Mindfulness for dummies ?

Tullio Giraldi

Department of Life Sciences, University of Trieste, giraldi@units.it

Summary

Meditation was initially introduced by Kabat Zinn as mindfulness in a program of stress reduction. Since then, mindfulness has steadily become very popular, and has been also incorporated into the cognitive approach of Mindfulness Based Cognitive Therapy. During this process, a main role for meditation has been progressively lost, and mindfulness has become a series of short periods of meditation which are one among the other home assignments received by the patient. Numerous studies have been made to evaluate the clinical and cost effectiveness of these approaches, and their results appear encouraging, particularly for long lasting effects on depressed patients. However, in spite of these efforts, the available studies do not provide unquestionable evidence of effectiveness and superiority to other psychotherapies, in particular psycho-dynamically oriented humanistic and interpersonal approaches. In the application of mindfulness to cognitivism, the moral principles of Buddhism have been neglected, and the idea to apply meditation in psychotherapy with the aim to focus on the "self" of the patients, contrasts with the aim of Buddhist meditation which is the realization of the illusory nature of the self. Efforts to avoid the numerous limitation of the recent reductionist and mechanistic developments of the blending of mindfulness with cognitive psychotherapy appear to be required. Meditation, when wisely chosen or integrated with other form of psycho-social intervention for the existential difficulties of the persons which are clinically and culturally more suitable, may result an additional useful offer for personal growth.

Key words: Meditation, mindfulness, intervention, effectiveness

1. Introduction

Mindfulness has become a surprisingly popular subject, and a steadily increasing number of publications is published, which includes academic articles and books, as well as articles in newspapers and periodical magazines. Manuals addressed to the general public are easily available; book stands are present even in airport shops, where on display are books like *Meditation for Dummies*, *Mindfulness at Work for Dummies* and *Mindfulness for Dummies*, hence the title of this contribution. The internet site of the publishers of these books (http://www.dummies.com), and a large number of similar sites is available on line; a Google search for "mindfulness" provides approximately 40 million entries.

A similar diffusion occurred for meditation and mindfulness, either as a simple way to promote *well being*, or as an approach employed alone or in combination with other forms of psychotherapy for the treatment of mental suffering (Bucholz, 2015).

The first approach which encountered wide popularity is the *Mindfulness Based Stress Reduction* (MBSR) program developed by Jon Kabat Zinn in 1979. It offered a well defined intervention package, and great efforts were made to provide evidence of its efficacy in a medical perspective (Bishop, 2002). One significant avenue subsequently followed in the use of mindfulness has been its incorporation into cognitive psychotherapy, leading to a specific approach named *Mindfulness Based Cognitive Therapy* (MBCT), and great investments were made, similar to those made for *Cognitive* (CT) and *Cognitive and Behavioural Therapy* (CBT), to provide scientific evidence of its effectiveness (Beck, 1997; Baer, 2003).

The basic rational behind these approaches is the use of meditation, since it is the Buddhist traditional way for avoiding suffering. The general term of "meditation" was soon replaced by "mindfulness", a *pali* word indicating one the concepts of the *Noble Eightfold Path* (Suzuki, 2010).

I recently decided with a certain reluctance, being a practicing Buddhist in addition to being a clinical psychologist, to test an intervention based on meditation in a sample of young people, suffering of psychological problems that were followed in Trieste by the National Health Service Community Care. The results obtained in a feasibility study are of preliminary nature, and although being encouraging are not yet ready for communication. However I believe that few considerations coming from the experience I am gaining in realizing this intervention may deserve to be reported succinctly in this presentation.

2. Does mindfulness really work ?

The main reason for making this study was the diffusion that meditation and mindfulness have progressively achieved in western countries in the last 30 years. I always had a substantial reluctance to introduce meditation into the practice of clinical psychology and psychotherapy because of my training and practice of meditation in the Buddhist tradition of Rinzai zen, which also began approximately in the same period. On the other hand, the approaches used for treating the mild conditions, which often are of an existential nature, progressively rely on the prescription of a SSRI antidepressant medication. Meditation appears an alternative for pharmacotherapy, in some cases providing results greater and of longer duration than those of psychotherapy.

The literature on meditation and on mindfulness is constantly growing and meta-analysis are available indicating their effectiveness, as happened with cognitive and cognitive behavioural therapy, in relieving the symptoms of depression (Goyal, 2014; Gotink, 2015; Davidson, 2016).

In spite of the apparent convincing evidence of effectiveness accumulating, there are substantial aspects concerning the diagnosis of the conditions treated and the criteria employed for the evaluation of the effects of the treatment deserving attention. The same structure of the protocols employed, as well as the theoretical grounds on which the meditative approaches are based, constitute an area open to critical considerations.

I will therefore briefly mention the main relevant issues:

- In the *Mindfulness Based Stress Reduction* program, the main aim of Kabat Zinn's work was that of employing "meditation without Buddhism" for treating stress. This implicitly adopts the idea that meditation can be employed also when it is taken out of Buddhism, depriving at same time the practice of meditation of the moral principles of Buddhism which constitute large part of its nature and practice.
- Stress is not simply an external isolated factor which may negatively affects us when we encounter it. The term was originally coined by Hans Selye for the physiological reactions to physical challenges constituted by the "general adaptation syndrome". The classical works of Paykel has clearly shown that specific life events, requiring significant efforts of adaptation, are significant "stressors", and may lead to depression and anxiety (Paykel, 1969). Emotional reactions are natural and physiological, and do not necessarily require intervention except relatively rare cases of morbid (psychiatric) conditions (Horwitz, 2007).
- In MBSR, the persons in the program meet weekly for 8 weeks, and are encouraged to practice meditation between the meetings, with the final aim to incorporate its practice into everyday life. The practice of meditation has been progressively transformed into mindfulness, and has been integrated into cognitive psychotherapy. In the end, meditation has become one of the "home works" that the psychotherapist assign during the treatment, having to be practiced for few minutes at home together with the other assignments.
- To provide scientific evidence of effectiveness of an intervention, there is universal agreement that protocols have to be controlled, randomized, double blinded and have to include a control placebo arm. The majority of the studies available for mindfulness do not meet these criteria; even the studies more carefully performed, in spite of the efforts made, do not fully adhere to these requirements. Moreover other relevant issues are disregarded, not being reported or discussed, such as;
  - the characteristics of the population to which a mindfulness based intervention is proposed,

- the frequency of acceptance of the offer of a treatment including meditation, and the characteristics of those accepting or refusing it
- the characteristics of those dropping out during the intervention, or during follow up
- the proportion of those with a favourable outcome, and of the person to which the intervention was originally proposed (these may be very limited, even when the study provides statistically significant evidence of effectiveness)
- the absence of these critical requirements in the trials so far performed is probably difficult to avoid, because of the nature of the intervention studied. It has to be noted that because of these limitations, the favourable outcomes available in the literature, in spite of the good faith of their authors, may be simply caused the Howthorne effect, a rarely considered factor which may affects psychological research unless excluded by an adequate research protocol (Draper, 2016; Braunholtz, 2001).

- The evolution of Cognitive Therapy to Cognitive Behavioural Therapy, and to Mindfulness Based Cognitive Therapy is still continuing, with the integration of mindfulness in even more specific new psychotherapeutic approaches. It is interesting to note that the birth of new "third wave" therapies and their use is occurring in the absence of any scientific evidence of their effectiveness and superiority above the other ones (Hunot 2013). The evidence of superiority of these cognitive based new psychotherapies in relation to those based on psychodynamic principles is also lacking (Aflalo, 2015).
- The diagnosis is made using the Statistic Diagnostic Manual (DSM) of American Psychiatric Association (APA), or psychometric scales such as the Beck Depression Inventory or similar, which are also used to determine the effects of the intervention. This leads to the serious criticisms encountered by the DSM, in particular for its use for depression diagnosis, and for use of psychometric questionnaires to evaluate the effects of the treatment (Frances, 2014). Moreover, cognitive psychotherapeutic interventions are carefully structured in manuals which have to be strictly followed by the therapist, which in its turn is evaluated for his capacity to apply the manual using another manual developed for this purpose. The details of the procedures, and the relevant citations, can be found in the recent paper by Kuyken on the cost effectiveness of Mindfulness Based Cognitive Therapy (Kuyken, 2015). This rigid role for the therapist leads to imagine that he might be replaced by a computer, and this exactly what happened with creation and progressive use of Computer Based Cognitive Therapy (CBCT) in UK and elsewhere (Kaltenthaler, 2008 .
- The same theoretical basis of MBCT requires critical consideration. The general aim of psychotherapy is to strengthen and to liberate the "ego" or the "self" by the constrictions which are at the base of the suffering for which the treatment is performed. Buddhism and meditation, as well as eastern approaches, have been already considered in depth for their application in western psychotherapy. The issue which I wish to mention here is that all the eastern approaches are based, as is Buddhism, on the realization of the illusory nature of the "self", and share a humanistic and interpersonal perspective. The recent developments of mindfulness and its integration into cognitive therapy are on the contrary concentrated on the strengthening of the self, and this contradiction does not seem to have been considered

3. Conclusions

Mindfulness, initially valued because of its origins rooted in the ancient eastern practices, has become a technique which is progressively modelled and inserted into newly developed psychotherapeutic approaches. These developments do not seem to be grounded on sound scientific and cultural bases. The moral precepts of "right thought" and "right action" of the *Noble Eightfold Path* are lost. Mindfulness is even integrated in programs of the Armed Forces of the United States with the aim to improve "the operational effectiveness and build warrior resilience in American soldiers" (Stanley, 2009).

The preliminary results of the feasibility study which is under way in Trieste is consistent with the published experiences showing that an intervention purely based on meditation can be usefully realized in young persons with psychological problems in community care. Its optimal use, when efforts to avoid the numerous limitation for the recent reductionist and mechanistic developments of the blending of mindfulness with cognitive psychotherapy are made, may reside in the wise integration of meditation with other form of psycho-social support for the existential difficulties of the persons clinically and culturally more suitable.

4. Literature

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Tullio Giraldi

Tullio Giraldi has been full professor of pharmacology in the Faculty of Medicine of the University of Trieste, and he currently teaches at the same University clinical psychology and psychopharmacology to under- and post-graduate students in the Faculty of medicine and psychology. He performed research, and published extensively, in the field of experimental and clinical pharmacology, and clinical psychology. He is a psychotherapist, trained in transactional analysis, and he is a lay Buddhist monk and a master of meditation in the Rinzai Zen tradition of Zenshinji. More information at http://www.tulliogiraldi.it/it_IT/.