

THE CLINICAL USE OF 'MINDFULNESS' MEDITATION TECHNIQUES IN SHORT-TERM PSYCHOTHERAPY

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In recent years, modern Western psychotherapists have begun to discover the rich diversity of potential psychotherapeutic techniques, most originating many centuries ago, which are available to us in the Eastern 'psychological literature' (Goleman, 1971; 1972a; 1972b). The purpose of the present report is to briefly discuss one such set of techniques and to demonstrate its use with short-term (2-12 weeks) psychiatric patients in a clinical setting.

'MINDFULNESS' (SATIPATTHANA) MEDITATION

Specifically, the techniques to be described here are adopted from the Buddhist Satipatthana, or "mindfulness meditation," described elsewhere by Soma (1949), Sayadaw (1970) and Thera (1972, 1973). Buddhism, far from being a 'religion' concerned with higher beings external to the individual human, is more accurately an exquisitely introspective, but highly systematic psychology and philosophy which obtains its data from the very bases of human experience, namely sensations, perceptions, emotions, thoughts, and consciousness itself, all of which taken together are frequently termed 'mind'. Buddhist psychology (Abhidharma) makes each individual a scientist, carefully observing his own mental processes in order to be freed of the melodramas generated by those very processes. Particularly painful are the melodramas of the ego-oriented realities so prevalent in the population of persons seeking help from professional psychotherapists.

*Buddhist
psychology
(Abhidharma)*

Thera (1973) renders the Pali term *satipatthana* as 'mindfulness', stating that *sati* has the general meaning of 'attention' or 'awareness', and *patthana* as 'keeping present'. The *SatipatthanaSutra* (Soma, 1949) is one of the oldest and most original teachings of the Southern or Theravada Buddhists, and outlines specific meditation techniques for cultivating mindfulness, or present awareness. This paper is an attempt to acquaint the reader with the very striking effectiveness of the satipatthana techniques when used as primary or secondary psychotherapeutic techniques with a variety of psychiatric patients.

*client centered
methods*

The mindfulness technique is a very 'client-centered' approach to psychotherapy, for at its heart is the assumption that only the individual has the ability to help himself. While the psychotherapist or other helping person can point the way for the client, only the client can carry out the psychotherapeutic process. Therefore, this technique is virtually a self-treatment regimen, and is thus highly efficient in terms of the therapist's time. As will be explained later, it is a technique which is compatible with either individual or group therapy and nicely complements most existing Western psychotherapies. It can serve as the primary mode of treatment with clients for whom it seems appropriate, or it can serve well as a supplementary form of treatment in conjunction with chemotherapy, somatotherapy, or other forms of psychotherapy.

The doctrine of mindfulness is not in any way mysterious or mystical, It simply states three objectives: to come to know *one's own mental* processes, to thus begin to have the power to shape or control the mental processes, and finally to gain freedom from the condition where the mental processes are unknown and uncontrolled, with the individual *at* the mercy of his own unbridled mind. The goal, then, is to come to know and understand one's own mental processes.

bare attention

According to Buddhist psychology, sense impressions are six-fold, including the five physical senses and the mind. Thus, perceptions stem directly from one or more of those six senses. Mindfulness is developed from what Thera (1972) chooses to call 'bare attention', an accurate, non-discursive registering of the events taking place in the six sensory modes without any reaction to those events through mental evaluation (good-bad), mental comment or naming (book, chair, dog), speech, or behavioral act. In fact, bare attention is the careful, deliberate observation of all mental and physical activity, the purpose of which is coming to know one's own mental processes as thoroughly as possible. The objects of observation in

mindfulness training can be of four types: (1) body processes (natural events such as breathing, walking, pain, or discomfort), (2) emotions or feelings, (3) thoughts themselves (the present condition of consciousness), (4) mental contents (objects of consciousness).

Thera (1972) compares the mind's everyday activities to a dark and unkept room cluttered with refuse. Lack of vigilance and awareness of mental activities accumulates over a long period of time into a condition where a large proportion of mental activities take place in a kind of twilight state, a semi-conscious background from which unwholesome neurotic behavior easily arises. Just as dust settles ever so gradually in a room, resulting in heaps of dust over the years, ignorance and reduced awareness settle in the mind. This mental refuse reduces one's living space just as effectively as would the collection of refuse in a room of one's house. The Satipatthana approach begins with inspecting, cataloguing, and coming to know intimately one's own mental refuse through the light of 'bare attention'.

PSYCHOTHERAPEUTIC APPLICATION

Mindfulness training with psychiatric patients has proven most effective by beginning with an obvious body process as the object of observation. Since many Westerners are overly self-assured that we know all there is to know about our minds, the first goal of mindfulness training is to begin to show the client the workings of his own mental processes. This is best done by instructing the client to sit quietly and comfortably in an upright chair for a period of several minutes and resolve to observe his own breathing without interruption. The patient simply 'watches' as he breathes in and as he breathes out, and he also watches the gap before the next in-breath. As he attempts to concentrate on his own inhaling and exhaling, activities of mind become very apparent, for thought follows thought, and each thought constitutes a noticeable interruption in breath observation. This exercise, if carried out faithfully for several minutes, will serve to begin to make a patient aware of his own mental preoccupations, for some patients notice a predominance of thoughts about past events (memories) interrupting their breath observation, while others notice that they are most frequently interrupted **in** breath observation by thoughts pertaining to the future (fantasies, planning, or worrying). Each person who tries this beginning exercise will also find a diversity of momentary interruptions which stem from the 'present'. Noises, temperature changes,

*breath
observation*

watcherself

pains, and discomforts related to body postures all constitute interruptions in breath observation. If the patient is taught over time to note interruptions in breath observation and to label each interruption with neutral terms such as 'remembering', 'fantasizing', 'hearing', 'thinking' or 'touching', he will quickly discover a rather complicated, but comforting, situation where there is one aspect of his mental 'self' which is calm and psychologically strong, and which can watch, label, and see the melodramas of the other 'selves' which get so involved in painful memories of the past or beautiful and escapist fantasies of the future. By helping the patient to identify for a time with the strong and neutral 'watcher self' there begins to develop within him the strength, motivation, and ability to fully participate in, and benefit from, whatever other forms of psychotherapy are being provided to him.

Buddhist psychology, of course, takes the point of view that there *is* no real, permanent, or final 'self' to discover or depend upon. All selves (collectively called the ego) are just a product of continuous brain processes. Thus, the 'watcher self' mentioned above is only a tool to be used within the context of the present discussion, for it, too, is not permanent or real in any way. The actual purpose of establishing the 'watcher self' is to ground the patient firmly in the present where there is a much higher probability of making significant progress in the psychotherapeutic process.

*increasing
mindfulness*

With continued work the 'watcher self' becomes more mindful, first noting and labelling thought interruptions in the breath observation practice, then coming to see what causes thoughts to begin and pass away, and what causes the next thought in an endless thought chain. Later the observation process gives insights into emotions, which can also be labelled with terms such as 'anger', 'joy', and 'fear'. Emotions, like thoughts, when labelled and observed objectively, *lose* much of their power to cause discomfort and confusion, and are therefore good objects for contemplation. Still later the breath observation technique can reveal to the patient much about the causes of his own behavior, for one begins to notice that intentions precede any act of speech or behavior. By becoming aware of the intention process, one can then intercept and cancel unwanted words or deeds before they are manifested in behavior—something many patients find useful since it places control of their own behavior back at the conscious level. There are many other levels of insight available to those who work to develop mindfulness, but the present discussion will be limited to the few previously mentioned. Perhaps a few case studies of patients who have successfully used this mindfulness technique will illustrate its practical applications.

Case # 1: Thought Contemplation. A 23-year-old newly-divorced female patient complained that her thoughts about previous bizarre sexual demands made by her former husband were triggering bouts of depression and severe anxiety attacks. She was trained to carefully observe these thoughts of the past using Satipatthana techniques, and to begin to label those bothersome thoughts as 'remembering, remembering'. Within a period of a few days she reported that while there was no significant decrease in the frequency of such thoughts about the past, there was a change in the way those thoughts affected her. The labelling process helped to break the causative relationship between the thoughts of the past and the depression and anxiety attacks, thus allowing the gradual disappearance of the anxiety and depression. What remained at that *point* were regret *about* the *past*, and considerable guilt, and these were worked on *in* a traditional group psychotherapy setting during the following weeks.

Case #2: Emotion Contemplation. During a group therapy session one member of the group, a 22-year-old married female who suffered from what had been diagnosed as an 'endogenous depression', expressed despair at her inability to 'feel anything anymore', relating a total lack of emotions of any sort. The only feeling which she could identify was one of gloom and depression. She was asked to begin to get in touch with her feelings, becoming more aware of, and carefully and accurately labelling any emotion which she experienced as she sat quietly watching her breathing or even during her normal daily activities. Over the next few weeks she increasingly found herself naming anger as her predominant emotion, and it became possible to identify the source of that anger in her marital relationships. She then began to become aware that she had been misinterpreting her emotions over a period of months, mistakenly believing that it was simply depression that she had been experiencing when there had been strong elements of anger, hostility, disappointment, and self-abasement as well. The realization that the feelings which she had been inaccurately labelling as depression freed her to begin to identify other feelings as well, and she was soon back in touch with the full spectrum of human emotions. Her depression disappeared, replaced by a renewed self-image and a greatly improved understanding of her feelings.

Case # 3: Insight into the intentional process. A married man, age 41, with two teenaged children at home was hospitalized for 'endogenous depression', complaining of loss of energy and concentration, poor job performance, and poor family relationships. The staff on the psychiatric unit reported that only superficial relationships could be established with the man and that he refused to discuss himself in an effort to gain insight. The man was referred by his psychiatrist to group therapy on his fourth day of hospitalization and he continued in the group through the few following days of his stay in the hospital and for approximately two weeks as an outpatient.

Since this man perceived his primary problem as one of communication, both at home and at work, this seemed to be an appropriate problem on which to attempt to employ a limited set of Satipatthana techniques. The group therapy situation proved to be a very good place to engage this man in such techniques, for in the beginning he had difficulty communicating in the group as well. When this difficulty in communication was expressed by the patient he was simply asked what he wanted to communicate. He mentioned certain thoughts and feelings which had not been verbalized. The approach used with this patient consisted of asking him to sit quietly by himself for a brief period or two each day and to 'get acquainted' with the feelings he was experiencing and the thoughts he had during those periods. Some days later he was further instructed to examine carefully the situations where he wanted to speak, but **did** not. He rather quickly gained insight into not only the nature of his thoughts and emotions, but more importantly the nature of how acts, particularly verbal acts, are carried out. He saw the effectiveness of seeing what thought or emotion is present in consciousness and then intentionally choosing to express that verbally or not. He was then able to discuss and analyze events, feelings, and thoughts which had been troubling him for long periods of time, and this alleviated his depressed condition, allowing him to return to home and work.

widerrange of techniques

These examples demonstrate the use of selected mindfulness techniques applied to patients for whom the techniques were appropriate. Seldom is **it** appropriate or necessary to use the full range of mindfulness techniques with any individual patient. The following cases demonstrate the use of a somewhat wider range of techniques.

Case #4: Thought Contemplation, Concentration Training, 'Watcher' Contemplation. A 27-year-old divorced female had been hospitalized for 2½ months for a condition which had been variously diagnosed as 'manic-depressive psychosis', 'depressive psychosis', and 'schizophrenia'. She had responded to chemotherapy to the extent that she was able to begin group psychotherapy free of psychotic symptoms, but still suffered from recurring episodes of depression, anxiety, loss of interest in life, and loss of self-esteem. A period of several weeks of intensive group psychotherapy failed to produce relief of this young woman's symptoms, and she was soon readmitted to the hospital suffering from severe depression and thoughts of self-destruction. Her primary concerns were loss of concentration and racing thoughts, in addition to feelings of depression. The mindfulness technique used in this case was presented to the patient as a concentration exercise where she was asked to sit quietly and look at the second-hand of an electric clock, trying very hard to attend fully to its movement. She was instructed to notice carefully when her concentration on the moving second-hand was lost, then to identify what constituted the interruption, and to name that interrupting factor. She very quickly found that her concentration was constantly being

broken by thoughts. Upon inspection, the nature of the thoughts which raced through her mind was always the same, being concerned with her past, her misfortunes with her ex-husband, and her regrets about that situation. She was instructed simply to label such thoughts as 'remembering, remembering'. The labelling process seemed to cause this young woman to withdraw some of her involvement in those depressing thoughts of the past and to give her the realization that there was more than just those thoughts present in her mind, for there was a 'she' who could watch and name thoughts, too. She learned to identify herself as the objective watcher of her disturbing thoughts instead of the depressed thinker, and she began to feel relief from her psychiatric complaints. Upon reflection, this patient reported that as a result of this psychotherapeutic endeavor she came to see more clearly the nature of her former illness. What she subjectively perceived that had happened to her was that she had become totally immersed in thoughts and regrets about the past, thus becoming less involved in what was happening around her in the present. She subsequently had no involvement in her future as well. Her thoughts of the past caused discomfort and depression, even anxiety, so she used large amounts of energy to defend against and to try to make those thoughts go away. She felt that all of her energies during her illness had been consumed in thinking about the past and simultaneously fighting to stop such thoughts, leaving her no energy with which to run her own life. The mindfulness technique of labelling was effective with this woman because it allowed her to see that thoughts cannot be forcibly stopped or prevented, and it allowed her to stop expending the energy in fighting against remembering.

After only a few days of employing the 'concentration exercise', this young woman reported a significant increase in the period of time she was able to concentrate. The increased concentration, which was accompanied by decreases in frequency and intensity of disturbing thoughts, allowed the woman to begin reading again, to carry on meaningful personal interchanges without the usual loss of what was happening, and to devote more time and energy to her personal appearance, which had been untidy during the period of her illness.

With the additional benefits deriving from the somewhat disguised Satipatthana techniques being employed with this woman, it was decided to have her investigate the nature of the 'watcher self' whom she had come to identify. This allowed her to get in contact with the calm and peaceful aspects of her own mind, her 'center' as she identified it at the time, and served to reestablish some enjoyment and pleasure in her life-dimensions which had been missing for many months. This, too, contributed to further improvements in her interpersonal relationships. Within a few weeks of these observations, *this woman* was able to make the decision to terminate her therapy, after which she moved to another city where she had decided to try to begin a new life.

Case #5: Modified Satipatthana techniques. A slightly disguised set of Satipatthana techniques was employed with a 23-year-old male who had been hospitalized for extreme periodic aggressiveness, fighting, and alcohol abuse which had occasionally led to brief periods of amnesial or fugue-like states. This young man, who was married and had young children, had been extremely irritable and explosive at home. often losing his temper over minor events which caused him to strike out physically or to storm out of the house for periods of time lasting up to three days. A typical, though infrequent, pattern of behavior for this individual was to go to a bar with friends for a few drinks during the evening, during which time he would become intoxicated. In his intoxicated condition he would often commit acts such as car theft, fighting, and even threatened homicide, but failed to have any memory of those acts on the following day. A crisis of that type which put him in conflict with the law precipitated his hospitalization on two separate occasions.

Upon his second admission to the psychiatric unit this young man proved to be quite warm and cooperative, but experienced high anxiety levels when he was engaged by staff to discuss his reasons for being in hospital. At that time he chose to characterize himself as an alcoholic. After a few days of chemotherapy he was referred by his psychiatrist for group therapy, and for the next few weeks received a therapeutic program consisting of brief daily visits by the psychiatrist, chemotherapy, twice-weekly group therapy, a weekly session of conjoint family therapy between the patient and his wife meeting with the group therapist, plus whatever sessions the patient chose to initiate with the psychiatric nursing staff. This program was continued throughout four weeks of hospitalization, and remained quite similar throughout four weeks of outpatient care as well.

During the initial group and family therapy sessions it became evident that there were numerous identifiable marital problems, and these were the focus of the family therapy sessions. Group and individual therapy sessions revealed problems in the personal area pertaining to expression of anger, self-image, hostility toward women, and extreme competitiveness with other males,

Since it did not appear that this particular man would be receptive to the Satipatthana approach previously described, it was decided to attempt a modified approach with him. His tendency to deny anger, and to express it explosively, seemed to be a good place to begin, so it was mentioned casually during a group therapy session, when the topic arose naturally, that one could perhaps come to know quite accurately the causes of his own behavior. The young man in this case study took issue with that statement, saying that he did many things which he could never hope to understand. At that point it was suggested that he attempt to look at and name the emotions he experienced throughout the next few days. He tried that suggestion, and reported that what he felt most

of the time was fear (of people, sometimes of nothing he could identify) and pain (psychological discomfort). He was instructed to keep watching and naming emotions, and over a period of weeks he began to see anger arising on certain occasions, as well as fear arising in certain interpersonal situations. He was also able to see his feelings of irritability, and began to see what events produced those feelings. Most importantly, he began to become aware of his maladaptive practice of not expressing anger, and often not even being cognizant of it, until it had overwhelmed him. He was taught to verbalize his anger, to vent it as he experienced it, and to view anger as something all humans normally feel, and this seemed to free him to progress in psychotherapy. He ceased to view his problem as being one of alcoholism and spoke of alcohol intoxication as another way of trying to hide from his anger. He soon ceased to mention alcohol at all.

Other Satipatthana techniques were then employed with this man, particularly thought contemplation, which made him aware of his ineffective and inaccurate self-image, and that helped him to progress toward improving his misunderstandings regarding male-female relationships. The man, at the end of eight weeks of the treatment described, took his job and ten months later is still functioning effectively at home and at work, with no recurrences of drinking, fighting, or fugue-states. The Satipatthana techniques employed in this case constituted a single portion of an overall therapy program which proved to be effective.

The significant discovery for the therapist in this case was that thought and emotion contemplation can be carried out quite effectively without the patient sitting quietly, watching the breathing process, or otherwise being busy 'doing something'. If the patient is sufficiently motivated, if he has some intellectual understanding of why he should watch and name thoughts or emotions, and if he is sufficiently instructed in techniques of watching, this process can be carried out, even from the very beginning, during normal daily activities. It is not necessary, it seems, for the patient to know that he is meditating in order for him to employ these techniques effectively in psychotherapy. The techniques can be readily modified to suit the individual patient's overall program of therapy.

*therapist's
discovery*

LIMITATIONS

Each of the cases cited above has primarily emphasized certain aspects of thought and emotion observation, followed by naming where those thoughts and emotions originate—in past, present, or future—thereby allowing the person direct and immediate insight into the workings of his own mental proc-

*caution
regarding
psychosis*

esses. As that insight builds, psychological discomfort stemming directly from previous lack of awareness about one's own mental processes (mind) is naturally alleviated. While this psychotherapeutic approach is extremely effective when employed with patients suffering from depression, anxiety, and a wide variety of neurotic symptoms, a caution should be issued regarding its use with patients experiencing actively psychotic symptoms such as hallucinations, delusions, thinking disorders, and severe withdrawal. To effectively carry out the Satipatthana techniques for self-observation requires an intact and functional rational component of mind, as well as sufficient motivation on the part of the patient to cause him to put forth the effort required to do that observation. The absence of either of those factors in any given patient automatically eliminates the potential usefulness of the Satipatthana techniques. In the experience of this author, it is necessary to postpone employing Satipatthana techniques until the patient is able to use them effectively if maximal results are to be obtained.

*experience of
the therapist*

A second caution is also in order concerning the employment of Satipatthana techniques in psychotherapy with patients. The sincere psychotherapist who wishes to apply such techniques with his own patients will find that it is necessary to explore the techniques with himself first, thus coming to know experientially the meanings of the terms used, the steps through which one progresses as the techniques are applied, and the nature of the insights available using this approach. He will then be better prepared to facilitate the experience of patients using this approach.

It is hoped that the present paper, which is much too brief to serve as a detailed guide for employing Satipatthana techniques with patients, will instead serve as an example of a psychotherapeutic technique successfully adopted from Eastern (Buddhist) psychology, and will encourage other practicing psychotherapists to incorporate other appropriate techniques from sources other than traditional Western psychological theory.

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It is worth distinguishing mindfulness meditation from all the other meditation techniques and traditions available to us today. In this article, mindfulness meditation is framed as a secular practice which is used in medical, therapy, or self-improvement context. Its effectiveness is backed up by 2,500 years of Buddhist tradition, as well as modern science. The concept of mindfulness has originated from Pali Buddhism (the earliest Buddhist tradition). Meditation and psychotherapy - is this a combination that works? And if so, how can it benefit you? What issues can meditation help in the therapy room? Meditation has come a long way in the last few decades. Now practised by business sorts and bohemians alike, it is used in schools, prisons, and major companies. Meditation was even introduced in Parliament here in the UK. But is mediation really suited to be part of psychotherapy? What sort of meditation do psychotherapists use, anyway? And how can it boost your results from attending therapy? What sort of meditation are we talking about? Meditation wears many hats these days.