The results of a study of the use of mindfulness, a meditation practice, are summarized with 13 beginning systemic therapists. In the excerpt, the therapists’ journal entries describe, in their own words, the effects of practicing mindfulness daily for 5–15 minutes on their therapy experiences. (Other benefits of using journaling as a method in supervision are described in Chapter 18 of the accompanying book.) The researchers then discuss the implications for supervision and training, and suggest ways for supervisors and trainers to implement mindfulness in their work. Innovative supervisors may find practicing mindfulness and encouraging this practice by supervisees to be helpful in developing the quality of presence in therapy and supervision and contribute to both professionals staying creative over the long term.

—Editors’ introduction

Our students described a rich and varied set of experiences arising from their mindfulness practice that they felt influenced their work as new therapists (see Table 4G.1 for a list of themes and subthemes, printed in bold in the text). In short, they said that mindfulness helped them be present in their sessions. “Being present” had a number of dimensions. The students reported being able to attend

to their inner experience during sessions as well as being aware of what was happening with the clients in front of them. They were further able to take their awareness of these two domains and bring them together in the therapist–client interaction; that is, the students reported being able to attend both to their own experience and that of their client and bring the awareness of both into the moment-by-moment interaction in session. While they reported being present, the students also made it clear that this was not a process of becoming absorbed. They described instances where they were able to remain present with intense or difficult material in sessions without becoming “infected” with it; that is, in contact but not overwhelmed, a theme we called centered.

The students credited several “effects” of their mindfulness practice with their ability to be present as therapists. They felt that formal practice of meditation helped them be calmer in general and specifically in their therapy sessions. They also felt that it helped them become more aware of their inner chatter and either decrease or disconnect from it. Meditation also helped them slow down their perceived inner pace or sense of hurry. Finally, some of them used brief periods of formal practice to create boundaries between sessions and when arriving at their clinical sites. This allowed them to set aside thoughts and feelings associated with the previous session or with their lives outside of the clinic and focus their attention on what was happening in the current client session.

The students’ experience of presence seems to have formed a foundation for them to shift their mode of being in the session. Using Segal, Williams, and Teasdale’s (2002) distinction between doing mode of mind and being mode of mind, the students report a gradual shift to more comfort with the being mode. Most started with the notion that therapy is primarily a doing activity, but were able to find more and more times when simply being with the client was therapeutic. Being did not become their sole mode in therapy sessions, but they appeared to reach more balance between the two modes. What helped them make this shift was seeing the positive effects on the clients of their changed presence. For

### Table 4G.1. Overview of themes and subthemes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>Being present</td>
<td>Attending to inner experience</td>
</tr>
<tr>
<td></td>
<td>Aware of what happens with client</td>
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<tr>
<td></td>
<td>Acting from awareness</td>
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<tr>
<td>Effects of meditation</td>
<td>Calmer</td>
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<tr>
<td></td>
<td>Managing inner chatter</td>
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<td></td>
<td>Slowing down</td>
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<td></td>
<td>Boundaries between sessions</td>
</tr>
<tr>
<td>Shift in mode</td>
<td>Doing mode balanced by being mode</td>
</tr>
<tr>
<td>Compassion and acceptance</td>
<td>Toward self</td>
</tr>
<tr>
<td></td>
<td>Toward client</td>
</tr>
<tr>
<td></td>
<td>Sense of shared humanity</td>
</tr>
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most students, this came through their interaction with clients in the session, but some actually meditated with their clients and were encouraged when clients found this a useful experience.

Interwoven through all of these experiences, the students reported explicitly experiencing a sense of compassion and acceptance. This had three components. First, they used the mindfulness practice to come to greater acceptance and compassion for themselves. As they came to accept themselves in the therapist role more, they were also able to accept their clients more. Finally, some students came to a stance of compassion that was consistent with the traditional meditation literature—seeing the commonality between their own struggles and their clients’ struggles and recognizing their shared humanity.

In the following sections, we flesh out these categories using the participants’ own words.

### Being Present

Our participants remarked that their meditation practice helped them be more present with clients. Implied in many of their comments was the notion that this represented a change of some kind, an increase in how present they felt they could be:

I have been able to be more present in the room with clients and this has helped me join with clients in a more natural way.

Another student summed up his thoughts this way:

*To meditate brings therapeutic presence. I think it’s that simple and yet that hard. By that I mean when I meditate I become more present. It takes no thought or technique to develop the presence. All the technique is in quieting the mind. That is the essence of presence I believe. When we quiet the mind and shut down all the background noise and mind chatter … we become aware of our surroundings … and in the therapeutic environment; we become more present for our clients … powerful stuff.*

### Components of Presence

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

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

Another student wrote:

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

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

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

Another student observed:

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

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

*One of my male clients had just woken up and had “bed head.” When he demonstrated shame for looking the way he did, I was able to bring it to light, instead of simply telling him that I didn’t care how he looked. I was able to say, “I’m wondering if it makes you really uncomfortable to be sitting there, across from me, in a non-perfect state.” Then I was able to hear his answer without fixing. We were then not only able to process his difficulty trusting women with who he really is, but our therapeutic relationship along those lines as well. The conversation flowed and I was not nervous in bringing so much unspoken truth to light.*
While they reported being more present as one “product,” as it were, of their mindfulness practice, the students also made it clear that presence was not without boundaries, nor was it a state of complete absorption in their clients’ world. They made this distinction most clearly when describing sessions in which difficult material was discussed or where difficult therapist-client issues had to be raised. One student provided a lengthy and compelling description of how the fruits of mindfulness practice helped in such a situation:

This client presented with a combination of narcissistic and nearly psychopathic personality traits early in our second session, and became very hostile. He started firing away pointed, personal questions at me about issues that seemed irrelevant to what we were discussing, and I found myself really shaken and defensive by his behavior. However, I was again able to recall an earlier intake, which I wrote about and shared with the class, in which case I was able to hold on for the ride and keep myself centered. This worked for me again in this instance.

This client was nearly bouncing from one side of the couch to the other. His eyes were fixed on me, his breathing shallow and rapid, and his mouth dry. He was having a great deal of difficulty staying in the room, and I am confident his behavior was not drug related. All of his angst was filling me up. He was projecting everything on to me, and I was soaking it up like a sponge, and not by choice! I could feel my insides constricting and my own throat getting dry. I felt as if I had “touched a nerve” inadvertently, and he felt really exposed by my observation.

Like the last time something similar happened, I steeled myself by breathing and remaining focused. Despite the high level of anxiety in the room, I felt confident in a way I didn’t expect; it was as if my memory of the last similar encounter rushed up into my consciousness and there I was, all over again, just breathing, maintaining eye contact and a firm position of body language, and a measured, calm voice. The client began to settle down a little, and slumped back onto the couch.

Again, I believe that my ability to draw upon my own peaceful sense inside helped me not only maintain control in the session, but impart something to the client that words alone could not have communicated.

Presence, then, was one important aspect of our students’ experience of mindfulness and their developing therapeutic expertise. It involved an ability to consider their own internal experience on a moment-to-moment basis while attending to their clients’ needs and experience at the same time. Sometimes, they were able to draw these two strands of data together and bring them into the immediacy of the therapy session in a way that brought issues of importance to their client right into the room (e.g., “I’m wondering if it makes you really uncomfortable to be sitting there, across from me, in a non-perfect state”). Despite the seeming potential for presence to lead to merging with or immersion in the client’s world, our students made it clear this was not the case. While staying emotionally connected to their client’s experience, they reported not being overwhelmed by it.
Connecting Meditation and Presence

What are the specific effects or outcomes of contemplative practice that lead to greater presence? Our students identified several. Many of our participants wrote that meditation practice helped them feel calmer in general and specifically in their clinical sessions:

So the meditations have been very helpful in calming me and preparing me for sessions with this client in particular. I try to infuse the session with this sense of calm and it does seem to help the clients control their anxiety.

A sense of calm resulting from meditation practice seems to function as a foundation for therapeutic presence for the students. One wrote:

I can’t say enough about how mindfulness training has helped me develop therapeutic presence. I think a huge aspect to this for me is being calm. Since I have an anxious running commentary in my head at all times, I think I tend to “jump in” to save the client so as to alleviate my own anxiety.

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

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

Another student noted:

My “internal clutter” seems to be more in check when I’m in therapy sessions.

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

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

Another student gave this example:

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

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

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

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

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

**A Balance of Doing and Being**

As they noted their ability to be present in the session and linked this to the effects of their meditation practice, our students also described finding themselves being able to *shift modes of mind* while in session with their clients. Although our students did not necessarily use this language, we found Segal and colleagues’ (2002) distinction between the doing mode of mind and the being mode helpful in understanding what they were describing. Segal et al. describe the “doing mode” as the mode of mind that orients us toward resolving discrepancies between our idea of how things should be and how things actually are. In therapy sessions, this may manifest as pursuit of a predetermined treatment plan despite evidence that it is no longer useful, efforts to quickly move clients’ negative affect states to more positive affect states, or other active, goal-directed efforts. The “being mode,” on the other hand, could be characterized as simply being present with whatever is occurring in the present without the need to change it. Thus, in therapy, the being mode may manifest as simply being aware and curious about whatever is happening without feeling driven to make it conform to a mental construction of how things “ought to be.” It is important to note that both modes of mind are necessary, and neither is either good or bad. Planning, intervening, pursuing
goals, and so forth are all important skills in therapy. However, it is our impression that our students often come as beginners with the notion that therapy is primarily a “doing” enterprise and need help entering and feeling comfortable in the being mode when it is appropriate. They credited the contemplative practice with helping them do so.

Ambiguity is difficult for people who like to plan. If I am uncomfortable or a little anxious about a test or an interview, I prepare and plan until my anxiety subsides. This strategy has not been so helpful in the clinic and I am discovering that so much of this process is about being rather than doing. Meditation has encouraged me to be open to going with the process rather than fighting against it.

Another student wrote:

It is astounding to me how sometimes just backing off in the therapy room … creates new opportunity for movement. It is almost like for some clients, putting energy in the room becomes an artificial barrier that they have to surmount, in addition to any other challenges they bring with them. Only when I become still enough to feel what is in the room am I able to accurately discern whether or not I should use more or less of my own energy during the session.

Initially, it was somewhat difficult for our participants to trust that the being mode was useful in therapy. In part, this may come from our doing-oriented culture as well as from the fact that most of their coursework focuses on therapy models and techniques—content that points toward action. What seemed to help the students feel more comfortable with the being mode was seeing the positive effects on clients when they could set aside a doing orientation and simply be.

I made time for 10 deep breaths just before going out to greet each client …. I noticed feeling calmer and more focused on the session as we began, and I felt that I was conveying a calming vibe to the client as well. One of my Thursday evening clients presented in the waiting room looking very sad and agitated, and I found myself instantly tapped into what she was experiencing. She commented to me in session that I seemed very serene today, and she expressed that it was helping her relax and be more comfortable about “something unpleasant I have to talk about tonight.”

Another student had a similar experience of linking her ability to be in the moment with a change in her client:

I also had a [good] session with a client who has never been able to be vulnerable and examine her feelings. I think, in being more congruent and having the presence of mind to be able to “stay with her” in terms of feeling states, she finally felt safe enough to enter that realm. I can only describe it as “she softened.”
Compassion and Acceptance

Throughout their journals, the students reported that they had found a growing sense of acceptance and compassion as a result of their meditation practice. Acceptance had three related components. First, students described feeling acceptance and compassion for themselves as a result of their practice:

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

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

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

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

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

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

*Interestingly, this week my client’s experience closely mirrored my own. She is recognizing that she is being kinder to herself and, in general, more forgiving of herself. This has given her freedom to enjoy situations and relationships she normally struggles with … Listening to her put to words some of what I am struggling with, and to see the problem from a distance, was powerful.*
Our students used their practice of mindfulness meditation and other contemplative practices in a variety of ways as they negotiated the often challenging waters of early clinical training. They reported feeling present in the therapy room with clients, finding ways to abandon a task-oriented doing mode of mind when that was not what was needed in favor of simply being with clients, and the recognition that compassion added to their effectiveness as therapists—compassion for themselves and for their clients.¹

**Implications for Supervision and Training**

Although based on a limited number of students’ experiences, this study provides support for expanding the scope of supervision to include assigning activities such as mindfulness to directly help students (i) develop therapeutic presence and (ii) manage the anxiety that many experience seeing clients for the first time. As discussed earlier, supervision in family therapy has privileged a doing orientation to therapy: how to conceptualize problems and how to effectively intervene. Arguably, this orientation should remain the primary focus of clinical training. However, student reports in this study indicate that there are other ways that supervisors can be helpful.

By encouraging students to practice mindfulness and related contemplative activities, supervisors are communicating to students that there is another important dimension to effective therapy: the therapist’s way of being in the room. Supervisors can add mindfulness activities as a specific and concrete means to help students develop a quality of being that can be useful in therapy. These activities also provide a highly efficient and well-researched stress management technique that enables students to better handle the challenges commonly experienced in the early years of training.

**Suggestion for Implementation**

Supervisor’s personal practice

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

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

Requiring practice

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

Down-to-earth style

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

Ethical issues

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

Concluding Reflections

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

Many questions remain, of course. First and foremost, we need to demonstrate that therapist mindfulness practice is associated with better client outcomes. One such study already exists (Grepmair et al., 2007). Grepmair and colleagues compared the client outcomes of a group of therapists randomly assigned to practice mindfulness in the Zen tradition to the client outcomes of a randomly assigned group of nonmeditating therapists. The clients of the meditating therapists did better on several outcome dimensions than the comparison group. While this study certainly suggests that there are beneficial effects of therapist mindfulness practice, it must be replicated in order for the association to be convincing. Further, we need to experiment with different forms and “dosages” of mindfulness practice. In our study, students varied in the amount and frequency with which they practiced. Some reported significant internal and external obstacles to practice as well. Knowing more about these issues can help us deliver this training component more effectively.

Despite the remaining questions, our students’ experience was meaningful to them and moving to us as we watched young, nervous, and often self-preoccupied clinical interns become calmer and more confident beginning-level therapists, in part through their practice of mindfulness. Most impressive was their ability to bring compassion and acceptance to both themselves and their clients and to see the common human longings for happiness and relief from suffering that occupy us all.

Note

1 For the researchers’ reflections on the findings and the limitations of the study, readers are referred to the article.

References