Psychotherapy: Meditation and Change

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The purpose of this paper is to propose that the practice of meditation can be useful in the treatment of depression and other mental disorders in conjunction with psychodynamic and other kinds of psychotherapy. Meditation brings a behavioral and “practice” component to a process of change that relies heavily on cognitive awareness and insight. In traditional psychoanalysis as well as in psychodynamic psychotherapy, patients explore the meanings, both conscious and unconscious, of their feelings, thoughts and behaviors and consider possibilities that they have not typically utilized. The process entails the activity of an “observing ego” that can notice and comment on one’s own behavior. Patients (or clients) try and learn about motivations driving their behavior with the generally unstated expectation that insight leads to change.

Similarly, cognitive therapies rely heavily on thought as well. As Nancy Schimelpfening writes: “Cognitive therapy makes the assumption that thoughts precede moods and that false self-beliefs lead to negative emotions. Cognitive therapy aims to help the patient recognize and reassess his patterns of negative thoughts and replace them with positive thoughts that more closely reflect reality.” Both psychodynamic and cognitive approaches in mental health have shown levels of efficacy equal or greater than the effects for medication, however, for many clinicians in their private practice offices, both insight-oriented psychotherapy and cognitive therapy have proved disappointing in their ability to generate real change.

In Mindfulness-based Cognitive Therapy for Depression, for example, the authors present the view that relapse in depression is, at least in part, caused by “the reactivation...of patterns of negative thinking similar to the thought patterns that were active during people’s previous episodes of depression.” They go on to state that “The patterns themselves also seem automatic, in the sense that the mind runs around some very well-worn mental grooves, or ruts, as old mental habits switch in and run off”. They understand these patterns of behavior as expressions of deeper states of mind that are the distillation of beliefs about the body, feelings and mind. These beliefs form a core, deeply held view that they believe drives depression. Segal et al review research indicating that relapse rates for depression can be anywhere from 33% to in excess of 80% across populations.

In a presentation at the American Psychological Association (Jan. 2009), Lowder, Hansell and McWilliams make a strong case for the “enduring” significance of psychoanalytic theory. They present a range of sources, including empirical research, supporting the importance of psychoanalytic theory as a general theory of mind, as a theory of psychopathology, as a theory of social and group phenomena and as the basis for psychotherapeutic treatments. In particular, they cite research supporting the clinical

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4 ibid.
5 ibid, p. 14.
use of psychoanalytic theory in the treatment of panic disorder, depressive disorders, eating disorders, borderline personality disorders and others.

Even some psychoanalysts, however, make a case for a more active approach to healing patients with psychiatric disorders. In his book, Practical Psychoanalysis for Patients and Therapists, Owen Renik describes the impracticality that has become the image of psychoanalysis today, and his approach that he labels “practical”. “Practical clinical psychoanalysis”, he writes, “is a treatment that aims to help the patient feel less distress and more satisfaction in daily life through improved understanding of how his or her mind works.” He adds that “Psychoanalysis is a scientific study of the mind, and clinical psychoanalysis an application of psychoanalytic science to therapy.”

Meditation (and here we are talking about vipassana meditation in particular), approaches these same issues from a different vantage point – one that emphasizes habit, long-term over short-term satisfaction, and developing new skills. While it recognizes that understanding thought patterns and/or meanings can be a helpful, even essential aspect of change, the role of meditation is to provide an arena (sitting on the cushion initially) to “do something” different – that “doing” often consisting of “not reacting” in the face of automatic reactions. It is a kind of training that involves wisdom and insight, but repeatedly comes back to the present, the here-and-now, the way we behave in the moment.

For instance, Germer, et. al., view anxiety as a potentially adaptive approach that become maladaptive when it is in response to danger that is not real. They suggest that while the underlying cause may be genetic, environmental or other, anxious individuals all share an inability to tolerate the experience of anxiety. “What they have in common is intolerance for the experience of anxiety. Effective treatments address, directly or indirectly, the patient’s adversarial relationship to anxiety symptoms.”

Issues in Psychotherapy and Behavior Change

One of the difficulties of producing change through insight is the heavy reliance on understanding and the resultant hazard of the process becoming an intellectual one. As Freud, in “The Dynamics of Transference” (1912a), wrote: “When all is said and done, it is impossible to destroy anyone in absentia or effigy”. What this means in effect is that the process of change entails experiencing as well as understanding one’s own patterns of behavior. Unfortunately, unless one is able to talk about the transference, i.e. the living, breathing relationship with the therapist and all that arouses in the patient, many psychotherapy experiences do become highly intellectual and therefore not particularly effective in bringing about true behavior change. As sometimes is said, the results of psychotherapy may in fact appear to be a lot like “rearranging the deck chairs on the Titanic”; because meditation engages that part of us that is used to reacting, and encourages us to refrain from behaving in familiar patterns. It brings the process of change to behavior as well as to how we think about ourselves and our world. It dares us not to continue those patterns of behavior we have relied upon for so long. If nothing else, the mantra of meditation may be summarized in the phrase “Just don’t do it!”

For many patients, then, insight has often not been sufficient to bring about behavior change and both cognitive-behavioral and insight-oriented treatment often leaves patient and therapist alike frustrated and less than satisfied with the actual results of treatment. Many clinicians eventually find themselves exploring other avenues for

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8 ibid.
10 ibid, p. 153.
change to help patients suffering from depression, anxiety and other disorders of the mind.

Meditation as an Adjunct to Insight-Oriented Psychotherapy

Recent advances in neuroscience have opened doors to the impact of both meditation and psychotherapy on the human brain. Peter Fonagy writes: “Recent reviews of neuroscientific work confirm that many of Freud’s original observations, not least the pervasive influence of non-conscious process and the organizing function of the emotions for thinking, have found confirmation in laboratory studies.”\(^{12}\) While a full review of current research and findings is beyond the scope of this paper, there is extensive documentation for the growing body of evidence connecting psychoanalytic constructs with neuroscience findings.

However, while the field of neuroscience is a very significant arena that appears to support the overlap of meditation and psychotherapy, especially around potential changes in the brain, it is not the only one. Treatment programs such as DBT (Dialectical Behavior Therapy), ACT (Acceptance and Commitment Therapy) and MBSR (Mindfulness-based Stress Reduction) all grew out of meditation and its various manifestations and are experiencing success in a variety of treatment populations. DBT, for example, is believed to relieve clients’ suffering because it gives them concrete, practical ways to address and change their behaviors.

In a similar vein, Dewane writes: “Psychodynamic approaches that emphasize insight imply that a change in attitude will most likely result in a change in behavior. In contrast, pure behavioral approaches suggest that altering behavior does not demand a change in attitude. However, changing a behavior may eventually result in a change in attitude or emotion. Focusing on changing behavior regardless of accompanying emotion is the emphasis…[of ACT].”\(^{13}\)

This paper will explore three of the ways in which meditation provides “training” that supports change by engaging that part of us that moves towards reactivity - this is in the arenas of:

- Affect tolerance
- Reality testing
- Loosening of defenses

In each of these arenas, the training that meditation supplies can increase the possibility of change in each moment, so that insight can actually be translated into new ways of responding to the world. The paper will conclude with a discussion of how meditation contributes to the development of a mentally “healthy” individual.

Affect Tolerance

Meditation, and particularly vipassana meditation, has a peculiar (to Western psychologists, anyway) view of feelings. In fact, what we in the West call feelings are labeled mental states, or mental formations, and always involve a desire for action as well as a positive, negative or neutral tone. In fact, in Buddhist psychology, the word “feeling” is only used to delineate the “tone”, i.e. positive, negative or neutral. “I like this”, “I don’t like this”, or “I don’t have strong feelings one way or another about this”, are the only expressions of feeling in Buddhist conceptualization. “I feel happy” or “I hate this” are

expressions of mental states that tend to be powerful organizers of behavior. Anger is a mental formation that many individuals struggle to control and contain.

One of the primary practices of vipassana meditation is to notice mental states, as well as feelings, which arise and pass away while sitting on the cushion. It is understood that at least for the period in sitting meditation, no action will result from these mental states. They are continually experienced, observed, tolerated and accepted without the need for changing them, judging them or behaving in any particular way because of them. Mental states simply are and our task is to try and see them clearly.

For many of us, just observing mental states without the almost immediate translation into action (or an action plan) is radical. One can then observe, for instance, a mind obsessed with anger and can try to see that anger as a mind state rather than as a call to action. Love can be observed impartially and without concern for outcome. Impatience can be seen as a particular constellation of physical sensations that can be endured rather than changed. At best, the process results in an ability to tolerate mindstates in a new way – without the automatic segue into action that is so familiar to us. Eventually, we may still decide to act, however, that action has a better chance of being a “response” rather than a “reaction” because one has had time to reflect and consider before acting.

In psychotherapy, this practice may result in the capacity to tolerate and observe a wider range of mental states and the ability to experience these mental states in a setting in which they can be understood. It has generally been accepted that psychotherapy benefits from the capacity to understand, rather than “act out” what we are experiencing and meditation practices such as sitting still and observing mindstates can increase the development of that capacity. While that generally does occur in the setting of the therapist’s office, meditation provides the opportunity for individuals to “practice” that skill between sessions and on their own time.

Reality testing

One of the goals of vipassana meditation is the possibility of increasing one’s ability to see things “as they really are”. In Buddhist psychology, we are all born with tendencies towards living out the “Three Poisons”: greed, hatred and delusion. Delusion, in the sense it is meant here, indicates our difficulty in seeing the world as it is. We have the tendency to create “stories” about what is going on, especially when what is going on is not to our liking. In psychoanalytic terms, we are referring to projection, or transference or the myriad ways we distort reality as we view it through the lens of our own experience. We make assumptions, develop theories and categorize the behavior of others as a way of attempting to make their behaviors more palatable. Sometimes we perceive the world through the lens of our upbringing, the philosophies we were raised by or the politics of our families. In vipassana meditation, however, we practice stripping away the layers of delusion that automatically color how we see the world, and try to see things in their bare essence. As the behaviors of others are observed without interference, we are often left having to admit that there is much we do not know in terms of the other’s thoughts, feelings, and motivations. There is a greater sense of uncertainty because we are not falling back on our usual prejudices to make meaning of the world.

Loosening of Defensive Structure

It is generally believed that defenses develop out of the need to deny unpleasant thoughts and/or feelings. From the psychoanalytic perspective, we defend ourselves “against” a thought, feeling or perception because we don’t want to see it, don’t want to accept it. Every defense is a distortion of reality, so that in the most “primitive” defenses such as denial, there is an unwillingness to “see” outright something which has occurred, i.e. the death of a dear one or a terminal diagnosis. In less primitive defenses, there will
be a less obvious distortion: I didn’t study for my test because my dog was sick, rather than because it makes me anxious to study for the test.

If vipassana meditation makes it more possible to “sit” with and have awareness of unpleasant thoughts, feelings and perceptions, then a further result of meditation may be less need for defenses. If I can embrace without shame the idea that I said a foolish thing to my best friend, then I don’t need to rationalize it (i.e. he “deserved” it), intellectualize it (i.e. I meant it as a compliment only he didn’t get it), or turn it into self-criticism (i.e. what an idiot I am!). I can accept that as a human being I am subject to making mistakes. I can apologize for bad behavior and make an effort not to repeat the mistake. I can also turn to self-analysis if I want to try and understand if there was a deeper, unconscious meaning to my remarks.

**Enlightenment or Mental Health?**

Perhaps the primary difference in viewpoint between western psychology and Buddhist view on personality has to do with the relationship one has with one’s own thoughts, feelings, perceptions and moods. While there is no enduring “self” in Buddhist psychology, as there is in western psychology, there is a “bundle” of functions (called skandhas) that include one’s perceptions, ideas, feelings, moods, and awareness. Thinking, feeling, perceiving, and paying attention (i.e. awareness) are all considered ongoing important functions of human beings that influence how we interact with the world. They also influence how we relate to our experiences internally. In Theravada Buddhism, the goal of meditation (ultimately enlightenment) is to reach a level where one is free of attachment to any of these factors – in other words, one is no longer reacting to the world in terms of thoughts, feelings, perceptions, mental states or awareness. For example, someone may say something that hurts my feelings. If I am able, I do not respond out of that hurt, but rather understand: all of us are subject to having our feelings hurt and that lashing out or responding in kind in some way only contributes more to the suffering of the world. It also doesn’t change the fact that MY feelings were hurt. Nothing will change that which has already occurred.

**The “Healthy” Personality**

Rebecca Clay, in *Monitor on Psychology*, writes that, “For many humanist psychologists, the recent positive psychology movement is simply humanist psychology repackaged.” While Freud most famously enumerated the factors of a healthy personality as the ability to work and love, there have been numerous attempts since his time to define the healthy personality in broader terms, beginning with the humanist psychology movement in the 1950’s. In 1958, Jahoda enumerated six aspects of the healthy personality:

1. The degree of personal integration achieved by the individual.
2. The degree of autonomy achieved by the individual.
3. The adequacy of the individual’s perception of reality,
4. The degree of environmental mastery achieved by the individual.
5. The attitudes shown by a person towards his or her own self, and
6. The style and degree of the individual’s self-actualization.

Like many other attempts at defining the factors of the healthy personality, this one tends towards descriptions that are difficult to operationalize.

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Other conceptions of the healthy personality were offered by Gordon Allport, Carl Rogers, Abraham Maslow, and Fritz Perls. A brief review of these theorists’ conceptions of the healthy personality highlight some of the commonalities and differences that exist between them. Allport, for example, saw the qualities of self-acceptance, frustration tolerance and emotional control as important factors in the healthy personality.\(^{15}\) He further defined frustration tolerance as the ability to tolerate “the thwarting of wants and desires”.\(^{16}\) He also included the ability to regard the world objectively – in other words, not to distort reality in order to make it more compatible with the wants and fears of individuals.

Carl Rogers emphasized present perceptions as well as openness to experience. He believed that openness to experience was the opposite of defensiveness, and allowed the individual greater personality flexibility and present-moment awareness.

Abraham Maslow, in his description of the healthy personality agreed with other humanists in crediting the importance of the ability to perceive reality without distortion, a general acceptance of self and others and being present and fresh in momentary experience. Taking this concept to an extreme was Fritz Perls who saw present moment experience as the only reality. He believed that, “The here and now is all we have and we must take responsibility for experiencing every moment.”\(^{17}\) He placed a high level of value on awareness and acceptance of self as ingredients of the healthy personality.

Case Examples

Mrs. R.

Mrs. R is a fifty-four year old married Caucasian woman who was referred to me by her physician for psychotherapy in conjunction with medical treatment for irritable bowel syndrome. Mrs. R. had experienced gastrointestinal difficulties since she was a child, however in recent years and following a surgical intervention removing her gall bladder, Mrs. R. had experienced more severe symptoms and chronic anxiety. Her anxiety propelled her to search for a doctor who could “cure” her of her symptoms and return her to a physical state in which she experienced no distress at all. She had tried many, many doctors, all of whom she met with high expectations and who gradually she discarded as they failed to cure her totally of her symptoms. Finally, her most recent physician had referred her to me, recognizing that the search for a cure had roots in psychological issues and that Mrs. R. needed help coming to terms with what would probably continue to be an ongoing, chronic condition requiring medical management on the part of Mrs. R.

As she had in the past, Mrs. R. came to me with the expectation that I would cure her. When, in fact, she continued to experience symptoms of IBS, Mrs. R. became discouraged and depressed. At the same time, her highly intelligent mind understood that she was overreacting to an unpleasant but not necessarily debilitating physical condition. I taught Mrs. R. to meditate and she began regular mediation for about 30 minutes at a time. I gave Mrs. R. the standard instructions concerning focusing on the breath and returning to that focus whenever she became distracted. In sessions, Mrs. R. and I talked about her fear of illness and her difficulty accepting that she might have a chronic condition that could not be cured. Repeatedly, she returned to ruminations about how her life used to be and her wishes to return to the past. Ms. R. had very little memory of her childhood; however it did appear that when she was ill as a child she did not receive much parental reassurance. Apparently, she was raised by anxious parents who were

\(^{15}\) N. Eddington and R. Shuman. The Healthy Personality, Continuing Psychology Education, Springfield, Ill. 2006 p. 3.

\(^{16}\) ibid.

\(^{17}\) ibid, p. 13
unable to soothe Mrs. R. or demonstrate how she might soothe herself. The only possibilities for Mrs. R. were to be sick and incapacitated, or, be completely well. She had never considered the gray area in which one might have an illness that needs to be managed but does not ever go away completely.

Throughout the therapy, Mrs. R. continued to mourn the inability of doctors to cure her. She never completely let go of that hope and therefore remained somewhat dissatisfied with her life. At the same time however she began to return to some of the activities that she had given up. She started taking horse-back riding lessons and was able to return to walking as a form of exercise. She became more philosophical about her situation and was able to consider the possibility that her situation was not completely debilitating. More and more, Mrs. R. was able to live in the present moment and worry less about what would happen were she to travel to her daughter’s home for a visit, or have a meal in a restaurant. Her level of anxiety dropped considerably. She began to appreciate the ever-changing nature of her body and its condition and therefore was able to “ride the waves” of her feelings more easily, i.e. “I may feel lousy today but I will probably feel better tomorrow. Things change.”

**Mr. M.**

Mr. M. came to see me with his wife to work on their marital relationship. Many of their arguments stemmed from difficulties with their demanding 11 year old son who dawdled and misbehaved, causing stress to Mr. and Mrs. M. In particular, Mr. M. acknowledged his own temper and that he often yelled at his son – a parenting intervention that did not appear to help the situation but which had been habitual for many years. Mrs. M. would then attempt to protect this son from his father’s rage and the two parents would end up angry with each other. Both parents agreed that they played a role in this scenario – Mr. M. by allowing his temper to dominate and organize his behavior, and Mrs. M. by joining with her son and treating Mr. M. like he was the “enemy”. Both parents were willing to try and change this pattern of behavior.

Mr. M. and I talked about his anger. There were many conditions that had led to this behavior – identification with an angry father, frustration from his work environment, a tendency towards attention deficit disorder and perfectionism in his personality. At the same time, he was taught to meditate, starting with 5 minutes a day, practicing in particular noticing his feelings and watching them come and go. He was encouraged to “sit” with angry thoughts even if he felt like ending the meditation. He was instructed to view his angry behavior as a pattern of behavior that had been learned and that could be unlearned. We discussed returning to focusing on the breath when he started to feel that he would be overwhelmed by angry thoughts.

Fairly quickly, Mr. M. was able to notice his anger as it was arising. He and his wife were helped to recognize the approaching storm and divert it through a variety of interventions. For one thing, Mr. M. began to be able to recognize his anger without having to express it. He could focus on the breath, or even leave the room if necessary. Mrs. M did not meditate, but she accepted responsibility for “siding” with her son. When she understood that her husband was trying to deal with his anger in another way, she was able to support his efforts. She understood that if he left the room it was in order not to yell. She refrained from criticizing him when he did get angry. In addition, I referred the couple to a child therapy specialist to get help for their son. As they fought less about him, they were able to renew their relationship, enjoying each other’s company.

**Teaching Meditation in Psychotherapy**

Most individuals who come into the office for help are not seeking training in meditation. People have problems of living and want help to solve those problems. In an
environment of managed care, individuals often have expectations of fast (but lasting) results!

Teaching meditation in psychotherapy often requires a skillful and especially light touch. Sometimes I don’t call this meditation at all, but rather suggest that a breathing exercise I know might be useful in this situation. While certainly considered less than ideal in the meditation world, I suggest that individuals only practice this exercise for 5 minutes a day. I compare it to brushing your teeth and tell people not to expect immediate results, but that if they practice it regularly, at least 4 or 5 times a week, they will notice a difference in a few weeks.

Many people have the notion that meditation means to have a blank mind. They have already decided that this is something they could never do. I spend some time explaining that there are different kinds of meditation, and indeed some kinds do involve trying to have a blank mind, but that the kind of meditation I teach is different. It is not about stopping thought; it is about having thoughts and letting them go.

In the current social climate, meditation is not relegated as much to the realm of flakey or weird, as it used to be. Many individuals have tried acupuncture or yoga and have found these practices helpful as well. I have found it important, however, to keep the expectations low—a few minutes a day. This is in part because meditation, while simple, is actually quite difficult to do, and also to make a very small demand on people’s time. At the present time, I am working with a police officer, a salesman, a teacher, and a mental health professional, all of whom are meditating.

The instructions are to sit comfortably but erect and to bring the attention to the breath. I advise the patient that he or she will very quickly begin to be distracted with thought, or with sounds. I tell them to acknowledge the thought or sound (or feeling) but then to try and let it go and return to the breath. I tell them that this is what they will do, over and over again until the time is up. I advise people that there are meditation timers available for downloading on their cell phones and that they can use these timers as a way to end their session. I ask them to try and avoid grading themselves on how they do, that meditation is a skill, a way of training the mind, and that we all have difficulty doing it. We are teaching the mind to stay where we put it, rather than wherever it wants to go.

I usually spend only a few minutes on the meditation portion of the session, keeping in mind that individuals have the expectation that talking about their problems is the most helpful way of solving their problems. After the session in which I teach them the technique of meditation (often the second session), I follow-up with them in later sessions, inquiring on how they are doing. Most people report that they meditated only once or twice during the week. I let them know that this is common, that most folks have a hard time in the beginning remembering to practice or finding the time. I continue to encourage them and refrain from any criticism regarding the practice. Most people assume that psychotherapy only occurs in the office and they are not usually prepared to “practice” anything in between sessions. Over time, however, I find that people become attracted to the practice, initially for the feeling of peace it brings, and eventually for the changes it allows them to make in their lives.

Conclusion

I have tried to show in this paper that vipassana meditation can be used in conjunction with standard psychotherapy practices to help patients change their behavior. Most therapists find that while a great deal of insight often emerges in the therapy session, it can be slow to translate into noticeable behavioral changes. Yet, most patients are most eager for “real” change, however it may occur.

Meditation can, in the lingo of psychoanalytic theory, assist individuals in tolerating difficult affect, in seeing reality more clearly and become less dependent on or
rigid, defensive psychological maneuvers. It also treats much of human behavior as “habit” and therefore works to diminish repeated patterns of unsuccessful behavior. These additions to psychotherapy can make the treatment process less intellectual and more behaviorally satisfying to patient and therapist alike.
References


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