Mindfulness-Based Interventions

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Introduction

Mindfulness-Based Interventions (MBIs) is the term used to describe applications of Buddhist mindfulness techniques in Western psychological medicine. In this paper, I will describe the philosophical and practical roots of mindfulness in Buddhist thought, then review how these methods have been adapted for use with clinical populations in the West. I will then explore the evidence for the effectiveness, and potential problems, of teaching MBIs to specific populations.

Buddhist Approaches to Suffering

Buddhism teaches that all forms of suffering originate in the mind, because "through mind alone are we aware of the so-called external world including our own body" (Thera 1954/1996, p21). The Buddha embarked on his quest for awakening in response to the suffering he perceived as inherent in all life, particularly sickness, old age and death. His message, known as the Doctrine of Mind, teaches three basic things: how to know the mind; how to shape the mind; and how to free the mind (Thera, p23). Hence, to be mindful is offered as a solution to the problem of human suffering in all its forms.

Mindfulness is the activity of paying conscious attention to the stream of experience that moves through awareness, including the thoughts in the mind, the sensations and feelings in the body, and what we notice through our hearing, sight and other senses. Learning to notice all the phenomena that flow through our awareness is the method through which, Buddhism teaches, we can develop a new relationship to our suffering.

Thera describes being mindful as paying "bare attention" to "what actually happens to us and in us at successive moments of perception" (Thera, p30). He acknowledges that great application, thoroughness and perseverance are needed when beginning to learn this method. The value of paying bare attention is that it "allows things to speak for themselves" (Thera, p35), as we remove the layers of habitual judgement and freshly observe phenomena just as they arise.

According to Buddhist thought, these observations will lead, over time, to a different understanding of oneself and the world; one in which suffering is no longer seen as necessary, no matter what our external circumstances. It may be difficult for a newcomer to imagine such a viewpoint, but with sufficient experience in the practice of mindfulness, it can be developed.

Thera argues that our suffering arises from wanting things to be different to how they are, and true freedom lies in recognising and accepting this fact (Thera, p41). The liberation which Buddhism promises comes when we discover an inner landscape of detachment, peace and contentment, along with insight into the impermanence of all things (Thera, p44). Thus, Buddhist philosophy and methods offer a way to understand and deal with suffering of any kind.

Pema Chodron elaborates on the traditional Buddhist view and writes specifically for Western readers. She describes mindfulness as a path of loving-kindness towards ourselves, one in which we do not try to change things but merely "befriend who we already are" (Chodron 1991/2003, p4). She states that the ground of practice is to study ourselves and accept whatever we find with an attitude of friendliness, gentleness and curiosity.

Chodron recommends an approach that balances discipline and precision with loving-kindness and acceptance of our limitations. She advises us to "be as honest and warm-hearted in the process as you can, to learn gradually what it means to let go of holding on and holding back" (Chodron, p22). She sums up mindfulness as simply "to see what is… and acknowledge it without judging it as right or wrong" (Chodron, p36).

Tarthang Tulku has also adapted traditional Buddhist practice to what he perceived as the needs of Westerners. He formulates meditation as a way to gradually relax the mind, body and breath. He suggests that at the deepest level of relaxation, our body energies will loosen their many layers of constriction, and activate a healing flow of vitality and awareness (Tulku 1977, p48). He states that when we experience our subtle body energy we are also in touch with a non-dualistic quality of mind, in which we naturally experience the interplay of calmness, openness and joy (Tulku, p58).

Scientific Evidence

As early as the 1980s, Ian Gawler detailed the benefits of meditation in Western scientific terms. He describes how meditation improves the body's natural ability to repair itself, by improving the dynamic equilibrium of our chemical, immune and others biological systems (Gawler 1987/2004, p3). He documents how stress impairs the body's ability to self-regulate, and how meditation induces the relaxation response, enabling physical repair and enhanced mental stillness. Gawler states that Insight meditation enables us to expand our options and learn "to act consciously rather than react subconsciously" (Gawler, p6).

Rick Hanson provides an overview of the neuro-scientific evidence on how the human brain has evolved to respond to stress, and how we can regulate and improve on our natural reactions. He conceptualizes suffering as the evolutionary by-product of survival mechanisms such as vigilance, anxiety, sensitivity to negative information, and repetitive learning (Hanson 2009, p40-42).

Hanson describes how stressful experiences lead to psychological consequences of anxiety and depression, as well as physical consequences in the gastrointestinal, cardiovascular, endocrine and immune systems of the body (Hanson, p56).

The evidence from neuro-science helps explain why the experience of stress leads us to over-use our brains' survival mechanisms, and how we can find a healthier equilibrium between arousal and relaxation through the practice of mindfulness. The demonstrated health benefits of cultivating spacious awareness result from dampening the stress response and strengthening the relaxation response throughout the central nervous system, which has profound effects on the body, emotions and mind (Hanson, p113).

Dan Seigel has examined how mindfulness training might change brain patterns away from stress and towards well-being. He states "with repetition… mindful practice can create intentional states of brain activation that may ultimately become traits in the individual" (Seigel 2007, p259).

Seigel quotes one study by Farb and colleagues, in which brain images of people who had done a course in mindfulness were compared with others awaiting entry to the course. The post-training group showed "a diminishment of medial pre-frontal cortex activation", suggesting a greater capacity to uncouple narrative chatter from present-moment experience (Seigel, p260). He speculates that after sustained practice, "a stabilized focus of the mind may have become a generalized trait" (Seigel, p261).

Mindfulness-Based Stress Reduction (MBSR)

Jon Kabat-Zinn systematised the use of mindfulness in a medical setting, working with patients with chronic, stress-related pain and illness. Similar to Gawler's holistic approach of teaching meditation to cancer patients, Kabat-Zinn explored the implications of bringing "wholeness and connectedness" into medicine and health care (Kabat-Zinn 1990, p151).

The MBSR program first offered in 1979 by Kabat-Zinn is an eight-week experiential group training in mindfulness practices. Particularly useful for patients with chronic conditions who have exhausted available treatment options, MBSR teaches participants how to cultivate a new relationship to their pain and suffering. Kabat-Zinn defines mindfulness as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally, to things as they are" (Kabat-Zinn, p29).

Kabat-Zinn drew directly from Buddhist teachings in developing MBSR, but he removed all reference to Buddhist beliefs or spirituality. He determined that the MBSR program would be "secular, non-pathologizing and transformational for teachers and participants alike," and positioned it "not as a clinical intervention… but rather as an educational program" (McCown, Reibel & Micozzi, p6-7).

This educational orientation offers participants a way to help themselves and expand their self-awareness by developing important life skills, which have the potential to improve how they manage whatever illness or condition they may be suffering.

The effectiveness of MBSR training has been research and demonstrated over the long-term as well as shortly after the course. Miller, Fletcher and Kabat-Zinn reviewed a group of MBSR participants three years after their initial training, and found that "ongoing compliance with the meditation practice was… demonstrated in the majority of subjects at three years" (Miller, Fletcher & Kabat-Zinn 1995, p192). Participants also showed significant reductions in anxiety and depression scores after three months, and these gains were still evident three years after doing the course.

Evidence from meta-analyses of a large number of MBSR courses shows that learning mindfulness does have significant positive effects on mental and physical well-being in patients with conditions such as anxiety, depression, fibromyalgia, cancer and psoriasis (McCown, Reibel & Micozzi 2011, p5).

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT is a relapse prevention program developed by a group of cognitive psychologists, Segal, Williams and Teasdale, who saw parallels between MBSR and cognitive behaviour therapy (CBT). They combined elements of both in a mindfulness program specifically for patients with a history of major depressive disorder (MDD) (Segal, Williams & Teasdale 2002/2013, p5).

Segal et al identified that negative, ruminative thinking habits were more common in patients whose depression relapsed, and hypothesised that these patients would benefit from a training that helps them switch to a 'decentred' mode of thinking, in which they can detach from and observe their negative thoughts. Mindfulness helps patients with MDD develop an attitude of welcoming and allowing the full range of thoughts, sensations and feelings, and cultivate a mental orientation of 'being' rather than 'doing' (Segal et al, p58).

In MBSR, the attitudes that are taught and encouraged are: non-judging, patience, beginner's mind, trust, non-striving, acceptance and letting go (Kabat-Zinn, p33-40). MBCT replicates this, and the instructor's role is to model all these qualities to participants, particularly kindness and compassion (Segal et al, p137).

MBCT does not attempt to analyse or change a patient's thoughts, as regular cognitive therapy would do. Instead, it teaches a new way of relating to thoughts and perceptions: one of observation and gentle acceptance (Segal et al, p89). The program teaches participants how to meditate by paying attention to their thoughts, feelings and sensations, and observing the breath, mind and body.

MBCT groups include both experiential exercises and feedback discussions. In the latter, facilitators help identify the mental habits such as self-blame, self-criticism, dwelling on the past or the future, etc., which contribute to depressive thinking. Teachers model a spirit of inquiry and acceptance of "things as they are" (Segal et al, p253). "The core skill to be learned is how to exit… these self-perpetuating cognitive routines… freeing oneself from the need for things to be different" (Segal et al, p89).

The MBCT program requires participants to practice mindfulness exercises every day at home, to gradually build these new mental habits. The authors stress that commitment, patience and perseverance are needed, and add that cultivating a kinder, gentler attitude towards themselves is "one of the most important things people learn from an MBCT program" (Segal et al, p137). Rather than teaching self-compassion in a didactic way, MBCT models and invites participants to try this new way of viewing life and the self.

MBCT, like MBSR, has an impressive evidence base. A number of randomised controlled trials found that MBCT significantly prevented relapse of MDD in patients who had experienced three or more episodes (Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau 2000). The relapse rate for one MBCT group was 37% compared to 66% in the control group (Segal et al, p397). MBCT has been shown to be as effective as continuing with antidepressant medication in preventing relapse, and "more effective than medication in reducing residual depressive symptoms… and improving quality of life" (Segal et al, p403).

Martine Batchelor is a long-time Zen practitioner who analysed the similarities between MBCT and the 'four great efforts' recommended by the Buddha. She summarised these efforts as: (1) Letting go of negative mental states that have arisen; (2) Cultivating the conditions in which negative mental states do not arise; (3) Cultivating the conditions that enable positive mental states to arise; and (4) Sustaining positive mental states (Batchelor 2011, p159-60).

In Batchelor's view, MBSR and MBCT systematically teach the same mindfulness skills that are required to achieve the four great efforts, skills that over time "enable us to recognise and deal more effectively with our mental patterns" (Batchelor, p163).

Self-Compassion

It is clear that one of the major benefits of MBIs is that they actively encourage the development of loving-kindness towards ourselves and others. Many participants in both MBSR and MBCT report significant improvements in their capacity for kindness and acceptance towards their own suffering, even if the actual illness or condition cannot be cured.

In the words of Christopher Germer, the hard work of struggling with emotional pain can be over if we begin to accept ourselves and find compassion for our own suffering (Germer 2009, p6). This involves a simple but profound change of attitude, one in which we turn towards our suffering and accept it. Germer's research indicates that mindfulness practice helps people move through the stages of acceptance, which he identifies as Aversion, Curiosity, Tolerance, Allowing, and Friendship (Germer, p28).

Tara Brack, like Germer, advocates the active cultivation of self-compassion and "radical acceptance" of ourselves and our lives as they are (Brack 2003, p25). Both these writers are psychologists and Buddhist practitioners, who have worked with many clients with the common Western mindset of negativity, blame, self-criticism, perfectionism and inadequacy. They suggest that if we are caught in physical or mental suffering we can benefit from cultivating self-compassion in everyday life, as well as through regular mindfulness meditation.

Limitations of MBSR and MBCT

One might ask how realistic and manageable it is for people in different contexts and walks of life to put this advice into practice. The research on MBCT showed one important and curious result, which suggests that MBIs may not be suitable for everyone. It showed that MBCT appears to be *less* effective, and possibly even detrimental, with patients who have experienced only one or two previous episodes of major depression. It was also not effective with patients who were currently experiencing a depressive episode (Segal et al, p399).

The authors speculate that patients who have had only one or two depressive episodes may be suffering from a more exogenous (externally-generated) form of depression than those who go on to have three or more episodes (Segal et al, p401). The question remains, why would their depression have worsened through practicing mindfulness? Perhaps their real-life problems felt too difficult to face and accept.

The authors acknowledge that someone in the grip of a major depression may not have sufficient discipline or perseverance to practice mindfulness consistently. This is an important point to recognise, as depressed people are often aware they need to do exercise or certain tasks, but due to their illness they lack the energy and motivation to do so.

This might also apply to people with high levels of anxiety or other forms of mental illness, which make it difficult to sit down and meditate on the breath for any length of time. These individuals might benefit from appropriate psychiatric assessment, and possibly medication to stabilise their mood, before embarking on a mindfulness course.

MBCT requires patients to do up to an hour of daily homework, which may be quite challenging for some, particularly if difficult feelings and thoughts keep arising. I wonder about the drop-out rate in MBCT and MBSR groups, and what impact the sense of failure may have on those who cannot maintain the daily practice. Segal et al acknowledge that the home practice requirements could be a deterrent to some patients, and state: "those who are most prone to ruminate and/or avoid difficult experiences are most likely to drop out early" (Segal et al, p99).

In my view, the toleration of negative experiences is a major challenge that some people may find unsurmountable. There may also be practical obstacles, in terms of finding the time and sufficient commitment to attend class and do the daily homework.

Another query is how long would participants need to continue meditation, in order to prevent a relapse: might it be a self-care practice they need to continue for many years, or the rest of their lives? While meditation may be an attractive lifestyle choice for those with sufficient time and resources, it may not be as viable for people whose parenting or work commitments mean they cannot easily make time to practice.

MBSR and MBCT do not explore or resolve participants' individual problems; instead they teach self-observation and self-acceptance, which will hopefully broaden a person's view of their problem, and may well lead to unexpected, creative solutions.

However, there may be participants who need more individual support to grapple with the problems that are contributing to their stress or depression. While it is clear that MBIs are educational rather than therapeutic in their focus, I think it is responsible when teaching vulnerable populations to ensure adequate intake assessment and ongoing monitoring takes place, to identify any participants whose life circumstances warrant referral for more intensive support.

Conclusion

MBIs are a powerful educational tool that has been proven in numerous studies to be effective for a wide range of physical and mental health conditions. However, they require significant effort to practice the skills and change one's lifestyle, and there are some individuals for whom this may be too difficult. MBIs, to be effective, depend on the willingness of participants to take responsibility for their state of mind and work patiently to consolidate the improvements that are possible, in an attitude of perseverance, non-striving, and trust.

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