><strong>75</strong></td>
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<td><strong>+73</strong></td>
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<td></td>
</tr>
<tr>
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<td>23</td>
<td>25</td>
<td>26</td>
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<td>+11</td>
</tr>
<tr>
<td>Regard</td>
<td>14</td>
<td>24</td>
<td>26</td>
<td>27</td>
<td>27</td>
<td>+13</td>
</tr>
<tr>
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<td>+18</td>
</tr>
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<td><strong>Total</strong></td>
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<td><strong>77</strong></td>
<td><strong>86</strong></td>
<td><strong>88</strong></td>
<td><strong>92</strong></td>
<td><strong>+46</strong></td>
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</tbody>
</table>

* Termination occurred at end of Fall 2017 semester
unconditionality of regard subscale score reported by CL-A-3, which decreased by nine points and remained lower than the initial administration score until the final termination administration. At final administration of the *BLRI-OS-40*, which occurred during week 13 (final termination) for CL-A-1 and CL-A-3 and during week seven (semester end/termination) for CL-A-2, the mean for total change in scores from initial administration to final administration were: 49.7 (range = +30 to +73), 39 for empathetic understanding (range = +6 to +22), 8 for level of regard (range = +1 to +13), 15.3 for unconditionality of regard (range = +4 to +24), and 11 for congruence (range = +5 to +18). While there was a marked increase in total assessment scores from baseline session one to intervention session one, with CL-A-2’s scores showing the most dramatic increase of the three clients, scores remained relatively stable with only moderate increases over the remaining administrations of the *BLRI-OS-40*.
Cora. At initial administration of the BLRI-OS-40, following baseline session one, the mean total score across clients was 63, with total assessments scores ranging from +54 to +72. Within the total score, the mean subscale scores were 16.7 for empathetic understanding (range = +11 to +22), 19.7 for level of regard (range = +16 to +23), 13 for unconditionality of regard (range = +11 to +17), and 13.7 for congruence (range = +9 to +18). As Cora did not enter the intervention phase of this study until week 10, following Fall semester end only two (CL-C-1 and CL-C-2) of the three clients completed the BLRI-OS-40 following intervention session one at week 11; CL-C-3 terminated at the end of week seven, semester end/termination. The mean scores for baseline session one, excluding CL-C-3 as they did not complete the forms following Cora’s transition to the intervention phase, remained fairly similar to the mean scores presented above: 67.5 (total), 19.5 (empathetic understanding), 18 (level of regard), 14 (unconditionality of regard), and 16 (congruence). The mean scores following administration at intervention session one was 110.5 (range = +102 to +119) for the total of all subscales, 27.5 for empathetic understanding (range = +25 to +30), 28 for level of regard (range = +26 to +30), 26.5 for unconditionality of regard (range = +24 to +29), and 28.5 for congruence (range = +27 to +30). At final administration of the BLRI-OS-40, which occurred during week 14 (final termination) for CL-C-1 and CL-C-2, respectively, and during week seven (semester end/termination) for CL-C-3 the mean for total change in scores from initial administration to final administration were: 43 (range = +24 to +57), 10.7 for empathetic understanding (range = +8 to +13), 9.7 for level of regard (range = +5 to +14), 10.7 for unconditionality of regard (range = +0 to +19), and 12 for congruence (range = +8 to +16). Overall, a marked increase in total BLRI-OS-40
Table 4.7 Total scores reported by Cora’s clients on the Barrett-Lennard Relationship Inventory-OS-40 at each administration.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Baseline Session One</th>
<th>Semester End/ Termination</th>
<th>Semester Start</th>
<th>Intervention Session One</th>
<th>Final Termination</th>
<th>Total Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CL-C-1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathetic Understanding</td>
<td>22</td>
<td>27</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>+8</td>
</tr>
<tr>
<td>Regard</td>
<td>16</td>
<td>30</td>
<td>28</td>
<td>30</td>
<td>30</td>
<td>+14</td>
</tr>
<tr>
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<td>23</td>
<td>25</td>
<td>29</td>
<td>30</td>
<td>+19</td>
</tr>
<tr>
<td>Congruence</td>
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<td>29</td>
<td>27</td>
<td>30</td>
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<td>+16</td>
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<td>110</td>
<td>119</td>
<td>120</td>
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</tr>
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<tr>
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<td>25</td>
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<td>+13</td>
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<tr>
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<td>+13</td>
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<td>Congruence</td>
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<td>26</td>
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<td>+12</td>
</tr>
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<td><strong>Total</strong></td>
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<tr>
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<tr>
<td>Unconditionality of Regard</td>
<td>11</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Congruence</td>
<td>9</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>54</td>
<td>78</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+24</td>
</tr>
</tbody>
</table>

* Termination occurred at end of Fall 2017 semester
scores is visible between the first two administrations of the assessment. Of the two clients who returned for counseling sessions in the Spring 2018 semester, overall scores remained consistent despite the five-week lapse due to the University break.

**Interobserver Agreement**

It is recommended that Interobserver agreement (IOA) be assessed for using 20-33% of observations within each phase, with a minimum of 80% IOA recommended as a cut-off to ensure validity of results (Ayers & Gast, 2010; Kazdin, 2011). The observed occurrences of dispositional expressions, as operationally defined for this study, were recorded and IOA was calculated using a frequency ratio (Kazdin, 2011). Frequency ratio is computed by dividing the smaller total by the larger total and then multiplying this number by 100 to form a percentage. This percentage indicates the consistency of which the target behavior was observed. Frequency recording was used when observing occurrences of empathetic understanding and level of regard, while whole interval
recording was used when observing for congruence. While the method of recording varied among the dispositions being investigated, the same frequency ratio calculation was used to determine degree of IOA.

A team of three observers; the primary researcher and two independent observers who were blinded to the study conditions, acted as both primary and secondary observers at various times throughout the investigation. During the first seven weeks, the two independent observers served as primary and secondary observers to each other. As there were up to nine counseling session recording requiring review each week, splitting the observations between the two independent observers was required to obtain quick returns of data so that analysis may remain continuous. The primary researcher acted as observer minimally during the first seven weeks of data collection though was required to act as a primary observer during the second half of data collection as one of the independent observers left the study. During this time, the remaining independent observer continued to act as a secondary observer for IOA data collection. To mediate the effects of potential bias, IOA data points for each participant and phase were randomly selected using the random sort function in Microsoft Excel.

IOA data was collected for 37.5% of Betsy’s baseline sessions and 31.8% of total intervention sessions. For Amelia, IOA data was collected for 30.8% of baseline sessions and 29.4% of total intervention sessions. Finally, IOA data was collected for 30.8% of Cora’s baseline sessions and 37.5% of total intervention sessions.

Across dispositions, participants, and phases, IOA remained above the recommended 80% cutoff for all except Amelia and Cora’s baseline phases measuring level of regard, where IOA fell to 78.7% and 74.9%, respectively. Notably, while most
IOA data exceeded 80%, ranges indicate that IOA data showed greater variability during baseline phases for all participants. During this time IOA was closely monitored and observer training sessions were occurring weekly. As the study progressed, IOA data showed less variability and more stability across participants. See Table 4.8 for IOA data and ranges collected throughout the investigation.

Table 4.8 Interobserver agreement data for baseline and intervention phases of the study.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Empathetic Understanding</th>
<th>Level of Regard</th>
<th>Congruence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IOA (%)</td>
<td>Range</td>
<td>IOA (%)</td>
</tr>
<tr>
<td>Betsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>87.3</td>
<td>75-100</td>
<td>82.3</td>
</tr>
<tr>
<td>I</td>
<td>81.9</td>
<td>0-100</td>
<td>87.4</td>
</tr>
<tr>
<td>Amelia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>81.2</td>
<td>60-100</td>
<td>78.7</td>
</tr>
<tr>
<td>I</td>
<td>82.2</td>
<td>50-100</td>
<td>83.2</td>
</tr>
<tr>
<td>Cora</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>82.4</td>
<td>50-100</td>
<td>74.9</td>
</tr>
<tr>
<td>I</td>
<td>81.6</td>
<td>71.4-90</td>
<td>82</td>
</tr>
<tr>
<td>Overall</td>
<td>B/I</td>
<td>82.8</td>
<td>0-100</td>
</tr>
</tbody>
</table>

Treatment Integrity

Treatment integrity, or intervention fidelity, refers to the degree to which the procedures described for the intervention phase were implemented across participants (Gast, 2010). Differences in intervention implementation may result in variability of outcome and loss of reliability in results (Kazdin, 2011). To determine the degree of
intervention fidelity, a random selection of 25% of video recorded intervention sessions were selected using the random sort function in Microsoft Excel. Of the potential 12 recorded intervention sessions, two were eliminated from the random sort due to incomplete recording of the intervention and one was eliminated due to recording device malfunction resulting in a lack of video recording for that session. Of the remaining nine recorded intervention sessions, four were randomly selected for review.

The recorded intervention sessions were then reviewed by an outside observer, who had not previously been involved with the study, using the Intervention Fidelity Checklists for each intervention session (see Appendix H-K). To determine the percentage of treatment integrity, the number of observed events were divided by the number of planned events and then this number will by multiplied by 100. Intervention fidelity was calculated at 100% for all each intervention session, allowing for an overall intervention fidelity of 100%.

**Social Validity**

To determine the social validity of the intervention, counselor-in-training participants were asked to complete a post-intervention questionnaire after the completion of the study. Use of questionnaires and surveys is considered an appropriate method for collecting participant perceptions when attempting to determine social validity of the intervention or procedures of the study (Gast, 2010). The questionnaire used in this study was created by the researcher to ascertain participants thoughts and perceptions of the intervention, not to determine the effectiveness of the intervention on the dependent variables (Kazdin, 2011). Social validity of an intervention demonstrates how accepted and well-liked that intervention was by the participants. An intervention
with high social validity is more likely to be completed with fidelity and replicated following completion of the study. As mindfulness is a practice, with the benefits of mindfulness growing with continued practice, social validity of the intervention may predicate continued use and practice. The social validity of the intervention does not assess for intervention effectiveness (Kazdin, 2011). Of the three counselor-in-training participants, all completed and returned the questionnaires.

The questionnaire consisted of seven questions as well as a space for additional thoughts or opinions related to the intervention. Questions 1-3 sought to obtain information related to whether the participants liked and found value from participating in the intervention. Participants answered using a five-point Likert scale ranging from 1(not at all) to 5(very much), with an overall mean rating of 4.6 ($M = 4.6$, range = 4 to 5). Questions 4 and 5 sought to obtain information related to participants’ future use and engagement with the skills learned during the intervention. Participants answered using a five-point Likert scale ranging from 1(not likely) to 5(very likely), with an overall mean rating of 4 ($M = 4$, range = 3 to 5). Questions 6 and 7 were questions related to whether they would participate in the intervention again and whether they would recommend the intervention to others. Questions were answered by stating “Yes”, “No”, or “Maybe”. All three participants stated “Yes” they would participate in the intervention again, with two participants stating that they would recommend the intervention to others and one participant stating they would maybe recommend the intervention to others. Finally, in the area available to leave additional comments, when referencing the intervention, one participant stated that they would have enjoyed practicing “staying mindful of self and other” within a group format as well as the individual format this intervention followed.
Another participant stated that while recording of her mindfulness activities decreased as the intervention went on, she:

…started being more mindful throughout my day, and in my conversations with people in general. I truly believe that incorporating mindfulness in my daily routine has decreased my overall anxiety and increased my self-efficacy toward my career in counseling.

The full questionnaire may be viewed in Appendix O.

**Chapter Summary**

Chapter Four presented the results of the analyses procedures which included discussion of: (a) visual analysis of data, (b) interobserver agreement, (c) procedural fidelity, and (d) social validity of the intervention. Chapter Five includes a discussion of the results, recommendations for future research, implications for counselor preparation, and limitations of the study.
CHAPTER FIVE: DISCUSSION

Chapter Five includes a summary of the investigation, including the purpose, the research methodology, and the results. Conclusions drawn from the results will be discussed, along with limitations of the study, and implications for future research and counselor preparation presented.

Summary of the Study

The purpose of this research study was to measure the effect of a brief mindfulness intervention on counselors’-in-training facilitative dispositions of: (a) empathetic understanding, (b) level of regard, (c) unconditionality of regard, and (d) congruence (as observed through weekly in-session engagement with clients). In addition, the investigation examined the effects of counselors-in-training participation in a brief mindfulness intervention on client outcomes (as measured by the Personal Growth Initiative Scale-II; [Robitschek et al., 2012] and the Outcomes Questionnaire-45.2; [Lambert et al., 1996]) and the influence of counselor-in-training engagement with mindfulness on clients’ perception of the strength of the therapeutic alliance (as measured by the Barrett-Lennard Relationship Inventory Form OS-40; [Barrett-Lennard, 1962, 2015]). More specifically, this study analyzed the effect of mindfulness education and engagement in mindfulness activities on the in-session occurrences of counselor-in-training expressions of additive empathetic understanding, subtractive empathetic understanding, positive regard, negative regard, the unconditionality of their regard,
congruence, and incongruence, as well as the effect of counselor-in-training engagement in mindfulness education and mindfulness activities on client outcomes.

While the strength of the therapeutic alliance has been found to account for the largest portion of intra-therapeutic outcome variance (30%; Norcross & Lambert, 2011), and from the time Carl Rogers (1957) put forth his “necessary and sufficient conditions”, a strong therapeutic alliance is believed to be built upon counselor empathy, counselor unconditional positive regard, and counselor congruence. Building upon Rogers’ foundational work, Barrett-Lennard (1962) asserted that Rogers’ conditions may be better conceptualized as personal attributes held by the clinician and perceived to exist within the counselor by the client, rather than change producing mechanism of the therapeutic process as asserted by Rogers. Further, as perception is guided by the interaction of an individual’s personality characteristics and personal attributes with those of another, the conditions of empathetic understanding, congruence, level of regard, and unconditionality of regard are better understood as counselor attributes or dispositions (Barrett-Lennard, 1962). Furthermore, as therapies becomes less purist and more integrative in nature (Norcross & Goldfried, 2006; Norcross, 2005), it may be imperative that counselor training programs attend more heavily to the dispositional qualities of a counselor that prove conducive to the formation of an effective therapeutic alliance (Lambert, 1992; Messer & Wampold, 2002; Norcross & Lambert, 2011). Therefore, exploring effective methods of cultivating such dispositional qualities in counselors for the purpose of enhancing client outcomes is warranted.

CACREP accredited training programs are required to assess and evaluate students for professional dispositions as a component of student progress and gatekeeping
(Section 4, Standard B, G), however it appears that while counselor training programs continue to produce skillful and technically competent clinicians, there is less attention on the cultivation of students’ cognitive and dispositional development (Greason & Cashwell, 2009; Greason & Welfare, 2013; Miller et al., 2013; Roach & Young, 2007). And, as the counselor is responsible for implementing treatments and obtaining positive outcomes, it is logical to view the counselor, more specifically the person of the counselor (McConnaughy, 1987), as a form of treatment that also requires attention and facilitative cultivation. Therefore, identification of empirically-tested methods of dispositional cultivation will serve to support the continued advancement of the counseling field by producing clinicians who are both technically-competent and who embody the dispositions required to cultivate strong therapeutic alliances able to produce the greatest degree of positive client change.

In recent years, the use of mindfulness to enhance counseling skills self-efficacy (Buser et al., 2012) and cultivate various facilitative dispositions (Campbell & Christopher, 2012; Duffy et al., 2017) have shown promising results. However, many studies investigating dispositions such as empathy, regard, and congruence are correlational (Greason & Cashwell, 2009; Greason & Welfare, 2013), therefore a causal relationship cannot be determined. Additionally, while several qualitative studies Campbell & Christopher, 2012; Christopher et al., 2006; Duffy et al., 2017) have offered rich descriptions of the experiences of counselors-in-training who have engaged in mindfulness practice, they are retrospective by nature and do not account for observable or in-session behavior, or client outcome, as a result of their mindfulness practice. The second edition of the Task Force on Evidence-Based Therapy Relationships (Norcross &
Wampold, 2011) noted this scarcity of research related to counselor attributes and client outcome. The authors emphasized the need to move beyond correlational research designs when investigating counselor relationship behaviors and counselor contributions to client outcome; encouraging researchers to become familiar with methodologies that will allow for the exploration of complexities inherent to counselor variables, client variables, and outcome.

This study attempted to address Norcross & Wampold’s concerns related to a lack of research exploring the impact of counselor attributes on client outcome by using a concurrent multiple baseline single case research design to isolate the effects of counselor-in-training engagement with mindfulness on their facilitative dispositions and client outcome. Throughout baseline and intervention, participant in-session engagement with clients were observed and coded for occurrences of the dispositions under investigation. Clients completed an assessment of outcome, *Personal Growth Initiative Scale-II* [Robitschek et al., 2012], following each session. Supplemental assessments of client perception of the therapeutic alliance (*Barrett-Lennard Relationship Inventory Form OS-40;* Barrett-Lennard, 1962, 2015) and outcomes (*Outcomes Questionnaire-45.2;* Lambert et al., 1996) were completed at selected times throughout the study: (a) baseline session one, (b) intervention session one, (c) fall semester end, (d) spring semester start, and (e) termination session. Data collection was conducted from October 2017 through March 2018. This study was approved by the University of South Carolina’s Institutional review Board.
Participant Demographics

The sample for this study included three counselors-in-training and nine clients. The counselors-in-training were enrolled in the Marriage, Couples, and Family Counseling \((n = 2)\) and School Counseling \((n = 1)\) tracks of a CACREP-accredited graduate counseling program at a large university in the Southeast. The counselors-in-training were in the clinical experiences portion of their training (e.g. practicum and internship) during the entirety of this investigation. The nine clients were all currently enrolled undergraduate students of the university who were enrolled in counseling minor courses during the Fall 2017 semester. While all nine clients continued their participation in the study through the end of the Fall 2017 semester, three clients were unable to continue due to graduation \((n = 1)\), lack of scheduling availability \((n = 1)\), and referral for additional services \((n = 1)\). The remaining six clients remained in the study through data collection completion.

All three counselors-in-training identified as White/non-Hispanic, cisgender females, with a mean age of 30 years (range = 23 to 43). Of the total client sample \((N = 9)\), the majority identified as cisgender females \((n = 8)\) with one participant identifying as “other”. One participant identified as biracial (Asian American and Native American), while the remaining eight participants identified as Caucasian/White (non-Hispanic). The mean age for the sample was 20.7 years (range = 19 to 23). All clients were currently enrolled undergraduates, four were seniors, four were juniors, and one was a sophomore.

Methods

This study used a concurrent multiple baseline across-participants single-case research design to investigate the research questions. Use of multiple baseline SCRD was
appropriate for this study as it allowed for isolation of the intervention effect on the primary dependent variables (dispositions) while also replicating results across participants to increase validity of the results (Gast, 2010; Heppner et al., 2008; Kazdin, 2011). Further, through use of a multiple baseline design, all changes to the dependent variables were able to be closely observed and analyzed for effect. While single case research is often used when studying obvious and overt behaviors, and this study was investigating less discrete constructs, the inherent nature of the design offered the continuous and detailed observation and analysis required of this study. As this investigation was measuring the effect of engagement in mindfulness, a skill that encompasses many internal cognitive and emotional processes, on counselor-in-training dispositions, also considered to be internal processes that may be accompanied by overt behavioral expressions, the detailed analysis of data was required to draw conclusions related to the effectiveness of the intervention.

Data collection was continuous and consisted of 14 weeks of scheduled counseling sessions separated by a five-week university break. Seven weeks of data collection occurred during the second half of the Fall 2017 semester and the remaining seven weeks of data collection occurred during the beginning half of the Spring 2018 semester. During the Fall 2017 data collection period, each counselor-in-training was randomly assigned three clients with whom they met for weekly counseling sessions. Due to attrition, each counselor-in-training continued seeing two clients weekly during the Spring 2018 data collection period. Across the 14 weeks of data collection, a total of 101 counseling sessions were scheduled between the three counselor-in-training participants, of which clients attended 94, for a session adherence rate of 93%. All scheduled
counseling and intervention sessions were held on the same day of the week, at the same
time of day, and within the same University counseling clinic room when possible.

During baseline, counselors-in-training met with their clients for weekly 50-
minute counseling sessions. Video recordings of sessions were then reviewed by trained
observers and coded for occurrences of the dispositions being investigated. During
intervention, counselors-in-training continued meeting with their clients for weekly 50-
minute counseling sessions, which were then reviewed and coded by trained observers.
Counselors-in-training also individually participated in a two-phase mindfulness
intervention led by the primary researcher. During the first phase, guided practice,
counselors-in-training attended four 75-minute mindfulness sessions over the course of
two weeks. Following the fourth guided intervention session, counselors-in-training
transitioned into phase two; independent practice. During both the guided and
independent practices, counselors-in-training recorded their daily mindfulness activities
and returned their logs to the researcher each week.

**Discussion of the Results**

The results of this investigation, originally presented in Chapter Four, are further
discussed below. Comparisons between the results of this investigation and earlier
research related to mindfulness, counselor dispositions, and client outcome, outlined in
Chapter Two, will also be made. Finally, conclusions and inferences drawn from the
results of each research question will be presented.

**Empathetic Understanding**

Across participants, phase levels showed a two-to-three-point increase between
baseline and intervention for occurrence of additive empathetic understanding. Further,
across participants, data showed increased stability and less variability between baseline and intervention phases. The results indicate that counselors-in-training were demonstrating more observable expressions of additive empathetic understanding at a more stable rate following their participation in the mindfulness intervention. As a demonstration of effect, across participants, there is a one- to three- point increase in data point values directly following the introduction of the intervention. While this effect size is relatively small, when considering the nature of dispositions as being related to an individual’s personal characteristics and personality, both of which are considered to be considerably stable constructs, the expectation of large or immediate change may not be realistic. As this study is the only known investigation to measure the effect of mindfulness on dispositions using direct observation, a comparison with existing knowledge is not possible.

Regarding occurrences of subtractive empathetic understanding, a one- to five-point decrease in phase level was observed across participants. While the presence of a treatment effect was observed in both Betsy and Cora’s data, there was a lack of effect observed in Amelia’s data. Therefore, a conclusion of causality based on the presence of three basic effects at three distinct points in time cannot be made regarding mindfulness and subtractive empathetic understanding.

However, the presence of an observable intervention effect in each participants’ additive empathetic understanding data so soon after intervention may warrant a discussion of the possible relationship between additive empathetic understanding and the content of the first two guided intervention sessions. During the first two sessions, the foundations of mindfulness were presented along with the attitudinal qualities of non-
judgement, patience, and beginner’s mind. When comparing the definitions of these attitudinal qualities with the definitions and clarifiers used to identify and record occurrences of additive empathetic understanding, connections may be made in relation to the practice of setting aside of presumptions, pre-existing knowledge, and evaluation (via mindfulness) so that one may seek to more fully understand and experience the content of another person’s experience without projection of one’s own experience (via additive empathetic understanding). The finding that additive empathetic understanding increased following counselor-in-training engagement in mindfulness supports prior findings of a positive relationship between mindfulness and empathy (Fulton, 2005; Greason & Cashwell, 2009) and the inferences presented through qualitative studies of counselor-in-training participation in mindfulness (Campbell & Christopher, 2012).

**Level and Unconditionality of Regard**

Across participants, a one- to three- point change in level was observed between phases for occurrences of positive regard. Similar to additive empathetic understanding, data showed increased stability and less variability between baseline and intervention phases. The results indicate that counselors-in-training were demonstrating more observable expressions of positive regard at a more consistent rate following their participation in the mindfulness intervention. While each participants’ data showed the presence of a basic treatment effect following introduction of the intervention, ranging from a one- to three- point increase in data point values, there are also higher rates of overlapping data across participants. The high degree of overlapping data across phases may be due, in part, to the increased variability in data during baselines, with increased stabilization occurring during the intervention phases for each participant. As with the
effect size noted for additive empathetic understanding, this size of the effect is relatively small. However, as noted earlier, the nature of the constructs must be considered when interpreting change and latency of change. Further, as this study is the only known investigation to measure the effect of mindfulness on dispositions using direct observation, a comparison of effect with existing knowledge is not possible.

Regarding occurrences of negative regard, a two- to two and half- point decrease in phase level was observed across participants. While the presence of a treatment effect was observed in both Amelia and Cora’s data, there was a lack of effect observed in Betsy’s data. Therefore, a conclusion of causality based on the presence of three basic effects at three distinct points in time cannot be made regarding mindfulness and negative regard. Further, as unconditionality of regard was assessed through comparing the rates of occurrence for positive and negative regard, and a shift in conditionality of regard appears to have taken place as rates of occurrence for both positive and negative regard appeared to stabilize or continue on a decreasing (negative regard) or increasing (positive regard) path following introduction, a causal relationship is challenging to ascertain due to the absence of three distinct treatment effects for both positive and negative regard across participants.

A closer look at the data points directly following the introduction of the intervention indicate an increase in the final data point for positive regard prior to their transition into the independent practice phase of the intervention. This is interesting as the attitudinal qualities presented during the fourth and final guided intervention session were acceptance and letting go, with a guided loving-kindness meditation practiced that emphasized acceptance of self and others. When comparing the definitions of these
attitudinal qualities with the definitions and clarifiers used to identify and record
occurrences of positive regard, connections may be made in relation to the practice of
accepting self, people, and situations as they are through releasing expectation for
what/who they should be (via mindfulness) so that one may more readily offer love,
warmth, and appreciation for events or to self/others (via positive regard). The finding
that positive empathy increased following counselor-in-training engagement in
mindfulness supports the inferences presented through qualitative studies of counselor-in-
training participation in mindfulness (Campbell & Christopher, 2012).

**Congruence**

Conclusions related to the presence of a causal relationship between mindfulness
and congruence or incongruence are not able to be fully interpreted. While an overall
reduction in the variability of data reflective of both congruence and incongruence is
observable across participants following the introduction of the intervention, the high
degree of variability across participants and phases does not allow for accurate inferences
regarding congruence or incongruence to be made. The difficulty in drawing conclusions
may be due to the low number range of occurrences, between 0-3, making stability of
data difficult to attain and change difficult to observe. Further the nature of congruence,
as a disposition that generally accompanies another rather than as presenting by itself, can
create confusion and ambiguity in the observation process. As direct observation of
occurrences of congruence has not been presented in prior literature, there is uncertainty
related to best methods of observational measurement.
Client Perception of the Therapeutic Alliance

Data related to clients’ perceptions of the therapeutic alliance was not collected continuously throughout baseline and intervention phases, and therefore a functional relationship cannot be determined as threats to internal validity cannot be ruled out. However, several trends emerged in the data that may offer support for existing knowledge related to mindfulness and client perception of the therapeutic alliance. Further, data trends discussed below may also serve to support the data collection process used throughout this investigation.

Scores reported by Betsy’s clients demonstrated a gradual and consistent upward trend; absent of large changes that are present in the client-report scores of other counselors-in-training. Betsy’s dispositional data obtained from review of her recorded counseling sessions was also the most stable, lacking large variability, of the three counselors-in-training. Further, scores obtained from Amelia’s clients indicate high variability across client perception of the facilitative dispositions under investigation. When reviewing early baseline data obtained through review of video recorded counseling sessions, Amelia’s data is also reflective of high variability across dispositions. The similarities across client-report data and observer recorded data may offer support for the validity of operational definitions used throughout this investigation as well as support for the use of the BLRI-OS-40 (Barrett-Lennard, 1962) to assess for client perception of the therapeutic alliance. Further, similarity across client and observer data may also indicate that direct observation of counselors’ in-session dispositional expressions is a reliable method of measurement and gatekeeping during counselor training and preparation.
Client Outcomes

As noted in Chapter Four, two methods of obtaining client-report data were used. The first, the *Personal Growth Initiative Scale-II* (PGIS-II; Robitschek et al., 2012), is a measure of personal growth and was administered to clients following all counseling sessions in an effort to draw causal conclusions related to the effect of counselor engagement in mindfulness on client outcomes. The second, the *Outcomes Questionnaire-45.2* (OQ-45.2; Lambert et al., 1996), is a measure to assess change in distress and symptomology and was administered at pre-determined points in time and data was used to supplement findings related to client outcome.

Regarding data obtained from the *PGIS-II*, results indicate that a functional relationship exists between counselor-in-training participation in the mindfulness intervention and client outcome as it relates to personal growth initiative. The degree of change following introduction of the intervention varies across clients, though an observable increase in client scores is present; thereby allowing a causal relationship to be interpreted. These findings support the results of prior studies investigating counselor mindfulness and client outcome (Grepmair et al., 2007). Interestingly, data obtained from the *PGIS-II* is reflective of the nature of dispositional expression data recorded by observers and the nature of the data collected from the administrations of the *BLRI-OS-40*. As with observational data and data obtained from the *BLRI-OS-40*, Betsy’s clients reported growth that was the most stable, lacking large variability, of the three counselors-in-training. While Amelia’s clients’ scores continue to show the most variability across phases.
Data obtained from the *OQ-45.2* was not collected continuously throughout baseline and intervention phases, therefore a functional relationship between mindfulness and changes in distress and symptomatology cannot be determined. However, analysis of trends in data following each administration may be helpful in making relational inferences that may then inform future research studies. Across clients, scores demonstrated flat or downward trends, though how much of the change in client scores was a result of the intervention or other extraneous variables is unable to be ascertained. Unlike data collected through the *PGIS-II, BLRI-OS-40*, and direct observation; data collected from the *OQ-45.2* does not align in a comparable manner. For example, when comparing CL-C-1’s baseline session scores (Table 4.7), she reported an overall *OQ-45.2* score of clinical significance; 83. However, her reported score on the *PGIS-II*, 58, was the third highest score across clients; exceeded only by CL-B-2 (59) and CL-A-1 (61). Total *OQ-45.2* score reported by CL-B-2 was 59, while total score reported by CL-A-1 was 53; both below the clinical significance score of 63. Similar trends may be viewed in *OQ-45.2* scores reported by CL-B-3 and CL-C-3.

**Social Validity**

Data reflective of counselors’-in-training thoughts and opinions related to the intervention was collection after completion of the investigation using the *Post-Intervention Follow-Up Questionnaire*. Results of this questionnaire indicate that all three participants liked and found value in the intervention and would likely use the skills learned from their participation in the future. Further, all three counselors-in-training indicated that they would participate in the intervention again. Responses indicate that the intervention was both useful and relevant to the participants. This finding is further
supported by the entries on counselors’-in-training Daily Mindfulness Activity Logs. Entries indicate that counselors-in-training continued to engage in mindfulness activities throughout their time in the independent practice phase of the intervention. While frequency of practiced decreased from daily practice, as was required during the guided practice phase of intervention, logs indicate consistent engagement in mindfulness activities each week.

**Limitations**

While the results of this study offer meaningful results, limitations exist that should be considered during interpretation and replication. First, this was the first study to measure the effect of a mindfulness intervention on the observable expressions of facilitative dispositions. While this study shows promise when utilizing direct observation of counselors-in-training, generating operational definitions for dispositions that are specific enough to ensure accuracy of measurement, as is required by single case research, while remaining broad enough to capture the spirit of the dynamic and interactional nature of counseling is challenging. Furthermore, as many of the constructs measured in counseling research are internal to the individual, rather than distinct and overt behavioral expressions, identifying instances of occurrence may prove difficult to do when using direct observation as a method of data collection. The challenge of operationally defining such internal constructs for accurate observation and measurement may be reflected in the percentages of Interobserver Agreement (IOA) collected throughout this investigation. While all but two scores met or exceeded the 80% agreement threshold (Kratochwill et al., 2010), there was wide variability in raw scores as is noted in the ranges for each IOA%.
Limitations related to the sample used in this study include the homogenous nature of the sample. All three counselors-in-training identified as White/non-Hispanic cisgender females, while 89% \( (n = 8) \) of clients identified as White/non-Hispanic and 89% \( (n = 8) \) of clients identified as cisgender females. Further, while purposive sampling was required to uphold a high degree of experimental control, this did limit the sample to individuals from one university in the Southeast which may not be representative of other counseling programs or regions.

Regarding instruments used to collect client-report data; while the *Barrett-Lennard Relationship Inventory Form OS-40* (BLRI; Barrett-Lennard, 1962) and the *Outcomes Questionnaire-45.2* (OQ-45.2; Lambert et al., 1996) are readily used instruments within counseling research, each with numerous studies reporting strong psychometrics, the *Personal Growth Initiative Scale-II* (PGIS-II; Robitschek et al., 2012) is a less common assessment with limited research. However, within the available research discussed in Chapter Three, strong psychometric properties were identified when tested on populations that were similar to that of this investigation. Further, as is inherent when using self-report measures, the potential for malingering and responding in what be viewed as a socially desirable manner exist.

A final limitation includes that time frame this study was conducted in. While fourteen weeks was sufficient to collect data across participants, adherence to a university schedule introduced unique challenges. For example, the lapse in data collection that occurred during the semester break had the potential to introduce threats to internal validity that may not have existed otherwise. Also, counselors-in-training were matriculating through their practicum and internship phases of clinical training. The
nature of their training offers the potential for maturation. However, the effects of maturation may have been mediated as counselors-in-training did not enter baseline at the beginning of their clinical experience training. Instead, counselors-in-training entered baseline midway through their practicum experience and completed the study midway into their internship experience.

**Implications**

This study sought to measure the effects of mindfulness on counselor dispositions and client outcome. The results of this study offer empirical support that counselor-in-training engagement in mindfulness is an effective method of cultivating the dispositions of additive empathetic understanding and positive regard, while also enhancing client outcomes. Further, analysis of data across participants, clients, and measurement systems offers support for the valuable role the counselor plays in obtaining positive client outcomes. Clients of counselors-in-training who presented with lower or highly variable disposition data also reported lower and highly variable outcomes data. Implications for counselor training, clinical practice, counselor wellness, and the use of single case designs within counseling research are outlined below.

**Counselor Preparation**

As the general goal of counseling is positive client growth, conceptualizing the role of the counselor as needing to be both a technically-competent clinician, as well as an individual who has the capacity to embody the facilitative dispositions shown to cultivate strong and efficacious therapeutic relationships, is appropriate. Viewing the person of the counselor as a filter through which all learned skills and techniques flow, lends support to the call for dispositional cultivation and gatekeeping within counselor
training. Viewing the person of the counselor as a filter or a unique form of treatment that requiring appropriate cultivation, may serve to enhance client outcomes and continue progressing the counseling field forward.

Both the American Counseling Association (ACA, 2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) state that importance of cultivating counselor professional dispositions. However, little research exists outlining empirically supported methods for do so. The current study suggests that mindfulness may be an effective method for cultivating facilitative dispositions in counselors-in-training. Furthermore, mindfulness is grounded in tenets and perspectives that are complimentary to the counseling profession and offer benefits to both the counselor and the client; as outlined throughout this study. Additionally, as both the mind attitudinal foundations of mindfulness (e.g. non-judging, patience, acceptance, letting-go, etc.) and the heart attitudinal foundations (e.g. non-harming, kindness, compassion, empathetic joy, etc.) as described by Kabat-Zinn (2013), parallel the professional values of counseling (ACA, 2014), mindfulness appears to be a complimentary practice to counseling.

Counselor educators should consider integrating mindfulness into their courses or creating courses specific to mindfulness. Examples of how mindfulness has been integrated into counseling coursework may be found within the counseling literature (Christopher & Maris, 2010). Carmody and Baer (2008) also outlined five factors that have been found to be constant throughout mindfulness interventions: (a) observing (attending to/noticing internal and external stimuli), (b) describing (mentally labeling those stimuli with words), (c) acting with awareness (responding intentionally vs
reactivity), (d) nonjudgement of inner experiences (refraining from evaluating sensations, thoughts, or emotions), and (e) non reactivity to inner experience (allowing feelings to come and go without rumination). These factors may be helpful for counselor educators in understanding the multi-faceted and holistic nature of mindfulness when crafting mindfulness-based counselor training interventions.

When incorporating mindfulness into counselor training it is important to be intentional about who leads the course. Kabat-Zinn (2003) noted that it is challenging for an individual to offer to another something that they themselves do not possess. Meaning, that an individual who wishes to teach mindfulness should they themselves be practitioners of mindfulness. This is meaningful and complimentary to a common belief within the counseling profession; an individual who has engaged in their own work and practice will be better equipped to assist others with the difficulties and challenges that may arise in their practice.

Clinical Practice

Based on the finding of this investigation, it may be concluded that counselors who engage in mindfulness practice demonstrate more additive empathy and positive regard with their clients. When analyzing the components of a therapeutic relationship in relation to client outcome, empathy was found to be a demonstrably effective element of the relationship with positive regard found to be a probably effective element (Norcross & Wampold, 2011). Just as learning of skills and techniques does not end with graduation from a counselor preparation program, neither should the attention placed on increasing one’s ability to embody such facilitative dispositions as empathy, unconditional positive regard, and congruence. Practicing clinicians are encouraged to engage in ongoing
mindfulness practices as a means of continued dispositional cultivation and personal insight for the benefit of themselves, their practice, and their clients’ outcomes.

Also, many common therapies such as Dialectical Behavioral Therapy (Linehan, 1993), Mindfulness-Based Cognitive Therapy (Segal et al., 2002), and Acceptance and Commitment Therapy (Hayes et al., 1999) incorporate mindfulness into their processes and change models. Beginning, or continuing, a mindfulness practice as a clinician will allow for the acquisition of a foundational understanding of the function and purpose of various approaches that may be beneficial to the clinician during implementation. A familiarity with the function and purpose of mindfulness and various mindfulness-based activities is also important as the use of counselor-led mindfulness-based clinical interventions continues to grow in popularity.

**Mindfulness and Counselor Wellness**

Finally, while this study did not investigate the effects of mindfulness on facets of counselor wellness, the cultivation of mindfulness leads to calmness, relaxation, and increased insight into oneself (Kabat-Zinn, 2013). Mindfulness-based interventions have been found to effectively treat a variety of medical and mental health disorders, including: anxiety (Miller et al., 1995), depression (Lenz et al., 2016; Smith et al., 2008), and insomnia (Cincotta et al., 2011; Ong & Sholtes, 2010). And as the practice of mindfulness is not restricted by time or location, it may be practiced at any time and in any place. In fact, the informal practices associated with mindfulness training are considered fundamental to the cultivation of mindfulness and the adoption of a regular contemplative practice (Kabat-Zinn, 2013). Examples of informal practice may include brief meditations, talking mindful walks, journaling, breathing exercises, and integrating
a wakefulness into pre-existing daily activities. Offering counselors and counselors-in-training such a portable and accessible skill may be helpful in mediating both personal and professional distress; potentially reducing burnout and increasing clinical efficacious by allowing the clinician to be more fully present and self-aware during their training and their counseling practice.

**Single Case Designs and Counseling Research**

As noted in earlier chapters, despite the inherent “goodness of fit” (Lenz, 2015, p. 388) between single-case research design and the counseling profession, there is a lack of single case research studies published in counseling journals. In recent years efforts have been made by researchers to begin integrating single case designs into their work, while counseling journals such as the *Journal of Counseling & Development* (JCD) has begun highlighting the applicability of single case research design to counseling research through the publication of a special issue dedicated to single case research. However, despite the positive steps being taken to produce high quality counseling research studies through use of single case designs, several areas of improvement to the use of single case designs in counseling research exist. Foremost, while single case research designs are rigorous experimental designs capable of producing meaningful results when implemented appropriately, they are also complex and nuanced in their methodology and analysis. As many counselor education programs do not train emerging counselors and counselor educators in this unique methodology, researchers should carefully attend to their training regarding many of the nuances within the analysis and reporting of single case research and actively consult with experienced single case methodologists prior to and throughout investigations using this design. By doing so counseling researchers will
be better able to fully understand the designs and implement them with increased fidelity, while also being better equipped to competently critique existing literature in which the designs were used.

Regarding many of the nuances associated with single case research designs, what may be considered the most important element of the design and analysis of results is the presence of a stable baseline prior to introduction of an intervention (Kazdin, 2011; Kratochwill et al., 2010). Without baseline stability, intervention or treatment effect cannot properly be analyzed as experimental control was not demonstrated. Treatment effect through the observation of a change in data following introduction of the intervention can be more fully trusted if a stable and predictable pattern of behavior, or data, has been documented during baseline. While achieving stable baselines are necessary, this does pose challenges for many researchers who may be restricted by time, participant availability, and budget concerns. A second nuance of single case design and analysis includes determining whether or not causality may be inferred based on the study results. When inferring a causal, or functional, relationship exists between independent and dependent variables, a researcher must show a minimum of three distinct demonstrations of a treatment effect that occurred at three separate points in time (Gast, 2010; Kazdin, 2011; Kratochwill et al., 2010). Without demonstration of experimental control through the observation of three distinct treatment effects that occurred at three separate points in time, causality cannot be inferred. A third consideration when using single case research designs involves the actual analysis of data. Analysis of data is most commonly conducted through visual analysis of the graphed data points. While visual analysis has many benefits such as the ability to be
comprehended by a broad audience, there are also many challenges that a researcher may encounter when conducting visual analysis. One such challenge may include comfortability of a researcher to rely on a method of analysis that does not involve traditional statistical analysis. However, *What Works Clearinghouse* (Kratochwill et al., 2010) offers researchers a robust technical document that addresses quality standards to abide by when conducting visual analysis. Further, the technical document also outlines the necessary criteria a study must meet in order to meet fidelity and evidence standards. While proactive and continuous consultation with an experienced single case methodologist is still recommended for researchers who are only just becoming familiar with the complexities of single case research, the *What Works Clearinghouse* technical document offers researchers a convenient guide when designing and implementing their investigation.

A final area to address when using single case designs is the degree of experimental control. High experimental control indicates that threats to internal validity are low. When a researcher has controlled for various threats to internal validity, a change in data following introduction of an intervention can be more readily trusted to have resulted from the intervention and not from extraneous variables. A researcher must show that the only thing to change between baseline and intervention phases was the introduction of the intervention. Similarity across participants is also considered ideal when using a single case research design, this is especially important when utilizing across participant multiple baseline designs. Gast & Ledford (2010) view the identification of participants who exhibit “similar learning histories and who emit the same target behavior at similar frequencies under similar pre-intervention conditions”
(p.313) as an ideal, or even conservative, approach to the research design as this allows for even greater demonstration of experimental control and reduction of threats to internal validity.

As use of single case research designs continues to grow, it becomes even more imperative that researchers attend to the technical design standards outlined above and within the *What Works Clearinghouse* technical document for single case research. Further, as counseling journals serve as a trusted resource for both counselor educators and clinicians, journal reviewers must also educate themselves on the nuances and complexities of single case research so that they may better evaluate studies that are being submitted for publication. Publication of studies that do not meet quality standards is detrimental to both counselor training and clinical practice.

Through this investigation, I sought to demonstrate the proper use of a multiple baseline, across participants, single case research design to analyze the complexities of the interpersonal engagement between counselor and client throughout the baseline and intervention phases. Further, through detailed description of the visual analysis procedures, I sought to demonstrate how to attend to each variable of visual analysis outlined by Kratochwill et al. (2010): (a) level, (b) trend, (c) variability, (d) immediacy of effect, (e) overlap, and (f) consistency; as well as how each analysis variable influences findings and the inferences able to be made from findings.

**Future Research**

The results of this study indicate that engaging in mindfulness education and practice may be effective when cultivating the facilitative dispositions of additive empathetic understanding and positive regard. Further, results indicate that increases in
positive client outcomes may be achieved through counselor engagement in mindfulness education and practice. While a functional relationship was not able to be drawn between mindfulness and increasing levels of congruence, while also decreasing levels of incongruence, subtractive empathy, and negative regard; results are promising in these areas and warrant future investigation. Additionally, a comparison of effectiveness between use of mindfulness-based interventions with more traditional empathy education courses to cultivate facilitative dispositions within counselors-in-training is suggested for future investigations.

The mindfulness intervention employed in this study, while heavily informed by the work of Kabat-Zinn (1982, 2003, 1994, 2013) and the foundational teachings of Thera (1962/1996), was created and implemented by the primary researcher. Replication of study results using a more diverse sample and a different interventionist would be beneficial to further validate the findings of this study. Additionally, continued investigation into the mechanisms of change that exist within mindfulness, and how these mechanisms influence the dependent variables in question would be helpful in the creation of future interventions.

Although this study found that client outcomes, as measured by the PGIS-II (Robitschek et al., 2012), increased following the introduction of the intervention follow-up studies, it should be noted that the PGIS-II is a measure of a client’s personal growth initiative. While personal growth is widely considered to be a goal of counseling, as well as a key indicator of wellness, investigating how counselor engagement in mindfulness may affect client outcomes through the lens of change in symptomology and distress are also warranted.
Finally, research investigating the lasting effects of counselor-in-training engagement in mindfulness is called for. Longitudinal studies investigating the lasting effects of mindfulness on such constructs as counselor retention in the clinical field, burnout, client outcomes with various populations, continued self-efficacy, and post-graduation success as a clinician would be beneficial in determining the temporal impact of both initial exposure to mindfulness as well as the influence of continued mindfulness practices. Information obtained from such investigations would be informative for both counselor training programs and practicing clinicians.

Conclusion

Of currently published studies, this study was the first to use a concurrent multiple baseline across participants single case research design to attempt to isolate the effects of a mindfulness intervention on observable expressions of counselor-in-training facilitative dispositions and client outcome. Results show an increase in the rate of occurrences of additive empathetic understanding and positive regard and increases in client outcomes following introduction of the intervention. Results of this study are supported by prior research findings related to the positive relationship between counselor mindfulness and empathy (Greason & Cashwell, 2009) and counselor mindfulness and client perception of the therapeutic alliance (Greason & Welfare, 2013).

Data collected related to clients’ perception of the therapeutic alliance, as measured by the *BLRI-OS-40*, was not used to draw causal conclusions related to effectiveness of the intervention. However, the similarities across client-report and observer data trends were useful in supporting the validity of operational definitions used throughout this investigation. Further, similarity across client and observer data may also
indicate that accurate observation of counselors’ in-session dispositional expressions is a reliable method of dispositional measurement during counselor training and preparation.

While this study has multiple limitations and future investigations are needed to support the findings discussed, the results are helpful for counselor preparation programs. The results offer empirical support for the integration of mindfulness education and engagement with mindfulness activities for the purpose of dispositional cultivation and enhancement of client outcomes. Finally, future studies are needed to demonstrate a functional relationship exists between mindfulness, increased congruence, and the reduction of incongruence, subtractive empathetic understanding, and negative regard
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*Department of Child, Family, and Community Sciences, University of Central Florida, Orlando, FL.*


doi:10.1002/jclp.20736


growth initiative on posttraumatic growth, posttraumatic stress, and depression over and above adaptive and maladaptive rumination. *Journal of Clinical Psychology, 73*(9).


APPENDIX A

UNIVERSITY OF SOUTH CAROLINA IRB APPROVAL

INSTITUTIONAL REVIEW BOARD FOR HUMAN RESEARCH
APPROVAL LETTER for EXEMPT REVIEW

Therese Marfield
College of Education
Educational Studies / Counselor Education
Warfield College
Columbia, SC 29208

Re: Pro00072126

This is to certify that the research study, "Measuring the Effects of a Mindfulness intervention on Counselors’-in-Training Dispositions, Strength of the Therapeutic Relationship, and Client Outcomes," was reviewed in accordance with 45 CFR 46.101(b)(1), the study received an exemption from Human Research Subject Regulations on 10/16/2017. No further action or Institutional Review Board (IRB) oversight is required, as long as the study remains the same. However, the Principal Investigator must inform the Office of Research Compliance of any changes in procedures involving human subjects. Changes to the current research study could result in a reclassification of the study and further review by the IRB.

Because this study was determined to be exempt from further IRB oversight, consent document(s), if applicable, are not stamped with an expiration date.

All research related records are to be retained for at least three (3) years after termination of the study.

The Office of Research Compliance is an administrative office that supports the University of South Carolina Institutional Review Board (USC IRB). If you have questions, contact Arlene McWhorter at arlenem@usc.edu or (803) 777-7085.

Sincerely,

Lisa M. Johnson
ORC Assistant Director
and IRB Manager
APPENDIX B

INFORMED CONSENT - COUNSELOR-IN-TRAINING

UNIVERSITY OF SOUTH CAROLINA

CONSENT TO BE A RESEARCH SUBJECT
(Counselor-in-Training Participants)

STUDY TITLE:
Measuring the Effects of a Mindfulness Intervention on Counselors’-in-Training Dispositions, Strength of the Therapeutic Relationship, and Client Outcomes

PURPOSE AND BACKGROUND:
You are being asked to volunteer for a research study conducted by Therese Newton, MA, LPCA, NCC. I am a Doctoral Candidate in Counselor Education & Supervision program within the Department of Educational Studies at the University of South Carolina. The University of South Carolina, Department of Educational Studies is sponsoring this research study. The purpose of this study is to measure the effects of a brief mindfulness intervention on dispositions of counselors-in-training and client outcomes, while concurrently assessing for client perception of the therapeutic relationship. You are being asked to participate in this study because you are a current counselor-in-training enrolled in a practicum course and receiving weekly group and individual/triad supervision of your clinical experiences.

This study is being done at the University of South Carolina, and will involve approximately 12 volunteers (three counselors-in-training and nine clients). This form explains what you will be asked to do, if you decide to participate in this study. Please read it carefully and feel free to ask questions before you make a decision about participating.

PROCEDURES:
If you agree to be in this study, the following will happen:
1. You will be asked to complete a general demographic survey.
2. You will be randomly assigned three undergraduate students who will serve as clients, each of whom you will offer weekly individual counseling sessions to through the duration of this study. Each individual session will last approximately 50-minutes.
3. The researchers will video record the counseling sessions in order to record observable/behavioral expressions of dispositions.
4. Each video recorded session will be independently reviewed by two trained outside observers who will record observable/behavioral expressions of dispositions.
5. During the intervention, you will participate in eight 45-minute mindfulness sessions, facilitated by the lead researcher.
6. During the intervention, you will engage in weekly mindfulness activities outside of the in-person mindfulness sessions.
7. You will continue to offer weekly individual counseling services to your clients until the conclusion of this study.

DURATION:
Participation in the study may take 10 or more weeks.

RISKS:
There are no unique or foreseeable risks associated with participation in this study.

BENEFITS:
Counselor-in-training participants may benefit by engaging in skill development through participation in the mindfulness intervention and through the opportunity to engage in additional clinical practice offered by participating in this study.

COSTS:
There will be no costs to you for participating in this study other than (i.e., for parking or transportation).

PAYMENT TO PARTICIPANTS:
In return for your time and effort, you will receive the following:
1. Direct clinical hours spent engaging in counseling activities will be credited toward the completion of total required practicum hours
2. Indirect clinical hours spent engaging in intervention activities will be credited toward completion of total required practicum hours
3. A $25 gift card to a store of their choosing

If you do not complete the study, you will be able to count hours accrued.

USC STUDENT PARTICIPATION:
Participation in this study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. Your participation, non-participation, and/or withdrawal will not affect your grades or your relationship with your professors, college(s), or the University of South Carolina.

If extra credit or research credit is required for successful course completion, other alternative means for obtaining research credits or extra credit is available and you may discuss these options with your course instructor.

CONFIDENTIALITY OF RECORDS:
Sensitive and personal information may be disclosed during the course of individual counseling sessions. In accordance with the American Counseling Association’s Code of Ethics (2014), confidentiality of client information will be maintained except in instances where there is serious concern for the client’s safety or the safety of another, disclosures of abuse/neglect of a
vulnerable individual, or court subpoena. In the event that confidentiality cannot be maintained, the counselor-in-training will immediately contact their assigned supervisor for consultation.

Study information and recordings will be securely stored in locked files and on password-protected computers/electronic storage devices. All video recordings will be deleted at the conclusion of this study. Results of this research study may be published or presented at seminars; however, the report(s) or presentation(s) will not include your name or other identifying information about you.

**VOLUNTARY PARTICIPATION:**
Participation in this research study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner. If you wish to withdraw from the study, please call or email the principal investigator listed on this form.

**PARTICIPANT AGREEMENT:**
I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study I am to contact Therese Newton, MA, LPCA, NCC at ThereseM@email.sc.edu.

Questions about your rights as a research subject are to be directed to, Lisa Johnson, Assistant Director, Office of Research Compliance, University of South Carolina, 1600 Hampton Street, Suite 414D, Columbia, SC 29208, phone: (803) 777-7095 or email: LisaJ@mailbox.sc.edu.

I agree to participate in this study. I have been given a copy of this form for my own records.

If you wish to participate, please sign below.

______________________________  _____________________
Signature of Subject / Participant  Date

______________________________
Printed Name of Subject / Participant

______________________________  _____________________
Signature of Qualified Person Obtaining Consent  Date
APPENDIX C

INFORMED CONSENT - CLIENTS

UNIVERSITY OF SOUTH CAROLINA

CONSENT TO BE A RESEARCH SUBJECT
(Client Participants)

STUDY TITLE:
Measuring the Effects of a Mindfulness Intervention on Counselors’-in-Training Dispositions, Strength of the Therapeutic Relationship, and Client Outcomes

PURPOSE AND BACKGROUND:
You are being asked to volunteer for a research study conducted by Therese Newton, MA, LPCA, NCC. I am a Doctoral Candidate in Counselor Education & Supervision program within the Department of Educational Studies at the University of South Carolina. The University of South Carolina, Department of Educational Studies is sponsoring this research study. The purpose of this study is to measure the effects of a brief mindfulness intervention on dispositions of counselors-in-training and client outcomes, while concurrently assessing for client perception of the therapeutic relationship. You are being asked to participate in this study because you are a currently enrolled undergraduate student over the age of 18 years old.

This study is being done at the University of South Carolina, and will involve approximately 12 volunteers (three counselors-in-training and nine clients). This form explains what you will be asked to do, if you decide to participate in this study. Please read it carefully and feel free to ask questions before you make a decision about participating.

PROCEDURES:
If you agree to be in this study, the following will happen:
1. You will be asked to complete a general demographic survey at the beginning of the study.
2. You will be asked to complete additional surveys throughout the duration of this study to collect information related to your perception of the counseling relationship and treatment outcomes.
3. You will be randomly assigned to a counselor-in-training who will serve as your counselor, whom you will receive weekly individual counseling sessions from through the duration of this study. Each individual session will last approximately 50-minutes.
4. The researchers will video record the counseling sessions in order to record observable/behavioral expressions of dispositions exhibited by the counselor-in-training.

5. Each video recorded session will be independently reviewed by two trained outside observers who will record observable/behavioral expressions of dispositions exhibited by the counselor-in-training.

DURATION:
Participation in the study may take 10 or more weeks.

RISKS:
There are no unique or foreseeable risks associated with participation in this study.

BENEFITS:
Participants may benefit from participating in this study by receiving weekly individual counseling services.

COSTS:
There will be no costs to you for participating in this study other than (i.e., for parking or transportation).

PAYMENT TO PARTICIPANTS:
In return for your time and effort, you will receive the following:

1. Extra course credit applied to your final grade in the EDCE 510 class.

If you do not complete the study, you will be unable to receive the above payment or incentive. However, alternatives for obtaining extra course credit may be offered to you.

USC STUDENT PARTICIPATION:
Participation in this study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. Your participation, non-participation, and/or withdrawal will not affect your grades or your relationship with your professors, college(s), or the University of South Carolina.

If extra credit or research credit is required for successful course completion, other alternative means for obtaining research credits or extra credit is available and you may discuss these options with your course instructor.

CONFIDENTIALITY OF RECORDS:
Sensitive and personal information may be disclosed during the course of individual counseling sessions. In accordance with the American Counseling Association’s Code of Ethics (2014), confidentiality of client information will be maintained except in instances where there is serious concern for the client’s safety or the safety of another, disclosures of abuse/neglect of a vulnerable individual, or court subpoena. In the event that confidentiality cannot be maintained, the counselor-in-training will immediately contact their assigned supervisor for consultation.
Study information and recordings will be securely stored in locked files and on password-protected computers/electronic storage devices. All video recordings will be deleted at the conclusion of this study. Results of this research study may be published or presented at seminars; however, the report(s) or presentation(s) will not include your name or other identifying information about you.

VOLUNTARY PARTICIPATION:
Participation in this research study is voluntary. You are free not to participate, or to stop participating at any time, for any reason without negative consequences. In the event that you do withdraw from this study, the information you have already provided will be kept in a confidential manner. If you wish to withdraw from the study, please call or email the principal investigator listed on this form.

PARTICIPANT AGREEMENT:
I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study I am to contact Therese Newton, MA, LPCA, NCC at ThereseM@email.sc.edu.

Questions about your rights as a research subject are to be directed to, Lisa Johnson, Assistant Director, Office of Research Compliance, University of South Carolina, 1600 Hampton Street, Suite 414D, Columbia, SC 29208, phone: (803) 777-7095 or email: LisaJ@mailbox.sc.edu.

I agree to participate in this study. I have been given a copy of this form for my own records.

If you wish to participate, please sign below.

_________________________________________  ________________________
Signature of Subject / Participant                             Date

_________________________________________
Printed Name of Subject / Participant

_________________________________________  ________________________
Signature of Qualified Person Obtaining Consent                             Date
APPENDIX D

GENERAL DEMOGRAPHIC SURVEY - CIT

General Demographics Survey
(CIT-Participants)

Directions: Please complete the following general demographics survey. All responses are confidential.

Gender: ___Cisgender Male ___Cisgender Female ___Transgender Woman ___Transgender Man ___Other

Age: ___

Ethnicity: ___African-American ___Asian-American ___Caucasian/White (Non-Hispanic) ___Hispanic ___Native-American ___Pacific/Islander ___Other

EDUCATION:

Highest Degree Completed: ___High School ___Associate ___Bachelor ___Masters ___Specialist ___Doctoral

What degree(s) do you currently hold?

_______________________________________________

What university/college will you complete your current academic training at?
College/University: ___________________________________________________________
Expected Graduation Year: ___________

What year are you in your counselor training program? ___________
How many years are in your program? ___________
Are you currently in: _______ Practicum _______ Internship
Specialty Areas: _______ MCFC _______ School
Current Theoretical Orientation: _____________________________________________

MINDFULNESS:

Do you currently practice mindfulness and/or meditation? ____Yes_____No
If yes, please describe your mindfulness and/or meditation practice, type of practiced, frequency of practice, how long you have been practicing:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you practiced mindfulness and/or meditation before today? ____Yes_____No
If yes, please describe your exposure to mindfulness and/or meditation, when you practiced, why you stopped:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**RESEARCHER USE ONLY:**

CIT-Participant Unique Identifier: _____________________
APPENDIX E

GENERAL DEMOGRAPHIC SURVEY - CLIENTS

General Demographics Survey
(Client-Participants)

Directions: Please complete the following general demographics survey. All responses are confidential.

Gender: ___Cisgender Male ___Cisgender Female ___Transgender Woman ___Transgender Man ___Other

Age: ___

Ethnicity: ___African-American ___Asian-American ___Caucasian/White (Non-Hispanic) ___Hispanic ___Native-American ___Pacific/Islander ___Other

EDUCATION:

Highest Degree Completed: ___High School ___Associate ___Bachelor ___Masters ___Specialist ___Doctoral

What degree(s) do you currently hold?

________________________________________________________

What university/college will you complete your current academic training at?
College/University: ______________________________________________________
Expected Graduation Year: __________

What year are you in your current academic program? (e.g. freshman, sophomore, etc.) __________________________________________________________

What is your major? ________________________________________________

What is your minor? ________________________________________________

PRIOR COUNSELING EXPERIENCE:
Do you currently receive individual, family, couples, or group counseling services?  
___Yes ___No  

If yes, please indicate length of time and frequency of service:  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  

Have you ever received individual, family, couples, or group counseling services?  
___Yes ___No  

If yes, please briefly describe the nature of the counseling, length of time spent in counseling, and why you stopped:  
________________________________________________________________________  
________________________________________________________________________  
________________________________________________________________________  

RESEARCHER USE ONLY:  
Client-Participant Unique Identifier: _________________
APPENDIX F

OPERATIONAL DEFINITIONS AND CLARIFIERS - DISPOSITIONS
Facilitative Dispositions: Operational Definitions & Clarifiers

Counselor Dispositions are defined as “the commitments, characteristics, values, beliefs, interpersonal functioning, and behaviors that influence the counselor’s professional growth and interactions with clients and colleagues” (CACREP, 2015, p. 43). This study will specifically investigate the following counselor facilitative dispositions: (a) empathic understanding, (b) level of regard, (c) unconditionality of regard, and (d) congruence.

Empathic Understanding

Empathetic understanding is defined as the extent to which one desires to know and experience the process and content of another’s awareness. Further, it is the ability to sense the immediate quality and intensity of another’s experience while being able to recognize the context of the feeling or thought (i.e. what/whom the feeling is directed toward or the conditions that produced the feeling). Empathetic understanding is demonstrated through experiential recognition of perceptions or feelings that another has directly expressed, as well as through the sensing and inferring of that which another has been implied or indirectly expressed. Empathetic understanding is diminished when one projects perception of another’s experience that has originated within oneself and one’s own experiences (Barrett-Lennard, 1962, 2015).

<table>
<thead>
<tr>
<th>Clarifiers</th>
<th>Additive (+)</th>
<th>Subtractive (-)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>CIT accurately reflects client’s directly expressed or verbalized feelings. Demonstrated through reflection of feeling (e.g., “I hear you saying you are angry…”)</td>
<td>CIT offers superficial responses, demonstrates an inability to recognize the deeper context of the client’s thoughts and/or feelings.</td>
</tr>
<tr>
<td></td>
<td>CIT accurately infers client’s indirectly expressed or nonverbalized feeling. Demonstrated through an inference of feeling (e.g., “I am sensing you are angry…”)</td>
<td>CIT projects feelings, thoughts, beliefs, or experiences onto client’s feelings, thoughts, beliefs, or experiences. Demonstrated through bias and/or assumptions related to client’s feelings, thoughts, experiences, or beliefs (e.g., inaccurate reflection of feeling, inaccurate inference of feelings or thoughts, inaccurate interpretations or reframes, or inaccurate reflection of meaning).</td>
</tr>
<tr>
<td></td>
<td>CIT accurately interprets and/or reframes client’s feelings, experiences, beliefs, etc. Demonstrated through paraphrases and/or reflection of meaning using client’s frame of reference, without projection of bias or assumption from counselor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CIT asks exploratory questions that seek to elicit deeper meaning behind client stories, experiences, or feelings (e.g., “What does…mean to you?”, “What sense do you make of…?”, “What value do you place on…?”)</td>
<td></td>
</tr>
</tbody>
</table>
**Level of Regard**

Level of regard is defined as the affective aspects, both positive and negative, of one's response to another. Positive aspects may include indicators of leaning into another's experience, warmth, respect, affection, and appreciation. Negative aspects may include indicators of pulling away from another, impatience, dislike, rejection, and contempt (Barrett-Lennard, 1962, 2015).

**Unconditionality of Regard**

Unconditionality of regard is defined as the degree of variability, or constancy, that exists in one's affective response to another. Conditionality exists when one's communication of experience is tailored to obtain desired affective responses from another (Barrett-Lennard, 1962, 2015). *Variability of regard will be demonstrated through differences in occurrence of positive and negative regard

<table>
<thead>
<tr>
<th>Clarifiers</th>
<th>Positive (+)</th>
<th>Negative (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal or nonverbal validation of client's positive and negative feelings, thoughts, experiences</td>
<td>Verbal or nonverbal validation of only positive or only negative feelings, thoughts, experiences (e.g., selective attention). As demonstrated by repeated minimization or nonattention to certain feelings, thoughts, or experiences</td>
<td>Verbal or nonverbal expressions of impatience, disrespect, disregard, or rejection toward client, client's disclosures, or client's experiences (e.g. facial expressions, lack of eye contact, administrative vocal tone, fidgeting, foot/ finger tapping, interruptions)</td>
</tr>
<tr>
<td>Verbal or nonverbal expressions of warmth, concern, or caring toward client following disclosures (e.g., vocal tone, facial expressions, patience)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal or nonverbal expressions of respect, appreciation, or gratitude toward client, client's disclosures, client's experiences (e.g., vocal tone, facial expressions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIT appears nonjudgmental and refrains from evaluative statements about client's experiences or following client disclosures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIT's demeanor is one of openness and acceptance during client disclosures, interactions, or communication (e.g. leaning in, body position (e.g., open posture, mirroring client), eye contact, and vocal tone (e.g., warmth, curiosity, compassionate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Congruence**

Congruence is defined as consistency between present experience, awareness, and response. Congruence is enhanced when an individual is psychologically unthreatened, therefore allowing openness to awareness of another’s experience while also responding to their experience with honesty, directness, and sincerity. Incongruence is demonstrated through discomfort, tension, anxiety, and inconsistency between what one says and what is implied through expression, gesture, or tone of voice (Barrett-Leenard, 1962, 2015).

<table>
<thead>
<tr>
<th>Congruence (+)</th>
<th>Incongruence (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency between CIT’s spoken word and nonverbal gesture or expression</td>
<td>Inconsistency between CIT’s spoken word and nonverbal gesture or expression</td>
</tr>
<tr>
<td>CIT appears able to freely communicate in an honest and sincere manner, without appearing apprehensive or as if measuring words/responses</td>
<td>CIT appears to struggle to freely communicate in an honest and sincere manner, showing apprehension or a careful measuring of words/responses</td>
</tr>
<tr>
<td>CIT appears relaxed and genuine in interactions with client, does not appear to present with a façade or as if playing a role</td>
<td>CIT appears to present with a façade or as if playing a role</td>
</tr>
</tbody>
</table>
APPENDIX G

CIT DISPOSITIONAL DATA - COLLECTION FORM
Counselor-in-Training (CIT) Dispositional Data-Collection

CIT Identifier: ________________________________  Date of Session: ________________________________
Observer Identifier: ________________________________  Session #: ________________________________

Code: (+) positive
(-) negative

Directions:
1. Using a tick-mark (!), record each instance of the below dispositions during the noted interval time.
2. At the conclusion of each interval, tally the counts for each disposition. See disposition definitions for clarification.
3. At the conclusion of each observation session, add the occurrences of each disposition from the intervals for a total session count.
4. Place completed data collection forms in the provided pre-labeled envelopes, place the envelopes in the provided filing location.

<table>
<thead>
<tr>
<th>0:00-10:00</th>
<th>Empathy</th>
<th>Regard</th>
<th>Congruence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(-)</td>
<td>(+)</td>
<td>(-)</td>
</tr>
<tr>
<td>Total count:</td>
<td>Total count:</td>
<td>Total count:</td>
<td>Total count:</td>
</tr>
</tbody>
</table>

### 20:00-30:00

<table>
<thead>
<tr>
<th>Empathy</th>
<th>Regard (+)</th>
<th>Congruence (+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(+)</td>
<td>(+)</td>
</tr>
<tr>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
</tbody>
</table>

Total count:  Total count:  Total count:  Total count:  Total count:  Total count:

### 40:00-50:00

<table>
<thead>
<tr>
<th>Empathy</th>
<th>Regard (+)</th>
<th>Congruence (+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(+)</td>
<td>(+)</td>
</tr>
<tr>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
</tbody>
</table>

Total count:  Total count:  Total count:  Total count:  Total count:  Total count:

### Summary:

<table>
<thead>
<tr>
<th>Total Empathy</th>
<th>Total Regard</th>
<th>Total Congruence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+)</td>
<td>(+)</td>
<td>(+)</td>
</tr>
<tr>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>(+)</td>
<td>(−)</td>
<td>(+)</td>
</tr>
<tr>
<td>(−)</td>
<td>(+)</td>
<td>(−)</td>
</tr>
</tbody>
</table>
APPENDIX H

INTERVENTION FIDELITY CHECKLIST - INTERVENTION ONE

**Intervention Fidelity Checklist**

**Intervention Session ONE**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduction &amp; Welcome</td>
<td>Orientation to Intervention:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How meetings will be structured</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Participant expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Homework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Formal/informal practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Introduction to Mindfulness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Definitions of Mindfulness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Thera (1962/1996)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Kabat-Zinn (2013)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Bishop et al. (2004)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o History and current research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Overview of heart and attitudinal qualities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Heart: non-harming, generosity, gratitude, forbearance, forgiveness, kindness, compassion, empathetic joy, and equanimity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Attitudinal: non-judging, patience, beginner’s mind, trust, non-striving, acceptance, letting go</td>
</tr>
<tr>
<td></td>
<td>Opening Practice</td>
<td>Singing bowl and breathing exercise, asking participant to focus on the tones emitted from the bowl</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Process experience (e.g. “What did you notice?”)</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>Mindfulness Attitudinal Qualities:</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non-judging</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o “paying attention to moment-to-moment thoughts and experiences while refraining from placing evaluation on them (e.g. good/bad, right/wrong, like/dislike).”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o “the practice of allowing experiences to come to fruition in their own time”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o “beneath impatience often lies anger stemming from our belief that something, or someone, should be in a way that is different than what is”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guided Meditation(s)</th>
<th>Mindful Breathing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• No “right” way to breathe, use of breath as the center of practice</td>
</tr>
<tr>
<td></td>
<td>• Process Experience (e.g. “What did you notice?”)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Closing Practice</th>
<th>Brief breathing meditation, allowing the participant to come back to the present moment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poem</td>
<td></td>
</tr>
<tr>
<td>Singing bowl</td>
<td>to end session</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review of Homework</th>
<th>Review homework expectations to be completed before next session:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Practice Mindful Breathing Exercise once a day. Audio recording will be emailed.</td>
</tr>
<tr>
<td></td>
<td>• Continue integrating wakefulness into daily activities. Offer examples</td>
</tr>
<tr>
<td></td>
<td>• Practice non-judging by simply noticing judgmental thoughts and then returning to the present moment</td>
</tr>
<tr>
<td></td>
<td>• Chart experiences. Give participant Mindful Activity Log. Ask that they bring this log next time they come to intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Opportunities Completed</th>
<th>Total Opportunities Available</th>
<th>Intervention Fidelity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>(___________ / ___________ ) x 100</td>
<td>___________________________</td>
<td>____________</td>
</tr>
</tbody>
</table>
## APPENDIX I

### INTERVENTION FIDELITY CHECKLIST - INTERVENTION TWO

#### Intervention Fidelity Checklist

**Intervention Session TWO**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Welcome</td>
<td>Welcome participant to session</td>
</tr>
<tr>
<td></td>
<td>Opening Practice</td>
<td>Singing bowl and breathing exercise • Process experience (e.g. “What did you notice?”)</td>
</tr>
<tr>
<td></td>
<td>Review of Homework and Questions</td>
<td>Discuss how many times CIT engaged in mindfulness practice (formal and informal) • Discuss participant insights, questions, experiences</td>
</tr>
<tr>
<td></td>
<td>Psychoeduction</td>
<td>Discussion of Mindfulness Attitudinal Qualities: • Beginner’s Mind o “viewing and experiencing phenomena as if for the first time by setting aside opinion, evaluation, and prior experience” o “an attitude of not knowing, approaching situations, sensations, and experiences as if for the first time; without judgement, evaluation, or familiarity”</td>
</tr>
<tr>
<td></td>
<td>Guided Meditation(s)</td>
<td>Mindful Eating Practice: a practice in using Beginner’s Mind • Process Experience (e.g. “What did you notice?”) Body Scan Meditation • Process Experience (e.g. “What did you notice?”)</td>
</tr>
</tbody>
</table>
| Closing Practice | Brief breathing meditation, allowing the participant to come back to the present moment  
Poem  
Singing bowl to end session |
|-------------------|-------------------------------------------------------------------------------------------------------------------|
| Review of Homework | Review homework expectations to be completed before next session:  
  - Practice the Body Scan once a day. Audio recording will be emailed.  
  - Continue integrating wakefulness into daily activities. Offer examples  
  - Practice embracing an attitude of ‘not knowing’, see things as if for the first time without judgement or bias  
  - Continue practicing non-judging by simply noticing judgmental thoughts and then returning to the present moment.  
  - Chart experiences. Give participant Mindful Activity Log. Ask that they bring this log next time they come to intervention |
| **Total Opportunities Completed** | **Total Opportunities Available** | **Intervention Fidelity %** |
| ( _________  /  _________ )  x  100 | | __________ |
# APPENDIX J

## INTERVENTION FIDELITY CHECKLIST - INTERVENTION THREE

### Intervention Fidelity Checklist

### Intervention Session THREE

<table>
<thead>
<tr>
<th>Completed</th>
<th>Event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Welcome participant to session</td>
<td></td>
</tr>
</tbody>
</table>
| Opening Practice | Singing bowl and breathing exercise  
  - Process experience (e.g. “What did you notice?”) |
| Review of Homework and Questions | Discuss how many times CIT engaged in mindfulness practice (formal and informal)  
  - Discuss participant insights, questions, experiences |
| Psychoeduction | Discussion of Mindfulness Attitudinal Qualities:  
  - Trust  
    o “Trusting in our thoughts, feelings, sensations as we become more familiar and intimate with our minds”  
    o Trust vs naivete  
  - Non-Striving  
    o “described as “being”, allowing experiences and sensations to flow naturally, staying in the present-moment, without striving or pushing through to the next moment”  
    o “Meditation embodies non-striving: nowhere to go, nothing to do, being where you are” |
| Guided Meditation(s) | Gentle Yoga/Stretching: emphasizing the mind/body connection  
  - Process experience (e.g. “What did you notice?”) |
<table>
<thead>
<tr>
<th>Mountain Meditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Process experience (e.g. “What did you notice?”)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Closing Practice</td>
</tr>
<tr>
<td>Brief breathing meditation, allowing the participant to come back to the present moment</td>
</tr>
<tr>
<td>Poem</td>
</tr>
<tr>
<td>Singing bowl to end session</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Review of Homework</td>
</tr>
<tr>
<td>Review homework expectations to be completed before next session:</td>
</tr>
<tr>
<td>• Practice the Mountain Meditation once a day. Audio recording will be emailed.</td>
</tr>
<tr>
<td>• You may integrate the Body Scan or Mindful Breathing into daily practice.</td>
</tr>
<tr>
<td>• Practice being where you are, “This is it”, without striving to the next moment, becoming aware of moments as they unfold</td>
</tr>
<tr>
<td>• Continue integrating wakefulness into daily activities.</td>
</tr>
<tr>
<td>• Continue noticing your thoughts, without judgement, as an observer rather than an active participant in your inner dialogue.</td>
</tr>
<tr>
<td>• Chart experiences using the Mindful Activity Log. Bring this log next time they come to intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Opportunities Completed</th>
<th>Total Opportunities Available</th>
<th>Intervention Fidelity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>( __________ / __________ ) x 100</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

212
### APPENDIX K

**INTERVENTION FIDELITY CHECKLIST - INTERVENTION FOUR**

**Intervention Fidelity Checklist**

**Intervention Session FOUR**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Event</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Welcome event</td>
<td>Welcome participant to session</td>
</tr>
<tr>
<td>Opening Practice</td>
<td>Singing bowl and breathing exercise</td>
<td>• Process experience (e.g. “What did you notice?”)</td>
</tr>
<tr>
<td>Review of Homework and Questions</td>
<td>Discuss how many times CIT engaged in mindfulness practice (formal and informal)</td>
<td>• Discuss insights, questions, experiences</td>
</tr>
</tbody>
</table>
| Psychoeduction | Discussion of Mindfulness Attitudinal Qualities:  | • Acceptance  
  o “allow things to be as they are, without comparison, judgement, or expectation”  
  o “seeing things as they are in the present-moment, allowing clarity of thought and decision-making”  
 • Letting Go  
  o “a form of acceptance, letting go of attachment to thought, experience, sensation, or emotion while inviting awareness of them without judgement”  
  o “Letting go vs detachment. Letting go allows us to be fully present and experience, with bare attention, the reality of the moment.” |
| Guided Meditation(s) | Choiceless Awareness           | • Process Experience (e.g. “What did you notice?”)                                                                                                                                                          |
|              | Loving Kindness Meditation     |                                                                                                                                                                                                              |
- Process Experience (e.g. “What did you notice?”)

<table>
<thead>
<tr>
<th>Closing Practice</th>
<th>Review of Homework</th>
</tr>
</thead>
</table>
| Brief breathing meditation, allowing the participant to come back to the present moment Read Poem Singing bowl to end session | Review homework expectations to be completed before next session:  
  - Practice Choiceless Awareness once a day. Audio recording will be emailed.  
  - Practice Loving-Kindness Meditation one time formally, and then informally for a moment or two each day. Audio recording will be emailed.  
  - You may integrate the Mountain Meditation, Body Scan, and the Mindful Breathing Exercise into your daily practice.  
    - begin transitioning your practice to self-guided meditation.  
  - Practice being where you are, “This is it”, without striving to the next moment. But becoming aware of moments as they unfold, allowing yourself to receive  
  - Continue integrating wakefulness into daily activities.  
  - Continue noticing thoughts, without judgement, as an observer rather than an active participant in your inner dialogue.  
  - Chart your experiences using the Mindful Activity Log. Bring this log next time they come to intervention. |

<table>
<thead>
<tr>
<th>Total Opportunities Completed</th>
<th>Total Opportunities Available</th>
<th>Intervention Fidelity %</th>
</tr>
</thead>
<tbody>
<tr>
<td>(__________ / __________) x 100</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>
APPENDIX L

DAILY MINDFULNESS ACTIVITY LOG
**Daily Mindfulness Activity Log**

Directions: Engage in a formal and informal mindfulness practice each day. Record the details of your practice and questions or comments below. Practice logs will be collected by the researcher at the beginning of each meeting.

<table>
<thead>
<tr>
<th>Day / Date</th>
<th>Activity/Practice</th>
<th>Time of Day</th>
<th>Context of Practice (1. Why now? 2. Why this practice?)</th>
<th>(E) Experiences, (O) Observations, (T) Thoughts, (F) Feelings</th>
<th>Insights?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal:</td>
<td>T</td>
<td>1</td>
<td>E:</td>
<td>O:</td>
<td></td>
</tr>
<tr>
<td>Informal:</td>
<td>D</td>
<td>2</td>
<td>T:</td>
<td>F:</td>
<td></td>
</tr>
<tr>
<td><strong>Tuesday</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal:</td>
<td>T</td>
<td>1</td>
<td>E:</td>
<td>O:</td>
<td></td>
</tr>
<tr>
<td>Informal:</td>
<td>D</td>
<td>2</td>
<td>T:</td>
<td>F:</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX M

PERSONAL GROWTH INITIATIVE SCALE - II

Please mark how much you agree or disagree with that statement. Use the following scale:

0 = Disagree Strongly
1 = Disagree Somewhat
2 = Disagree A Little
3 = Agree A Little
4 = Agree Somewhat
5 = Agree Strongly

1. I set realistic goals for what I want to change about myself.
2. I can tell when I am ready to make specific changes in myself.
3. I know how to make a realistic plan in order to change myself.
4. I take every opportunity to grow as it comes up.
5. When I try to change myself, I make a realistic plan for my personal growth.
6. I ask for help when I try to change myself.
7. I actively work to improve myself.
8. I figure out what I need to change about myself.
9. I am constantly trying to grow as a person.
10. I know how to set realistic goals to make changes in myself.
11. I know when I need to make a specific change in myself.
12. I use resources when I try to grow.
13. I know steps I can take to make intentional changes in myself.
14. I actively seek out help when I try to change myself.
15. I look for opportunities to grow as a person.
16. I know when it’s time to change specific things about myself.

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Received April 6, 2011
Revision received September 9, 2011
Accepted October 6, 2011

219
### APPENDIX N

**BARRETT-LENNARD RELATIONSHIP INVENTORY-OS-40**

<table>
<thead>
<tr>
<th>Name or code</th>
<th>Answer date</th>
</tr>
</thead>
</table>

Barrett-Lennard Relationship Inventory: Form OS--40 (version 3)
Developed by Godfrey T. Barrett-Lennard, PhD

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with __________, mentally inserting his or her name in the space provided. For example, if the other person's name was John, you would read the first statement as "John respects me" and the second as "John usually senses or realizes what I am feeling".

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Write in a minus number (−3, −2, or −1) when your answer is on the "no" side, and a plus number (+1, +2, or +3) when your answer is a "yes." Here is the exact meaning of each answer number:

+3: YES, I strongly feel that it is true  
+2: YES, I feel it is true  
+1: (Yes) I feel that it is probably true, or more true than untrue  
−1: (No) I feel that it is probably untrue, or more untrue than true  
−2: No, I feel it is not true  
−3: NO, I strongly feel that it is not true

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. __________ respects me.</td>
</tr>
<tr>
<td>2. __________ usually senses or realizes what I am feeling.</td>
</tr>
<tr>
<td>3. __________'s interest in me depends on my words and actions (or how I perform).</td>
</tr>
<tr>
<td>4. I feel that __________ puts on a role or front with me.</td>
</tr>
<tr>
<td>5. __________ feels a true liking for me.</td>
</tr>
<tr>
<td>6. __________ reacts to my words but does not see the way I feel.</td>
</tr>
<tr>
<td>7. Whether I am feeling happy or unhappy with myself makes no real difference to the way he/she feels about me.</td>
</tr>
<tr>
<td>8. __________ doesn't avoid or go round anything that matters between us.</td>
</tr>
<tr>
<td>9. __________ is indifferent to me.</td>
</tr>
<tr>
<td>10. __________ nearly always sees exactly what I mean.</td>
</tr>
<tr>
<td>11. Depending on my behavior, __________ has a better (or a worse) opinion of me sometimes than s/he has at other times.</td>
</tr>
<tr>
<td>12. I feel that __________ is genuine with me.</td>
</tr>
<tr>
<td>13. I know I'm valued and appreciated by __________.</td>
</tr>
<tr>
<td>14. __________'s own attitudes get in the way of understanding me.</td>
</tr>
<tr>
<td>15. No matter what I tell about myself, __________ likes (or dislikes) me just the same.</td>
</tr>
<tr>
<td>16. __________ keeps quiet about his/her real inner impressions and feelings.</td>
</tr>
<tr>
<td>17. __________ finds me rather dull and uninteresting.</td>
</tr>
<tr>
<td>18. __________ realizes what I mean even when I have difficulty in saying it.</td>
</tr>
<tr>
<td>19. __________ wants me to be a certain kind of person.</td>
</tr>
</tbody>
</table>
20. ___________ is willing to say whatever is on his/her mind with me, including feelings about either of us or how we are getting along.

21. ___________ cares for me.

22. ___________ doesn't listen and pick up on what I think and feel.

23. ___________ likes certain things about me, and there are other things he/she does not like in me.

24. ___________ is openly himself/herself in our relationship.

25. I feel that ___________ disapproves of me.

26. ___________ usually understands the whole of what I mean.

27. Whether thoughts or feelings I express are 'good' or 'bad' makes no difference to ___________’s feeling toward me.

28. Sometimes ___________ is not at all comfortable but we go on, outwardly ignoring it.

29. ___________ is friendly and warm toward me.

30. ___________ does not understand me.

31. ___________ approves of some things about me (or some of my ways), and plainly disapproves of other things (or ways I act and express myself).

32. I think ___________ always knows exactly what s/he feels with me: s/he doesn’t cover up inside.

33. ___________ just tolerates or puts up with me.

34. ___________ appreciates exactly how the things I experience feel to me.

35. Sometimes I am more worthwhile in ___________’s eyes than I am at other times.

36. At moments I feel that ___________’s outward response to me is quite different from the way s/he feels underneath.

37. ___________ feels affection for me.

38. ___________’s response to me is so fixed and automatic that I don’t get through to him/her.

39. I don’t think that anything I say or do really changes the way ___________ feels toward me.

40. I believe that ___________ has feelings s/he does not tell me about that affect our relationship.

Please double check and make sure that you have given an answer to every item. Thank you for doing so.

Please note the other person’s relation to you, e.g., a personal friend, spouse or partner, mother, or other family member, teacher or supervisor, counselor/therapist.
APPENDIX O
POST-INTERVENTION FOLLOW-UP QUESTIONNAIRE

Post-Intervention Follow-Up Questionnaire

When answering the below questions, please consider your participation in the following study: “Measuring the Effects of a Mindfulness Intervention on Counselors’-in-Training Dispositions, Strength of the Therapeutic Relationship, and Client Outcomes”.

1(not at all) - 2(very little) - 3(indifferent) - 4(mostly) - 5(very much)
1. As a whole, how much did you like the intervention? ______

2. Do you feel the outcome of your participation (i.e. what you gained from participation) was worth the time and effort that was required of your participation? ______

3. Was the content of the intervention helpful to you as a counselor-in-training? ______

1(not likely) - 2(somewhat likely) - 3(unsure) - 4(probably likely) - 5(very likely)

4. What is the likelihood that you will use the skills and knowledge acquired from participating in this intervention in the future? ______

5. What is the likelihood that you will seek out additional information or trainings related to the intervention topic (mindfulness)? ______

(Yes - No - Maybe)
6. Would you participate in the intervention again? ______

7. Would you recommend this intervention to others? ______

Additional thoughts/opinions related to the intervention or your participation in the intervention:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________