Journal of Psychotherapy Integration

The Reactive Therapist: The Problem of Interpersonal Reactivity in Psychological Therapy and the Potential for a Mindfulness-Based Program Focused on "Mindfulness-in-Relationship" Skills for Therapists

James Macdonald and Christopher J. Muran

Online First Publication, April 16, 2020. http://dx.doi.org/10.1037/int0000200

Journal of Psychotherapy Integration

ISSN: 1053-0479
http://dx.doi.org/10.1037/int0000200

The Reactive Therapist: The Problem of Interpersonal Reactivity in Psychological Therapy and the Potential for a Mindfulness-Based Program Focused on "Mindfulness-in-Relationship" Skills for Therapists

James Macdonald
Headington Psychotherapy, Oxford, United Kingdom

Christopher J. Muran
Adelphi University

This article highlights subtle negative interpersonal reactions on the part of therapists that can be detrimental to outcome in psychological therapy. Mindfulness training is considered as a means of supporting therapists to develop the "reflection-in-action" skills needed to successfully navigate inevitable interpersonal tensions in therapy. An adapted version of mindfulness-based cognitive therapy (MBCT) is proposed, which focuses on training therapists' "mindfulness-in-relationship." A synthesis of research literature highlighting the impact of relational variables on outcome in psychological therapy is offered. This is followed by a review of theoretical and empirical literature suggesting that mindfulness training and skills are likely to be of value for therapists, especially when they encounter interpersonal difficulties with clients. Based on these findings, and the criteria for adapting mindfulness-based programs (MBPs) advocated by Crane et al. (2017), a case is made for an MBP for therapists. Preliminary ideas for how this would differ from a standard MBCT program are offered. The article argues that the field of psychological therapy would benefit from an MBP aimed at increasing therapists' capacity to embody mindfulness skills in therapeutic relationships. The proposed adaptation of MBCT is a starting point for further research in this area. It is hoped that this may in due course contribute to improved outcomes in psychological therapy.

Keywords: alliance-focused training, interpersonal process in psychotherapy, mindfulness-based cognitive therapy, psychotherapy integration, therapeutic ruptures

Dimidjian and Segal (2015) and Crane et al. (2017) argue that new Mindfulness Based Programs—or extensions of existing programs—should be grounded "in a clearly articulated aim and intention regarding the benefit and relevance of the program for a particular context and/or population" (Crane et al., 2017, p. 996). This article articulates the aims and proposed elements of a mindfulness-based program (MBP) that focuses on enhancing therapist relational skills.

Research on psychotherapy outcomes suggests a glass at least half empty. Around 20% of psychotherapy clients drop out (Swift & Greenberg, 2012), around five to 10% deteriorate (Lambert, 2013) and in naturalistic settings as few as 35% actually achieve clinically meaningful change (Lambert, 2013). Furthermore, to date we have not been able to improve on this relatively modest success rate, especially in routine clinical practice (Lambert, 2013). This may be because research efforts have tended to de-

James Macdonald, Headington Psychotherapy, Oxford, United Kingdom; Christopher J. Muran, Gordon F. Derner Institute of Advanced Psychological Studies, Adelphi University.

Correspondence concerning this article should be addressed to James Macdonald, Headington Psychotherapy, 110 Old Road, Oxford OX3 8SX, United Kingdom. E-mail: james@headingtonpsychotherapy.co.uk

rive from a medical model that overemphasizes the role of therapy techniques (Beutler & Forrester, 2014; Elkins, 2016; Hubble, Duncan, Miller, & Wampold, 2010; Wampold & Imel, 2015), which have not in themselves proved to be an essential ingredient of positive outcomes (Ahn & Wampold, 2001; Bell, Marcus, & Goodlad, 2013; Longmore & Worrell, 2007).

A more relational paradigm for psychotherapy makes sense given the spectrum of research findings that are inconsistent with the medical model (as reviewed by Wampold & Imel, 2015), the degree to which social connectedness appears to be hard-wired in our minds and bodies (e.g., Fonagy, 2008; Geller & Porges, 2014; Keysers, 2011; Parker, Nelson, Epel, & Siegel, 2015; Siegal, 2010; Stellar & Keltner, 2017), and the extensive evidence linking relationally impoverished or abusive developmental trajectories to the onset and maintenance of psychological problems (e.g., Allen, 2001; Beebe, 2014; Beebe & Lachmann, 2014; Feldman, 2007; Fonagy, Gergely, Jurist, & Target, 2004; Sroufe, Egeland, Carlson, & Collins, 2005; Teicher & Samson, 2016; Tronick, 2007; Van der Kolk, 2016).

Unsurprisingly, there are positive associations between an array of relational variables in therapy and outcomes (Norcross & Lambert, 2019). For example, meta-analyses indicate that a better therapeutic alliance (Flückiger, Del Re, Wampold, & Horvath, 2019) and empathy (Elliott, Bohart, Watson, & Murphy, 2019) are positively associated with client outcomes. Of particular relevance to our emphasis on therapist reactivity, research on various negative therapist reactions indicates that these are common (e.g., Pope & Tabachnick, 1993) and inversely related to therapeutic outcome. Fine-grained research on subtly hostile therapist reactions to difficult client communications (known as "negative process," Binder & Strupp, 1997) has demonstrated that while "the *absence* of a negative interpersonal process may not be sufficient for therapeutic change, the *presence* of even relatively low levels of negative therapist behavior may be sufficient to prevent change" (Henry, Schacht, & Strupp, 1990, p 773. See also, Critchfield, Henry, Castonguay, & Borkovec, 2007; Samstag et al., 2008; Strupp, 1980a, 1980b, 1980c, 1980d, 1993; Von der Lippe, Monsen, Rønnestad, & Eilertsen, 2008). A body of recent work unpicking reasons some therapists are more effective than others (Castonguay & Hill, 2017; Wampold & Brown, 2005) indicates that therapists' ability to respond in an affiliative way to hostile or difficult client communication is key to therapist effects (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; See also Wampold, Baldwin, Holtforth, & Imel, 2017). Such facilitative interpersonal skills (FIS) predict clinical outcomes of clinical psychology trainees a year after they have been assessed (Anderson, McClintock, Himawan, Song, & Patterson, 2016). Furthermore in a comparison between "therapists" who were either clinical psychology trainees with 2 years of training or graduate students with no clinical training, "training status" had no overall effects, while high FIS predicted better outcomes, faster rate of change, and better therapeutic alliances (Anderson, Crowley, Himawan, Holmberg, & Uhlin, 2016). A parallel literature on the management of countertransference summarized in a meta-analysis by Hayes, Gelso, Kivlighan, and Goldberg (2019) suggests that successfully managing potentially problematic countertransference reactions is associated with better psychotherapy outcome (see also Gelso & Perez-Rojas, 2017).

Building on the work on negative process described above, researchers began to frame negative therapist reactions as one kind of inevitable "rupture" in therapeutic relationships (Safran & Muran, 2000). A rupture is defined as any "tension or breakdown in the collaborative relationship between patient and therapist" (Safran, Muran, & Eubanks-Carter, 2011, p. 224). Patients report ruptures in 19 to 42% of sessions, therapists report them in between 43 to 56% of sessions and trained raters identify ruptures in between 41 to 100% of sessions (Eubanks, Muran, & Safran, 2019; Safran et al., 2011). A meta-analysis by Eubanks et al. (2019) of 11 relevant studies showed that resolving ruptures has a positive effect on outcome. Failure to resolve ruptures has been linked to patients dropping out of therapy (Muran et al., 2009). The research on ruptures adds to the work on negative process. It includes study of interpersonal difficulties that are characterized by distance or disengagement rather than hostility per se, and it also distinguishes between the impact of interpersonal difficulties that are resolved in the relationship versus those that are not.

Research on negative process, countertransference, FIS, and resolving ruptures in therapeutic relationships all suggests that therapists' ability to remain responsive, and to work through relational challenges, is critical if we are to improve the help we provide, and improve on the relatively modest success rate of psychotherapy (Wolf, Goldfried, & Muran, 2017). Of note, each of these areas concerns processes of social communication that are normally enacted in an implicit and unarticulated manner and therefore out of awareness. Given the importance of self-awareness in detecting and managing such difficulties, mindfulness training has been advocated as an essential element in therapist development, supporting awareness of and skillful responsiveness to the relational difficulties that are inherent in psychotherapeutic work (e.g., Anderson & Perlman, 2020; Gehart & McCollum, 2008; Geller & Greenberg, 2012; Gelso & Hayes, 2007; Hayes & Vinca, 2017; Muran & Eubanks, 2020; Pollak, Pedulla, & Siegel, 2014; Safran & Muran, 2000; Wolf et al., 2017). There is a growing literature on the relationship between therapist trait mindfulness or mindfulness practice and therapeutic outcomes. While earlier reviews of this literature (Davis & Hayes, 2011; Escuriex & Labbé, 2011) found the evidence was mixed, perhaps due to methodological problems, more recent and methodologically sophisticated studies support a positive impact of therapist mindfulness on client outcomes (Grepmair, Mitterlehner, Loew, & Nickel, 2007; Pereira, Barkham, Kellett, & Saxon, 2017; Ryan, Safran, Doran, & Muran, 2012).

The mindful attitude that therapists endeavor to embody in the therapeutic relationship has been conceptualized as "therapeutic presence" (Geller & Greenberg, 2012; Hayes & Vinca, 2017). Geller and Greenberg (2012) define therapeutic presence as "the state of having one's whole self in the encounter with a client by being completely in the moment on a multiplicity of levels" (p. 7). This includes "(a) being grounded and centered in [one]self, while (b) feeling deeply immersed in the moment, with (c) a larger sense of expansion or spaciousness . . . [and] (d) being compassionately with and for your client, in service of their well-being" (Geller, 2017, p. 4). Geller and Greenberg (2012) and Geller (2017) suggest that therapeutic presence initially emerges from the therapist's attunement to their own immediate internal experience. This is a basis for empathic attunement to their client's experience, which, as Rogers (1980, p. 142) describes it, involves being sensitive to the "changing felt meanings which flow in th[e] other person." Geller and Greenberg suggest that when the therapist becomes present with the client in this way, the "resonance circuit" between therapist and client is activated—clients' nervous systems begin to calm, and their "social engagement system" kicks in. Clients are then likely to be less defensive, more present, and more connected with the therapist (Geller, 2017). By maximizing empathic attunement and the provision of relational safety, therapeutic presence minimizes client challenges to the therapeutic relationship. It offers a way of dealing with therapist reactivity by minimizing the likelihood of it occurring in the first place. Initial research on therapeutic presence indicates that clients report greater improvement following sessions in which they rated the therapist as more present, regardless of the type of therapy (Geller & Greenberg, 2012), and trainee therapists engaging in a 5-minute "centering" mindfulness practice prior to sessions rated themselves as more present and had higher client-rated therapeutic alliance scores and session effectiveness scores compared to when they had not engaged in the centering practice (Dunn, Callahan, Swift, & Ivanovic, 2013; see also Stone, Friedlander, & Moeyaert, 2018).

While Geller and Greenberg's work helps us to specify the subtle relational qualities that minimize therapist reactivity, Safran and Muran (1996, 2000) and Muran and Eubanks (2020) outline a "direct expressive" means of resolving therapeutic ruptures when they do (inevitably) occur. Their approach stresses mindfulness in interaction expressed as *meta-communication*: "the process of making explicit what is being unwittingly enacted in the therapeutic relationship" (Safran & Muran, 2000, p. 6), and is applicable to therapeutic impasses that involve the therapist's moments of unhelpful reactivity. In brief, based on a program of qualitative and quantitative analysis of resolved versus unresolved ruptures, they outline a four-stage model of rupture resolution. First, the therapist recognizes the rupture and draws the patient's attention to it. Second, the experience of the rupture is explored collaboratively. Third, if the client

withdraws from this exploration, their avoidance becomes the focus of the exploration. Finally, therapist and patient work on clarifying the patient's fears or wishes underlying the rupture (Muran & Eubanks, 2020). This four-stage process requires therapists to "disembed" from their unconscious participation in unhelpful complementary relational patterns, requiring awareness of their own subtle feelings as "the best indicator that something is taking place that warrants further exploration" (Safran & Muran, 2000, p. 144). Studies have shown that a model of Brief Relational Therapy based on this approach was more effective at preventing dropout than two established treatments for patients with personality disorders (Muran, Safran, Samstag, & Winston, 2005; Safran, Muran, Samstag, & Winston, 2005). More recent research has documented the value of switching to supervision based on this model (alliance-focused training, AFT) from a baseline of high quality Cognitive Behavioural Therapy (CBT) supervision in treatments of Cluster C personality disorder patients conducted by clinical psychology doctoral interns (Muran, Safran, Eubanks, & Gorman, 2018; Safran et al., 2014). Muran et al. (2018) found significant changes in both client and therapist interpersonal behavior as a result of AFT. Therapists became less controlling and critical and more affirming and self-expressive. Clients became less dependent and more expressive. With regard to outcomes, "client following" and "therapist directing" were negatively related to sessional impact and "client expressing" was positively related to sessional impact and final treatment outcome. This pattern of findings suggests that AFT is successful in reducing negative therapist reactivity and increasing both therapist facilitative interpersonal responsiveness and client expressiveness. To date, Safran and Muran's (2000; see also Muran & Eubanks, 2020) mindfulness-oriented method of resolving the problem of therapist interpersonal reactivity is considerably more developed than any other approach.

The research summarized thus far implies that in the relational field of psychotherapy it makes sense for therapists to cultivate mindfulness both as a pathway to increased therapeutic presence and as a basis for mindfulness in interaction and metacommunication. However, as Geller (2017) notes, "guidance on how to cultivate and sustain [therapeutic presence] is virtually absent from the psychotherapy literature and training" (p. 4). In the remaining part of the article we explore why and how an established MBP, MBCT, could be adapted specifically for psychotherapists. MBCT has been chosen for several reasons. First, its development was strongly informed by research on the role of cognitive reactivity in triggering depressive relapse (Segal, Williams, & Teasdale, 2013). This has directly inspired the current proposal, which aims to offer a parallel program that systematically addresses the problem of interpersonal reactivity in the context of relational ruptures in psychotherapy and is equally rooted in the empirical literature. Second, MBCT creatively adapts exercises from the research and practice of CBT to further the aim of helping patients decenter from reactive thinking patterns. This has inspired the development of exercises based on the research underpinning AFT designed to further the process of decentering from implicit relational reactivity. Finally, the first author is an MBCT teacher and is most familiar with the structure and practices of MBCT.

How Might MBCT Be Adapted for the Purpose of Training Therapists to Deal With Interpersonal Reactivity?

> [T]herapists must succeed in integrating their *professional* capacities and expertise with their *personal* attributes in a way that almost blurs the distinction between them. (Nissen-Lie et al., 2017, p. 2)

Safran and Muran (2000) point out that "growth as therapists is . . . inextricably tied to personal growth and the development of self-awareness" (p. 4). It follows that "training therapists to deal with negative process . . . and therapeutic impasses is a formidable task" (p. 5). And yet clinicians in routine practice highlight their wish for more understanding of these relational and experiential aspects of therapy (Tasca et al., 2015). Might an adaptation of MBCT make a significant contribution to this "formidable task"?

Limitations of Existing Training Programs

Studies of training programs designed to help therapists deal with ruptures or negative process in therapy have had mixed success. A heroic failure in this regard is the first major initiative in the field, the Vanderbilt Two project. This

study found that a 100-hr, 1-year training in a manualized form of psychodynamic therapy, which emphasized management of negative complementarity, increased technical adherence to the model. However, training paradoxically resulted in more hostile and controlling behavior by therapists (Henry, Schacht, Strupp, Butler, & Binder, 1993). The researchers later found that this was because the therapists had not actually achieved competence (Bein et al., 2000) and subsequent consideration led to the conclusion that the traditional training methods used in the study "had not improved the therapists' ability to 'reflect-in-action'" (Binder & Henry, 2010, p. 300). In other words, the training did not improve therapists' "mindfulness-in-relationship"—their capacity for decentered awareness in the midst of emotionally demanding interpersonal situations. A recent meta-analysis of controlled studies on training and supervision in rupture resolution shows that overall there was no statistically significant improvement in client outcomes, although there is considerable variation between studies (Eubanks et al., 2019).

To date studies have not focused on systematic mindfulness practice as a central element in training this capacity to "reflect-in-action," in spite of the emphasis on mindfulness skills in the literature and recognition that mindfulness training is a form of "deliberate practice," conforming to principles shown to be effective in various forms of training (Rousmaniere, 2017). In Safran and Muran's (2000) promising method of AFT (described above), mindfulness is considered one of three key training strategies, alongside videotaped analysis of rupture moments and awareness-oriented role plays (Eubanks-Carter, Muran, & Safran, 2015). However, in the current model of AFT, while mindful awareness is promoted in the experiential role plays, the mindfulness training component is undeveloped. Supervision sessions may start with a brief mindfulness exercise, and trainees are encouraged to develop their own mindfulness practice; however, AFT does not currently offer detailed instruction, support, or feedback for trainees who seek to develop their own mindfulness practice. Neither does it help them to explore links between their personal mindfulness practice and their clinical skills. This appears to be a source of dissonance. Eubanks-Carter et al. (2015) note that although trainees generally described mindfulness practice as helpful, some raised concerns that "it was not sufficiently integrated with the rest of AFT" (p. 172). Safran (personal communication, 2016) has described mindfulness as an underdeveloped element of AFT. The adaption of MBCT for therapists and trainee therapists described below is intended to sit alongside and extend the existing supervision-based model of AFT.

The "Warp" of Mindfulness Based Programs

Crane et al. (2017) have helpfully outlined characteristics that are "essential" if an intervention is to be properly considered *mindfulness-based*: using a metaphor from weaving, they term these characteristics the "warp" of MBPs, referring to the strong longitudinal yarns which are held in tension and through which the vertical "weft" yarns are threaded. These essential "warp" elements are: (a) a grounding in a confluence of Buddhist psychology, contemporary science, and a helping discipline such as psychology; (b) a theoretical underpinning that explains how distress is maintained by processes such as experiential avoidance that can be addressed by the practice of mindfulness; (c) the intervention helps people develop a new way of relating to difficulties characterized by present moment focus, decentering and an approach orientation; (d) the intervention helps people improve "attentional, emotional, and behavioral self-regulation" as well as qualities such as compassion; (e) the intervention includes sustained and intensive mindful meditation practice. Table 1 illustrates how a mindfulness-based program (MBP) focusing on skills for dealing with therapist interpersonal reactivity meets each of these five essential requirements.

Practices from MBCT that form the warp of the proposed program include the bodyscan, breath and body sitting meditations, awareness of sounds and thoughts, and slightly adapted versions of the exploring the difficult meditation and the breathing space (Segal et al., 2013).

The "Weft"

Regarding innovations or adaptations to existing models, the changeable "weft" of MBPs,

Table 1
Crane et al.'s (2017) Essential Characteristics of an MBP and How These Relate to the Proposal for an MBP Focused on Therapist Reactivity

Five essential characteristics of an MBP	Necessary element of proposed program (yes/no)	Rationale	Background literature
Basis in a confluence of Buddhist psychology, contemporary science, and a helping discipline such as psychology	Yes	Theoretical views of therapeutic presence and resolving ruptures in therapeutic relationships explicitly draw on Buddhist psychology in addition to contemporary theory and research in psychology (and in neuroscience for "therapeutic presence")	Geller and Greenberg (2012); Geller (2017); Safran and Muran (2000)
Theoretical underpinning that explains how distress is maintained by processes such as rumination and experiential avoidance which can be addressed by the practice of mindfulness	Yes	Mindful awareness in therapy, operationalized as "therapeutic presence" supports the activation of a neurobiological "resonance circuit," which facilitates client engagement; Mindful awareness in relational impasses enables recognition of relational distress—characterized as ruptures, disembedding from the enactment, and metacommunication	Geller and Greenberg (2012); Geller and Porges (2014); Geller (2017; Safran and Muran (2000); Safran et al. (2014); Muran, Safran, Eubanks, and Gorman (2018); Siegal (2010)
Intervention helps people develop a new way of relating to difficulties which is characterized by present moment focus, decentering, and an approach orientation	Yes	Therapists need to learn present moment focus, decentering, and an approach orientation to work with therapeutic ruptures. These same skills are also likely to minimize the occurrence of ruptures.	Safran and Muran (2000); Siegal (2010); Muran et al. (2018); Muran and Eubanks (2020)
Intervention helps people improve "attentional, emotional, and behavioral self-regulation" as well as qualities such as compassion, wisdom, and equanimity	Yes	Therapists need to learn to be highly attentive to internal and external signs of relational difficulty, and need to be able to regulate their emotional reactions, so that they can respond compassionately	Geller and Greenberg (2012); Geller (2017); Safran and Muran (2000); Eubanks-Carter, Muran, and Safran (2015); Muran et al. (2018); Muran and Eubanks (2020)
Intervention includes a sustained and intensive mindful meditation practice	Yes	Therapeutic presence and mindful awareness can be cultivated in intensive mindful meditation practice.	Geller and Greenberg (2012); Geller (2017; Safran and Muran (2000); Eubanks-Carter et al. (2015)

Note. MBP = mindfulness-based programs.

Crane et al. (2017) argue that developers of new MBPs need to pose the question "What are the specific curriculum elements that may be required to support the mindfulness-based learning experience in this specific context?" (p. 991). Changes should only be made when "there is clearly an added value of the adaptation over existing MBPs" (p. 991).

Let us first examine the issue of whether current MBPs are already suitable for the context we have in mind. There is a small literature on the value of MBPs in fostering therapist self-care and well-being, which has been recently reviewed by Rudaz, Twohig, Ong, and Levin (2017). Although many of the studies in this field lacked control conditions, the tentative conclusion was that MBPs increase therapist mindfulness and self-compassion, with some evidence of a positive effect on stress and burnout (see also Eriksson, Germundsjö, Åström & Rönnlund, 2018). None of these studies explored the impact of these existing MBPs on therapist interpersonal behavior in sessions. However, given the evidence of a positive impact on mindfulness and self-compassion, this might suggest that existing MBPs are sufficient

to the task of training therapists to cope with interpersonal reactivity. How, then, might a new MBP add value to those that already exist?

Eubanks-Carter et al. (2015) highlight the need for therapists to develop three critical skills in order to resolve ruptures in the therapeutic relationship. These are, first, *self-awareness*, needed in order to become aware of the subtle clues that may reveal that a rupture is taking place and as a basis for metacommunication. Second, the skill of *affect regulation*, so that therapists can manage uncomfortable experiences and remain empathic without either resorting to complementary hostility or avoidance in order to regulate their discomfort. Finally, therapists need to develop *interpersonal sensitivity*, necessary in order to communicate about the rupture in an empathic way, which does not exacerbate the rupture and helps the client become aware of their own experience and their impact on others. Each of these can be regarded as a skill of "mindfulness-in-action." Each may be more readily accessible in times of interpersonal safety, when our "resonance circuit" is more easily primed, but especially essential in interpersonal situations that are challenging, when we feel threatened and our resonance circuit is more liable to be "off-line." In short, these mindfulness-in-action skills need to be available to therapists in interpersonally stressful situations when, for most of us, they are less likely to be available.

A number of writers have observed that mindfulness practiced in an individual format can often fail to generalize to interpersonal situations. For example, Fulton and R. Siegal (2013) comment that "the lore among meditators is replete with stories of individuals who fall into familiar neurotic interpersonal conflicts despite years of meditation practice" (p. 52). As Kramer (2007) puts it "We meditate alone but live our lives with other people; a gap is inevitable" (p. 3). He suggests that "the most sticky and painful knots in our being" are those "associated with our relations to other people" (p. 7)—an observation in line with the interpersonal roots and manifestations of psychological distress noted in the first part of this article.

Kramer (2007) suggests that the discipline of individual mindfulness practice can be brought into the relational sphere, so that mindfulness can be cultivated in and through relational practices. This can "enable insights that may be difficult to access through personal meditation" (p. 93). Furthermore, relational practices can also constitute "a powerful way to cultivate a living compassion, freed from any abstraction of 'practice'" (p. 93). Given that therapists need to be able to access mindfulness in the midst of relational stress and difficulty, the introduction of explicitly interpersonal forms of mindfulness in an MBP optimized for this purpose is congruent both with the observations of many expert commentators and the recent literature on the value of deliberately practicing challenging skills as a means of developing expertise (Muran & Eubanks, 2020; Rousmaniere, 2017). If we want to cultivate mindfulness skills specifically for a relational context, it clearly makes sense to practice them in such a context.

What Might Relational Mindfulness Practices Look Like?

Kramer (2007) has developed an approach to relational mindfulness practice—Insight Dialogue—which is rooted in Buddhist *dharma* practice. Surrey and Kramer (2013) have considered its value for psychotherapists. Defining *relational mindfulness* as "the practice and cultivation of mindfulness in an engaged, person-to-person relational context," they see this as a means for therapists to cultivate "mindful awareness of [their] internal states, observing the moment-to-moment empathic connection with the patient, and continuous awareness of the changing relationship *between* both patient and therapist" (p. 93).

In spite of the depth and richness of Kramer's work, its explicitly Buddhist framework would be problematic in the context of a secular MBP (Crane et al., 2017). Fortunately, Kramer, Meleo-Mayer, and Turner (2008) outline a secular "offshoot" of Insight Dialogue, the Interpersonal Mindfulness Program (IMP), which is loosely modeled on MBSR and "designed to be accessible to people with no . . . interest in the Buddhist roots" of Insight Dialogue (p. 197). The key Insight Dialogue guidelines, as Kramer et al. point out, are transferable to a nonspiritual context. IMP participants are therefore taught the Insight Dialogue guidelines for relating mindfully—termed *Pause*, *Relax*, *Open*, *Trust Emergence*, *Listen Deeply*, and *Speak the Truth*—in a secular context. IMP participants practice the guidelines while in dialogic "con-

templations" offered by the teacher. These are selected:

> to encourage a reevaluation of one's assumptions and behavior patterns and to foster deeper insight into the human condition. They also provide a present moment conversational basis for meditators as they use the guidelines to cultivate mindfulness, tranquility, adaptability, compassion, and the ability to respond authentically. (Kramer et al., 2008, p. 201)

Kramer (2007) explains how the relational practice guidelines support awareness and letting go of interpersonal patterns of reactivity. The guideline Pause "is an invitation to step out of our reactions and identification with our own and others' stories. It is the same basic movement as returning to the breath in individual meditation" (p. 109) and it enables us to "see and release the old run-on habits of the mind and develop a tendency toward mindfulness . . . in the moment of interpersonal contact" (p. 110). It is often supported by an invitation to anchor awareness in the experience of the body. The guideline Relax invokes the intention to accept with friendliness whatever we find when we Pause: "When we Pause, we step out of reaction and into the moment; when we Relax, we meet thoughts and feelings with acceptance . . . Relax heals what Pause reveals" (p. 123). The guideline Open "invites us to extend the accepting mindfulness developed in Pause and Relax to the world beyond the boundaries of our skin . . . [It] opens the door to mutuality" (129). Flowing from these guidelines Trust Emergence (now restated as Attune to Emergence), Listen Deeply, and Speak the Truth support (a) mindful engagement with another person, based on open awareness of what emerges in the present moment (finding the "bare moment together"; p. 212), (b) being fully present as one listens to another person, and (c) learning to speak from internal awareness of our own subjective "truth".

Kramer (2007) notes that this kind of mindful communication and its "quality of attention" "falls outside of most social norms" (p. 212) and is helpfully supported by "silent, solitary meditation" (p. 221). Kramer et al. (2008) and Surrey and Kramer (2013) discuss how learning the guidelines can support therapists in dealing with countertransference. For example, "Practicing Pause supports the therapist's mindful awareness of his or her reactions and emotions, and allows them to be examined rather than defended against" (Kramer et al., 2008, p. 205).

Unfortunately, there are no published empirical studies of the impact of the IMP; and yet, in such an undeveloped field, the existence of a well-thought-out program for training mindfulness skills in relationship is a natural starting point for introducing relational mindfulness exercises into an MBP for therapists. In line with Dimidjian and Segal's (2015) recommendations for the development of MBPs, it would be especially desirable to start exploring the impact of the IMP in an empirical way.

Kramer and his colleagues have pioneered a way of cultivating mindfulness in an emotionally evocative relational context, and relational practices of this kind should clearly be one element of the MBP we are proposing—in order to help participants develop mindful awareness, affect regulation and interpersonal sensitivity where it matters—in relationship.

Additional Exercises to Support an Understanding and Practice of Mindfulness-in-Relationship

In our view, there is a second area of potential adaptation. A pioneering element in MBCT for depression is the use of tasks drawn from cognitive therapy and research that help participants gain insight into the way depressive experience is "constructed." This includes helping participants "parse" an experience into its basic internal elements by discriminating the thoughts, bodily sensations and emotions that contribute to it. Sensitizing participants to their internal experience in this way is, of course, designed to help them decenter from depressive patterns of thinking—for example understanding that "thoughts are not facts" (Segal et al., 2013; see also Feldman & Kuyken, 2019 for a perspective on decentering in mindfulness training that is not exclusively focused on depression).

A relational adaptation, as sketched here, would promote a similar understanding in the context of relationships. As Safran and Muran (2000) have written:

> The failure to distinguish between one's constructs and the underlying phenomenon that these constructs represent, is one of the key sources of dysfunction in everyday life and one of the major roadblocks for therapists. As therapists we must constantly struggle with the temptation to hold on to fixed conceptions of what is taking place between us and our patients. (p. 37)

Just as Segal et al. (2013) ingeniously use the Automatic Thought Questionnaire (ATQ) in an exercise designed to help depressed participants decenter from depressive thinking, we propose that therapist participants be introduced to the Experiencing Scale (EXP; Klein, Mathieu, Gendlin, & Kiesler, 1969, see also Pascual-Leone & Yeryomenko, 2017) to help them build awareness of the subjective constructive dimension of their relational experiences. The EXP is an observational coding system designed to measure the degree to which clients in therapy make sense of events by identifying and reflecting on internal experience. The scale ranges from low scores, which indicate an external focus, suggestive of identification with one's perceptions, to high scores, which indicate that a person is actively struggling to articulate and become aware of subtle internal dimensions of experience. Safran et al. (2014) used the EXP to measure trainee clinical psychologists' capacity to reflect on their internal experience of clients before and after AFT. They found that AFT significantly increased EXP scores, suggesting that after training therapists were better able "to reflect on their relationships with their patients in a personally involved, experientially grounded fashion" (p. 14). Participants in the proposed program are introduced to the EXP, and initially supported to explore moving toward more reflective exploration of their experience in a dyadic exercise in class. This learning is then extended in a diary homework task in which participants are encouraged to explore deeper levels of experiencing while reflecting on recent clinical sessions. While the EXP is more usually associated with Gendlin's Focusing-Oriented Psychotherapy (Gendlin, 1996) or research on Emotion-Focused Therapy (e.g., Pos & Choi, 2019), in the proposed mindfulness program, following Safran et al. (2014), it is designed to support participants' capacity to decenter from potentially problematic implicit beliefs and feelings occurring in the therapy relationship.

In a similar vein, the development of the relapse prevention plan starting in Session 6 of MBCT for depression has inspired a task in which participants are invited to explore their own recurring patterns of interpersonal expectation and reactivity. This draws on the methods used in the research by Schattner, Tishby, and Wiseman (2017) and Wiseman and Tishby (2017) using the Core Conflictual Relationship Theme (CCRT) method applied to "Relationship Anecdotes" (Luborsky & Crits-Christoph, 1990). The aim is to foster curiosity and exploration of personal patterns of relational reactivity in order to promote greater self-awareness and self-acceptance, and hence more "internal space," when these patterns are inevitably triggered in relational enactments with clients. (Like the work using the ATQ in MBCT, an objective is to see such patterns as an inevitable part of being human).

Given the relational focus of the program, and the need for therapists to develop compassion for themselves and others, we propose including the befriending practice (as described e.g., in Williams & Penman, 2011, and drawn from Buddhist *metta* meditations). Befriending practices were not included in MBCT for depression by Segal et al. (2013) because of the phenomenon of depressed individuals rebounding into negative feelings when introduced to these practices (p. 142). However, befriending practices in nonclinical samples have been shown to increase self-compassion (Shahar et al., 2015), increase altruistic behavior (Galante, Bekkers, Mitchell, & Gallacher, 2016; Weng et al., 2013), reduce empathic distress (Klimecki, Leiberg, Ricard, & Singer, 2014; Singer & Klimecki, 2014), decrease implicit intergroup bias (Kang, Gray, & Dovidio, 2014) and increase emotional well-being (Galante et al., 2016). Given (a) this promising research, (b) the fact that our participants are therapists rather than patients, and (c) the need for both self- and other-directed compassion when practicing psychotherapy, it seems appropriate to include the befriending practice.

Finally, key elements of the program's home practice component are (a) the use of a presession mindfulness exercise modeled on MBCT's breathing space practice, as recommended in AFT (Muran & Eubanks, 2020), drawing on evidence from the Dunn et al. (2013) study, and (b) the use of posttherapy session journaling tasks inspired by Muran and Eubanks' (2020, p. 176) description of the use of emotion journaling to regulate negative therapist emotions and to promote greater awareness of, and insight into, difficult therapist experiences. In our program journaling tasks are tailored specifically to the content of the preceding weekly session.

While a detailed description of such a program is beyond the scope of this article, Table 2 summarizes some existing and novel practices that we suggest might be included along with

Table 2
Existing and Novel Practices for Potential MBCT Adaptation for Therapists, Including Session Placement and Purpose

Practice	Existing or novel	Adaptations	Session no.	Purpose
Body scan	Existing	Shorter	1 and 2	Building interoceptive awareness of "felt sense" supporting affective attunement to self and other (Siegal, 2010)
Insight Dialogue relational practice	Novel	Using "contemplations" that are congruent with therapist experiences	1, 2, 3, 4, 5, 6, 7 and 8	Applying mindfulness skills to interpersonal situations. Developing self-awareness, affect regulation and interpersonal sensitivity in a relational context (Eubanks-Carter et al., 2015)
Sitting meditation	Existing	Shorter	2, 3, 5, 6, and 8	Learning to work with difficulty; decentering (Segal, Williams, & Teasdale, 2013). Developing self-awareness and affect regulation (Eubanks-Carter et al., 2015)
Mindful movement	Existing	Shorter	4 and 8	Developing mindfulness-in-action skills (self-awareness, Eubanks-Carter et al., 2015)
Breathing space	Existing	Invitation to use as centering exercise before sessions. Linking to relational practice guidelines Pause, Relax, and Open	2 and 7	Cultivating therapeutic presence (Dunn, Callahan, Swift, & Ivanovic, 2013)
Experiencing scale exercise	Novel	Link to Insight Dialogue practice	4	Understanding internal constructive processes and decentering in relationship (Safran & Muran, 2000; Safran et al., 2014)
Befriending practice	Novel	Adapted from *Finding Peace in a Frantic World* (Williams & Penman, 2011)	3, 4, 5, 7 and 8	Developing compassion and interpersonal sensitivity (Eubanks-Carter et al., 2015)
Relationship anecdotes exercise	Novel	Adapted from Schattner, Tishby, and Wiseman (2017); Wiseman and Tishby (2017); Luborsky and Crits-Cristoph (1990)	6 and 8	Developing awareness of own habitual relational patterns of reactivity in order to foster self-acceptance and awareness (Eubanks-Carter et al., 2015)

Note. MBCT = mindfulness-based cognitive therapy.

their theoretical rationale and background literature.[1]

Summary and Conclusion

We reviewed literature suggesting that psychotherapy outcomes might be improved if we could find a way of increasing therapists' capacity to respond in an affiliative way to challenging client communications. We then explored mindfulness, conceptualized as therapeutic presence and as mindfulness-in-relationship, as a way of understanding and developing the intra and interpersonal skills that can enable therapists to deal more effectively with relational challenges. This led to ideas regarding the warp and the weft (Crane et al., 2017) of a proposed adaptation of MBCT designed to enhance therapeutic presence and

[1] A session-by-session synopsis of the course showing how the various elements can be brought together is available from the corresponding author on request.

mindfulness-in-relationship. The proposed program takes the first steps toward harnessing the deliberate practice principles long associated with mindfulness (Rousmaniere, 2017) for the purpose of enhancing therapist skills of reflection-in-action, or mindfulness-in-relationship during relational challenges in therapy. Deployed hand-in-hand with complementary approaches such as AFT, we anticipate that the program has the potential to help therapists develop and enhance implicit relational abilities (captured in research measures such as the FIS task reviewed above) as a result of greater awareness of their countertransferential reactions, alongside enhanced skills in emotion regulation and metacommunication. Evidence reviewed in the first part of this article suggests that this is likely to improve their effectiveness as therapists.

We hope that the rationale and outline of this program, designed to complement supervision-based AFT, will inspire further empirical research, alongside other efforts to address the "impasse of outcomes" in psychotherapy. Initial research should test the impact of the program on therapist self-awareness, emotional regulation, and interpersonal sensitivity—the key therapist attributes targeted by AFT (Eubanks-Carter et al., 2015). Further research might involve a "component" strategy of documenting the impact of adding the program to AFT supervision.

References

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal of Counseling Psychology, 48,* 251–257. http://dx.doi.org/10.1037/0022-0167.48.3.251

Allen, J. (2001). *Traumatic relationships and serious mental health disorders*. Chichester, UK: Wiley.

Anderson, T., Crowley, M. E. J., Himawan, L., Holmberg, J. K., & Uhlin, B. D. (2016). Therapist facilitative interpersonal skills and training status: A randomized clinical trial on alliance and outcome. *Psychotherapy Research, 26,* 511–529. http://dx.doi.org/10.1080/10503307.2015.1049671

Anderson, T., McClintock, A. S., Himawan, L., Song, X., & Patterson, C. L. (2016). A prospective study of therapist facilitative interpersonal skills as a predictor of treatment outcome. *Journal of Consulting and Clinical Psychology, 84,* 57–66. http://dx.doi.org/10.1037/ccp0000060

Anderson, T., Ogles, B. M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist effects: Facilitative interpersonal skills as a predictor of therapist success. *Journal of Clinical Psychology, 65,* 755–768. http://dx.doi.org/10.1002/jclp.20583

Anderson, T., & Perlman, M. R. (2020). Therapeutic interpersonal skills for facilitating the working alliance. In J. Fuertes (Ed.), *Working alliance skills for mental health professionals* (pp. 43–68). New York, NY: Oxford University Press.

Beebe, B. (2014). My journey in infant research and psychoanalysis: Microanalysis, a social microscope. *Psychoanalytic Psychology, 31,* 4–25. http://dx.doi.org/10.1037/a0035575

Beebe, B., & Lachmann, F. (2014). *The origins of attachment: Infant research and adult treatment*. New York, NY: Routledge.

Bein, E., Anderson, T., Strupp, H., Henry, W., Schacht, T., Binder, J., & Butler, S. (2000). The effects of training in time-limited dynamic psychotherapy: Changes in therapeutic outcome. *Psychotherapy Research, 10,* 119–132. http://dx.doi.org/10.1080/713663669

Bell, E. C., Marcus, D. K., & Goodlad, J. K. (2013). Are the parts as good as the whole? A meta-analysis of component treatment studies. *Journal of Consulting and Clinical Psychology, 81,* 722–736. http://dx.doi.org/10.1037/a0033004

Beutler, L. E., & Forrester, B. (2014). What needs to change: Moving from "research informed" practice to "empirically effective" practice. *Journal of Psychotherapy Integration, 24,* 168–177. http://dx.doi.org/10.1037/a0037587

Binder, J., & Henry, W. (2010). Developing skills in managing negative process (2010). In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 285–303). New York, NY: Guilford Press.

Binder, J. L., & Strupp, H. H. (1997). "Negative process": A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology: Science and Practice, 4,* 121–139. http://dx.doi.org/10.1111/j.1468-2850.1997.tb00105.x

Castonguay, L., & Hill, C. (Eds.). (2017). *How and why are some therapists better than others?: Understanding therapist effects*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000034-000

Crane, R. S., Brewer, J., Feldman, C., Kabat-Zinn, J., Santorelli, S., Williams, J. M. G., & Kuyken, W. (2017). What defines mindfulness-based programs? The warp and the weft. *Psychological Medicine, 47,* 990–999. http://dx.doi.org/10.1017/S0033291716003317

Critchfield, K. L., Henry, W. P., Castonguay, L. G., & Borkovec, T. D. (2007). Interpersonal process and outcome in variants of cognitive-behavioral psychotherapy. *Journal of Clinical Psychology, 63,* 31–51. http://dx.doi.org/10.1002/jclp.20329

Davis, D. M., & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, 48,* 198–208. http://dx.doi.org/10.1037/a0022062

Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist, 70,* 593–620. http://dx.doi.org/10.1037/a0039589

Dunn, R., Callahan, J. L., Swift, J. K., & Ivanovic, M. (2013). Effects of pre-session centering for therapists on session presence and effectiveness. *Psychotherapy Research, 23,* 78–85. http://dx.doi.org/10.1080/10503307.2012.731713

Elkins, D. (2016). *The human elements of psychotherapy*. Washington, DC: American Psychological Association.

Elliott, R., Bohart, A., Watson, J., & Murphy, D. (2019). Empathy. In J. Norcross & M. Lambert (Eds.), *Psychotherapy relationships that work* (pp. 245–287). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med-psych/9780190843953.003.0007

Eriksson, T., Germundsjö, L., Åström, E., & Rönnlund, M. (2018). Mindful self-compassion training reduces stress and burnout symptoms among practicing psychologists: A randomized controlled trial of a brief web-based intervention. *Frontiers in Psychology, 9,* 2340. http://dx.doi.org/10.3389/fpsyg.2018.02340

Escuriex, B., & Labbé, E. (2011). Health care providers' mindfulness and treatment outcomes: A critical review of the research literature. *Mindfulness, 2,* 242–253. http://dx.doi.org/10.1007/s12671-011-0068-z

Eubanks, C., Muran, C., & Safran, J. (2019). Repairing alliance ruptures. In J. Norcross & M. Lambert (Eds.), *Psychotherapy relationships that work* (pp. 549–579). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med-psych/9780190843953.003.0016

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2015). Alliance-focused training. *Psychotherapy, 52,* 169–173. http://dx.doi.org/10.1037/a0037596

Feldman, C., & Kuyken, W. (2019). *Mindfulness: Ancient wisdom meets modern psychology*. New York, NY: Guilford Press.

Feldman, R. (2007). Parent–infant synchrony: Biological foundations and developmental outcomes. *Current Directions in Psychological Science, 16,* 340–345. http://dx.doi.org/10.1111/j.1467-8721.2007.00532.x

Flückiger, C., Del Re, A., Wampold, B., & Horvath, A. (2019). Alliance in adult psychotherapy. In J. Norcross & M. Lambert (Eds.), *Psychotherapy relationships that work* (pp. 24–78). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med-psych/9780190843953.003.0002

Fonagy, P. (2008). The mentalization-focused approach to social development. In F. Busch (Ed.), *Mentalization: Theoretical considerations, research findings, and clinical implications* (pp. 3–56). New York, NY: Taylor and Francis.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2004). *Affect regulation, mentalization, and the development of the self*. London, UK: Karnac.

Fulton, P., & Siegel, R. (2013). Buddhist and Western psychology: Seeking common ground. In C. Germer, R. Siegel, & P. Fulton (Eds.), *Mindfulness and psychotherapy* (2nd ed., pp. 35–56). New York, NY: Guilford Press.

Galante, J., Bekkers, M. J., Mitchell, C., & Gallacher, J. (2016). Loving-kindness meditation effects on well-being and altruism: A mixed-methods online RCT. *Applied Psychology: Health and Well-Being, 8,* 322–350. http://dx.doi.org/10.1111/aphw.12074

Gehart, D., & McCollum, E. (2008). Inviting therapeutic presence. In S. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (pp. 176–194). New York, NY: Guilford Press.

Geller, S. M. (2017). *A practical guide to cultivating therapeutic presence*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000025-000

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic presence: A mindful approach to effective therapy*. Washington, DC: American Psychological Assoc. http://dx.doi.org/10.1037/13485-000

Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration, 24,* 178–192. http://dx.doi.org/10.1037/a0037511

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience*. Mahwah, NJ: Erlbaum. http://dx.doi.org/10.4324/9780203936979

Gelso, C., & Perez-Rojas, A. (2017). Inner experience and the good therapist. In L. Castonguay & C. Hill (Eds.), *How and why are some therapists better than others?* (pp. 101–115). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000034-007

Gendlin, E. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. New York, NY: Guilford Press.

Grepmair, L., Mitterlehner, F., Loew, T., & Nickel, M. (2007). Promotion of mindfulness in psychotherapists in training: Preliminary study. *European Psychiatry, 22,* 485–489. http://dx.doi.org/10.1016/j.eurpsy.2007.02.004

Hayes, J., Gelso, C., Kivlighan, M., & Goldberg, S. (2019). Managing countertransference. In J. Norcross & M. Lambert (Eds.), *Psychotherapy relationships that work* (pp. 522–548). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/med-psych/9780190843953.003.0015

Hayes, J. A., & Vinca, M. (2017). Therapist presence, absence, and extraordinary presence. In L. Castonguay & C. Hill (Eds.), *How and why are some therapists better than others?: Understanding therapist effects* (pp. 85–99). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000034-006

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology, 58,* 768–774. http://dx.doi.org/10.1037/0022-006X.58.6.768

Henry, W. P., Schacht, T. E., Strupp, H. H., Butler, S. F., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Mediators of therapists' responses to training. *Journal of Consulting and Clinical Psychology, 61,* 441–447. http://dx.doi.org/10.1037/0022-006X.61.3.441

Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 23–46). Washington, DC: American Psychological Association.

Kang, Y., Gray, J. R., & Dovidio, J. F. (2014). The nondiscriminating heart: Lovingkindness meditation training decreases implicit intergroup bias. *Journal of Experimental Psychology: General, 143,* 1306–1313. http://dx.doi.org/10.1037/a0034150

Keysers, C. (2011). *The empathic brain: How the discovery of mirror neurons changes our understanding of human nature*. Lexington, KY: Social Brain Press.

Klein, M. H., Mathieu, P. L., Gendlin, E. T., & Kiesler, D. J. (1969). *The Experiencing Scale: A research and training manual* (Vol. 1). Madison: University of Wisconsin Extension Bureau.

Klimecki, O. M., Leiberg, S., Ricard, M., & Singer, T. (2014). Differential pattern of functional brain plasticity after compassion and empathy training. *Social Cognitive and Affective Neuroscience, 9,* 873–879. http://dx.doi.org/10.1093/scan/nst060

Kramer, G. (2007). *Insight dialogue*. Boston, MA: Shambhala.

Kramer, G., Meleo-Mayer, F., & Turner, M. (2008). Cultivating mindfulness in relationship: Insight dialogue and the interpersonal mindfulness program. In S. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (pp. 195–214). New York, NY: Guilford Press.

Lambert, M. (2013). The efficacy and effectiveness of psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169–218). Hoboken, NJ: Wiley.

Longmore, R. J., & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavior therapy? *Clinical Psychology Review, 27,* 173–187. http://dx.doi.org/10.1016/j.cpr.2006.08.001

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method*. New York, NY: Basic.

Muran, C., & Eubanks, C. (2020). *Therapist performance under pressure: Negotiating emotion, difference, and rupture*. Washington, DC: American Psychological Association.

Muran, J. C., Safran, J. D., Eubanks, C. F., & Gorman, B. S. (2018). The effect of alliance-focused training on a cognitive-behavioral therapy for personality disorders. *Journal of Consulting and Clinical Psychology, 86,* 384–397. http://dx.doi.org/10.1037/ccp0000284

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 46,* 233–248. http://dx.doi.org/10.1037/a0016085

Muran, J. C., Safran, J. D., Samstag, L. W., & Winston, A. (2005). Evaluating an alliance-focused treatment for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 42,* 532–545. http://dx.doi.org/10.1037/0033-3204.42.4.532

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love yourself as a person, doubt yourself as a therapist? *Clinical Psychology & Psychotherapy, 24,* 48–60. http://dx.doi.org/10.1002/cpp.1977

Norcross, J., & Lambert, M. (Eds.). (2019). *Psychotherapy relationships that work: Vol. 1: Evidence-based therapist contributions* (3rd ed.). New York, NY: Oxford University Press.

Parker, S., Nelson, B., Epel, E., & Siegel, D. (2015). The science of presence: A central mediator of the interpersonal benefits of mindfulness. In K. Brown (Ed.), *Handbook of mindfulness: Theory, research, and practice* (pp. 225–244). New York, NY: Guilford Press.

Pascual-Leone, A., & Yeryomenko, N. (2017). The client "experiencing" scale as a predictor of treatment outcomes: A meta-analysis on psychotherapy

process. *Psychotherapy Research, 27,* 653–665. http://dx.doi.org/10.1080/10503307.2016.1152409

Pereira, J. A., Barkham, M., Kellett, S., & Saxon, D. (2017). The role of practitioner resilience and mindfulness in effective practice: A practice-based feasibility study. *Administration and Policy in Mental Health and Mental Health Services Research, 44,* 691–704. http://dx.doi.org/10.1007/s10488-016-0747-0

Pollak, S., Pedulla, T., & Siegel, R. (2014). *Sitting together: Essential skills for mindfulness-based psychotherapy*. New York, NY: Guilford Press.

Pope, K. S., & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24,* 142–152. http://dx.doi.org/10.1037/0735-7028.24.2.142

Pos, A., & Choi, B. (2019). Relating process to outcome in emotion-focused therapy. In L. Greenberg & R. Goldman (Eds.), *Clinical handbook of emotion-focused therapy* (pp. 171–191). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000112-008

Rogers, K. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Rousmaniere, T. (2017). *Deliberate practice for psychotherapists*. New York, NY: Routledge.

Rudaz, M., Twohig, M. P., Ong, C. W., & Levin, M. E. (2017). Mindfulness and acceptance-based trainings for fostering self-care and reducing stress in mental health professionals: A systematic review. *Journal of Contextual Behavioral Science, 6,* 380–390. http://dx.doi.org/10.1016/j.jcbs.2017.10.001

Ryan, A., Safran, J. D., Doran, J. M., & Muran, J. C. (2012). Therapist mindfulness, alliance and treatment outcome. *Psychotherapy Research, 22,* 289–297. http://dx.doi.org/10.1080/10503307.2011.650653

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64,* 447–458. http://dx.doi.org/10.1037/0022-006X.64.3.447

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance*. New York, NY: Guilford Press.

Safran, J., Muran, J. C., Demaria, A., Boutwell, C., Eubanks-Carter, C., & Winston, A. (2014). Investigating the impact of alliance-focused training on interpersonal process and therapists' capacity for experiential reflection. *Psychotherapy Research, 24,* 269–285. http://dx.doi.org/10.1080/10503307.2013.874054

Safran, J. D., Muran, C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. In J. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 224–238). New York, NY: Oxford University Press. http://dx.doi.org/10.1093/acprof:oso/9780199737208.003.0011

Safran, J. D., Muran, J. C., Samstag, L. W., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training, 42,* 512–531. http://dx.doi.org/10.1037/0033-3204.42.4.512

Samstag, L. W., Muran, J. C., Wachtel, P. L., Slade, A., Safran, J. D., & Winston, A. (2008). Evaluating negative process: A comparison of working alliance, interpersonal behavior, and narrative coherency among three psychotherapy outcome conditions. *American Journal of Psychotherapy, 62,* 165–194. http://dx.doi.org/10.1176/appi.psychotherapy.2008.62.2.165

Schattner, E., Tishby, O., & Wiseman, H. (2017). Relational patterns and the development of the alliance: A systematic comparison of two cases. *Clinical Psychology & Psychotherapy, 24,* 555–568. http://dx.doi.org/10.1002/cpp.2019

Segal, Z. V., Williams, J. M., & Teasdale, J. D. (2013). *Mindfulness-based cognitive therapy for depression* (2nd ed.). New York, NY: Guilford Press.

Shahar, B., Szepsenwol, O., Zilcha-Mano, S., Haim, N., Zamir, O., Levi-Yeshuvi, S., & Levit-Binnun, N. (2015). A wait-list randomized controlled trial of loving-kindness meditation programme for self-criticism. *Clinical Psychology & Psychotherapy, 22,* 346–356. http://dx.doi.org/10.1002/cpp.1893

Siegal, D. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York, NY: Norton.

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24,* R875–R878. http://dx.doi.org/10.1016/j.cub.2014.06.054

Sroufe, A., Egeland, B., Carlson, E., & Collins, W. A. (2005). *The development of the person: The minnesota study of risk and adaptation from birth to adulthood*. New York, NY: Guilford Press.

Stellar, J., & Keltner, D. (2017). Compassion in the autonomic nervous system: The role of the vagus nerve. In P. Gilbert (Ed.), *Compassion: Concepts, research and applications* (pp. 120–134). Abingdon, UK: Routledge. http://dx.doi.org/10.4324/9781315564296-7

Stone, M., Friedlander, M. L., & Moeyaert, M. (2018). Illustrating novel techniques for analyzing single-case experiments: Effects of pre-session mindfulness practice. *Journal of Counseling Psychology, 65,* 690–702. http://dx.doi.org/10.1037/cou0000291

Strupp, H. H. (1980a). Success and failure in time-limited psychotherapy. A systematic comparison of two cases: Comparison 1. *Archives of General*

Psychiatry, 37, 595–603. http://dx.doi.org/10.1001/archpsyc.1980.01780180109014

Strupp, H. H. (1980b). Success and failure in time-limited psychotherapy. A systematic comparison of two cases: Comparison 2. *Archives of General Psychiatry, 37,* 708–716. http://dx.doi.org/10.1001/archpsyc.1980.01780190106013

Strupp, H. H. (1980c). Success and failure in time-limited psychotherapy: Further evidence (Comparison 4). *Archives of General Psychiatry, 37,* 947–954. http://dx.doi.org/10.1001/archpsyc.1980.01780210105011

Strupp, H. H. (1980d). Success and failure in time-limited psychotherapy: With special reference to the performance of a lay counselor. *Archives of General Psychiatry, 37,* 831–841. http://dx.doi.org/10.1001/archpsyc.1980.01780200109014

Surrey, J., & Kramer, G. (2013). Relational mindfulness. In R. Siegel & P. Fulton (Eds.), *Mindfulness and psychotherapy* (2nd ed., pp. 93–110). New York, NY: Guilford Press.

Strupp, H. H. (1993). The Vanderbilt psychotherapy studies: Synopsis. *Journal of Consulting and Clinical Psychology, 61,* 431–433. http://dx.doi.org/10.1037/0022-006X.61.3.431

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80,* 547–559. http://dx.doi.org/10.1037/a0028226

Tasca, G. A., Sylvestre, J., Balfour, L., Chyurlia, L., Evans, J., Fortin-Langelier, B., . . . Wilson, B. (2015). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy, 52,* 1–11. http://dx.doi.org/10.1037/a0038252

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *The Journal of Child Psychology and Psychiatry, 57,* 241–266. http://dx.doi.org/10.1111/jcpp.12507

Tronick, E. (2007). *The neurobehavioural and social-emotional development of infants and children*. New York, NY: Norton.

van der Kolk, B. (2016). Commentary: The devastating effects of ignoring child maltreatment in psychiatry—A commentary on Teicher and Samson 2016. *Journal of Child Psychology and Psychiatry, 57,* 267–270. http://dx.doi.org/10.1111/jcpp.12540

von der Lippe, A. L., Monsen, J. T., Rønnestad, M. H., & Eilertsen, D. E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research, 18,* 420–432. http://dx.doi.org/10.1080/10503300701810793

Wampold, B., Baldwin, S., Holtforth, M., & Imel, Z. (2017). What characterizes effective therapists? In L. Castonguay & C. Hill (Eds.), *How and why are some therapists better than others?* (pp. 37–53). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000034-003

Wampold, B. E., & Brown, G. S. J. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73,* 914–923. http://dx.doi.org/10.1037/0022-006X.73.5.914

Wampold, B., & Imel, Z. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. New York, NY: Routledge. http://dx.doi.org/10.4324/9780203582015

Weng, H. Y., Fox, A. S., Shackman, A. J., Stodola, D. E., Caldwell, J. Z. K., Olson, M. C., . . . Davidson, R. J. (2013). Compassion training alters altruism and neural responses to suffering. *Psychological Science, 24,* 1171–1180. http://dx.doi.org/10.1177/0956797612469537

Williams, M., & Penman, D. (2011). *Mindfulness: An eight-week plan for finding peace in a frantic world*. Emmaus, PA: Rodale.

Wiseman, H., & Tishby, O. (2017). Applying relationship anecdotes paradigm interviews to study client-therapist relationship narratives: Core conflictual relationship theme analyses. *Psychotherapy Research, 27,* 283–299. http://dx.doi.org/10.1080/10503307.2016.1271958

Wolf, A. W., Goldfried, M. R., & Muran, J. C. (2017). Therapist negative reactions: How to transform toxic experiences. In L. Castonguay & C. Hill (Eds.), *How and why are some therapists better than others?: Understanding therapist effects* (pp. 175–192). Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/0000034-011

Received September 19, 2019
Revision received February 18, 2020
Accepted March 6, 2020 ■