

Are We Becoming Contemplatives?

Mindfulness Meditation as the Integrative Element in Professional Training

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Silence and stillness gradually fill the room. This is the first day of intentional silence that some therapists have ever experienced, especially as professional development. For others, this training retreat is a welcome return to a meditative learning process. Whether it is their initial experience or not, silence works its magic by deepening relaxation and ripening self-reflection. After we process this period of mindful sitting, I introduce the first question: “Does your work begin when the client walks into your office and does it end after the session is over?”

Over the past twelve years of providing clinical training, I have asked that question to more than two thousand helping professionals and graduate students. Their answers to this question are revealing. More than 99 percent have answered with certainty that essential aspects of their clinical work continue even after the session is over.

As the discussion progresses, I introduce my next question. “If you believe that your clinical work continues, then what specifically does this work consist of when no clients are around?” In response, the cultivation of heart-based qualities and receptive skills is by far the most consistently given answer. A short list of the most commonly described *heart-based qualities* include compassion, patience, warmth, calmness, and flexibility. Clinically essential *receptive and being skills* also consistently emerge. A few examples include openness, personal presence, listening skillfully, being empathic, being non-reactive, being less judgmental and more self-aware.

Therapists are becoming increasingly aware that these desirable clinical qualities can grow out of contemplative-based practices, such as mindfulness meditation. This stands in contrast to any expectation that *heart-qualities* and *receptive skills* can be cultivated from merely attending lectures about theory or research. Clinical training that involves little more than power point presentations has left many clinicians yearning for professional development that is more experiential and personally transformative. Many helping professionals are not only practicing meditation in their private lives, but are now seeking actual meditative practice that is embedded within the very training they attend. An evolution is underway when therapists attend seminars in order to cultivate clinical skills through real contemplative practices, such as mindfulness meditation. This specific dimension that is emerging and growing within professional development is what I have named the *therapist-as-contemplative* paradigm.

In examining this perspective, my focus is twofold: 1) To draw attention to the expanding interest therapists have for actually practicing contemplative processes *during* clinical training, (rather than only studying them conceptually), and, 2) To emphasize that the deepest knowing and learning of a contemplative way of being, such as mindfulness meditation, occurs from direct experiential practice of it. This exploration highlights how actual meditation practice itself is both central to and necessary for the fullest benefits of mindfulness. Clinicians from a wide cross section of backgrounds -- from regular clinicians to prominent researchers -- will be presented as they encounter and utilize mindfulness in their own professional development, sometimes in unexpected ways.

There is a growing body of literature that demonstrates that contemplative-based practices, such as meditation, are not only being adapted for client interventions, but are specifically being considered as deep professional preparation for clinicians themselves (1, 2, 3, 4, 5, 6). Mindfulness-

related practices in particular are accumulating significant empirical support for their transformative effects on meditators (7, 8).

Mindfulness, then, will serve as a primary example throughout this exploration of a contemplative-based process that can be deeply integrated with traditional clinical curriculum. This is particularly true if mindfulness, as Jon Kabat-Zinn puts it, is “taught within a context of on-going practice, inquiry, and dialogue, and in its own language... The practice would have to be presented on its own terms, as a radical non-doing, inviting a counterintuitive inward stance of acceptance and opening rather than fixing or problem-solving” (3). Mindfulness practice is ideally suited for the deeper work that remains for us after the session is over.

Doing Exactly What We Are Studying

There are many signs of this growing movement. The Center for Mindfulness in Medicine, Healthcare and Society (CFM), located within the University of Massachusetts Medical School reports that as many as 7,000 helping professionals from a variety of disciplines have attended the CFM’s experiential training in mindfulness in the past two decades (9).

Since 1996, when I began designing mindfulness-based training retreats for helping professionals, there has been an amazing growth in the numbers of professionals attending. Clinicians – ranging from interns to seasoned professionals – have increasingly sought out clinically focused mindfulness practice and experiential training retreats to address the on-going inner work across the span of their helping career.

Drawing on my own mindfulness practice of almost 20 years, as well as 17 years of private-practice, I have designed ways to clinically integrate these strands for helping professionals. These mindfulness-related trainings reflect my emphasis that actual meditative practice provides deep and immersive training for helping professionals interested in mindfulness.

One training format is a weekly mindfulness class and practice group that examines immediate experience for its relevance to specific aspects of each participant's clinical work. When helping professionals begin this class many common issues emerge: these range from not wanting to sit and practice, to not having enough time for practice and to dealing with what I refer to as *saturated states*: being bored, sleepy, restless, having non-stop thinking, anxiety and even fear about what they may become aware of in their stillness and silence. They sometimes lament that there is no short cut to cultivating mindfulness. But if we desire to bring the deepest healing and revealing aspects of mindfulness to our work, then the "royal road" is through the practice. In the end, it always comes down to taking off our shoes so to speak -- whether at a retreat center or not -- and doing what those in the contemplative life have always done -- sitting in an intentional silence and gradually coming to know more deeply the workings of our mind, body and heart. In other words, it comes down to having a regular meditation practice -- to doing exactly what is that we are studying and teaching.

Like Discovering A Treasure

One promising aspect of this training is that therapists can pick up a meditative practice at any point in their helping careers, regardless of their theoretical orientation. Jennifer's work is a good example of how utilizing mindfulness at the beginning of her professional path enhanced her depth, integration and clinical skills in unexpected ways.

Jennifer described her first placement as a Ph.D. intern as "difficult." Her site was a residential program for adolescent boys with a history of aggressive behavior. During the two semesters she was at this site she attended my weekly "Mindfulness and Psychotherapy" study and practice group. This class involved a weekly lesson to integrate mindfulness with clinical practice, an in-class meditation, and then a processing of the participants immediate experience. Students

were strongly encouraged to supplement their in-class meditation with a daily mindfulness practice. They were also asked to keep track of, or journal about, any relevant clinical issues.

Jennifer said that a few of the supervisors at her site emphasized the value of a “tough-love” type of approach. She said that she liked and trusted her supervisor who seemed to have a more flexible approach toward the boys. However, most of the senior staff recommended having an unruffled demeanor, particularly during difficult encounters with the boys. Interns were encouraged to “not put up with anything” such as rudeness or defiance. When counselors deemed a response to be inappropriate, they were to immediately say: “One demerit!” If necessary: “Another demerit!” and so forth. Demerits added up to a loss of significant privileges for the boys. Jennifer’s observation was that, when used very sparingly and strategically, this technique occasionally worked well. Her impression, however, was that it was not used this way. Jennifer noticed that soon she was becoming like some of the other staff by starting to mete out demerits too readily.

After Jennifer’s mindfulness study group had been together about 7 or 8 weeks, the members had become both more skillful in their meditation, more self-aware and more trusting of each other. During the group processing, Jennifer spoke more freely about her situation. She reported an increased self-awareness growing directly out of her meditation practice. She described this as “more awareness of my subtle feelings and reactions” to situations at work. She said, “In the past few weeks, I finally had to admit to myself what I was really feeling – that I was getting more and more afraid around a few of the boys, particularly George.”

I asked Jennifer if she knew what the fear was about. She paused a long time but did not appear lost. Then she said, “I wondered this myself at first. I definitely don’t feel physically afraid of George. No, it’s more like he and some of the other boys have this amazing ability to blurt out

these painfully true observations about themselves and the people around them. At first, it was startling since it was so direct and to the point. It was so different from the total indirectness in my family. Nobody was ever allowed to be angry or confront each other.”

Jennifer went on to describe the different dimensions of her fear. She said that her biggest fear was that George would openly confront her in front of the others. “I don’t know what I would do. I don’t know if I’d cry or what. Maybe this placement isn’t for me!”

She closed her eyes and said that she was afraid and “felt like running away.” Instead of analyzing the fear intellectually or providing immediate reassurance, I asked her if she would be willing to try something. She said yes. I guided her to stay present by maintaining one part of her attention on the fearful thoughts and feelings while widening her experience of the present moment to include attention on the movement of her breathing. I suggested that if she felt like running away, she did not need to fight that feeling or act on it, but to try and simply acknowledge its presence and then widen her attention back to including her immediate breathing sensations. Then, for about ten minutes, I had the group mindfully sit together in silence and stillness, each member cultivating more awareness about their own resonance to our discussion. After we finished this reflection, I also recommended that Jennifer discuss her feelings with her site supervisor. We briefly processed this idea and then moved on to another group member.

My intention with Jennifer in this “Co-Awareness of Feeling and Breathing” meditation was to help her stay present and more fully aware of the automatic organizing processes such as her feelings and related meanings that got activated by being with George. From the meditative perspective, by having Jennifer practice simultaneously being in contact with her immediate, visceral, non-conceptual breathing sensations while having strong feelings, she could learn to maintain a more balanced and integrating attention in the present moment. This could gradually be

used to help her tell the difference between habitual, automatic reactions and what type of responding might be immediate and new. My goal was to help broaden her awareness in the present moment as it narrowed down around clinically limiting reactivity or meaning. As her ability to be mindful grew, Jennifer could become more available to new possibilities in both her perceiving and clinical responding when she was activated.

Several weeks later, Jennifer spoke up about George again, “I’d like to share something surprising that happened. Believe it or not, I had a major run-in with George like the one I was afraid of and I lived to tell about it. It was as if something shifted in me while it was happening.” I asked her to describe that event.

“Last week, after a break, I asked the boys to come back inside for a group. Of course, after everyone else went back inside, George was still sitting outside on a bench reading a magazine. I wondered if he was testing me, so I said, ‘George let’s go inside, please.’ ‘OK’ he said still looking at the magazine. Remembering the staff’s advice about tough love, I mustered up the command, ‘Come in now, or I’ll give you a demerit.’ ‘Wait a second, I just want to finish this page first.’ ‘Fine. One demerit for not listening’ I found myself saying. ‘I just told you I was coming right in,’ he said loudly. I became aware of everyone watching us, and wanted to stay in control, ‘Two demerits!’ I said. I felt my blood pressure rising and was getting afraid of a major confrontation. Then George looks right at me and says quietly ‘I said I was coming right in. What kind of power-trip are you on?’

“The directness of his words suddenly woke me up and I took it in. I could not block out the truth in his observation that I might actually be on a ‘power trip’. But I knew inside it was actually more like a ‘fear trip.’”

Jennifer described how in that split second, she became more aware of the larger, complex picture that included the real possibility that George was being defiant, but also that she was also becoming very afraid. She went on to tell our group, “I was also immediately aware that there might be a better way I could handle this while it was happening. That I might be able to somehow be different in the course of this interaction. It was like a felt opening or new possibility. I wanted to step out of the fear or power, and just talk to him. I heard myself simply saying something like, ‘Maybe we got off on the wrong foot here... let’s go inside and talk about it.’ And so we did.”

Jennifer started to observe many openings in herself as a clinician that grew out of our class reflection and her supervision over the next few weeks. By practicing mindfulness, she became more aware of her immediate feelings such as fear and her automatic reactions. She came to trust that, when held in mindful awareness, even strong saturated states like fear and anxiety might end up being teachers in their own right. Her regular mindfulness meditation, in combination with supervision, helped reduce her habitual responding and opened her to new communication skills that she could use rather than feeling out of control or being automatically lost in fear. She expressed how being calmer and more flexible was “like discovering a treasure.” She said that she felt closer to the way she had imagined herself being during her work as a therapist.

The Picture That's Worth a Thousand Words

Even seasoned professionals report a deepening of their ability to be more centered, receptive and aware. Steve, a licensed medical social worker, was not a regular member of our clinician’s mindfulness group, but regularly attended another of our mindfulness training formats -- a one-day mindfulness-oriented clinical retreat. Steve has participated in one of these every six months or so for the past several years. He has worked full time in a large urban hospital for the

past 15 years. “I cover the ER and the whole house because I'm the only social worker on site in the evenings. I provide supportive counseling to patients after they get bad medical news.”

Steve’s job frequently involved helping people in a worst-case medical scenario. Even when the patient’s concrete needs were met, such as by a referral to a detox program or shelter, many situations were so intense that something deeper and more relational was needed. Steve explained “I can't imagine more intense emotions than what I see, for example, within families where a loved one has died. It may be a teenager who was shot and died in the ER or a newborn baby who dies or an elderly person who dies, leaving a spouse of 40 plus years behind. People can be so upset that they sob, or scream uncontrollably, sometimes off and on over a period of several hours that I spend with them. I may be shuttling around through an extended family of 20 or more people, who are to varying degrees, in states of distress, overwhelm or anguish.”

Steve described how his work at the hospital was often providing the eye in an emotional storm. The deepest part of his work involved being present and holding the center. “What people who are in emotional pain or crisis need, I think, is a compassionate presence.” Steve’s profound daily experiences confirmed time and again for him that words of comfort or explanation can seem hollow or meaningless in a time of great loss. As he beautifully elaborated: “A compassionate presence brings a sense of fullness and true caring. Full presence speaks louder than words. Or, full presence itself is the picture that's worth a thousand words. My total presence conveys understanding that this event is the most important thing in the world, or is the world, for that person at that time.”

Steve elaborated on how his regular participation in clinically the oriented mindfulness retreats that emphasized personal presence and moment-to-moment awareness built on his history of meditation practice. He described how our mindfulness trainings helped him maintain the

foundational elements for staying present in both mind and body. Although we present a wide variety of ways to work with silence, as well as sensory meditations for staying in the present moment, the most potent meditations for Steve were focused on breathing and body awareness. He states, “These are especially helpful meditations since they keep me from being pulled into the patient’s emotions by staying centered in my own experience. I am mindful that I’m in a purposeful activity, attending to the drama around me and not just being carried away by it.”

In many ways, Steve exemplifies the value of regular mindfulness training in his ability to stay aware during clinical encounters, even when those moments are in a firestorm of emotion. He summarized: “Mindfulness meditation has taught me to keep returning to the task at hand. In clinical work, that task involves a gentle and continual return to the now, which is where healing for the client occurs.

Scientists Are Also Becoming Contemplatives

Emerging trends suggest that regular clinicians are not the only ones interested in contemplative-related practices. Prominent cognitive scientists and clinicians such as Zindel Segal and Mark Williams were intrigued by the clinical relevance of their own personal meditation experience especially after studying those who teach and actively practice mindfulness. These clinician-researchers report never having any meditation training or on-going meditation practice prior to their research (2, 3, 7). But when it came to their own experience of meditating, they directly had to come to terms with what many discover -- that being the undeniable value, necessity and centrality of actual meditation practice for themselves as therapists, as well as those they help.

In their seminal book, "Mindfulness-Based Cognitive Therapy for Depression," Segal, Williams and John Teasdale describe their careful study of the renowned University of

Massachusetts mindfulness-based stress reduction model (MBSR) created by Jon Kabat-Zinn and his colleagues twenty-seven years ago at the University of Massachusetts Medical School (8).

The purpose for Williams, Segal and Teasdale in studying the MBSR program in person was to consider if there would be a specific value to adding a mindfulness component to their treatment protocol for chronic depression. These cognitive scientists summarized their initial reaction to being unexpectedly drawn to the substantive benefits of mindfulness meditation for clinical purposes: "We must admit that we were unsure how such a move might affect our scientific colleagues. Meditation seemed too close to a form of religious practice, and though each of us had a different "take" on religion we all felt that such personal issues were best left outside the lab and the clinic" (7).

As they studied the MBSR program, they started seeing other levels of the mindfulness practice besides its impact on the patients. Specifically, they found themselves making ongoing and detailed clinical observations of the MBSR's program's *instructors* as well. As Williams, Segal and Teasdale became convinced of the value of adding mindfulness to their landmark treatment for depression, they offered these compelling reflections on coming to terms with having a personal meditation practice:

As we contemplated this change, we became aware of an issue that we could not put off any longer: our own mindfulness practice. ...The staff at the Stress Reduction Clinic has consistently emphasized the importance of instructors having their own meditation practice... And we had seen the MBSR instructors going further in their work with negative affect than we had been able to do in the group context, by staying within our therapist roles. We now saw more clearly how these two things were connected: that this ability to relate differently to negative effect came from having their own on-going mindfulness practice, so that they might teach mindfulness out of their

experience of it. ...If therapists themselves are not mindful as they teach, the extent to which class members can learn mindfulness will be limited (7).

Daniel Siegel, M.D., professor of psychiatry at UCLA School of Medicine and an internationally recognized mind/brain researcher whose work has illuminated details about attachment processes, has expanded his research to include the relevance of mindfulness for clinical practice. Like Williams and Segal before him, Dan Siegel has extended his research to include the personal experience of mindfulness meditation.

Speaking at the 2006 "The Embodied Mind" conference about his own formal meditation experiences, he stated, "Before January, I had zero training in meditation. I had never really been taught how to meditate..." (2). Siegel then described his own attendance at two formal, silent mindfulness-oriented retreats in 2006. He detailed how even his very first retreat experiences directly deepened both his visceral and theoretical understanding of mindfulness as a way of being and perceiving. In a recent Psychotherapy Networker article, Siegel specifically offered: "I feel a new sense of harmony since the retreat. I no longer become locked on any judgment that one way of being is better than another." Even further, he states, "In my professional world, I've found that teaching mindfulness has taken on a new dimension with my patients" (11).

This is noteworthy for two primary reasons. First, it demonstrates that a clinician's understanding of mindfulness can be enhanced even during one's initial experience with actual mindfulness practice. Additionally, it highlights that the actual practice of mindfulness meditation can be useful for expanding one's understanding to include experiential and felt dimensions. As Siegel aptly summarizes, "It would be helpful to do exactly what it is that we are studying" (2).

For Dan Siegel as well as John Teasdale and his colleagues, tasting mindfulness through actual meditation experience has provided an opportunity to understand mindfulness as an

integrated way of being. This is a richer way of knowing mindfulness than encountering it as only research data or as an effective CBT protocol.

In his book, *Coming To Our Senses*, Jon Kabat-Zinn's reflections grow out of his 25 years of teaching mindfulness for clinical purposes as well as his 40 years of sustaining a personal meditation practice. Kabat-Zinn's comments provide an appropriate summary regarding both the value of and the necessity for therapists in having a mindfulness practice. He writes:

Yet, as mindfulness becomes more popular, inevitably first as merely a concept, it is very easy for it to become divorced from its grounding in practice and thus from its transformative potential. Because it is on its face such a good and compelling idea to be more present in one's life and less judgmental, some professionals naturally assume that it can merely be grasped intellectually and then taught to others that way as a concept, and that that can be done without a solid grounding in one's own personal practice. But without the practice, no matter how clever or articulate or sensitive or therapeutic what one is offering may be, it just isn't mindfulness... (3).

In conclusion, the majority of clinicians for whom I have provided clinical training have consistently described being aware of three major perspectives about their work. First, that cultivating heart-based and receptive skills is a key element in their professional development and clinical work. Next, these clinicians know that cultivating these essential qualities often extends beyond the time spent with clients. Finally, and perhaps most pertinent, helping professionals are becoming increasingly aware of the value and centrality of having their own meditation practice, and are specifically seeking mindfulness that is adapted for professional development. This first-hand, actual contemplative practice done as clinical training is what I have termed the therapist-as-

contemplative paradigm. In the end, this courtship between mind, soul and neuroscience is particularly promising since it offers helping professionals a deeper integration than can be found within traditional training. Perhaps best of all, this courtship reveals exciting, new possibilities for pursuing the deeper clinical work that continues after the session is over. ©

Exercise: In the Spirit of Meditative Practice

To honor meditation as experiential practice and provide a taste of mindfulness as a way of being, here is a simple meditation to try. Additional layers of instruction can be added later to cultivate specific applications that are relevant to clinical practice. Start with the idea that you are not trying to meditate nor even deliberately relax. Think of this more as a time when you are simply doing moment-to-moment, real-time inner observations. Find a time and a place where you can sit silently in any comfortable position, without interruptions. Try this for any length of time that feels comfortable to you.

If you prefer, let your eyes close. Begin by first observing what you are already actually paying attention to as you close your eyes, without any attempt to change this. Next, as you are ready, see if you can intentionally shift your attention to hearing any sounds coming to you. Be open to how the sounds may also register in your body. Try noticing the difference between thinking about and naming these sounds versus simply receiving them as sensations that also can be experienced non-conceptually.

Don't become discouraged if your thinking mode is a powerful default setting that seems to take over again and again. You might additionally try cultivating patience by opening yourself up to a heart-felt willingness to stay with your process, rather than sitting in frustration. When you decide to finish, deliberately infuse awareness back into the rest of your body to notice which specific body areas, if any, might need a little extra attention such as massaging or gentle stretching.

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