What about “Mindfulness” in Mindfulness-based Intervention?

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Since the post-World War II fascination with the “religions of the Far East,” there appears to be a resurgence in public interest in various contemplative practices related to Buddhism in recent years. Part of that fascination may be due to the noticeable, yet somehow “mysterious,” effects on the mind that these practices seem to offer. The Buddhist teachings, however, may not be so “mysterious.” To be sure, they are based on the experiential and phenomenological “education” system first taught by a human teacher called the Buddha, about 2,600 years ago. They focus on the active investigation and modification of the behavior of one’s mind that often result in physiological alterations. As such, it appears to have become a locus of scientific inquiry for its qualitative, as well as quantitative effects.

This paper will discuss a few such positive effects of the Buddhist-based meditation techniques, commonly referred to as “mindfulness-based intervention” (MBI), on various physical symptoms and illnesses. Among them, to specifically focus on, are: chronic pain, depression, and post-traumatic stress disorder (PTSD), which have been reported to respond well to the so-called “mindfulness” training programs. One aim of this paper, then, is to demonstrate the documented effectiveness, as well as limitations, of such techniques employed by contemporary psychotherapy. The central claim, however, is that “mindfulness” may not be a multivalent “cure for all” as it is often marketed to be; rather, “mindfulness” may be technically understood as merely one of numerous qualities.

1 During the 1950’s, numerous factors contributed to the public’s fascination with various forms of Buddhism and Hinduism in the U.S. One major factor may have been the diaspora of the Tibetan monks, which consequently brought fame to the Dalai Lama and popularized his Buddhist tradition in the West. Zen Buddhism was also popularized by authors such as D.T. Suzuki around the same time, as well as by Zen priests including Shunryū Suzuki who authored a book and founded a Zen center in California in later years. The popularity of the Beatles and the drug culture in the 1960’s also appeared to have made the “mysterious” religions of the Far East appealing among the younger generation of the time.

2 In recent years, there appears to be a renewed interest among scholars and scientists in integrating certain aspects of Buddhist teachings, such as “mindfulness” and “insight,” into psychological and neurological therapeutic interventions. An increasing number of conferences on the topic nationwide attest to this renewed interest.

3 What I mean by the “experiential and phenomenological education system” here differs from empiricism in the scientific sense. While the former employs analytical and evaluative processes as in science, its emphasis is not on a compilation of quantitative, empirical data that may offer predictive patterns and formulations. Rather, it underscores the experiential processes of a practitioner and an individual’s analysis of his/her perceptions of phenomena or conditions. The experiential and phenomenological education system offered by the Buddha, thus, is different from the scientific empiricism in that it can be quite subjective.

4 Guang Xing, “The Historical Buddha: A Psychological Analysis,” in New Horizons in Buddhist Psychology, ed. Maurits G.T. Kwee (Chagrin Falls, Ohio: Taos Institute Publications, 2010): 53-78. In this chapter, Xing passionately refutes the “mystical” and metaphysical notion of the Buddha and his teachings, delineating the evidence of his humanness and his practical teachings.

5 Xing discusses how physiological and psychological alterations shown to have resulted from meditative practices in Buddhist teachings are not reflective of the “metaphysical” aspects of the teachings. Xing, “The Historical Buddha,” 53-78.

6 Examples of symptoms and illnesses on which the mindfulness-based interventions (MBI) purportedly have positive effects include: anger, chronic pain and pain-related illnesses such as fibromyalgia, chronic/mild depression, anxiety disorders, eating disorders, post traumatic stress disorder (of varying levels), etc. Also, according to Michael de Vibe, the MBI is reported to generate a general sense of wellbeing and health. Michael de Vibe, “Mindfulness and Health Intervention,” in Horizons in Buddhist Psychology: Practice, Research & Theory, eds. G. T. Maurits Kwee, et al., (Chagrin Falls, Ohio: Taos Institute Publications, 2006), 197-207.
cultivated in the traditional Buddhist paradigm. In other words, it is only one essential part of the complex and comprehensive training system of the mind taught by the Buddha; and as such, by itself, it is only tapping the full therapeutic potential to treat various human “dis-eases.” Calling any practice “Buddhist-based,” then, requires a critical attention to the other indispensable portions of the educational enterprise, such as the Eightfold Path, which includes establishing a moral foundation as a wholesome basis for developing self-esteem and self-worth.

Towards that end, first this paper will discuss a movement in recent years that integrates Buddhist teachings to psychotherapy. The discussion will then be followed by the description of “meditation” as popularized by contemporary teachers and adopted by clinicians, as well as treatments particular to specific symptoms or illnesses. Then, this paper will also supplement these discussions with some issues associated with the descriptions of meditation as secularized and adopted by the researchers. In the brief concluding remark, the paper reiterates the importance of adopting all Buddhist teachings, especially the observance of moral precepts and the Eightfold Path, in order to achieve the optimal effects of meditation as taught by the Buddha.

**New Buddhist Psychology: Neoyana?**

In two volumes of interdisciplinary books related to Buddhist psychology, Maurits G. T. Kwee credits much of the 20th century scientific interest in Buddhist meditation and practices, not to the Beatles, but to the 14th Dalai Lama. As a great proponent of science, however, this 1989 Nobel Peace Prize winner has purportedly asserted, “If the words of the Buddha and the findings of modern science contradict each other, then the former has to go.” While owing gratitude to the Dalai Lama for his progressive stance and advocacy toward integration of science and Buddhist practices, Kwee points out that such assertion is based on the reductionist “modem view of reality” and thus limited from a “postmodern” perspective. To be sure, the Buddha’s awakening preceded any form of modern science, and “awakening may be achieved without science,” while science itself can be supplemented by the Buddha’s teachings—that is, the dharma. He thus clarifies the superiority of the Dharma over science.

Prior to the 14th Dalai Lama’s rise in popularity in the West, however, the fusion of science and the Dharma was already being galvanized into an interdisciplinary movement in its nascent form by the late 1960s. Kwee calls this fusion and the growing integration of psychotherapy with the Dharma “New Buddhist Psychology” with its reference to the social constructionist views, as well as to the Buddha “who expounded a down-to-earth

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7 I use the term “dis-ease” to signify a sense of “imbalance” and various forms of health conditions that can cause diseases, as well as symptoms of diseases. Irene S. Switankowsky elaborates on this point in her article, “Can Dis-ease cause Disease?” A Journal of the Art and Science of Medicine, Vol. 10, No. 3 (2010), published in Humane Medicine Health Care website: http://www.humanehealthcare.com/Article.asp?art_id=903 (accessed May 19, 2015).

8 The Eightfold Path consists of: Right View, Right Intention, Right Speech, Right Action, Right Livelihood, Right Effort, Right Concentration, and Right Mindfulness. Observance moral (sila) precepts are also presumed in the Path.


12 Kwee, New Horizons in Buddhist Psychology, 39.

13 Even if one does not subscribe to such a devout evaluation of Dharma over science, one could still take exceptions to the anachronistic sentiment of evaluating the Dharma strictly through scientific lens.
discipline” and “the traditional spirit of upāya… [as] the guiding principle.”

Adding a touch of the Dalai Lama’s interfaith conviction to the spirit of upāya, then, Kwee and likeminded psychotherapists have begun to promote a “transcultural” tradition called “Neoyana” that encompasses both Theravāda and Mahāyāna teachings for their unique “applied, evidence-based, and integrated psychology of the Buddha.” This new name “Neoyana” is meant to be a “new vehicle” built on the social constructionist ideas, which requires a “re-construction of several key concepts, terms, and themes derived from religious and metaphysical languaging” in order to present it as the “New Buddhayana…as a way of life for secular audiences.”

The advocates of New Buddhist Psychology are thus appealing to the wider secular audiences beyond the confines of science.

This wider appeal seems to be prima facie a good way to promulgate the Buddha’s teachings that focus on the experiential and psychological approaches to experiences. It may also present some critical issues, however, as Thānissaro Bhikkhu cautions about popularizing Buddhism at the expense of its integrity:

So the Buddhist attitude toward life cultivates samvega - a clear acceptance of the meaninglessness of the cycle of birth, aging, and death - and develops it into pasada: a confident path to the Deathless. That path includes not only time-proven guidance, but also a social institution that nurtures it and keeps it alive. These are all things that our society desperately needs. It’s a shame that, in our current efforts at mainstreaming Buddhism, they are aspects of the Buddhist tradition usually ignored. We keep forgetting that one source of Buddhism’s strength is its ability to keep one foot out of the mainstream, and that the traditional metaphor for the practice is that it crosses over the stream to the further shore. My hope is that we will begin calling these things to mind and taking them to heart, so that in our drive to find a Buddhism that sells, we don’t end up selling ourselves short.

What is cautioned here is the danger of taking bits and pieces that appear convenient from the time-proven traditions to fit into the new. In the process, some cardinal teachings and principles may be omitted from this new system of “scientific” integration, watering down the Dharma as it were, so that it is no longer as efficacious as it was intended. 

It may also at times lead to a misnomer of practices, such as “mindful meditation,” which I will explore next.

Buddhist-based Meditation:

Science and religion received a special attention with the advent of modernity in the 19th century as a potential for interdisciplinary field. Since then, that potential seems to have grown to a reality. With the substantial technological advancement and the ever-expanding globalized market, it appears that various research fields are also becoming

14 Kwee, Horizons in Buddhist Psychology, 23-25, 436. The term upāya is used here to mean “wholesome and skillful means.”
15 Kwee, Horizons in Buddhist Psychology, 478.
16 Kwee, New Horizons in Buddhist Psychology, 39.
18 It may be criticized that a wholesale and non-discriminant adoption of Buddhist teachings might be irrelevant, pious, and/or maladaptive to the scientific discourse. Against such criticism, I would respond with an assertion that the Buddha’s effective system was already “scientific” before modern science began in the 19th century. I would add that science is now “catching up” with what the Buddha knew and taught 2,600 years ago. Also, I am not a Buddhist apologist, and I am not advocating that one must adopt the Dharma in order to benefit from the MBI as they are currently offered. However, practicing the Dharma diligently would offer the wholesome benefits that may supersede the benefits gained by cultivating only this one quality (i.e., “mindfulness”). I will elaborate on this point in the pages that follow.
increasingly multi- and inter-disciplinary. In clinical psychology, for example, research in “mindfulness-based” approaches has been a locus of both curiosity and pursuit among the clinicians who have seen or experienced the effects of Buddhist-based meditation. While such empirical study is relatively nascent and its precise measurement is difficult, the literature related to “mindfulness-based” intervention programs has been rapidly growing, disseminated, and popularized.\(^{19}\)

Among the most well-known are: “mindfulness-based stress reduction (MBSR; Kabat-Zinn 1982, 1990) and mindfulness-based cognitive therapy (MBCT: Segal, Williams, and Teasdale 2002) which have been reported to “produce clinically significant improvements for people suffering from many important health problems, including depression, anxiety, pain, and stress.”\(^{20}\) Two other popular therapies that utilize some dimensions of mindfulness-based strategies include: “dialectical behavior therapy (DBT; Linehan 1993) and acceptance and commitment therapy (ACT; Hayes, Strosahl, and Wilson 1999) [which also] have strong empirical support for their efficacy.”\(^{21}\)

However, the methodologies and processes of understanding how the mindfulness-based techniques work are not clear. Gathering empirical data, or even acquiring qualitative data by observation or interviews, is difficult for a precise assessment of psychological effects of one’s mindfulness. Hence, objective testing mechanisms and methods for mindfulness-based treatments have not yet been developed.

Notwithstanding the inchoate system of assessment, the research interest and inquiry in the integration of mindfulness-based techniques continues to grow, along with the integration - or interdisciplinarity - of religion and psychology. In all of the aforementioned therapies, however, the “mindfulness-based” techniques seem to refer to a secularized version of Buddhist meditation, without involving any of the religious implications. The techniques for “meditation” utilized in psychotherapy and medicine also appear to be ecumenical and amalgamated, blurring the demarcation that separates different Buddhist traditions. Increasingly in the past few decades, “mindfulness meditation” and “Vipassanā (insight) meditation” have often been referenced and adopted as the user-friendly and “cure-all” techniques secularized by scientists such as Jon Kabat-Zinn,\(^{22}\) popularized by some contemporary teachers like Paul J. Griffith,\(^{23}\) and frequently promoted by the media including *Times Magazine* and *The Los Angeles Times*.\(^{24}\)

However, defining “mindfulness” and “insight” that is universally unanimous and true in every context has proven problematic, and the way they are phrased and utilized can also result in misnomers. For example, it appears that meditation has often been branded and marketed as either “mindfulness meditation” or “insight meditation.” Both mindfulness and insight refer to the indispensable qualities in meditation, and while they are intricately connected, neither one supersedes another.

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\(^{22}\) Biography of Jon Kabat-Zinn, Founding Executive Director of the Center for Mindfulness referenced from University of Massachusetts Medical School website, http://www.umassmed.edu/cfm/about-us/people/2-meet-our-faculty/kabat-zinn-profile/ (accessed November 21, 2014).


To distinguish these terms, Thānissaro Bhikkhu explains that “insight” is one of the “qualities used by and developed through the exercises leading to jhāna,” while “mindfulness, as defined in the canon, helps to accomplish the Buddha’s purpose [of finding a true happiness] not only by keeping it in mind, but also by remembering what to do and what not to do, and how to see things in order to actually bring that purpose about.” Specific definitions and their impacts on various practices are given, with emphasis on how mindfulness and insight work together in Buddhist practice.

Furthermore, meditation as taught by Zen and other popular traditions in the West is often understood as “bare attention” (or in Japanese, Shikantaza) - that is, without judgment or any self-discernable activity of the mind. It calls for a simple, passive observation and “just being in the present moment.” Scholars disagreeing with this view, such as Thānissaro Bhikkhu, assert that the early sūttas describe meditation as a participatory process whereby the meditator continues to actively engage in “knowing, shaping, and releasing” of the mind. This notion of active engagements of the mind, however, is often missed or ignored in the adaptation of the meditative practices in science and medicine, and the interpretation of meditation as a “non-judgmental observation” seems more prominent.

A study by McCraken and Thompson on the effects of mindfulness-based treatment on chronic pain also alludes to the difficulty of defining mindfulness in the cognitive behavioral science and reports that “mindfulness appears best conceptualized as a multifaceted construct.” As the study required some kind of definition, it adopted multiple “facets of mindfulness” as the basis of its analyses, including “non-reactivity to inner experiences, observing experiences, acting with awareness, describing experiences, and non-judging of experience.”

While such definitions or understanding of mindfulness may appear insufficient or inadequate from the perspectives of some Buddhist scholars and practitioners, the fact is that these secular studies have proven them to be adequate, at least as a useful corollary to a larger enterprise. Hence, below is a presentation of some of what has been reported as viable in “New Buddhist Psychology” in treating symptoms like pain and illnesses such as depression. The presentation will begin with the effects of meditation on treatment of chronic pain as documented in the aforementioned study.

### Chronic Pain:

The purpose of the said study, conducted and reported by McCraken and Thompson in 2008, was to “examine cognitive and behavioral processes underlying mindfulness,” using the “15-item Mindful Attention Awareness Scale” (known as MAAS) as the primary measure, as well as the Pain Anxiety Symptoms Scale (known as PASS-20), with 150 participants seeking treatment for chronic pain. While most studies of mindfulness examine the effects of mindfulness training in the form of meditation, this particular study attempted to directly analyze the “processes” of mindfulness in clinical samples by adopting the MAAS as its primary apparatus. These scales were measured by way of

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25 Thānissaro Bhikkhu, Right Mindfulness: Memory & Ardency on the Buddhist Path (Valley Center, CA: Metta Forest Monastery, 2012), 42, 83-84. Furthermore, the goal and function of Buddhist meditation entails “knowing, shaping, and releasing of the mind,” which can lead to a true happiness.


27 Thānissaro Bhikkhu, Right Mindfulness, 74-84. The “early sūttas” to which Thānissaro Bhikkhu refers in the book include: Anguttara Nikāya (AN), Dīgha Nikāya (DN), Majjhima Nikāya (MN), and Samyutta Nikāya (SN).


29 McCracken and Thompson, “Components of Mindfulness in Patients with Chronic Pain,” 75.

30 McCracken and Thompson, “Components of Mindfulness in Patients with Chronic Pain,” 75, 77.
questionnaires and self-reporting by the participants. The study, then, aimed at investigating the validity of the “multifaceted” definition it had adopted, as well as the multidimensionality of mindfulness and the cognitive behavioral processes of mindfulness, particularly by the participants who reported benefits of the treatments.

The result of the study showed that “mindfulness” as assessed by the MAAS appeared to include several distinct cognitive behavioral components, which were labeled as “Acting with Awareness, Present Focus, Responsiveness, and Social Awareness.” Among these four major cognitive behavioral component processes, the first two, “Acting with Awareness and Present Focus,” showed significant correlation with pain levels, pain related distresses or illnesses, and use of pain medications, demonstrating that awareness and focus levels were inversely related to the intensity of pain and an illness such as depression. In other words, the more “aware” one was with a particular activity one was engaging in, the less intensely the pain and related symptoms were experienced.

This observation may question the earlier studies that claimed that “bare attention” and “non-judgmental” led to acceptance, resulting in pain control. In fact, the researchers of the study have observed: “The non-evaluative and nonjudgmental qualities attributed to mindfulness in previous conceptualizations may appear absent from these results, and may require further examination.” The data, then, reflected the significance of “behavior” and the participant’s “process” of engaging in that behavior, and that “mindfulness” was comprised of multi-dimensional cognitive behavioral components and their processes. As such, mindfulness was understood to help modulate the intensity of pain and one’s relation to the presence and sensation of pain.

The study thus attempted to demonstrate the behavior and process of “mindfulness.” It, however, did not discuss the treatment methods or techniques with which the participants trained themselves in developing skills in “mindfulness” to employ while engaging in their daily activities. For development of such skills, Padmal de Silva, along with many other proponents, points to the Buddhist-based “meditation as a particularly well-suited strategy for pain control.” He references the Buddhist texts (Samyutta Nikāya IV) to support and expound on this view, particularly on the point that “meditation can reduce, or ‘block out’ the mental aspect of, the pain; while physical sensations may remain intact, one’s vulnerability to subjectivity of felt pain is reduced.” In other words, the sensation of pain no longer equals or leads to suffering for those whose mind is well trained in mindfulness and equanimity through meditation as taught by the Buddha. It appears, however, that de Silva focuses on mindfulness as the single cardinal quality of meditation and makes no mention of the significance of other stabilizing and transformative qualities such as equanimity in the Buddhist-based meditation.

The proponents of the integration of “mindfulness-based” meditation in psychology like de Silva also assert that the vast array of behavioral focused, pragmatic teachings of the Buddha parallel cognitive behavior therapy (CBT). Others who are cautiously interested also report the efficacy of other similar “psychologic” treatments in pain management, including the most frequently studied mindfulness-based stress reduction (MBSR). In an article on the effects of MBSR on pain management, for example, Chiesa and Serretti report that their studies show some “nonspecific effects for the reduction of pain symptoms and improvement of depressive symptoms in patients with chronic pain,” 31 McCracken and Thompson, “Components of Mindfulness in Patients with Chronic Pain,” 81.

32 McCracken and Thompson, “Components of Mindfulness in Patients with Chronic Pain,” 81-82.

33 McCracken and Thompson, “Components of Mindfulness in Patients with Chronic Pain,” 81.


while there is only limited evidence suggesting specific effects of such interventions.” 37 They conclude that further research is warranted with a larger sample size and measures to overcome various limitations such as non-randomization, distinguishing specific from nonspecific effects of the interventions, and accounting for differences among interventions. 38

The researchers describe this MBSR therapy as “a standardized group-based meditation program conceived in the late 1970s from the effort to integrate Buddhist mindfulness meditation with contemporary Western clinical and psychologic practice,” whose central feature is “cultivation of mindfulness.” 39 As such, the treatment typically involves three different techniques: body scan with guided meditation, sitting meditation, and hatha-yoga, all of which are aimed at cultivating mindfulness, breath awareness, and relaxation to achieve relief from some type of pain. The program normally follows a standardized duration but seems to be adjusted frequently according to the needs of individual or groups of patients, resulting in greater standard deviation across different groups.

Furthermore, the chronic pain which the therapy is purportedly effective in relieving may be just one, though significant, component or symptom of various illnesses such as lumbago, degenerative bone diseases, rheumatoid arthritis, tumor or cancer, fibromyalgia, and even depression. 40 This fact makes both compiling and objective analysis of quantitative data often required in the “empirical” studies especially difficult, and hence the effort to integrate the Buddhist-based meditation practice into “science” is more complex than it is often made out to be in many articles.

To further complicate the matter, the notion of “pain” is also multifaceted. While in healthcare generalized pain is often clearly distinguished from the specific, localized pain, the studies on effects of mindfulness-based interventions, as mentioned earlier, often lack distinctions and specificity. Moreover, the source of pain may be physiological, psycho-emotional, spiritual, or any combination of these. Due to this variance alone, the validity and reliability of the resulting data can vacillate even when measuring by standardized scales among the control group suffering from the same or similar illnesses associated with pain. Fibromyalgia, for example, is “associated with somatic comorbidities and absolutely defined by fluctuating widespread pain,” which is at times linked to depression. 41 For this reason, a study claims: “fibromyalgia and depression might represent two manifestations of affective spectrum disorder.” To the latter “affective disorder,” the presentation turns towards depression.

Depression:

Like pain, “depression” is a common but complex condition of varying types, manifestations, degrees of intensity, duration, and causes. The complexity of this mental condition is well documented in numerous studies. Among the more notable and frequently cited (besides Jon Kabat-Zinn, the founder of the MBSR program, himself) is the work by

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38 Chiesa and Serretti, “Mindfulness-Based Interventions for Chronic Pain,” 83.
39 Chiesa and Serretti, “Mindfulness-Based Interventions for Chronic Pain,” 83.
40 Chiesa and Serretti, “Mindfulness-Based Interventions for Chronic Pain,” 83. The effects of the MBI’s are documented in detail with a list of other illnesses treated partly for pain in a separate study by Eric L. Garland and Matthew O. Howard, “Mindfulness-Oriented Recovery Enhancement Reduces Pain Attentional Bias in Chronic Pain Patients,” in Psychotherapy and Psychosomatics, 82 (Karger, 2013): 311-318.
Segal, Williams, and Teasdale. 42 In their collaborative work, they begin by describing not only the vast scope of the mental condition called “depression” but also its chronic, “relapsing” tendency as documented both quantifiably and qualitatively, which led to test the viability of their MBCT as a maintenance program to prevent progression or relapse of the affect disorder.43

The researchers then detail their process of integrating the MBSR techniques to cognitive therapy, along with their discovery that their initial assumption that the content of the patient’s thoughts do not matter was false. They explain that in first approaching the MBSR, they had believed that the key to recovery and relapse prevention was the patient’s ability to control attention and form a different relationship to his/her thought content, rather than to change the content itself.44 Seeing thoughts “as they are” without attaching an idea of self to them would allow one to be detached from them and thus constitute forming of a “different relationship” with them. They referred to this wider perspective from which one views one’s thoughts as “metacognitive monitoring,” and relating to one’s thoughts in that wider field of awareness as “decentering.”45 They soon discovered, however, that the modification of content directly related to the practice of metacognitive monitoring and decentering, and that both were critical components of their MBCT program.46

They then devote more than half of their book to describing their eight-week program and delineating their findings. One critical finding was that the patients who underwent the eight-week program were less likely to relapse in the following 12 months, and that the more “chronic” and “at-risk” they were, the greater the benefits they gained from the treatment.47 They also conclude their book by asserting the importance of continued practice of the MBCT skills by not only the patients but also the therapists themselves, noting that: “Mindfulness is a way of life rather than a short-term therapy that will ‘cure’ whatever has ‘gone wrong’ with the person.”48 In short, the therapy requires ongoing practice by all involved.

The study appears to demonstrate that active evaluative skills in controlling attention, as well as decentering to modify the content and the relationship to content, are all involved in the MBCT skills building. This sounds contradictory to the notion that the central tenet of mindfulness is “bare attention,” non-judgmental acceptance, and non-discriminatory thinking—or “no thinking”—as described in many of the portrayals of Zen. However, “zazen” (i.e., sitting meditation in Zen tradition) appears indeed to be central to the MBCT program. The reason for it may be, at least in part, that it was first investigated and enthusiastically advocated by one of Japan’s leading psychiatrists, Tomio Hirai, who sought to measure the physiological changes induced by zazen “strictly scientifically” in 1989.49 Despite some issues and objections raised by neuroscientists concerning his

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42 Zindel V. Segal, J. Mark G. Williams, and John D. Teasdale, Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse (New York; London: The Guilford Press, 2002). This book’s foreword was written by Kabat-Zinn.
44 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 44-45.
45 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 39, 163.
46 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 61-63.
47 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 62-63, 311-323.
48 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 261.
methodologies and related findings, his influence in the field of “psychotherapy with Zen” resonates to this day.\textsuperscript{50}

Dialectic Behavioral Therapy (DBT), for example, is a relatively recent psychotherapy program that utilizes Zen concepts and is now gaining attention among therapists. One of the prominent proponents of this program, Marha M. Linehan, explains that it draws heavily from “the study and practice of Zen meditation” in its “tenets of observing, mindfulness, and avoidance of judgment,” with the “use of supportive acceptance versus confrontation and change strategies.”\textsuperscript{51} She claims that mindfulness skills, as gained through Zen practice, are so central to the success of DBT that they are referred to as the “core” skills.\textsuperscript{52}

Linehan divides these core skills into six categories: “three ‘what’ skills (observing, describing, and participating) and three ‘how’ skills (taking a nonjudgmental stance, focusing on one thing in the moment, and being effective).”\textsuperscript{53} She further explains that while the descriptions of these skills are heavily “Zen,” the content is “compatible with most Western contemplative and Eastern meditation practices.”\textsuperscript{54} Although she goes on to detail the six categories, she does not expound on the “most Western contemplative practices” that are compatible with Zen-based DBT, or the reason for the compatibility. The compatibility is related to the emphasis on developing the ability to describe one’s thoughts objectively, which can lead to modification of one’s relation to the thoughts and the content of these thoughts, common to most therapies as the key component.

Additionally, there are several articles contained as chapters in \textit{Horizons in Buddhist Psychology} that specifically treat Zen-related programs and studies.\textsuperscript{55} Among them is one that follows up on—and seems to corroborate—the research findings from both the aforementioned MBCT program submitted by Segal and Teasdale, et al., and the Zen-based DBT proposed by Linehan. The article is a study titled, “The Influence of Mindfulness/Zazen on Depression,” submitted by a group of three Japanese researchers.\textsuperscript{56}

The primary purpose of their research was to measure the effects of mindfulness, as it is particularly learned through the sitting Zen meditation (i.e., zazen), on acquisition of metacognitive skills (i.e., the previously mentioned “metacognitive monitoring” capability) and consequently on depression. For the evaluative tool, they adopted “the Measure of

\begin{thebibliography}{99}
\item John D. Dunne and Clifford Saron, Lecture: “Meditation and Neuroscience,” during the “Contemplative Psychology, Neuroscience, and Clinical Application” section of the Contemplative Studies Conference, University of San Diego, CA (November 20, 2014). During their lecture, Drs. Dunne and Saron discussed the difficulty of objectively quantifying correlations of the changes in the brain and the faulty conclusions frequently drawn from the testing the brain using the MRI. They asserted that some of the so-called “changes” induced by zazen in the brain of the practitioners measured might not necessarily or directly correlate to the zazen activities. This particular paper they presented is not yet published. However, Dr. Dunne’s published paper will be mentioned later in the “methodological issues” section of this paper.
\item Marsha M. Linehan, Cognitive-Behavioral Treatment of Borderline Personality Disorder (New York; London: The Guilford Press, 1993); 19, 21. Linehan also explains that there is a strong indication of “overlap between Borderline Personality Disorder (BPD) and parasuicidal behavior,” referring to depression and “affective instability” in BPD patients, especially women: 15-16, 47.
\item The “core skills” are also discussed, in agreement with Linehan, by Segal, Williams, and Teasdale, in Mindfulness-Based Cognitive Therapy for Depression, 75-77, 91. They, however, seem to emphasize more on the skill of “letting go” than Linehan.
\item Linehan, Cognitive-Behavioral Treatment, 144.
\item Linehan, Cognitive-Behavioral Treatment, 144.
\item Maurits G.T. Kwee, Kenneth J. Gergen, and Fusako Koshikawa, eds., Horizons in Buddhist Psychology: Practice, Research & Theory (Chagrin Falls, Ohio: Taos Institute Publications, 2006). There are five chapters in the book that overtly discuss Zen/Chan, which are as follows: “Chapter 6: Zen Meditation As A Source For Therapeuetic Practice” by Herman Kief; “Chapter 10: Zen Buddhism And Psychology: Some Experimental Findings” by Fusako Koshikawa and Yasutomo Ishii; “Chapter 11: Shikanho: A Zen Based Cognitive-Behavioral Approach,” by Fusako Koshikawa, Ayako Kuboki, and Yasutomo Ishii; “Chapter 14: The Influence of Mindfulness/Zazen on Depression,” by Yoshinori Ito, Rieko Katsukura, and Kaneo Nedate; and “Chapter 17: Chan-Based Sensory Awareness and Managerial Functioning,” by Michael Tophoff. Other chapters also often refer to descriptions of “mindfulness” that are similar to Zen meditation.
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Awareness and Coping in Autobiographical Memory (MACAM) (Moore et al., 1996) that evaluates the extent to which one objectively experiences thoughts as thoughts (mental events) in the moment they occur, used on 22 undergraduate students experiencing mild depression or having a tendency for depression. The result of their study seemed to support the findings of the MBCT and the Zen-based DBT researchers mentioned above along with their own hypothesis that mindfulness skills gained from meditation impacted the metacognitive awareness acquisition and capability. Mindfulness skills thus were deemed efficacious in decreasing depression by some measure. However, as with the other studies mentioned in this paper, the lack of specificity in the measure in this research also proved to be problematic. In other words, it was not possible to precisely identify which component of the mindfulness (or zazen) training contributed to which effects on depression or what mental states. They also found the self-reporting mechanism of assessment via questionnaires to be subjective and less reliable for empirical quantification. They thus conclude that while the study confirmed their position that zazen has some positive effects on depressive tendencies, further research with more quantifiable and empirically demonstrative assessment tools is needed.

One other important research limitation they experience is, to confirm the findings of Segal and others with MBCT, that mindfulness can be effective in lessening depressive proclivity and prevention of relapse, but not so in acute depression; in fact, meditation can induce current depressive tendency. Hence, the more acute and severe the symptoms of mental illnesses, the more complex the treatments need to be, and the more difficult quantitative empirical inquiry may become. This point may be attested to in the studies of a complex mental condition called PTSD, to which subject is presented next.

Post-Traumatic Stress Disorder (PTSD):

PTSD is a mental disorder that was first listed as a distinct diagnosis in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. According to the definition of the disorder in this version, its feature is the development of various “autonomic, dysphoric, or cognitive symptoms” following a “psychologically traumatic event.” By the following edition (DSM-IV-TR 2000), it came to be the “best-known trauma-specific diagnosis.” However, while the third edition defines “trauma” to include threats to psychological integrity, the subsequent two editions (IV and V) restrict the criteria to only the life-threatening ones and exclude traumas that are not always related to death, thus presenting the possibility of grossly underestimating “the extent of actual trauma in the general population.”

Diagnosing individuals with PTSD is further complicated by the fact that no two persons respond to the same traumatic event in the same way, and their symptom expressions often depend on a number of variables referred to as “risk factors for traumatic stress.” For example, current studies show that among those that have experienced life-threatening events, only a minority is diagnosed with PTSD, while others show no outward or different symptoms such as depression or generalized anxiety. Such individual

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57 Ito et al., “The Influence of Mindfulness/Zazen on Depression,” 225, 228, 234.  
58 Ito et al., “The Influence of Mindfulness/Zazen on Depression,” 234.  
60 Ito et al., “The Influence of Mindfulness/Zazen on Depression,” 232.  
64 Briere and Scott, Principles of Trauma Therapy, 7.  
65 Briere and Scott, Principles of Trauma Therapy, 19.  
66 Briere and Scott, Principles of Trauma Therapy, 19.
variations not only make diagnosing difficult but also complicate the evaluation of the effects of specific treatments for the varied symptoms.

However, DSM-IV has categorized symptoms of PTSD into three major clusters, for which there are various interventions. The three clusters of symptoms include: “re-experiencing of the traumatic event, avoidance of trauma-relevant stimuli and numbing of general responsiveness, and persistent hyperarousal.”

The second category, “avoidance,” can be especially difficult to treat as it often leads to dissociation and substance abuse, and subsequently dropping out of treatments, which further prevents the trauma survivors from recovery. It thus requires skills and caution for therapists, as well as building of trust for patients, due to this high risk for drop-out and other complications.

The interventions for these three categories of symptoms can be divided into two sets: one treats acute conditions that require immediate distress reduction techniques, called “grounding”; and the other set addresses chronic “affect dysregulation.”

The latter group focuses on the patient’s capacity to self-regulate his/her own negative emotional states, and thus mindfulness interventions belong to this group that treats “sustained hyperarousal and anxiety experienced by many survivors of major, chronic trauma.” Such interventions involve meditation (sitting, standing, or walking), as well as yoga, often using breath for attention control and emotive regulation.

While a number of studies show general positive effects of mindfulness interventions for stress reduction, increasing equanimity, and potentially gaining existential insight, empirical studies specifically for mindfulness interventions of PTSD are still very few. The reason for the dearth is also unclear; however, it is suspected that it may be due to the apparent greater severity of the symptomology and comorbidity that PTSD often presents. As mentioned earlier, response to trauma varies greatly among the individuals, which makes the manifestation of symptoms somewhat unpredictable. This also means that “some traumatized people are more easily overwhelmed than others, and possibly more vulnerable to interventions that increase access to negative internal states.” For this reason, screening for appropriateness of mindfulness intervention by trained professional is critical in treating not only PTSD but also other severe and acute mental conditions.

Furthermore, the few studies conducted in the use of mindfulness interventions for PTSD and other mental conditions (such as severe depression and generalized anxiety) suggest a hybrid approach, in which mindfulness-based interventions are used as an adjunct to the traditional trauma-focused psychotherapy. The studies also point to the difficulty in overcoming non-specificity in data acquisition and the need for ongoing research with various innovative methodology and empirical designs. This leads to the next and final section of the paper.

Methodological Issues and Limitations of Mindfulness:

The above survey of the mindfulness interventions in the treatment of pain, depression, and PTSD has hopefully demonstrated the general professional movement toward interdisciplinarity, especially in the field of mental healthcare to integrate spiritual

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67 Briere and Scott, Principles of Trauma Therapy, 29.
68 Briere and Scott, “Chapter 8: Emotional Processing,” in Principles of Trauma Therapy, 137-169. In this chapter, the authors describe the emotional processing, which is used in conjunction with the cognitive interventions, and explain the complexity of treating excessive avoidance.
69 Briere and Scott, Principles of Trauma Therapy, 111, 114.
70 Briere and Scott, Principles of Trauma Therapy, 114.
71 Briere and Scott, Principles of Trauma Therapy, 117, 191.
72 Briere and Scott, Principles of Trauma Therapy, 191.
73 Briere and Scott, Principles of Trauma Therapy, 192-195. This point is echoed by Dennis Tirch and Richard Amodio in their article, “Beyond Mindfulness And Post-Traumatic Stress Disorder,” in Horizons in Buddhist Psychology, 101-117.
practice. This presentation also attempted to highlight the persistent demand for empiricism with the need to “prove” the efficacy of the method, and hence legitimize the practice “scientifically” - which sounds reminiscent of the 20th century trends of modernity. As mentioned earlier in the current paper, this “scientific” verification is especially emphasized by Hirai in *Zen Meditation and Psychotherapy*, in which he discusses his investigation of the brain waves of priests who regularly practiced zazen. More than half of the book consists of the examples of the electroencephalograms (EEG) readings and mapping images to demonstrate the positive effects of zazen on the brain.

The late 1990’s and later have seen a resurgence of research interest in meditation vis-à-vis neuroscience, probably due to advancement of neurobiology and increased adaptation of mindfulness-based techniques in mental healthcare. More recent studies sound somewhat reticent to stress so much on the imbued objectivity and “strictly scientific” hermeneutics of the research data. Rather, as discussed above, they seem more readily accepting of the inevitable hermeneutical subjectivity, limitations of the current measures including the lack of specificity, and the need for further investigation and ongoing development of appropriate measures. For example, Lutz, Dunne, and Davidson in their chapter on “Meditation and Neuroscience of Consciousness” explain the possibility of the EEG results being “contaminated by muscle activity” that may not necessarily be related to meditation. They further explicate:

> The majority of these EEG studies focused on the change in the brain’s oscillatory rhythms, particularly in the slow frequencies (alpha and theta rhythms). It is important to keep in mind that such measures reflect extremely blurred and crude estimates of the synchronous processes of the ~10¹¹ neurons in a human brain. Because slow oscillations have high electrical voltages that make them visually detectable, early studies only reported coarse visual descriptions of EEGs. Changes in fast-frequency oscillations during meditation have been rarely reported possibly because the lower voltage of these oscillations requires spectral analysis instead of simple visual inspection. The investigation of fast-frequency synchrony during meditation has become more common since the 1990s following developing understanding of its functional role in the “binding problem.”

They thus explain that the EEG method employed by Hirai and others in the past is a “coarse way” to measure the brain activity and demonstrates the need for further development of viable methodology and empirical design.

In addition, there is the problem of “perennialism” in amalgamating all meditative or contemplative traditions and their vicissitudes into one category of “mindfulness” as they are adopted in MBCT, DBT, and other mindfulness-based intervention programs. The perennialism, in which diverse meditative practices are put in the same rubric or genre of “mystical experience,” presents problems in formulating valid hypotheses, as well as testing them, as Lutz, et al., again explain:

> From the standpoint of the neurosciences, the problem with such a position is that it begins from a set of hypotheses that are difficult to test because they assume that

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74 Hirai, *Zen and Psychotherapy*, 13, et al. The author contends for “the truly scientific nature of Zen meditation” on page 13 and various other places in the book.

75 Hirai, *Zen and Psychotherapy*, 33-141. Chapters 4 through 9 (pp.33-141), which constitute more than half of the book, are devoted to the “scientific” research data with diagrams and photographs of EEG and MRI recordings.


77 Lutz, Dunne, and Davidson, “Meditation and the Neuroscience of Consciousness,” 531.

78 Lutz, Dunne, and Davidson, “Meditation and the Neuroscience of Consciousness,” 533.
the common element in mystical experience necessarily transcends thought, language, reason, and ordinary perception—most of which are required for any reliable neuroscientific procedure to test the hypotheses. In addition to the problem of unverifiable hypotheses, the generic use of meditation as applying to such a wide range of diverse practices inevitably trivializes the practices themselves...A typical result of such an approach is the extremely general model...in which all forms of meditation - exemplified by Zazen and some unspecified “Yoga” practice - fall along the same trophotropic scale of hypoarousal, even though attention to the details of many Buddhist practices, including Zazen (Austin, 1998), makes a description in terms of hypoarousal extremely problematic.79

Hence, overgeneralization of all meditative or contemplative practices as “mindfulness” has presented difficulty in not only defining and formulating hypotheses for testing, but the content and mechanics of testing and measuring as well.

With regard to the measuring design, as mentioned earlier, many of the recent studies rely on self-reporting mechanisms with the use of certain questionnaires and on the adherence of the participants to the instructions while at home. This subjective reliance generates problems of non-specificity (i.e., the inability to distinguish which elements of meditative/mindfulness activity affect what part of the brain or behavior), possible inconsistency in the application of the techniques in practice (or correctly following the instructions outside of the clinical setting for homework), and variations in the duration of practice.

Furthermore, the effects of meditative/mindfulness practice, either along with or apart from the traditional cognitive therapy, are difficult to quantify, especially among the participants seeking treatment for various levels of mental “dis-eases.”80 Generally, it is accepted among the researchers that it takes at least eight weeks for any level of positive effects, which can be qualitatively observed and assessed in the patients seeking relief from mild and/or chronic conditions.81

For acquisition of the quantitative data such as from EEG, as in the cases of Lutz et al.82 and Hirai,83 the subjects of the research are often well-trained practitioners of meditation known with certainty to be without preexisting mental conditions or possibilities of becoming overwhelmed by the testing. Among these experienced meditators, there were also individual variances which are generally difficult to predict and account for in the results, as it is noted: “The emphasis on stabilizing the mind on an object or on the awareness of the intentional relation itself depends not only on the given technique but also likely on the degree of the practitioner’s accomplishment in a given practice.”84

In the context of psychotherapy, the “accomplishments” signify the skill levels of the practitioners in applying the Buddhist-based meditative techniques, often referred to as simply “mindfulness” interventions, in amelioration of “dis-eases.” It is also important to note that the “participants” in this context refer to both the patients and the therapists. Not only should the therapists be licensed and well trained in the traditional psychotherapy, but if they were to apply the Buddhist-based meditative techniques skillfully into treatments, they also must be apt in practicing them in their own lives. Unhappy minds cannot make others happy; to be sure, unhappy minds can potentially harm others. Briere et al., concur:

79 Lutz, Dunne, and Davidson, “Meditation and the Neuroscience of Consciousness,” 500.
80 As mentioned earlier, the term “dis-ease” is used here signify various conditions of physical and mental disorders, as well as a wide range of experiences of “imbalance” in human life that can cause diseases.
81 Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 261.
82 Lutz, Dunne, and Davidson, “Meditation and the Neuroscience of Consciousness,” 536.
83 Hirai, Zen and Psychotherapy, 13-17.
84 Lutz, Dunne, and Davidson, “Meditation and the Neuroscience of Consciousness,” 536.
The therapist’s mindfulness not only allows him or her to foster attunement and compassion toward the client, but it also serves as a partial protection from his or her own excessive or inappropriate reactivity during psychotherapy,” and hence, “potentially, vicarious traumatization.”

Thus, as noted earlier, the Buddhist-based meditation is not merely a set of techniques but a “practice” and a way of life to be exercised continually by both the patients and therapists to experience its optimal efficacy.

Finally, to return to the central point, the term “mindfulness” meditation or intervention is a misnomer, as it refers to but one essential quality necessary in cultivation of the mind in the Buddhist-based meditation; and as such, it is insufficient by itself. Additionally, mindfulness requires an object, and a careful selection of the object is significant, especially with patients habitually plagued by negative thoughts. The content of thoughts does matter, and the transformation of the content through the right practice of mindfulness with the right object is an essential part of the entire enterprise of the Buddhist-based meditation that offers the use of precepts. Hence, an important, yet often ignored, aspect of Buddhist meditation includes creating skillful contents, engaging in skillful fabrications, and engendering skillful internal and external conditions, rather than simply weathering through all things with “bare awareness.”

The proposal is for Right Mindfulness - the observance of moral precepts and other structured forms of self-imposed moral restraint is essential in realizing its full potential. However, Right Mindfulness is only one element of the Buddhist Eightfold Path. There are seven other critical ingredients in the right practice, which are mostly ignored by the mindfulness-based interventionists and researchers. The whole of the Eightfold Path contains indispensable components of the successful Buddhist-based meditation practices in psychotherapy. For example, if a meditator, who may be skilled in concentrating on a neutral object such as breath and sustaining “bare attention” without judgment during sitting meditation, habitually consumes intoxicating substances to the point of addiction, then that meditator is suffering. The meditator’s practice is not informing him/her to ameliorate stress or alleviate the poor sense of self-worth, even though intoxication can also induce an altered state of consciousness in which he/she would be fully present.” Adhering to the fifth precept, in this case, would be more helpful to this meditator than cultivating the ability to concentrate on breath alone.

As for the significance of the Eightfold Practice, Aung Mying contends that without it, psychotherapy using “mindfulness” technique is seriously undermined. The author argues: “the Eightfold Practice coherently addresses the universal flux of change connected with human suffering; interdependent causes and conditions of such experience; and the cessation out of such suffering through an integrated practice within cognitive, behavioral, and affective domains of psychotherapy.” The Eightfold Path is one of the foundational pillars of the Buddhist teachings, and by excluding it, Mying asserts that the Westernized “mindfulness” interventions miss the central underpinnings of effective Buddhist meditation that leads to liberation. In short, “mindfulness” is simply not enough.

85 Briere and Scott, Principles of Trauma Therapy, 198-199.
86 Kwee, New Horizons in Buddhist Psychology, 39. Segal, Williams, and Teasdale, Mindfulness-Based Cognitive Therapy for Depression, 261.
87 See pp. 4-8 above.
88 Substance abuse and addiction can result from numerous reasons, among which are a poor sense of self-worth and self-esteem. Establishing a moral foundation in the Buddhist teachings is an essential part of developing the sense of self-worth and compassion.
90 Myint, “Mindfulness Ain’t Enough in Psychotherapy,” 331.
Concluding Remark:

In this paper, one of the goals was to outline a few of the documented therapeutic practices known to be effective in treating certain health and mental disorders by using Buddhist-based meditation techniques commonly referred to as “mindfulness-based interventions.” The focus was on three disorders: chronic pain, depression, and PTSD - treated by two of the four major intervention programs, specifically: mindfulness-based cognitive therapy (MBCT) and dialectical behavior therapy (DBT). These intervention programs have shown to generate positive effects in treatment of the symptoms of these health conditions. However, most studies present various analytical limitations, and some of the quantitative measures and results may be problematic and inconclusive.

The central aim was to argue against the purported multivalency of “mindfulness” techniques and interventions as popularized and employed widely by some psychotherapeutic programs. In the effort to “fit” the Buddhist-based meditation into Western psychotherapeutic practices, these programs tend to neglect or omit many of the essential components of the Buddhist teachings. However, without the essential underpinnings of the Buddhist tenet, the so-called “mindfulness-based intervention” programs are grossly undermined and can also be potentially harmful. Thus, for the optimally effective application of the Buddhist-based meditation in therapeutic context, the practice of all of the dimensions of the Eightfold Path is essential.
Bibliography:


