

The practice of Mindfulness Based Behavior Therapy in Sri Lanka

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Summary

The Buddhist practice of cultivating mindfulness has been increasingly influencing psychotherapeutic work. However, in Sri Lanka, the documentation on the use of such practice in psychotherapy is scarce. This paper aims to discuss the influence of Buddhist mindfulness practice on psychotherapy; present a case of mixed anxiety-depressive disorder where mindfulness practice and behaviour therapy were used in its treatment and discuss issues that need to be considered in the use of mindfulness practice in psychotherapy. The combined use of Buddhist

mindfulness practice and behaviour therapy yielded a favourable outcome in the case reported. In Sri Lanka, a culturally rooted method such as mindfulness practice, in combination with behaviour therapy, is useful in the treatment of mixed anxiety-depressive disorder. The use of mindfulness practice in psychotherapy should be undertaken by those trained in psychological assessments and by those who have their personal mindfulness practice. Future studies on the use of mindfulness practice in other psychological disorders would be useful.

SL J Psychiatry 2010; 1 (2):67-69

Introduction

For centuries, there have been spiritual doctrines whose primary aim is the spiritual enlightenment of the spiritual seeker of which a by-product is the improvement of the person's psychological health. Buddhism is one such doctrine. In the past decades, psychology has shown a growing interest in the Buddhist doctrine whereby some of its practices have been incorporated into psychotherapy. Particularly so are the third wave Cognitive Behavioral Therapies of Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT) which are based on Buddhist mindfulness practice (1-4). In these therapies, the practice of mindfulness has at its ultimate aim the alleviation of a person's psychological distress and/or promotion of psychological well-being (5). This aim is achieved by enhancing attention to current experience, increasing receptive awareness and attention, disengaging individuals from automatic thoughts, and assisting acceptance of a situation while taking mindful action towards desired change where appropriate (3). Research has shown that these outcomes are therapeutic in several psychological illnesses (6). However, the use of mindfulness practice in psychotherapy in Sri Lanka is not common. This paper attempts to bridge this gap by presenting a case of a mixed anxiety-depressive disorder where such practice was used, successfully, at the National Hospital of Sri Lanka.

Case report

Ms.Z a 57 year old, was diagnosed with a mixed anxiety-depressive disorder at the psychotherapy service at the National Hospital of Sri Lanka (7). She was of an upper income family and of Islamic faith.

Ms.Z was referred by her family as they found her increasingly anxious and depressed after her husband's sudden demise an year ago. She was not on medication and other family or environmental contributory factors were not identified. Some of the symptoms Ms.Z presented were: feelings of sadness and hopelessness, tearfulness at the memory of her spouse, difficulty in maintaining relationships, palpitations, difficulty in falling and maintaining sleep, and anxiety towards hospitals, doctors and health investigations. As symptoms did not meet full criteria for a specific mood or anxiety disorder, it warranted the present diagnosis. Ms.Z's motivation for overcoming her illness and introspective nature were factors that facilitated the decision to offer a mindfulness based behaviour therapy program.

Measures

Sri Lankan psychological tests are few in number (8). Therefore, no standardised measure was identified to obtain pre- and post-treatment results. The author's clinical observations and patient's subjective reports were used to assess therapeutic progress.

Procedure

All sessions were conducted by the author, lasted 30-50 minutes totalling seven sessions, and took place every 7-10 days.

Stage 1: Baseline.

At the baseline interview, a psychological assessment was made, rapport established, and therapeutic goals set. Psychoeducation on the use of mindfulness practice in treatment was provided.

Stage 2: Use of mindfulness based behavioral therapy.

At the first session, a reiteration of the baseline interview's discussion about her problems and its link to mindfulness practice was presented. Ms. Z was then introduced to the mindfulness meditation of being aware of the movement of breath - to be practiced daily for 45 minutes (4). She was also instructed to be mindful when doing one daily activity, such as eating (4). Being mindful of a daily activity, along with mindfulness meditation of breath awareness increases the persons' overall level of mindfulness and hence her psychological health. Ms.Z was also introduced to techniques of improving sleep (9). At the second session, her previous week's homework assignments were discussed. Among other things, Ms.Z reported a significant reduction in palpitations and that she was less anxious than before to come to hospital. However, she reported it was difficult to practice mindfulness meditation for 45 minutes and had done so only for about 20 minutes. Ms.Z was encouraged to increase this to at least 25 minutes by the third session. A discussion on the therapeutic goal of being more independent of her children and lessening her irritability at them also ensued. These aspects were discussed along the tenants of mindfulness practice (5).

The third, fourth and fifth sessions focused mainly on discussing her anxiety towards hospitals, doctors and health investigations. Ms. Z was aware that this anxiety would have consequences as she needed to do a check-up recommended by her doctor a year ago. A behavior therapy program of systematic desensitization for overcoming this anxiety was implemented (10). These sessions were also spent discussing insights gained from her mindfulness practice in relation to her over-dependence on her children, irritability, and social withdrawal. By session six, Ms. Z reported an improvement in her mood. The palpitations and feelings of generalized anxiety had almost completely disappeared. Irritability and dependence on her sons had reduced. She had also succeeded on the initial steps of the hierarchy on the systematic desensitization program. These changes were also reported by her family. At the seventh session Ms. Z reported that she had her health check and had met her doctor about it. This was a milestone for her as she was avoiding this for over a year. Yet, there were also some obstacles that Ms.Z encountered in therapy. For instance, she experienced difficulty in "being with" unpleasant emotions in her mindfulness practice. These matters were addressed in the sessions.

Stage 3: follow-up.

To ensure maintenance of the above changes, Ms. Z was seen once more.

Outcome

As assessed at Stage 3, Ms. Z had made progress in these dimensions: (1) by mindfulness practice: reduction in depressive rumination and low mood, less control-oriented in her relationship with her children (e.g. allowing them more freedom), more socially

active and independent (e.g. initiating social meetings), able to manage anger, and (2) by behavior therapy: able to visit hospitals and doctors and do health investigations.

Discussion

The above case documents the favorable outcome in one of the first reported instances of the use of Buddhist mindfulness based behavior therapy on a mixed anxiety-depressive disorder in Sri Lanka. Baer postulates the therapeutic benefit of mindfulness practice due to the technique's training in viewing thoughts as simply thoughts rather than reflections of reality, an avoidance of the ruminating tendency, an increased recognition of depressogenic thoughts, an acceptance of negative experiences, not persistently trying to solve the insoluble, and more kindness towards self (6). Further, as in this case, combining mindfulness practice with therapies such as behavior therapy, provides a multi-pronged approach to combating a patient's difficulties.

When mindfulness practice is undertaken for the spiritual purpose of enlightenment, lengthy discussions with the meditation teacher on mindfulness experience are discouraged (11). However, in psychotherapy, detailed discussions on mindfulness experiences are encouraged so that the patient gains insight from these experiences, an exercise the present author found useful with Ms.Z (3).

Issues in the use of Buddhist mindfulness practice in psychotherapy

The author experienced some challenges when using mindfulness practice in her psychotherapy work. The lack of knowledge on mindfulness practice in psychotherapy among some led to some difficulty in accepting such method as being therapeutic. This is not surprising, as in Sri Lanka, meditation is considered a religious rather than a psychotherapeutic practice. The author's attempts at familiarizing colleagues on mindfulness practice yielded a somewhat positive outcome.

In using mindfulness practice in psychotherapy, service providers should be knowledgeable in psychological assessments as such practice may not be indicated for certain mental illnesses or would need to be modified to suit patient needs (5). In fact, Buddhist scriptures indicate that the Buddha too decided on an object of meditation for a given person, subsequent to assessing his or her psychological nature (12). Hence, one "size does not fit all" (13). However, in therapies such as MBCT mindfulness practice is offered to all patients, irrespective of their presenting problem or psychological nature. In the Buddhist doctrine, there are several techniques of cultivating mindfulness (one of which is breath awareness) which one could choose from so that the most appropriate technique that would suit the person could be utilized. This is an area worthy of further research. Psychological service providers are

required to have their own mindfulness practice if they are to use it on patients (5). By so, the therapist becomes a model of mindfulness for the patient as well as having her own personal experiences to deal with situations which arise in the patients' mindfulness practice. The University of Colombo's Master of Philosophy in Clinical Psychology program's curriculum has some teaching on mindfulness practice in psychotherapy. Such teaching ensures that mindfulness practice is introduced along other therapies such as the first and second wave cognitive behavioral therapies. However, it is the authors' experience that in Sri Lanka, some trainee clinical psychologists as well as clinical psychologists in practice are unwilling to use mindfulness practice because of the requisite that they too be practitioners of mindfulness as well as due to their lack of conviction of its effectiveness.

Declaration of interest

None

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