Mindfulness Meditation and Supervision

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If you could peek into our group supervision sessions at our MFT master's programs on any given day, you might see something like this: the class begins with the soft tone of a Tibetan meditation bell. The students gather around the conference table and sit straight with their eyes closed. “Take a moment to arrive,” the instructor says, “Bring your attention to your body . . . noticing whatever sensations arise . . . tension . . . relaxation . . . or perhaps no sensation at all.” The meditation continues for about 10 minutes, ending again with the lingering tone from the bell. Before moving on to the content for the day, we hold a brief discussion, a time for the students to report on their meditation experience or ask questions. “My mind was all over the place today,” one of them might say. “It wasn’t peaceful at all. I wish I had had a better meditation.” This comment might lead to a discussion about how important and challenging it is to simply observe one’s inner experience, not try to change or judge it. The point of mindfulness meditation isn’t necessarily to relax or feel peaceful, although this is wonderful when it happens. The point is to learn to be present with whatever is occurring. It is this point—the experience of presence—that led us to begin formally teaching mindfulness meditation to our new clinic interns about five years ago (Gehart & McCollum, 2008; McCollum & Gehart, in press).

Mindfulness Practice

Mindfulness is currently big news in the mental health field. Beginning with the work of Jon Kabat-Zinn (1990) in the early 1980s, variations of mindfulness meditation have been applied to a host of physical and psychological difficulties. Some treatment approaches like Kabat-Zinn’s mindfulness-based stress reduction (MBSR) or Segal, Williams and Teasdale’s (2002) mindfulness-based cognitive therapy (MBCT) are based extensively on mindfulness practice. Others, like dialectical behavior therapy (DBT) (Linehan, 1993) or acceptance and commitment therapy (ACT) (Hayes, Strosahl & Wilson, 1999), include mindfulness meditation as one of the components. The burgeoning research literature suggests that mindfulness is helpful with a wide array of problems—from dealing with the effects of chemotherapy to increasing the effectiveness of treatment for posttrauma to helping prevent relapse following episodes of major depression (Baer, 2003). People suffering from anxiety, insomnia, chronic pain, eating disorders, and many other problems seem to benefit from the practice of mindfulness.

But What Does Meditation Have to Do with Becoming a Therapist?

In our view, therapy is a balance between doing something and being with our own and the client’s experience, having therapeutic presence, in other words. Our treatment models and much of our training at MFTs is aimed at helping students learn to do. As we watched our beginning students, however, we were often struck with what struggles they had in just being with clients when that was the therapeutic necessity. Helping supervisees and students with these skills was typically addressed in the literature through working with the self of the therapist and this work often seemed to focus on removing obstacles to presence—becoming aware of hot button issues or understanding how one’s own family of origin experience might play out in the therapy room. In mindfulness, however, we saw a practice specifically designed to develop the ability to be present with experience. And that led us to begin teaching it to our students (Gehart & McCollum, 2008).

What is Mindfulness?

Mindfulness meditation may be simple, but it isn’t easy. It is typically taught by asking participants to sit quietly, with their eyes closed, that feels comfortable, and do their best to focus their attention on and observe the physical sensations of breathing, while noting whatever other experiences arise. When most of us try this, we quickly discover that our ability to focus lasts only for a second or two. Thoughts distract us, itches or muscle pains demand our attention, and doubts begin to arise (“How can this be worth anything?”). The next step is to recognize when our attention has wandered away from the breath and gently bring it back with acceptance of how the mind works and how it is working today. Repeat 10,000 times . . . In this process, we find a laboratory for many of the things that get in our way as therapists—frustration, judgment, distraction, preoccupation—the stories that our minds make up to fill in the blanks of unknown information, and most important, a very human struggle to stay present, especially with experiences we don’t like or wish were different than they are. By gradually learning to be present with our own experience, we become better able to be present with others’ experience as well (Gehart & McCollum, 2007). To that end, we ask our students to practice mindfulness every day and to report on their experience through weekly journals. We begin our supervision sessions with a brief meditation and discuss the experience as well.

What Is the Result?

Through the regular practice of mindfulness, our students began to notice an impact on their clinical work. As we have read and re-read our students’ journals, several themes emerged. Our students report feeling they are able to be present with their clients; they notice several effects of meditation showing up in their clinical work; they feel they are able to shift from doing mode to being mode when appropriate; and they report the development of compassion and acceptance for both their clients and themselves.

Being Present Is Critical to Good Therapy

Because we believe being present is so critical to doing good therapy, we were struck by this common thread in our students’ reports. MFT students often talk about their early experiences in doing therapy as being dominated by an evaluative focus on themselves and how they are doing, sometimes to the point that they miss important aspects of what their client is experiencing. Our students report they are better able to attend to both their experience and their client’s. At times, they have reported being able to bring both of these areas of experience into the moment-to-moment flow of the session. While being present brought our students closer to their clients’ experience, it was not without boundaries. Several students credit their meditation practice with helping them be present without becoming overwhelmed. One student described being able to stay calm through mindfulness techniques with a very anxious and somewhat hostile client and then use his own calm demeanor to help the client settle.

What are the Specific Effects of Meditation that Help Our Students Be Present?

Many of our students report that their mindfulness practice helps them feel calmer. Being a new therapist is anxiety provoking, and feeling calmer can provide a foundation for being present in the room. They also note that their meditation helps them become more aware of their “inner chatter” and be less affected by it. Inner voices of new therapists are often self-focused and critical, offering a play-by-play analysis of their every move during a session. Disconnecting from this chatter can help them turn their focus more fully to the client. Finally, our students have reported using brief periods of meditation to help ease the transition from one therapy session to the next, allowing them to appropriately leave behind the lingering experience with the previous client to be more present with the client sitting across from them now.

Important Considerations

While our students have found mindfulness meditation a helpful way for beginning therapists to bring more of themselves into the therapy room, and to be present for their clients, some caveats apply. The experience students have in their work with us does not, in our view, prepare them to provide mindfulness instruction or training to their clients. Training others requires substantial meditation practice so that the trainer is familiar with the pitfalls and wrong turns that can lead new meditators astray. Both of us had meditation practices of our own before we started helping our students practice.

In addition, because our classes are required, we make room for students to use another contemplative practice if they wish. While most religious traditions have a contemplative aspect, mindfulness is most closely associated with Buddhism and, while we teach meditation as a secular practice, we do not want students to feel they are being forced to do something against their beliefs. In fact, none of our students have objected, and many have used mindfulness to connect with other contemplative practices associated with their own religious tradition. Finally, despite its many useful aspects, learning this practice is not without struggle. One of the useful lessons for our students, however, is how hard it is to make a change in one’s life, even a change as simple sounding as meditating for a few minutes every day. Realizing how hard it can be for them at times, leads many of our students to have more compassion for their clients, whose struggles to make change are much more daunting.

Professional Resources

Mindful Awareness
Research Center at UCLA
Offers classes and workshops and information regarding ADHD.
www.marc.ucla.edu

Mindfulness Based Stress Reduction
Research and information; also information on chronic pain.
www.mbteastress.org
has had a mindfulness meditation practice for Buddhist psychology in family therapy. He has had a mindfulness meditation practice for over 25 years.

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References

Families of Juvenile Sex Offenders

Richard Gillespie, MDiv

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Clinical Assumptions About Families of Juvenile Sex Offenders

There is an assumption among the public and some professionals that families of juvenile sex offenders are chaotic or abusive, and that these family systems share common characteristics. While there are some common traits involved, these families are diverse. Araji (as cited in Righthand & Welch, 2001) described past studies of families of juvenile sex offenders that indicated there were high rates of parental separation, substance abuse, domestic violence, parental histories of childhood abuse, poor parent-child relationships, unsatisfactory role models, and highly sexualized environments, with family interactions often classified as a primary source of the problem.

Pithers et al. (as cited in Righthand & Welch) found that the caregivers and their families experienced much stress due to poverty, and much effort was exhausted in meeting basic needs. The families were often disorganized and had a high rate of sex abuse histories. Most families in this study (72 percent) had at least one sex abuse victim in the family. Bischof, Sitt, and Wilson (1992) indicated that research in this area is sparse, but concluded that families of juvenile sex offenders have greater family cohesion than other families, though juvenile sex offenders see their families as having less cohesion than non-problem families. There were no differences seen in family adaptability in the three kinds of families. Thornton et al. (2008) stated that families of intrafamilial adolescent sex offenders were characterized as disorganized, uncommunicative, and often adversarial. Talon (as cited in Righthand & Welch) indicated that families of juvenile sex offenders could be classified as one of two family types: chaotic with role confusion, or rigid and emmeshed with strict rules and perfectionist parental role expectations. Graves et al. (1996) indicated constructs that were collapsed into four bipolar variables that included chaotic-rigid, separated-connected, flexible-structured, and disengaged-emmeshed. Research suggests a variety of types of family systems are involved in this group.

Another incorrect thought about the families of youth with sexual behavior problems is that denial of the youth's offense is the main area of clinical work. Ryan and Lane (1997) stated that a number of areas are worthy of family assessment, including emmeshment, isolation, intergenerational sexual and physical abuse, internal and external stresses, abuse of power, conflicting relationship styles, emotional deprivation, and impaired communication styles. The issue of family secrets also looms over the evaluation. It is important to understand the family member’s perceptions of the abuse or disclosure of it, and to include the reaction of extended family and significant others. These families need a full assessment on regular systems issues (i.e., communication, openness, etc.) and also on the specific issues related to sex offending.

Diagnosis & Assessment

Most research on the psychiatric condition of juvenile sex offenders has focused on the adolescent rather than...