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ORIGINAL PAPER

Mindfulness in Clinician Therapeutic Relationships

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Abstract Mindfulness is increasingly becoming acknowledged as an effective therapeutic mechanism. However, the level of the clinician's mindfulness and its impact on the therapeutic alliance have been minimally explored. The objective of the study was to explore the relationship between clinicians' mindfulness and their perceived therapeutic alliance. A cross-sectional correlational design was implemented to examine the relationship. Seventy-six adult mental health professionals took part in the study. Participants were administered questionnaires examining mindfulness and therapeutic alliance. Subscales of the mindfulness questionnaire were inputted into a regression model to examine their relevance to the therapeutic alliance. All subscales were significantly positively correlated with the therapeutic alliance and significantly predicted the quality of the therapeutic alliance explaining 32.4 % of its variance. Non-judgemental acceptance and openness to experiences were both identified as individual significant predictors. There is clearly an important relationship between mindfulness and the therapeutic alliance, especially non-judgemental acceptance and openness to experiences. Staff training in mindfulness may well improve therapeutic alliances between staff and patients, thus benefiting overall care.

Keywords Mindfulness · Therapeutic relationship · Compassion · Mental health staff

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Introduction

The relationship between patient and clinician is central to the provision of mental health care. Where psychological therapies are concerned, decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is actually the nature of the therapeutic alliance (Gilbert and Leahy 2007). Indeed, key attributes of the therapeutic relationship have been shown to correlate more highly with client outcome than specialised treatment interventions (Lambert and Barley 2001; Priebe et al. 2011). Furthermore, there is now increasing evidence that the therapeutic alliance predicts outcome across various psychiatric settings, including acute settings (Hansson and Berglund 1992). The therapeutic alliance has been shown to improve outcome both indirectly, e.g. through compliance with medication, and also directly, i.e. the very nature of the interaction has a therapeutic effect in itself (Priebe and Mccabe 2008). This effect has been demonstrated for general psychiatric care as well as pertaining to specific diagnoses such as schizophrenia (Frank and Gunderson 1999) and depression (Krupnick et al. 1996). Some studies have also gone as far as to extrapolate the specific elements of the therapeutic alliance that facilitate such improvements, such as the feeling of 'being understood by the clinician' (Johansson and Eklund 2003).

Mindfulness is defined as the awareness that arises out of intentionally attending in an open and discerning way to whatever is arising in the present moment (Shapiro 2009). This refers to the internal environment (e.g. the clinician's own current thoughts and emotions) as well as the external environment (e.g. the patient's current feelings and reactions). It involves maintaining an attitude of non-judgemental acceptance towards all that is being experienced in the here and now. Additional widely identified components of mindfulness include awareness, being present, and compassion (Gilbert 2010; Hayes et al. 2006).

Mindfulness is becoming widely accepted as an extremely useful tool in improving service user's emotional distress and well-being. Kabat-Zinn (2003) has pioneered the use of mindfulness within the mental health field, and it is now an integral part of many psychological therapies, e.g. Mindfulness Cognitive Behaviour Therapy (MCBT), Acceptance and Commitment Therapy (ACT), Compassionate Mind Therapy (CMT) (Gilbert 2010; Hayes et al. 2006; Williams et al. 2007).

A clinician's mindfulness has been widely documented by enthusiasts as important in developing a strong therapeutic alliance with service users, as therapists who are mindful are more likely to notice subtle shifts in client behaviour and model mindfulness to the client (Wilson and Sandoz 2010). Mindfulness also enables clinicians to listen attentively to patients' distress, recognise their own errors, refine their technical skills, make evidence-based decisions, and clarify their values so that they can act with compassion, technical competence, presence, and insight (Epstein 1999). A number of studies have shown the efficacy of mindfulness as a therapeutic tool (Baer 2003), but there has been little exploration regarding a clinician's level of mindfulness and its impact on the therapeutic alliance. One qualitative study has shown that practising mindfulness within clinical training improved counsellors' therapeutic skills and their therapeutic relationships with clients. They described themselves as more attentive and more comfortable with silences (Newsome et al. 2006). However, the level of importance this plays in the therapeutic alliance has never been quantified. Furthermore, the specific components of mindfulness have not been examined for their importance to the therapeutic relationship.

Knowingly or not, mindfulness is likely to be a quality that most, if not all, clinicians are deploying to varying degrees in their relationships with patients. This study aimed to examine the degree to which mindfulness exists within a cross section of clinicians and its relationship to the therapeutic alliance.

Method

Participants

Sample size was based on recommendations for a linear regression analysis. Miller and Kunce (1973) recommended that the number of subjects should be 10–15 times the number of predictor variables. Tabachnick and Fidell (1996) also suggest that the sample size for multiple regression should be at least five times the number of variables. Based on these recommendations, this study aimed to recruit a minimum of 70 participants in order to give adequate power.

Participants were recruited on an opportunity sample basis from four multi-professional meetings within the adult mental health directorate of North East London Foundation Trust (NELFT). A total of 76 ($n=76$) participants took part in this study; 39 middle/junior grade doctors, 20 consultant psychiatrists, 11 nurses, 2 psychologists, 2 occupational therapists, 1 pharmacist and 1 medical secretary, with both of the latter having regular contact with patients as part of their routine work commitments.

Design

This study adopted a cross-sectional 'correlational' design. Four predictor variables were included in the analysis—mindful presence, non-judgmental acceptance, openness to experience and insight (subscales of the mindfulness inventory). The dependent (or criterion) variable was the therapeutic alliance.

Ethical Approval

Ethical approval was not sought for this study as the participant group was NHS staff members only. Since 2011, the NHS research ethics committee has not required ethical approval for research with staff (NRES 2011). However, ethical procedures of informed consent, confidentiality and data protection were strictly adhered to.

Materials

Two questionnaires were used for the purposes of this study. The first was the Freiberg Mindfulness Inventory (FMI) short form (Walach et al. 2006). This is a 14-item validated self-report questionnaire that measures the degree of an individual's mindfulness. This scale has illustrated good internal consistency (Cronbach $\alpha=0.93$). Participants rate items (e.g. I am friendly to myself when things go wrong) on a 5-point Likert scale from 1 (rarely) to 5 (almost always). Participants can score a maximum of 70. The questionnaire has four subscales—mindful presence (e.g. I watch my feelings without getting lost in them), non-judgemental acceptance (e.g. I see my mistakes and difficulties without judging them), openness to experiences (e.g. I feel connected to the here and now) and insight (e.g. I am able to smile when I notice how I sometimes make life difficult).

The second questionnaire used was the Working Alliance Inventory (WAI) (Hatcher and Gillaspy 2007) short form, which is a validated and robust measure (Cronbach $\alpha=0.92$) of the therapeutic alliance and compares well to other similar instruments (Fenton et al. 2001). It exists as either a therapist/clinician questionnaire or a client/patient questionnaire. Both have good validity, and for the purposes of this study, the clinician questionnaire was used. Minor referencing modifications were made to the questionnaire to make it more relevant to professionals working in acute mental health, e.g. referring to 'patient' instead of 'client'. Participants rate the 12

items (e.g. I appreciate each of the patients I treat) on a 7-point Likert scale from 1 (never) to 7 (always). When rating both measures, participants were asked to think about one or two recent client relationships that were significant to them in order to rate the questionnaires. Participants can score a maximum of 84.

Procedure

Questionnaires were distributed to each of the attendees of the four staff meetings within NELFT. Staff were free to take part in the study and withdraw at any point. The attendees were informed that the questionnaires related to a research project being conducted by the investigators into the nature of the therapeutic alliance. They were asked to fill in the forms and return them during an interlude in the meeting's usual proceedings. Both questionnaires were completed anonymously by each staff member and then returned to the researchers once finished.

Statistical Analysis

The Statistical Package for the Social Sciences version 18 (SPSS 2010) was used to conduct all the analyses of the data. All data were found to be normally distributed. The four individual subscales from the mindfulness inventory were then entered into a multiple regression analysis with therapeutic alliance as the dependent variable.

Results

The FMI was completed by 76 (100 %) participants. The mean score for this questionnaire was 37.67 (SD, 6.33; range, 25–56); scores were normally distributed (skewness, 0.41; kurtosis, 0.65). This score was slightly higher than the mean during its validation ($x = 34.52$; SD, 6.77; range, 18–52) (Walach et al. 2006) illustrating an expected level of mindfulness in the sample.

The WAI was completed by 75 (98.6 %) participants. Missing data was replaced with the group mean. The total mean score for this questionnaire was 59.91 (SD, 7.46; range, 47–84); scores were normally distributed (skewness, 0.48; kurtosis, 0.45). The individual item mean for the WAI was 5.00 which is slightly lower (5.88) than the original sample (Hatcher and Gillaspy 2007).

Initially, Pearson's correlational analysis was utilised to examine the relationship between the mindfulness variables and the therapeutic alliance. The correlations can be seen in Table 1. It is clear that all mindfulness scales significantly correlate with therapeutic alliance. *Openness to experiences* was the most important correlate with *insight* as the least important. The individual predictors, except insight, also correlated with one another indicating that they are related in measuring mindfulness.

Data met all assumptions necessary for the completion of a regression analysis. All data's standardised residuals were within the recommended value of 1.96 (in regard to normality), leverage and Cook's distance values did not illustrate any influential cases, residuals were normally distributed and linearity and homoscedasticity were also met.

To see whether the mindfulness variables were significant predictors of therapeutic alliance, a linear regression model with four predictor variables was examined. As illustrated by the correlation coefficient, the R value for this multiple regression was 0.57 which shows a well-fitted model. R^2 accounted for 32.4 % of the variance, a substantial amount of variance explained. Adjusted R^2 accounted for 28.5 % of the variance; this shows that the regression model is a good representation of the generalised population as there was little adjustment. This model was also shown to be significant ($F = 8.272$, $p < 0.001$).

The predictor variables were then considered individually in relation to the dependant variable. *Non-judgmental acceptance* ($\beta = 0.320$, $t = 2.055$, $p < 0.05$) and *openness to experiences* ($\beta = 0.340$, $t = 2.464$, $p < 0.05$) significantly predicted the *therapeutic alliance*; *mindful presence and insight* were insignificant.

Discussion

This study aimed to examine the level of clinician mindfulness and its relationship with the therapeutic alliance and identify specific predictive factors. Results illustrated that the sample had an expected level of mindfulness compared to the original sample population used by Walach et al. (2006). Furthermore, there was a clear identification of a relationship between

Table 1 Pearson's correlation and significance values of the predictive variables and dependent variables

	Mindful presence	Non-judgemental acceptance	Openness to experiences	Insight
Non-judgemental acceptance	0.703[a]	–	–	–
Openness to experiences	0.584[a]	0.624[a]	–	–
Insight	0.059	0.309[a]	0.362[a]	–
Therapeutic alliance	0.356[a]	0.499[a]	0.528[a]	0.270[b]

[a] Correlation is significant at the 0.01 level

[b] Correlation is significant at the 0.05 level

mindfulness and therapeutic alliance with mindfulness factors contributing to over 30 % of variance in the therapeutic alliance. Specific mindfulness factors of non-judgmental acceptance and openness to experiences are significant individual predictors of therapeutic alliance.

Openness to experience was the most significant predictor of the therapeutic alliance and included items such as *I feel connected to the here and now* and *I pay attention to what's behind my actions*. Openness is a fundamental component of mindfulness, 'In mindfulness practice, the focus of a person's attention is opened to admit whatever enters experience' (Segal et al. 2002, p. 322), and therefore illustrates the importance of mindfulness to the therapeutic alliance. Openness has been noted as an important quality of therapists across modalities (Gilbert and Leahy 2007) and is essential in generating a hypothesis about a client's difficulties (Beck 1979). By being open to clients, they will feel listened to and be able to speak honestly and freely about their experience without judgement. Furthermore, clients will be able to learn to be open themselves by modelling openness portrayed by the therapist.

Similarly, non-judgemental acceptance was also a significant predictor of the therapeutic alliance. Acceptance is a widely used concept within mindfulness therapies and a fundamental value within the ACT approach (Hayes et al. 2006). Acceptance has been defined as 'the active and aware embrace of those private events occasioned by one's history without unnecessary attempts to change their frequency or form' (Hayes et al. 2006, p.g. 7). According to the ACT approach, acceptance is essential to move towards valued actions and recovery. Therefore, if a clinician is accepting of the client's difficulties, the client will feel more able to accept his or her own problems. Studies which have examined service user experiences of therapy have outlined acceptance as important in the therapeutic process. For example, a service user-led study which examined patients' experiences of cognitive behavioural therapy for psychosis outlined that 'acceptance of self was… an important element of recovery' (Kilbride et al. 2013, p.g. 97).

Strengths and Limitations

One of the strengths of the study was the choice of questionnaires used. They are widely recognised and utilised as reliable and valid measures of mindfulness and the therapeutic alliance, respectively, within the third-wave CBT approaches (Mccabe and Priebe 2004). However, a limitation was not using the WAI to assess a specific client as it was originally designed which may impact on its reliability.

One of the main limitations of this study is the small sample size utilised. Although it meets recommendations for such analysis, these are considered conservative, and a larger sample would have been advantageous. For a regression analysis, statisticians have recommended as many as 30 participants per regression variable (Pedhazur and Schmelkin 1991). A larger sample would have given additional statistical power which should be considered in future analyses.

Another limitation is the correlational design of this study. Although the predictability of clinician mindfulness to the therapeutic alliance was examined and it is likely that mindfulness does improve the therapeutic alliance, the design does not allow examination of the direction of the relationship between the two variables. A longitudinal study which examines mindfulness and the therapeutic alliance will allow for examination of the direction of the relationship.

Further examination of the mindfulness and therapeutic alliance variables would allow for more detailed understanding of the relationship. In regard to mindfulness, assessment of mindfulness practice, use of mindfulness in clinical practice and examining more specific mindfulness factors, such as compassion, would provide a comprehensive understanding. For therapeutic alliance, monitoring therapeutic alliance from the clinician and client perspective would be advantageous. The WAI has a client form which could be used to gather more reliable information about the therapeutic alliance.

Clinical Implications

Mindful awareness of one's own thoughts and feelings would facilitate a deeper, more open, empathic, accepting and non-judgemental acceptance of the patient's experience. This attitude is, in turn, noticed by the patient who feels more emotionally understood, safer and, therefore, more able to open up and relate to the clinician. A virtuous cycle thus ensues. Staff training in mindfulness would, therefore, be a valuable aspect of clinical training, ultimately serving to improve the quality of therapeutic alliances and patient care, as well as the clinician's own mental health and well-being.

Specifically developing staff's level of openness and acceptance may be of particular value given the significant role both played in the regression model. The ACT approach (Hayes et al. 2006) offers many techniques to facilitate self-acceptance and openness, for example, developing acceptance of self, valued action and compassion (Luoma et al. 2007).

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