

Spiritual Help: A Buddhist Perspective

Dr. Paramabandhu Groves

Mindfulness is a key quality in the teachings of the Buddha. An important early sutta on mindfulness puts it like this:

‘This is the direct path for the purification of beings, for the overcoming of sorrow and lamentation, for the disappearance of pain and distress, for the attainment of the right method, and for the realization of Enlightenment — namely, the four foundations of mindfulness’ (*Satipatthana Sutta, Majjhima-Nikaya 10*).

Sāntideva, an eighth century sage, emphasised the role of mindfulness in controlling the mind to prevent suffering:

‘Rutting elephants roaming wild do not cause as much devastation in this world as the roaming elephant, the mind, let free, creates in Avici and the other hells... But if the roaming elephant, the mind, is tethered on every side by the cord of mindfulness, every danger subsides, complete prosperity ensues’ (*Bodhicaryavatara, 5, 2-3*).

In this talk I will look at the development of the use of mindfulness in the west; its use in depression and addiction; and how we are using mindfulness at the London Buddhist Centre to promote health and well-being.

Jon Kabat-Zinn started using mindfulness in America from the late 1970s, especially with people with chronic pain, but also with people suffering from stress and anxiety. He defined mindfulness as paying attention in a particular way: on purpose, in the present moment, and non-judgementally. He developed an 8-week course using mindfulness meditation together with some simple yoga exercises. This course became known as Mindfulness-Based Stress Reduction (MBSR) and early studies showed that people benefited from it, including at 4 years, in a follow-up of people with chronic pain. The benefit was particularly seen in people who continued to practise mindfulness, even if this was done informally as oppose to formal sitting meditation.

In 1992, Zindel Segal, Mark Williams and John Teasdale were tasked to develop a maintenance form of cognitive therapy for depression. The intention was to prevent further episodes of depression in those who had recovered, whether through antidepressants or psychological means. They wanted to use a group format for cost effectiveness. Depression has a high rate of recurrence – up to 80% after two episodes – which raises the question of why do people relapse? Although a first episode of depression may be associated with a major life event, studies show that subsequent episodes are less and less likely to be associated with a major life event. Moreover, when someone is no longer depressed, dysfunctional attitudes (that have been implicated in

the aetiology of depression) are no different from those who have never been depressed. Instead it seems that a transient low mood can reactivate negative thinking and dysfunctional attitudes in those who were formerly depressed. This in turn can lead to a ruminative thinking style, which is an attempt by the individual to solve why they are feeling low, but in practice acts to maintain and exacerbate the low mood, leading to a downward spiral that can end up relapsing back into depression.

Cognitive therapy is thought to work by 'decentring', in which thoughts are simply seen as thoughts rather than necessarily reflecting reality. In developing a maintenance form of cognitive therapy, Segal et al. aimed to find a way to decentre from negative thoughts and interrupt the ruminative response cycles. They approached Kabat-Zinn, initially planning to use mindfulness as an adjunct to cognitive therapy, but ended up with mindfulness becoming central. Called mindfulness-based cognitive therapy (MBCT), a 3-centre study showed that MBCT reduced the relapse rate by about half in those with 3 or more episodes of depression. Subsequently MBCT has been recommended in the NICE guidelines for prevention of recurrent depression.

MBCT may be thought of as having three steps: ABC. A is for developing Awareness. This is done through a 'body scan', sitting meditation, mindfulness of everyday activities such as walking or eating, and the breathing space (a mini-meditation that can be done at any time). Much of the time people operate on automatic pilot, running along without being fully aware of the contents of their experience. The intention the first step of MBCT is to become more aware of the full range of one's experience, including thoughts, emotions and body sensations, so that transient dips in mood or negative thoughts are caught early before leading down the path to depression. The second step is learning to Be with experience. Staying with negative experience helps to prevent suppression or other habitual reactions to push away unwanted experience. This can allow a change in perspective so that thoughts are not over-identified with, as though they were facts, but simply as objects of experience. Finally, the increased awareness and the ability to stay with difficulties rather than habitually pushing them away, enables skilful Choices to be made.

Some comments from course participants give a flavour of the effects of MBCT:

'Throughout the course I feel I have progressed significantly. Although I have not had time to do the practice every day, I have developed an awareness of my negative thought patterns, and reactions to situations. By using the 'breathing space' I have reacted in a different way to difficult situations – rather than trying to control or change, becoming aggressive, upset or angry, I have been able to recognise such situations, take a deep breath and accept that I can't change or improve the situation. I feel less aggressive than before and have an inner peace.'

'I feel I have been given an experience of applying a new set of tools that I can reach for both in times of crises and in daily routine. These tools are

simple yet effective – and have moved me beyond moments of despair and helplessness – in the face of recurring depression. The sitting meditation has opened my eyes to the transitory nature of my mental states in a way I've not experienced before... Personally it's been helpful that the course has avoided explicit Buddhist terminology and stuck to urban realities!

A frequent comment, as here, is gaining a set of tools that is helpful for working with the mind to prevent depression.

In a similar way to MBCT, Curtis Breslin has described how mindfulness may be helpful for preventing relapse into addictive behaviour. Negative affect can trigger relapse with substance use being used as a temporary means to escape negative affect. This leads to a conditioned association between negative affect and substance-related cognitions, e.g. 'I need a drink to cope with this'. Moreover attention is more easily recruited by transient dysphoric states, a phenomenon sometimes referred to as the cocktail party effect (you hear your own name spoken quietly in a noisy room, because you are attuned to responding to your name). Attempts to suppress substance-related thoughts lead to rebound activation of them from memory, so that resisting a thought such as 'I need a drink' can lead to stronger urges to drink, with more thoughts of needing a drink, referred to as mindless obsessing. Mindfulness may help to interrupt the automaticity of substance use to triggers such as negative affect by catching the trigger early on before it is too difficult to deal with and by staying with the difficult emotion to break the conditioned association between emotions and substance-related thoughts.

Mindfulness-based relapse prevention (MBRP) adapts the MBCT course for preventing relapse into addiction. Comments from a participant of the MBRP course at the London Buddhist Centre (LBC) indicated a desire for a spiritual approach to his recovery.

'Firstly I wanted a spiritual practice I found lacking in other recovery methods. This I wanted to help me through times I felt things were 'pointless' and I might not be able to ask for help from outside. Secondly it has helped me develop a more immediate and conscious awareness of how I am in a given moment. I can have more chance of responding to this.'

This contrasts with the comment quoted above (also from the LBC) of avoiding explicit Buddhist terminology and sticking to 'urban realities'. Although these mindfulness based therapies for mental health problems are derived from Buddhism, no commitment to or belief in Buddhism is necessary and the approach is pragmatic. For some the tools may be taken up and used at face value. For others it may be an entry into a spiritual path that meditation offers.

Mindfulness has also been applied for use in anxiety, suicidal behaviour, current depression (as oppose to preventing relapse in those currently well), binge eating and psychotic symptoms.

'Breathing Space' is the health and well-being project at the LBC, which has offered MBCT for depression, MBRP for addiction and retreats, drop-in and outreach for carers. MBCT courses have been run since 2004 and from last year there have been assisted places for residents of Tower Hamlets. Over 300 people have booked onto courses. Retreats for carers give people who are looking after a family member or friend (such as a spouse with dementia) a break in the Suffolk countryside for two days. As well as being looked after, carers are offered complementary therapies and simple mindful exercises to help manage the stresses of being a carer (similar to MBSR). The retreats are currently funded by 4 boroughs in East London. The drop-in provides an introduction or a follow-on to the retreats, teaching relaxation and stress reduction with group support. A short video on MBCT and interviews with some of the carers who have been on the retreats can be downloaded from the LBC website (www.lbc.org.uk).

© Dr Paramabandhu Groves 2008