THE USE OF MEDITATIVE TECHNIQUES IN PSYCHOTHERAPY SUPERVISION

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One of the frustrations I have encountered in supervising over the last twenty-five years is that the typical supervisee's focus is on what to do with the patient, as contrasted with how to be with the patient. The supervisee's ability to be with the patient tends to get swamped in a flood of self-generated pressure about having to do something with or for the patient. Being with the patient is seen as either not having efficacy or it is overwhelmed by what are felt as more urgent concerns. Although all therapists speak of establishing rapport and of maintaining a working alliance with the patient, relatively little is taught about the inner subtle qualities of relatedness. I have had extensive training in how to evaluate a patient, and how to treat a patient. However, in all my years of graduate school, internship, and psychoanalytic training I never had direct supervision on how to be with a patient. The idea that one's own being has a profound effect on others is rarely considered. Clearly, both being and doing are essential, but being has generally been slighted in our rush to make immediately visible things happen. Meditative techniques can be used to help therapists learn to ground their work in their own being. Fruitful therapy grows in this soil. The emphasis on being is to be integrated with the teaching of theory, case management, and countertransference, which are the usual focus of supervision. My intent is synthesis, rather than a replacement of the instruction of diagnostic and treatment skills.

A little personal history may be useful in providing a context for what follows. When I was in analytic training I took a course in short term therapy techniques with Lewis Wolberg. One evening

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I realized that I had a spontaneous awakening. He gave a lecture on hypnosis. As part of his presentation he hypnotized the class. I realized that I went into a light trance. In his later discussion he assured us that hypnosis was harmless and encouraged us to go home and try it. So that night I went home and embarked in what I later caned an autohypnotic psychoanalytic experience. For the next ten nights I hypnotized myself and proceeded rather classically to try to recover memories. After several nights of doing this I began going through periods of intense anxiety. I discovered that if I moved into the anxiety and continued to stay open to what I was experiencing that I would either have a memory and/or release of affect. In this way I was able to demonstrate to myself the basic tenets of psychoanalysis.

When I was anxious, I tended to be out of touch with my feelings and associations. When I allowed myself to simply remain aware of what I was encountering without trying to alter or prevent anything from happening, my experience remained fluid. and my anxiety disappeared. If I tried to impede the flow of my experience, anxiety would reappear and/or I would begin to have some symptom, i.e. muscle tension, heightened heart rate and the like. My fear was that if I allowed myself to remember and feel, that the intensity of my emotions would escalate and get out of control.

I went through cycles of acute anxiety, association, and release of feeling. If I did not actively interfere, my own homeostatic processes stabilized me. I found that rather than escalate, the experience would generally simply dissipate. I also began to have what the analysts call oceanic states. After a few nights I realized that I did not have to hypnotize myself in order to have these interludes. They emerged simply as the result of remaining aware of whatever was happening. I discussed my venture with a colleague who was in training with me, Sid Blau. He suggested that I read the Eastern mystics. Prior to that time my religious and spiritual background had been sparse and negatively tinged. I began reading Hindu and Buddhist works. These spiritual texts described my states of consciousness. I realized that I had had a spontaneous awakening which proved to be a turning point in my life.

I must say that I do not recommend that anyone try to repeat my experiment. My rather detached character structure was destabilized. Although I continued to function effectively, it took me some years to re integrate on a more flexible base. For a long period of time I had doubts and concerns about my experiment and about my growing involvement in spiritual growth. Was meditation a schizoid defense, a form of cosmic masturbation? People either immediately understood what I had to say about my experiences or they were put off by them. I decided that my path was to try to continue to develop while remaining in the world. I
slowly realized that my continuing spiritual work was opening me up to a more loving contact with the world. It was the opposite of a narcissistic withdrawal. The basic meditative practice that I spontaneously came upon in my self-analysis evolved into a way to be in relationships. So I began to try to find ways of integrating into psychotherapy and the training of therapists insights gained from spiritual practice.

I have been leading supervisory groups since the mid 1960s. As my own interest in meditative practice developed, I felt it would be helpful to somehow incorporate it in supervision. How to do this meaningfully was not at all clear to me. I had serious questions about the appropriateness of meditative exercises as part of supervision. Are they a waste of time or unsuited to psychotherapy supervision? I do not recall just how I started, but one day I brought in beach stones. I gave a stone to each of the supervisees and said, "This is a client. Be with your client." I took a stone myself and sat and contemplated the stone for about twenty minutes. Then I went around the group and asked each of the students to describe his or her experience. Their responses gave me a rather clear picture of what each student was struggling with as she or he began to work with a client. The difficulties with the stone were essentially the difficulties they had with clients. Of course, the stone exercise could be treated as a projective technique, but I took the diagnostic procedure a step further. I worked with each student in order to analyze the problems they were having being with the stone. This process provided an experiential teaching of analysis of resistance to being in an open receptive state. Then as we discussed their actual work with cases, we were able to connect their own experience doing the exercise with their approach to their own clients. This work also allowed me to demonstrate the way I work with clients.

Some reactions of supervisees in a recent session illustrate beginning responses. One student said that if she were relating to the stone as a stone she would have had less trouble. She could have accepted that the stone was merely an unresponsive inanimate object and she would not expect anything from it. However, if it were an alive patient, then she could not tolerate its unresponsiveness. I asked, "How does it have to be in order for you to be alright?" She said that it had to react to her. It had to do something. She tried moving it, holding it, leaving it alone. When it continued to do nothing, she wanted to get rid of it. "Let someone else have it as a patient." She became uncomfortable with the exercise, waiting impatiently until it was over. Doing rather than being is the usual misunderstanding of the exercise. Most people in our culture have a powerful set to do something. The notion of simply being with someone else is alien to them. The potency of
merely being open and receptive is usually overlooked or devalued as a monotonous waste of time.

This student's desire to get a response is a good example of difficulty in tolerating frustration. Not to obtain a reaction was intolerable to her. She got stuck in a restricted stance of taking the instruction, "This is a patient," literally, and she withdrew into a bored, irritated state. Inability to find alternative possibilities is characteristic of this kind of irritability. It would have been meaningful to explore her discomfort as a way to analyze her resistance to the exercise, but I decided not to pursue it. She was being honest, and I did not want to give the impression that there was a particular right solution. So I went on to the next student.

The next student's response illustrates an important class of problems that are encountered during the exercise. Namely, one's focus is disrupted by an underlying distress. The meeting was toward the end of the day on a Friday and the second student found that he was fatigued. He did not realize how exhausted he was until he started to examine the stone. He looked at the stone carefully, appraising its cracks, coloring, shape, and blemishes, but he was worn out and began having trouble sustaining his concentration. Finally, he gave up and sank into his weariness. After a few minutes he began to feel that it was alright to just be there with the stone and he started to feel somewhat better. It was a surprise to him that he felt more related to the stone toward the end of the exercise. Clearly, this student was more capable of altering his course in response to his own internal cues than the first student. He had a meaningful rather than a frustrating experience. He was able to relax into the pain of his fatigue. The first student contracted against her frustration, and thus intensified her own discomfort. The contrast in the two experiences clearly highlight two significantly different strategies for dealing with pain, relaxing into it, or contracting against it.

A third student associated the stone with a massively paralyzed patient with whom she had been working. She had a difficult time when she started treating the patient, assuming that she had to act like a restrained and removed "psychologist." She felt stymied with the patient because the patient was paralyzed from the neck down and thus could do practically nothing. Initially the patient was distant. To her surprise, she discovered that after she gave up being like her image of a constrained "professional" and started acting like a person, that the patient started to reveal his anguish and concerns to her. She just sat with this recollection. Her awareness of the passage of time abated. An alive tender bond surrounded her and the stone. She had a sense of fulfillment and cogency about what was happening.
One of the major impediments to being with clients is a sense of urgency about having to do something. Most students I work with are quite inexperienced and the issue of "Can I do this work?" is a powerful concern. In their rush to be helpful they frequently have difficulty staying balanced enough to really hear their clients. So it became evident that helping the students learn to slow down, clear away habitual obsessional inner chatter, and balance themselves would be useful in their training. Meditative practice seemed to provide a structure for shifting gears from their harried lives to a receptive state that is conducive to clinical work. If supervisees are unable to clear their minds of their own concerns, it is very hard for them to be truly available to clients. Thus, a preface to the exercises is given,

Suspend all expectation of outcome as you approach each of the exercises. Being balanced and centered is both physical and metaphorical. Allow yourself to sit in a balanced position. Move your head around until it is balanced over your shoulders, and sit up so that your back is reasonably straight.

At first it is necessary to learn to focus attention. So after the first stone exercise I began to use a variety of classical centering techniques. Typically I start with exercises focusing on breathing. The instruction is,

Simply follow your breathing. Do not try to change your breathing. Just observe it. In order to maintain focus, count 1 as you breathe in, 2 as you breathe out, 3 as you breathe in, 4 as you breathe out. Then start all over again with 1. If you lose your concentration, bring it back to the counting. Allow your breathing to reach a point about two inches below your navel in the center of your body. Then let the whole middle part of your body open up. It may be less distracting if you close your eyes.

The virtue of working with eyes closed, early on, is that it tends to reduce distraction and self-consciousness. It makes it easier to turn inward. The disadvantage is that it is difficult for some students to remain in a focused state with their eyes open. It is important to work some of the time with eyes open in order to help students learn to retain focus under a variety of conditions. And of course they are not going to work with clients with their eyes closed. After about 20-25 minutes of exercises, I typically end with,

When you are ready, open your eyes and just continue to be with the group. As I work with each one of you, all the rest try to follow what is going on in the same state of awareness.

Then I go around the group exploring each member's experience. My instruction about experience is,
By experience I mean thoughts, fantasies, day dreams, night dreams, feelings, and bodily sensations—all of the above.

Students tend to equate experience with either thoughts or feelings, thus the inclusion of bodily sensations is essential. Body tension is common among supervisees but rarely spontaneously reported. Particular attention is paid to working with their resistance to following the instructions given explicitly at the start of each exercise.

The notion of resistance is a broad one. Just as in psychoanalysis, resistance is violation of the basic rule of free association, reporting what is happening without censorship. Resistance to a meditative exercise is not following the instruction. Discussing their meditation gives each supervisee a chance to explore their own reactions to revealing themselves to the supervisor and their peers. At the same time the processing gives the other supervisees a chance to observe how the supervisor works with a client. Students who are observing are instructed to sustain their centeredness. This provides a mode which is closer to an actual therapy session. They actively observe while staying in a centered state, but are not on the spot themselves. All students are encouraged to share their reactions at any time.

The material which comes out of the processing is also used as clinical examples of theoretical constructs. The most common situation is of shifting back and forth between anxiety, somatization, intellectualization and open free experience. Typically, a student reports difficulty in focusing attention. Concerns of the week, or apprehension about the last session with a client frequently intrude. Indeed, one of the most common defenses is obsessional rumination. As they continue with the exercise, they become aware of fatigue and/or physical tension, i.e., tightness of the muscles at the back of the neck or shoulders, chest tightness, uncomfortable stomach sensations, etc. If they are able to keep bringing themselves back to the breath counting, they begin to report alterations in ego boundaries, sensations of floating, or heaviness, sensations of "energy," flow, light, and quiet relaxed peacefulness. When they experience the "altered states," they are not conscious of bodily tensions and obsessional activity, and the usual incessant internal dialogue ceases. The resulting peaceful centeredness is disrupted as soon as they start thinking, and/or start feeling some kind of pain. Often, underlying feelings and memories emerge. How they react to all of this becomes the subject matter of their interaction with me. An important focus of my work with them is to help them to identify more and more with themselves as observer or witness, rather than as a hapless recipient of the drama of external pressures and internal conflicts.
BEING WITH ANOTHER PERSON

After several weeks of centering exercises, and after the group has had a chance to form with a modicum of trust, I start by asking them to get centered. Then, after they have had an opportunity to settle into themselves, I instruct them to pair off, and be with each other. Being with someone else is much more difficult then being with a stone or by oneself. A recent example illustrates the process. There happened to be an odd number of supervisees that day, and I had to pair off with one of the members. I prefer to start with having them pair off with each other rather than having to pick one to be with me, but it is better for everyone to be involved than for one student to be left out. As we started out she looked into my eyes, but after a short time she looked away and did not make eye contact again. When we talked about what had happened, she said that she was afraid that she would start to giggle. She said that she felt some warmth from me and was afraid of exposing her vulnerability. She feared that if she opened up to me that she would never want to stop, and she had recollections of her father. She longed to be close to him but he was not consistently available. She also realized that her frustration could easily turn to anger and maintaining distance. Another student I worked with in the group expressed essentially the same thing. She was opposed to allowing herself to fully experience her sadness because she felt that what we were doing was becoming "too much like therapy" and that it was inappropriate in supervision.

These examples illustrate what typically happens. A transference to the supervisor as the loving father intensifies. Defenses against longing for closeness and loving connectedness are erected. I say "father" because I happen to be a male, and this is the usual immediate reaction to me. Needless to say, at a deeper level it is also a yearning for the good mother. From a self-psychology point of view I begin serving self-object functions for the supervisees.

Perhaps at an even more fundamental level there is a deep longing for transpersonal union. Several years ago a patient brought in a tape of a Ram Dass workshop on relationships. One of the central points of Ram Dass' exposition was, "We confuse the method with the state." His point was that when we feel we lack something, we have the mistaken idea that the method, namely, being with someone, provides us with that "something" that we feel we lack. Being with the special person helps us enter a state of joyous alive connectedness that we feel we cannot have by ourselves. From a transpersonal point of view, the states of consciousness that we seek are the realms of higher consciousness that all of the
great mystical traditions describe. Wilber (1980) explores this at length in his *Atman-Project*.

We saw that the individual being, from the very start, contains all the deep structures of consciousness enfolded and enwrapped in his own being. And in particular, he contains or participates in prior Atman-consciousness—from the start. The infant is not enlightened, obviously. But just as obviously, the infant is not without *Atman*. "All sentient beings," says the *Nirvana Sutra*; "possess the Buddha Nature." "Wherever there is consciousness," proclaims the *Tibetan Book of the Dead*, "there is Dharmakaya." "*Anima Naturaliter Christiana*,” said Tertullian, by which he meant that "the soul is endowed from the outset with the knowledge of God and that whatever God imparts in this manner can at most be obscured but never entirely extinguished." Likewise, "This is what the Jewish midrash means when it ascribed knowledge to the unborn babe in the womb, saying that over its head there burns a light in which it sees all the ends of the world." From the outset, the soul intuits this Atman-nature and seeks, from the start, to actualize it as a reality and not just as an enfolded potential. That drive to actualize *Atman* is part of the *Annan-project*.

One of the central points of meditative practice is to release transpersonal consciousness. I believe that this is what is happening when we open up to each other during the meditations. However, transpersonal consciousness is obscured by intrapsychic and interpersonal defensiveness. Hence it is necessary to work through the resistances in order to clear the way to transpersonal awareness.

The exploration of the supervisees' defenses is an experiential teaching about the kinds of resistances that they are likely to encounter as their work with clients deepens. From a transpersonal perspective, being with someone involves opening your heart to them. The experience is one of cessation of the usual chatter of the inner dialogue, a dissolution of ego boundaries, flow of energies within the merged field, and an experience of love and timelessness. I call this experience the core of rapport. This takes place naturally and spontaneously in a good parent-child relationship, with good friends, and of course, with lovers. It is easily disrupted for a multitude of reasons. The defenses against the longing for the state of loving connectedness are legion. It is important to note that the responses described above are common reactions which occur within a period of a few sessions. Indeed, frequently students begin sensing a warm connection in the first session. The possibility is always there. How we learn to open up to it and how we relate to it are important foci of our work.

It is one thing to encounter a supervisor with whom you feel some kind of warmth. One can easily be the recipient of someone else.
extending rapport. It is another thing to learn to work as a therapist who creates the conditions in which the rapport flourishes. The kind of personal development that is being described here is not generally taught. I believe that it is here that transpersonal psychology with its understanding and exploration of higher states of consciousness has a basic contribution to make in the training of therapists.

Another way of describing what happens is that the supervisor enters a non-ordinary state of consciousness. The supervisor's state of being affects the supervisee. And the supervisee senses it. The fact that one person's state of being is experienced by another is central to an understanding of the process. Put more simply— you not only perceive what I do, you are affected by how I am. In a paradoxical way, altering my state of being is a kind of doing. What all of this comes down to is an effort to explicate what I call the "posture" of the therapist and the notion of therapeutic neutrality. One of the ideals is that the therapist should not impose him or herself on the patient. The metaphor of the unblemished mirror is often used. Therapists maintain neutrality so as not to taint the transference. The logical end point of this position was the silent analyst sitting behind the couch. My first analyst explained, "It is to produce a pure culture" in which I could see my own reactions uncontaminated by my analyst. The analyst becomes the perfect mirror.

A corollary to neutrality is abstinence. The analyst was not to provide libidinal gratification. Pushed to its logical extreme, the ideal of neutrality becomes inertness. Inertness implies that the therapist has no effect on the patient. The observer would then have no effect on the observed. Thus, there is an important distinction between neutrality and inertness. Excesses in the direction of antiseptic neutrality create excessively frustrating regressions. Excesses in the direction of "touchy-feeliness" create another set of problems. If there is no way for the therapist not to affect the patient, what is a beneficial posture for the therapist? I do not think there is any escape from the fact that each therapist has a set of values. Detached scientific objectivity and human relatedness are two of many sets of values. What is important is that the therapist cannot avoid having an influence. Becoming conscious, and consciously knowing how the therapist affects the patient is what I am trying to teach. The point being made here is that there are dimensions of the therapeutic relationship that are not ordinarily explored and taught. These are the kinds of interactions at the psychic, subtle, and causal levels (Wilber, Engler & Brown, 1986) of communication between the patient and the therapist. If transpersonal psychology has to do with the study of these levels of awareness, then the influences of these levels of consciousness should be part of the training of therapists.
Freud spoke of unconscious communication between the analyst and the patient. In his paper on recommendations on analytic technique he states:

The technique, however, is a very simple one ... it rejects the use of any special expedient. ... It consists simply in not directing one's notice to anything in particular and in maintaining the same "evenly-suspended attention" ... in the face of all that one hears (Freud, *Standard Edition*, vol. 12, p. III).

It is easy to see upon what aim the different rules I have brought forward converge. They are all intended to create for the doctor a counterpart to the "fundamental rule of psycho-analysis" which is laid to the patient. Just as the patient must relate everything that his self-observation can detect, and keep back all the logical and affective objections that seek to induce him to make a selection from among them, so the doctor must put himself in a position to make use of everything he is told for the purposes of interpretation and of recognizing the concealed unconscious material without substituting a censorship of his own for the selection that the patient has foregone. To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound-waves the electric oscillations in the telephone line which were set up by the sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations.

But if the doctor is to be in a position to use his unconscious in this way as an instrument in the analysis, he must himself fulfill one psychological condition to a high degree. He may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious; otherwise he would introduce into the analysis a new species of selection and distortion which would be far more detrimental than that resulting from concentration of conscious attention. It is not enough for this that he himself should be an approximately normal person. It may be insisted, rather, that he should have undergone a psycho-analytic purification and have become aware of those complexes of his own which would be apt to interfere with his grasp of what the patient tells him. There can be no reasonable doubt about the disqualifying effect of such defects in the doctor; every unresolved repression in him constitutes what has been aptly described by Stekel as a "blind spot" in his analytic perception (Freud, *Standard Edition*, vol. 12, 115-16).

The "purification" being discussed here goes a step farther. As I understand it, Freud is talking about some kind of unconscious communication. He then instructs the analyst to enter a state of "evenly suspended attention" in order to enable the communica-
tion to take place. He says that the analyst has to go through a process of purification, of clearing away his own repressions in order to clear away his own distortions so that his unconscious could be connected to the unconscious of the patient. The purification from a transpersonal perspective goes beyond clearing repressions; it goes to opening oneself up to higher states of consciousness. Could Freud's unconscious communication be considered a kind of siddhis or ESP? I think so. Most therapists have had the experience of having a thought come to mind and then of having the patient utter it. Yes, the objection can be made that the analyst is listening to the patient and is filling in the blanks. But in my own work the experience of having these kinds of thoughts come to mind is different from my usual thought processes. When this kind of communication takes place I am in the still centered place that Freud discusses, and the message just appears faintly and quietly. [ do not have the sense that [ have been active in any way in making it happen or in thinking it up. We seem to be connected like a telephone, but there are no wires.

However, I find Freud's surgeon metaphor disturbing and inappropriate,

I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, in his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible.... The justification for requiring this emotional coldness in the analyst is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help that we can give him to-day. A surgeon of earlier times took as his motto the words: ... ["I dressed his wounds, God cured him"]). The analyst should be content with something similar (SE vol. 12, p. 115).

Clearly there is a distinction between being a family member, a friend, or a lover and being a therapist. It is crucial for the therapist to maintain his or her own balance while doing treatment. However, the metaphor of the emotionally disconnected surgeon is misleading. The distinction I have in mind is the contrast between clinical detachment and the kind of non-attachment that the mystics describe. The psychological defense of detachment is isolating thoughts from feelings, of insulating oneself from feelings. Non-attachment means not desiring any particular outcome, not being attracted to pleasure or actively avoiding pain. Not getting caught up emotionally does not mean being cold and not having any feelings. It does mean not being devoted to any particular outcome and not taking personally what is happening. For me a much more helpful recommendation is to be more like a compassionate Buddha than a detached surgeon.

*Freud's surgeon metaphor*
This brings us to exploration of a state which may be entered in the meditative exercises and is desirable for psychotherapeutic work.

THE CORE OF RAPPORT

Something happens when people are together in a good way. There is a sense of connectedness and flow among them. Rapport implies a relationship of harmony, accord, and affinity. This "something" is experienced directly. All involved know it when it happens. It often takes place naturally between parents and children, between lovers, and among friends. High speed motion pictures show synchronous body movements, a dance which literally and metaphorically takes place. The persons involved feel united by a sense of harmonious flowing contact. I repeatedly find that people who are in rapport describe an "energy" linking them with each other. Libido, chi, prana are some of the names that have been given to this energy. Don't lovers say they are drawn to each other? The word "powerful" is spontaneously used to convey the intensity and the immediacy of the experience.

As we have seen, rapport happens naturally and spontaneously. One can also deliberately establish rapport in a disciplined way. Therapists do this with patients routinely. The therapist becomes a good self-object to the patient. This is done by demonstrating empathic understanding. The therapist suspends his or her own personal concerns and responds to the patient in ways that convey understanding of the patient's own uniqueness. While it is possible to approach this cognitively, simply having cognitive/rational awareness misses the essence of rapport. There is also an inner aspect of being with the patient. The therapist is centered in his or her heart. The term, heart, does not refer to the organ which pumps blood in the chest. Heart, in the sense being used here, refers to a higher level of consciousness than being intellectual, or "being in one's head." Learning to be in one's heart starts out with a focus of attention in the area of the physical heart. However, the awareness is directed to a subtle center which is interior to the heart. The physical organ, the heart, is inside the chest. It has a physical location. By analogy, the mind is interior (Wilber, Engler & Brown, 1986, p. 157) to the body. That is, it somehow permeates the body, but it cannot be located tangibly. The heart is interior to the mind. The heart guides and modulates cognition. There is understanding and understanding. The core of rapport emerges when both the patient and the therapist are centered in their hearts.

Several things have to be mastered in order to learn to be in one's heart. Being able to focus attention is a crucial prerequisite. Typically one's attention is attracted to a variety of stimuli. One
of the most prominent is an ongoing inner chatter of what is sometimes called the inner dialogue. Before children have developed speech they probably simply experience whatever happens to them in a direct way. As we develop speech we are taught to label everything. The act of learning the designations enable us to communicate and think abstractly, but often at the cost of removing us from the immediacy of experience. There are extensive adaptive efficiencies in handling abstractions rather than actual physical objects. The movement from the more physical-emotional body-ego of the child to the mental-ego of the adult also tends to insulate one from emotions. Thus the child moves from immediacy and spontaneity to control and rationality. Intellectual structures are constructed and are valued. The meditative exercises are designed to help the supervisees transcend these intellectual levels. Transcendence is being used in Wilber’s (Wilber, 1980) sense: that is, going beyond the mind and being able to operate on it from a higher more inclusive level of consciousness. This is not being anti-intellectual. Rather it is being able to observe mental and intellectual operations without being caught up in them. As one becomes quiet and centered it becomes possible to witness the operations of the mind with “evenly suspended attention.” The capacity to utilize the intellect is retained, but it is used in the service of empathic compassion. Immediacy reemerges from the discipline of being centered and of being mindful. The now obsolescent metaphor is of the therapist being like an ideal phonograph cartridge with zero mass and infinite compliance which adds nothing to the faithful tracking of the complexity of sound. The therapist rides in the groove of the present. The therapist’s consciousness transduces his or her experience into a form that the therapist can appropriately play back to the patient. To get to the point of openness and receptivity needed to track all the twists, turns, ups, and downs of the relationship with the patient requires discipline and an ability to suspend one’s usual personal concerns.

THE POSTURE OF THE THERAPIST

The approach using meditative techniques evolves toward what I have called “the posture of the therapist,” where “posture” is to be taken both literally and metaphorically. The qualities of consciousness which start to emerge from the meditative practices are facilitated by the therapist learning to center and balance. Balance starts physically with actually sitting in a comfortable balanced posture with the spine being reasonable straight. In a conventional office setting the therapist sits in a chair with his or her feet on the floor rather than cross-legged on a cushion. These practices are to be applied in ordinary clinical situations where the therapist’s manner and attire are essential to a stance of
neutrality which does not draw significant attention to itself. Balance on the more internal or subtle levels, however, is difficult to achieve and even more difficult to sustain. In teaching I frequently use images from ice dancing. The cardinal rule in ice skating is, "Always be over your skates." Skaters are able to make incredible moves as long as their body's center of gravity is directly above the center of the skate’s edge. What you have to do in order to stay over your skates is what learning to skate is about. Most skating postures emerge because of what the skater has to do in order to stay balanced in the midst of change. Except for expressive embellishments, the skaters strike the postures they do as a way to stay in control and not fall down. The form emerges from the function. Another fundamental point is that you have to be able to do the dance alone before you can do it with a partner. You have to be secure in your own balance and know the steps before a synergy can emerge in a partnership. Discipline, conditioning, determination, and a willingness to confront pain and anxiety are essential. Although the forces in the therapy situation are not physical, they frequently toss the therapist off balance. The therapist needs a centered position which he or she can sustain through the pushes and pulls of the treatment. This is what is meant by the posture of the therapist.

The meditative exercises are calisthenics for expanding consciousness. They are an aspect of a large whole and should not be confused with it. Students frequently come into supervision in states of fatigue, stress, and obsession. These unbalanced conditions interfere with the work. Freud wrote of the necessity of purification of the therapist. The analysis of repression that Freud recommended is necessary but insufficient. Most counter-transference and counter-identifications can be thought of as a loss of balance. Repression is not the only source of these imbalances. Important additional sources of imbalance have to do with narcissistic issues. The patient does not give the therapist the kinds of gratification the therapist needs. The therapist's sense of himself is negated under conditions of transference, and of projective identification. It is typical for beginning therapists to want to not be the target of rage toward the bad object of a troubled patient. They are also disturbed by the excesses of idealization, and sexualization of the transference. Conversely, the transference that the supervisee makes to the patient can disrupt the work. To the extent that they are using the patient to fulfill their own soothing self-object functions, the therapist is vulnerable to destabilization by the patient. The meditative exercises are designed to help the supervisee suspend the usual clatter of egoistic concern, release bodily tension, and enter a quiet space where he or she can become aware of the subtle dance taking place in the relationship. The content which emerges from this silence can inform the therapist and guide his or her work. The balance being
discussed here is not a passive quietist stance. It is more like the activity of a navigational guidance system which in spite of external disturbances maintains a steady course.

**RELATION TO THERAPY AND SPIRITUAL WORK**

If this work is put in the context of Wilber's spectrum of consciousness (Wilber 1977, 1980; Wilber, Engler & Brown, 1986), it is at the existential or centauric levels,

, .. although this level has *access* to language, membership-cognition, egoic logic and will, it can and does reach beyond them, to a pristine sensory awareness and ongoing psychophysiological flow, as well as to the high-phantasy process of intuition and intentionality. This level is above language, logic and culture-yet it is not pre-verbal and pre-cultural but trans-verbal and trans-cultural.

And here is the point I want to emphasize: while this level is trans-verbal, it is *not* trans-personal. That is, while it transcends language, gross concepts, and the gross ego, it does not transcend existence, personal orientation, or waking psychophysiological awareness. It is the last stage dominated by normal forms of space and time—but those forms are still there (Wilber, 1980, p. 59).

However, as we explore the impediments to being balanced, significant issues from earlier developmental levels emerge. One of the complications of working with students at the beginning of their careers is they are trying to establish their identity as therapists and prove their abilities. This leads to competitiveness in the supervisory group and a great deal of anxiety about how they are being evaluated by the supervisor and their peers. The meditative work requires one to suspend egoistic concerns. The demands for non-defensive receptivity and self-revelation put the students into a very difficult situation. In Engler’s phrase, "You have to be somebody before you can be nobody" (Wilber, Engler & Brown, 1986). This kind of supervision creates a paradox—do it right you have to not do. There are periods of acute tension. These can inspire transcendent flashes of insight and/or crushing moments of pain. Students can be stern critics. The supervisor has to be very secure in her or his own balance so as not to lose one’s own way.

Supervision is neither therapy nor is it spiritual work. The work is grounded in dynamic analytic psychology and is permeated by the perennial philosophies. One of my objectives is to apply a transpersonal orientation to the training of therapists. Although I have been working with a Sufi teacher for the past six years, I try to be generic in my orientation. The transpersonal orientation helps put both the intrapersonal and the interpersonal in a broader
becoming more self-accepting, more empathic and compassionate perspective. The traditional analytic orientation addresses neurotic and character problems overlooked by the spiritual disciplines. The work being described here takes place in the training of psychotherapists not spiritual leaders. Even though spiritual dimensions infuse the approach, this training does not pretend to be a spiritual discipline per se. If the students get a glimpse of access-level meditation (Wilber, Engler & Brown, 1986, p. 60-61) by the end of the year, they have done well. The exercises help the students clarify where they are in their own development and highlight what they have to do in order to advance. Most students that I have taught have little notion that there is anything beyond rational thinking. They regard separation and individuation as the highest level of development. Many are struggling with issues of bodily appearance and autonomy. Some know that they have a “heart” but are leery of being guided by it, or of letting other psychologists know about it. The experience of being connected with another reactivates fears of vulnerability, intimacy, trust, and of being hurt and/or abandoned. Seeing other students struggle with similar issues, however, helps them to become more self accepting, more empathic and compassionate with each other and their clients.

My concerns about supervisees finding the work boring or beside the point have been unfounded. The major complaint that I have had about this work is that the students are more powerfully and quickly affected than they can comfortably handle. However, when they see that they are supported and that learning can be vivid, alive, and immediately relevant, they become enthusiastic. They come to see the supervisory meetings as a refuge where they can be more themselves in the presence of others than is customary. The group provides a living demonstration of the possibility of continuing personal, interpersonal, and transpersonal professional development.

REFERENCES


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