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DRAFT Discussion paper.

Managing depression with Buddhist practices.

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The following draft been written for a workshop on Buddhist practices for depression presented at the Buddhism and psychotherapy conference, Sydney 2002. It is a work in progress and its aims are to inform, stimulate ideas, and provide references about Buddhist practices for depression. It should not be considered as providing instructions on how to do these practices. References will, however, be made to texts that could be considered instructive. In addition, a mindfulness-based stress management course workbook is available on request. This workbook gives an indication of how Buddhist practices may be used to manage depression.

Abstract

Initially a description of (unipolar) depression as a disorder within contemporary psychiatric classification systems will be very briefly presented. This will include a mention of the causes and general management of depression within contemporary settings. A discussion will then follow on the use of Buddhist practices as a way to address depressive phenomena. This will be approached by firstly reflecting upon the teachings of the Buddha. The four noble truths will be outlined and the fourth noble truth will be highlighted as the essence of Buddhist practices and a way to psychological freedom from depression. Following this, Buddhist practice will be considered as a healing pathway. Within this path the therapeutic relationship will be considered. However, an emphasis will be placed upon the individual being able to “let go” of those tendencies that are both intrinsically distressing and also lead to further suffering as well as cultivating those tendencies that are liberating. Two forms of traditional Buddhist meditation practices will be highlighted as liberating strategies. These are awareness, also referred to as mindfulness, and the four divine abidings: love, compassion, joy and equanimity.

Depression

When we talk about being depressed we often refer to it as a mood that is dominated by sadness. Sometimes, this sadness may take over our mood for hours, days or sometimes weeks.

According to contemporary psychiatric classification systems, when this mood is prolonged, severe and involves a cluster of symptoms that impair social and occupational functioning, depression is classified as a mental disorder or an illness. Depression is marked by distress in five areas, namely: affect, thoughts, behaviour (with increased passivity), motivation (including loss of interest and suicidality) and vegetative function (Hollon & Carter, 1994). There are numerous types of depressive disorders with Major Depressive Disorder (MDD) being central. In commonly used psychiatric classification systems (e.g., the Diagnostic and Statistical Manual-fourth edition, American Psychiatric Association, 1994) the symptoms of depressive disorders can include:

- Depressed, dysphoric or sad mood
- Diminished interest and enjoyment in life
- Reduced appetite with either weight loss or gain
- Insomnia, hyper-somnia or disturbed sleep
- Psycho-motor agitation or retardation
- Irritability
- Physical and emotional fatigue
- Physical symptoms such as headache or backache
- Excessive guilt or feelings of worthlessness
- Recurrent thoughts of death commonly with suicidal content.
- Low self esteem or self care
- Feelings of hopelessness
- Inability to concentrate or make decisions and so on.

The symptoms of depressive disorders, more often than not, overlap, co-occur or are co-morbid with other mental disorders especially the anxiety disorders. For example, Generalised Anxiety Disorder (GAD) has been considered as the “basic” or core anxiety disorder (Andrews, Crino, Hunt, Lampe & Page, 1995).

The criteria for GAD includes difficulty controlling worry and at least three of the following symptoms:

- Restlessness or feeling keyed up
- Easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscular tension
- Sleep disturbance

Despite the symptom overlap some differentiating features are evident. Physiological hyper-arousal is more specific to anxiety while the absence of positive affect is more specific to depression. Conspicuous vegetative signs such as weight loss and psychomotor retardation are also more specific to depression (Clark & Watson, 1991 cited in Brown et al., 1997; Maser, 1995 cited in Yapko, 2001). In some cases people also experience what has been proposed as mixed anxiety and depressive disorders (APA, 1994).

As well as sadness or gloom, a person suffering with depression may be swept along by intense and often distressing emotions such as worry, fear, and anger. Depressive phenomena can range from mild to severe. Sometimes depressive symptoms are so severe that individuals become psychotic. Depression tends to be episodic but about 25% of those individuals who experience depression will exhibit a chronic course with little relief. Those who have discrete episodes are very likely to have multiple episodes throughout their lifetime (Hollon and Carter, 1994). Some depressive episodes have precipitating factors such as birth (as in the case of Post Natal

Depression) or the loss of a loved one. Depression seems to impact upon neuro-transmitter interactions in the brain, affects ones physical health and sense of well being, the way one relates to others, and the way one interprets and copes with stress. In medical settings those suffering from MDD have more pain, physical illness and decreased physical, social and role functioning than the general population (APA, 1994)

Even though its features may vary, depression can occur in all cultures. Depressive disorders and co-morbid anxiety disorders are very common. Some estimates of American populations, for example, state that about one in four women and one in ten men are likely to experience a depressive disorder sometime in their lives (cited in Segal, Williams and Teasdale 2002). Further to this, according to information from the World Bank, depression is the second only to Cardio Vascular Disease as the most costly illness in society (stated on National Radio by Prof Ian Hickie, CEO of the National Depression Initiative, 4/10/2002). Despite its pervasiveness in contemporary modern society depression is not confined to the 20th or 21st century. Shakespeare, for example, over five hundred years ago, wrote lucidly about what seems to have been melancholic type of depression experienced by Ophellia in Hamlet. Depression is pervasive and perennial.

It is easy to objectify and write about depression as a "topic". However, for the person who is experiencing this disorder it is much more than merely a diagnosis or list of symptoms noted in a diagnostic classification system. A severely depressed individual feels hopelessly trapped in a physical, emotional, mental, social and spiritual black hole. The dysphoria and distress is felt at all levels of their being. They feel cut off from their bodies because the experience of being "embodied" with depression is painful if not exhausting. They may feel socially isolated and alone and generally alienated from the universe. Their thoughts and perceptions may be tainted with negativistic views of themselves, the world and the future. In general, they

may feel entrapped by the triad of hopelessness, helplessness and worthlessness. In summary, people caught in depression suffer miserably.

Causes of depression

In some cases depressive symptoms may originate from physical causes and clearly be the result of physical illness. In other cases there may be significant developmental and/ or psychologically traumatic events, which precipitate depressive psychological patterns and resultant symptomatology. For some difficult social circumstances or plain hardship may be causal factors. In some cases depression may arise without any obvious precipitants. Depression also has strong genetic links. According to contemporary scientific perspectives, depression can have many genetic, biological, social and psychological causative factors, which can interact.

The management of depression

In the current discussion the management of depression refers to both the treatment of symptoms that may arise in an episode or chronic course as well as the prevention of relapse once symptoms or an episode have passed. Although the success or efficacy of treatments may vary, depressive disorders can be treated and prevented with a range of social, psychological and biological interventions. Treatment approaches include hundreds of different psychotherapeutic paradigms, pharmacological intervention, traditional holistic and spiritual forms of healing as well as social strategies, all of which may alleviate if not resolve the suffering related to depression. According to rigorous research, psychiatric treatment guidelines for the treatment of MDD recommend, depending upon severity, anti-depressant medications, psychotherapy (primarily Cognitive Behavioural Therapy or CBT and Interpersonal Therapy or IPT) or electro convulsive therapy (ECT) or combinations of these (American Psychiatric Association, 2000).

Depression has a biological component and a course of anti-depressant medication or alternative physical therapies can often be utilised. Appropriate

biologically based treatment may provide the necessary physical or biological changes to lift one's mood. Psychosocial treatments can also be used alone or be supported by biologically based treatments. With severe depression, a course of anti-depressants may be considered an essential prerequisite to psychological intervention (APA, 2000; Segal, Williams & Teasdale 2002).

Even though some body-oriented therapies have a Buddhist orientation the following discussion will now focus upon psychosocial Buddhist practices to address depression. Buddhism can provide an overarching or umbrella philosophical paradigm within which to consider a range of standard psychosocial interventions commonly used for depression. As well as this, specific Buddhist practices can offer an alternative and innovative perspective for the management of this condition.

Buddhism

Buddhism can be considered a religion, a doctrine, a philosophy, a way of life or a spiritual pathway. In the author's opinion, Buddhist practices are those practices purposefully utilised in Buddhism and/or those activities that are consistent with the Buddhist path. There are many different schools and perspectives of Buddhism. The following description is by no means comprehensive or inclusive of every possible perspective. It is however, based upon the author's experience and relationship with Buddhist practices over a period of about 25 years. Buddhism is, in this author's view, a way of understanding cause effect relationships between phenomena and how to be free from mental suffering. It is claimed that in the Kalama discourse the Buddha stated that this type of understanding is not based upon theory, speculation or logic. Nor is it based upon believing what others preach or recommend. It is, however, empirical in that it is based upon one's own experience (Rahula, 1979 in Rothberg, 2000).

By being attentive to his own experience the Buddha realised "the four noble truths" which are, in essence, four cause-effect relationships, suffering and

the cause of suffering, freedom from suffering and its cause. The four noble truths are the principles on which Buddhist psychology, philosophy, theory and practice are based. They constitute the basis of the Buddha's teaching regardless of school or individual perspective.

The four noble truths are based upon the understanding that all things change and are interdependent. Interdependence refers to the systemic interrelation between the changing conditions of life and phenomena in general.

The four noble truths are:

1. There is unsatisfactoriness, or suffering,
2. Suffering has causes,
3. There is freedom from suffering,
4. There is a way or a path to freedom.

The ultimate goal for Buddhists is complete freedom from suffering which is called Nibbana (Pali) or Nirvana (Sanskrit). The four noble truths point to this absolute goal. However, without trivialising the profundity of Nibbana the four noble truths also describe interactions between mental and physical conditions. In this way they are relevant for goals found in psychotherapy.

Dukkha, the first noble truth

Dukkha is a term derived from Pali, an ancient composite language from India about 2500 years ago. Dukkha usually means suffering. However, many Pali scholars claim that this word often has been misinterpreted and misunderstood (Rahula, 1959). "Kha" literally translates as the space or hub of a wheel and "duk" denotes difficult or problematic. Therefore dukkha literally refers to a poorly fitting hub and axle of a wheel. (Kearney, personal communication, 2002). As a "difficult grind" another translation of dukkha is "unsatisfactoriness" (Rahula, 1959). Dukkha can be understood in three ways: 1) dukkha as ordinary suffering, 2) dukkha as produced by change, and 3) dukkha as a characteristic of being someone in a 'conditioned

state' (Rahula, 1959; Sole-Leris, 1986). The first type of dukkha encompasses the difficulties associated with birth old age, sickness and death. Also included in this first category is the inevitable fact that individuals often get what they do not want, do not get what they want, and are, sometime or other, parted from what they like. Pain, grief, sorrow, lamentation and despair have also been explained as being part of this type of dukkha in texts. This first type of dukkha also includes mental distress such as confusion, anguish, worry, fear, anxiety, sadness, loneliness, and alienation (Rahula, 1959).

The second type of dukkha involves the paradox of living in happy and pleasant states and yet knowing these beautiful moments are transient and must inevitably change and disappear.

The last type of dukkha involves the suffering produced from clinging to the belief that transitory manifestations of sensations, thoughts, feelings and emotions, are a solid and concrete self which is usually labelled, by each of, us as "I", "mine", or "myself" (Rahula, 1959). Dukkha is pervasive and perennial.

The tormenting, unsatisfactory, frustrating and generally distressing aspects of many mental disorders with all their interactive and interdependent components are all obviously manifestations of the Buddhist 1st noble truth of suffering. The pain, grief, sorrow, lamentation and despair of the first type of dukkha clearly correlates with symptoms of depression as described earlier.

Interdependent causality of Dukkha: The second noble truth

The root causes of suffering in Buddhist psychology are: greed, ignorance and aggression or hatred. Some of the interdependent factors leading to suffering include: clinging to ideas that beings are discrete fixed solid independent selves that don't change; struggling with and resisting inevitable change; ignoring and avoiding change and wanting things to be other than the way things are. Another factor leading to suffering is identity confusion.

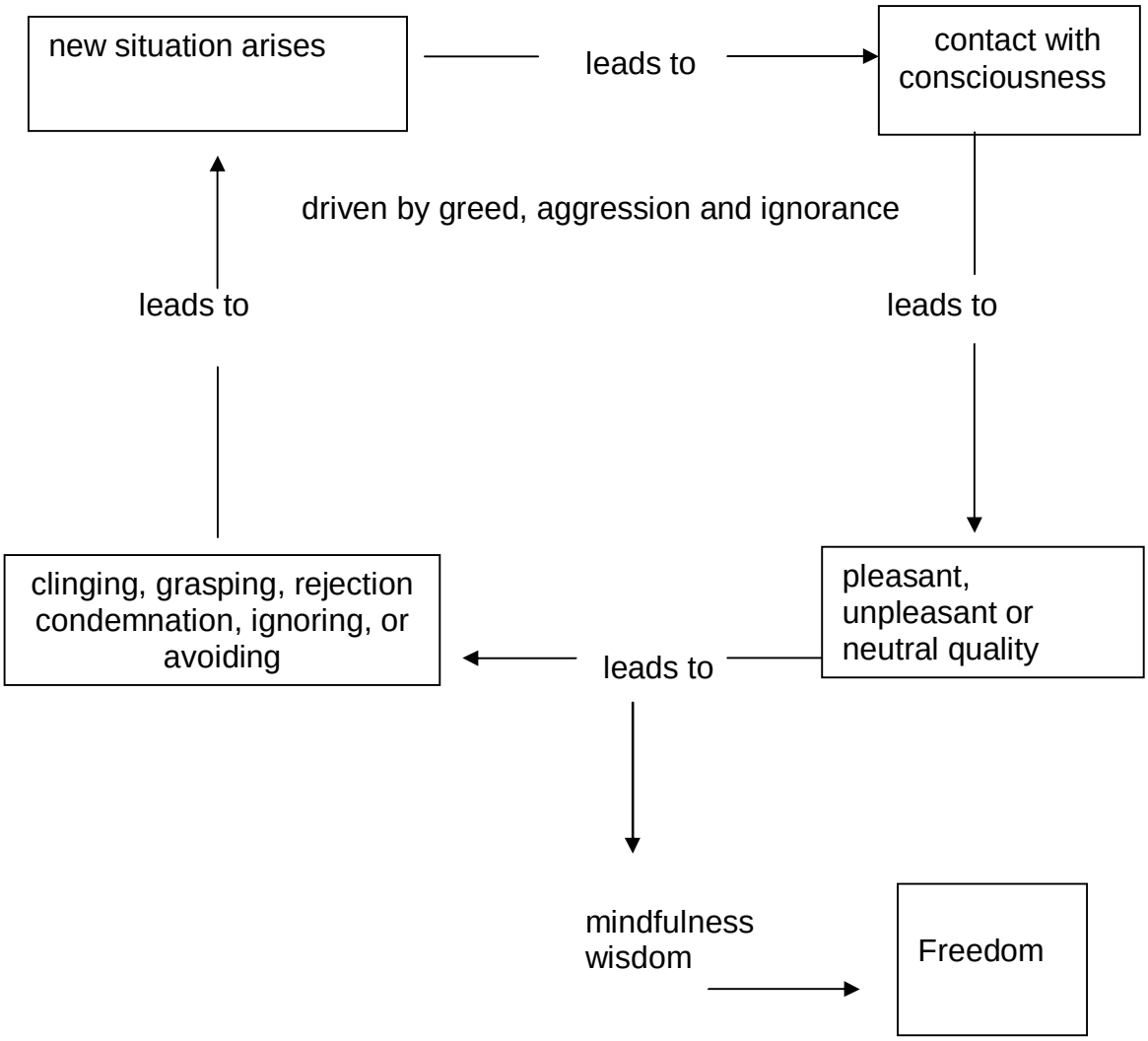
Identity confusion refers to reifying impermanent experiences or confusing changing experience, such as thoughts and emotions, as self.

In Buddhist psychology the types of affective, cognitive and behavioural patterns that lead to mental suffering are those that are consistent with the root causes of dukkha. As in western psychotherapies the patterns considered to be either intrinsically distressing or conducive to distress include: aggression, jealousy, gloominess, sadness, worry and rumination, impulsive recklessness, shamelessness, guilt, confusion, avoidance, mental dullness, hatred and so on (Fenner, 1995).

Conditional states are characterised by dukkha (Rahula, 1959). The figure below on the next page represents the interdependent, conditional and cyclic nature of suffering according to Buddhist ideas. In Buddhist psychology the arising of mental distress is conceptualised as an interdependent and cyclic relationship between environmental conditions and “unhealthy” mental and physical factors. Freedom, as indicated in the diagram, is largely dependent upon short-circuiting habitual cyclic reactions.

According to Buddhists “clinging” is central in the cycle of suffering. Clinging to views of hopelessness, helplessness, and worthlessness are recognised in CBT as some of the causative factors leading to depression (Beck, 1976). Further to this, clinging to dysfunctional and inaccurate concepts, particularly self-concepts, are instrumental in leading to depression. Finally, addictions to pleasant experiences, rejection and condemnation of unpleasant experiences and ignoring neutral experiences are, according to Buddhists some of the factors that lead to and perpetuate dukkha and consequently depression.

The cycle of conditional suffering and its exit (adapted from Fryba, 1995)



Freedom from suffering: The third noble truth

Fortunately, dukkha is conditional and not absolute and freedom from dukkha is possible. According to Theravada Buddhist texts, complete freedom from dukkha can only be found with Nibbana, which is unconditioned and beyond causal existence and hence suffering (Nanamoli, 1978). Language may be inadequate to describe Nibbana. However, it is usually considered to be a release from the reactive cycling described above.

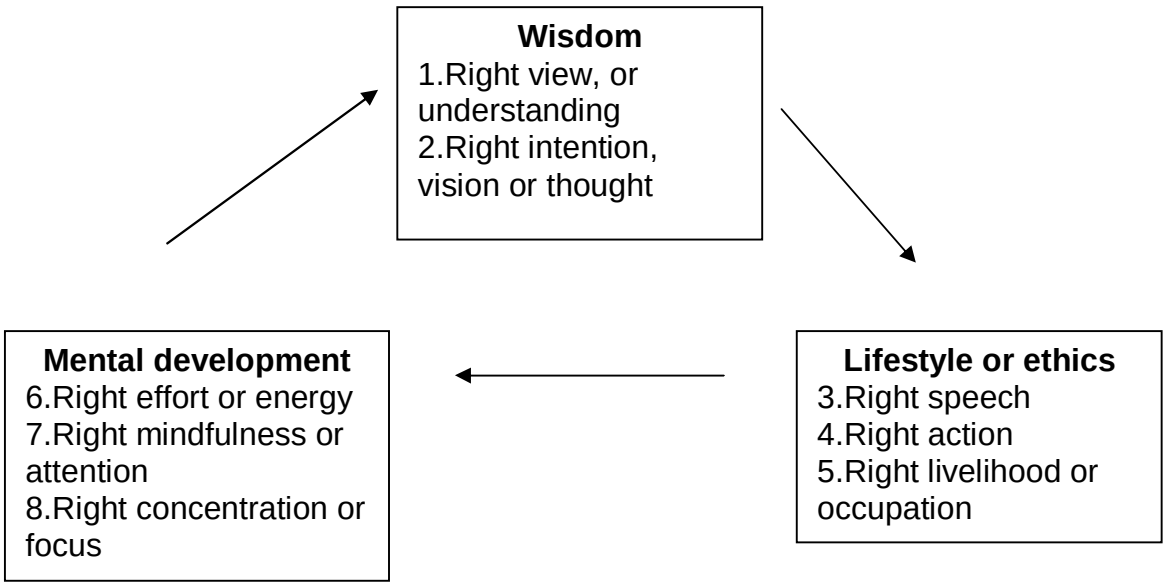
To the extent that “unhealthy” tendencies are countered or let go, to that extent there is release from suffering. Paradoxically this is a frame of mind that can only be experienced when one is accepting and content with things as they are. Acceptance does not refer to apathetically condoning dysfunctional patterns or events. Rather it means seeing things as they are in the present moment. “Acceptance” may not always be an effective strategy in the area of overt behaviours because some of these experiences may be abusive, negative or not constructive. In the realm of private internal experiences like thoughts and emotions, however, acceptance allows choice in how we react. Acceptance refers to being open to experience and being willing to take what has been offered by life (Hayes, Strosahl & Wilson, 1999). Willingness is like being open to the mystery of life with a big “yes” as opposed to rejecting life’s experiences with a “No” or a “yes but…..”.

In the author’s opinion, freedom from depression does not mean that distressing moods do not arise or one does not have periods of feeling “down”. It does mean, however, that one does not feel trapped by these experiences and they do not proliferate.

<u>The path to freedom from dukkha: The fourth noble truth.</u>

The “eight fold path” is the essential practice of Buddhism. The eight factors on this Buddhist path can be divided into three basic components that can be sequential. These are: ethics or lifestyle (“right”, skilful or appropriate action, speech and livelihood or occupation), mental development (right effort, mindfulness and concentration) and wisdom (right understanding or view and right intention or vision). The path is often considered as having two levels: 1/the basic or mundane and 2/a more refined or “noble” path (Thanissaro Bhikkhu, 1996). The noble path begins when individuals have a glimpse of Nibbana. The following description of the path is in reference to the more basic level.

The noble eight-fold path



Our actions or what we do and how we interact with the world influences the way we feel and think. An unhealthy or unethical lifestyle can create disharmonious interaction and disturb one's mind. If, on the other hand, one's mind is not disturbed then it is possible to have a fundamental degree of mental composure conducive to effort, mindfulness and concentration. Effort refers to the energy required to direct attention with motivation and perseverance. Mindfulness refers to the practice of being attentive to present moment experience in a focussed, non-judgmental and open-minded manner. Concentration is not separate from mindfulness and is a factor of mind that gathers and integrates attention whilst penetrating and sticking with its objects (Pandita, 1992). The mental development component of the path is often referred to as "meditation". Traditionally, meditation is only considered possible when there is the groundwork or foundation of ethics.

By bringing attention to the changing and interdependent nature of mental and physical conditions wisdom arises. In Pali wisdom is referred to as "punya". The meaning of punya is manifold and can refer to intuitive knowledge of ultimate truth (Pandita, 1992). Punya or wisdom may also include understanding the laws of change and interdependence governing life as well

as strategies to overcome mental suffering. Wisdom can also arise from hearing teachings and thinking clearly and realistically. Thus wisdom may include the rational and reflective cognitive processes encouraged with therapies such as Cognitive Therapy (CT) (Beck, 1976; Ellis, 1961). However, wisdom is not limited to this type of discursive thought.

Wisdom influences individuals to live healthier ethical life styles, which then contributes to the development of mental stability leading, in a cyclic manner, to increased insight or wisdom.

With wisdom struggling with change is released, and the suffering inherent in identifying with changing mental and physical conditions is reduced if not uprooted.

Buddhist practices for depression

The following discussion about Buddhist practices for depression is based on my experience in the healing profession over a period of about 20 years. During this time I have used the Buddhist path as an overarching philosophical paradigm to understand suffering and freedom from suffering and to guide the healing process. Nine years of this time were spent as a body therapist where it became very clear that body oriented modalities can alleviate and resolve much of the suffering of depression. Eleven years were spent as a psychologist in busy community health settings. In these settings a large percentage of people who presented suffered with depression. Often these presentations were complicated with suicidal thoughts and behaviours.

As far as I am aware, the Buddha did not distinguish “depression” as a discrete or separate mental disorder or illness as it was included in his general description of dukkha. A Buddhist approach to depression would therefore be accommodated within a general approach to dukkha and tailored to the individual.

The Buddhist path can provide an overarching therapeutic direction and a model for the therapeutic relationship. Buddhism can also offer specific practices to abandon or let go of those tendencies that lead to suffering and, instead, cultivate those tendencies that are liberating.

The therapeutic relationship

Volumes have been written about the importance of the therapeutic relationship in psychotherapy. Much has also been written about the importance of a teacher, mentor or spiritual friend in spiritual practices. Engaging a therapist and using Buddhist practices for the treatment of depression crosses the bounds of both the psychotherapist and the spiritual friend or mentor. Space limits extensive discussion of these relationships but a few brief points will be made.

A common issue that I have noticed when I see clients who suffer with depression is how isolated, alienated and lonely they feel. In some respects it is as if depression is perpetuated by sufferers' inability to realise their interconnected nature. At times it seems that one role of a therapist is to provide a lifeline to these individuals so the solid sense of an isolated separate self is partly dismantled enabling them to feel reconnected with the universe.

Carl Rogers's (1961, 1980) emphasis that a therapist should have three core qualities has become an accepted foundation for any therapeutic relationship. These qualities are 1/genuineness, congruence, or authenticity, 2/unconditional positive regard and 3/accurate empathic understanding or the ability to see the world from another person's perspective. Buddhist practices coincide with these qualities and it is important that therapists embody them. Being truly listened to and heard with compassion is not only healing, it also provides a model for clients suffering with depression to listen compassionately to themselves.

The therapist can act as a model, guide, cheerleader or coach (Linehan, 1993). The therapist can help to provide a model for awakening or freedom from depression. Part of this process can involve curious investigation or inquiry. Not only may a therapist, through investigation, help clients awaken to a more liberated perspective but also the style of inquiry provides a model for the client to investigate issues themselves.

“Externalising” is a strategy used with Narrative Therapy. Externalising has many elements consistent with Buddhist practices in the way that it leads towards understanding interdependence or a perception that the person is not the problem (Nichols & Schwartz, 1998). Clients are individuals who sometimes identify with and/or are identified as their problems such as “being depressed”. However, from an interdependent point of view, conditions (including problems) arise contextually due to the confluence of a number of factors. No one thing is to blame for depression arising, and identifying with it perpetuates suffering. Buddhist practices encourage a shift in identification away from troubling thoughts and emotions. This shift in identification does not deny responsibility but cultivates wisdom.

Buddhism as a healing pathway

Buddhism is replete with descriptions of cause effect relationships between mental and physical phenomena. Unhealthy tendencies lead to dukkha and healthy tendencies lead to freedom from dukkha. Intentional actions have natural consequences. The cycle of conditional suffering is one description of the causes of suffering. The noble eight-fold path is another description of cause effect relationships but in this case it is one between liberating strategies.

Ethics or a non-harmful lifestyle is considered as an essential first requirement on the Buddhist path to wisdom and freedom from dukkha. With a wise mind we are more able to choose how we respond to life events and act in a manner that will cause less suffering. With wise and respectful action we can

feel safe, have less regrets and our conscience may be clearer than if we act in a disrespectful manner. When our minds are not chaotically disturbed we are more able to cultivate focussed awareness, which leads to more wisdom more positive coping skills, a healthier lifestyle and generally wiser actions.

Living unhealthy lifestyles or being in unsafe, tumultuous, and frightening situations may or may not reflect one's ethics. However, these situations highlight principles found in the eight fold noble path. Such situations are not conducive to mental development and just as ethics are the foundation for meditation so are safe and healthy environments and situations.

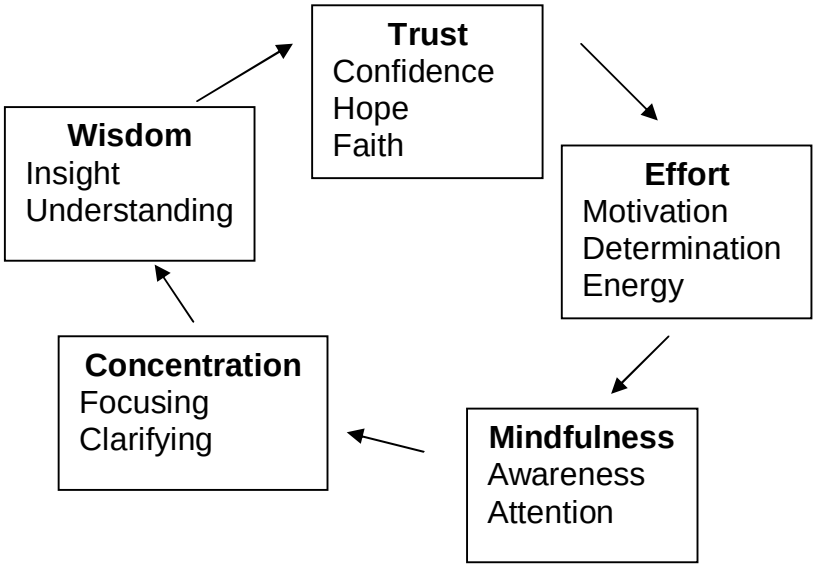
The Buddhist pathway is a model that can be applied beyond the confines of Buddhism. Individuals may be on this path without realising or acknowledging its connection to Buddhism. The hundreds of psychotherapeutic paradigms or psychologically healing modalities currently available reflect aspects of healthy non-harming lifestyles, mental development and wisdom. In this way they could be considered as consistent with the fundamental tenets of Buddhist teachings.

For example, individuals may be depressed because they are leading destructive lifestyles or are caught in destructive situations. Many standard therapeutic and "welfare" strategies could address such factors. These strategies include pragmatic problem solving, or direct action to change the situations (such as providing safety). Cognitive Therapy (CT), as another example, addresses attitudes, appraisal and perception. In some ways this approach could be considered consistent with the mental development and wisdom component of the eight- fold path.

Assessment of depression could include collaborative consideration of how an individual can follow a healing pathway and/or what may be stopping them following such a path. Treatment or intervention then becomes a collaborative effort to reinforce and support healing and address hindrances.

When I was working extensively with teenagers a large number of this group would present with symptoms of adolescent depression. Obviously adolescent depression is complex and requires more than simplistic solutions. However, in some cases the depression seemed, to me, related to lifestyle issues such as intentional violence, drug abuse, or petty crime. In these cases, without being moralistic or mentioning Buddhism I would firstly clarify what the teenagers really wanted that is, their aspirations. Once these young people recognised that the way they were feeling caused them suffering they were motivated to change. When the teenagers were motivated I would ask them to "experiment" with how their moods changed if they adhered to non-harm principles. In Buddhism there are five basic non-harm principles: 1/ avoiding killing 2/avoiding taking that which does not belong to oneself and is not freely offered 3/ avoiding untruthful, deceptive or harmful speech 4/ avoiding sexual misconduct or sexual conduct that hurts or harms someone. 5/ avoiding being intoxicated with drugs or alcohol. Generally the extent to which these particular teenagers avoided the drugs, violence and crime was commensurate with the extent to which their mood lifted.

Another Buddhist model of cause-effect relationships is referred to as the five controlling faculties (Pandita, 1992). These five faculties are 1/confidence or trust, 2/energy or effort, 3/mindfulness, 4/concentration and 5/wisdom. In similar interdependent manner to the eight factors described previously, faith, trust or confidence that freedom from suffering is possible leads to motivation or the willingness to put forth effort to practice. When one is motivated and brings awareness (or mindfulness) to an issue, this helps to focus, integrate ones mind and see clearly into an issue (concentration). With mindfulness and concentration, wisdom arises. Wisdom or understanding then helps to reinforce faith that the process is beneficial and so the cycle continues.



The first task of a therapist is often to clarify the client's intentions. If the purpose for the visit is clarified it helps to provide direction and meaning to the process of "therapy".

One defining feature of depression is hopelessness. Confidence or faith, in the context described above basically refers to the opposite of hopelessness. In many respects a depressed individual recognises accurately and perceptively the nature of the first noble truth. However, when this perception is not balanced by an equal recognition of the third noble truth (or freedom from suffering) seeing the depth and breadth of dukkha is understandably depressing. Trust is the acknowlegment of a possibility when not having experienced that possibility. Confidence, on the other hand, refers to having once realised some freedom and understanding that more practice can lead to more realisations.

There are numerous strategies used in contemporary psychology for the development of hope or confidence and motivation (e.g., Motivational Interviewing, Miller & Rollnick, 1991). Such strategies may include psycho-education about the bio-psycho-social or interdependent nature of depression

including aetiology, treatment and prevention. Other strategies may include value and intention clarification, goal setting, and/or the use of inspiring metaphors to highlight possibilities and engender hope. It has been my experience that when those who may be caught in depression find meaning or purpose in their activities their depression becomes less severe.

Suicidality is a common correlate of hopelessness. The assessment and treatment of this aspect of depression is complex and there are no simple solutions. The importance of having a stable platform of ethics, healthy lifestyle and safety before attempting in-depth psychotherapy or mental development has already been discussed. Understanding this sequence the first steps of dealing with a suicidal client usually involves ensuring safety by providing supervision, removing all means of self harm and neutralising precipitating issues (World Health Organisation, 1997). After the first steps are complete it is possible to build a therapeutic relationship and begin to address underlying issues. In accordance with Buddhist pathways, seeking out and nurturing hope, trust, confidence, purpose and meaning then becomes one way to ultimately be free from the suffering of suicidality.

Letting go of the unhealthy and cultivating the healthy

Unlike some modern psychiatric interventions a Buddhist approach to depression is not to get rid of, reject, deny or suppress it. In my understanding, the Buddhist approach to depression is to heal it's suffering. This may mean a deep acceptance and understanding of how depression may have arisen and allowing depression to be our teacher (Welwood, 2000). Paradoxically when we can accept depression with an open heart we also let go of the very tendencies that may have been causal for it's arising. "Letting go" of those tendencies that cause suffering is perhaps the essence of the Buddhist path to awakening and liberation (Sumedho, 1984). Letting go sounds simple but it can be extremely difficult to accomplish. One way that letting go of "unhealthy tendencies" can be realised is by cultivating their opposites.

According to Buddhist psychology the release, or resolution of suffering is seen to arise from an interdependent relationship between environmental conditions and "healthy" mental and physical factors (Goleman, 1988). Healthy mental factors include those cognitive, affective and behavioural patterns that reflect non-attachment, non-aversion and non-ignorance. The seven factors of awakening are examples of healthy tendencies and include: 1/Mindfulness 2/Investigation 3/Effort 4/Joy or rapture 5/Tranquility or calm 6/Concentration and 7/Equanimity (Pandita, 1992). Other examples include: generosity, love and compassion, mental flexibility, compunction, discretion, confidence, humility, and wisdom. These healthy tendencies are in direct opposition to some the unhealthy tendencies mentioned previously (i.e., aggression, jealousy, gloominess, sadness, worry and rumination, impulsive recklessness, shamelessness, guilt, confusion, avoidance, mental dullness, hatred and so on.)

As all conditions are interdependent, unhealthy mental factors such as gloominess and worry often arise together and influence each other. In the same way, when healthy mental factors arise they support and are supported by each other. When mindfulness is developed, for example, it may also influence the development of a focused mind, mental calm and physical relaxation. Mindfulness may also support and be supported by equanimity, joy, patience, concentration, loving kindness/compassion etc.,

In a manner similar to reciprocal inhibition healthy mental factors may inhibit unhealthy mental factors and their consequences (Goleman, 1988). Kindness, for example, may be incompatible with aggression. Similarly, calm is incompatible with agitation, equanimity or mental composure with worry, curious investigation with avoidance and so on. Mindfulness and wisdom are considered to be factors powerful enough to "reciprocally inhibit" and ultimately uproot all problematic "unhealthy mental factors" (Goleman, 1988).

Love, compassion and joy are other primary healthy or wholesome tendencies that, when cultivated can inhibit if not uproot the arising of depression.

Two forms of practice that are utilised by most Buddhists involve the cultivation of awareness or mindfulness and the cultivation of love, compassion, joy and equanimity with the four divine abidings. These two modes are, like all things Buddhist, interrelated and incorporate the cultivation of all the healthy factors mentioned above.

Mindfulness

Mindfulness is central in the noble eight-fold path. It is one of the five spiritual powers and is the first of the seven factors of enlightenment. In the psychotherapeutic literature mindfulness has been referred to as a coping skill (Linehan, 1993), a mode of being (Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000) as well as a meditation practice (Kabat-Zinn, 1990).

In Pali mindfulness is called satipatthana or just sati. Mindfulness refers to remembering to deliberately place attention or turn the mind to what is happening right now (Nyanapondika Thera, 1962; Kearney, 2000). Mindfulness could also be described as remembering to bring attention to present moment experience in a non-judgemental, focussed, curious and open- minded manner.

Mindfulness has been distinguished from spontaneous attention or perception in that it is a purposeful activity (Fryba, 1995; Goleman, 1988; Narada, 1979). Put simply, mindfulness refers to present centred awareness, detached observation (Nyanaponika, 1962), or “remembering to be here now” (Dass, 1972).

The four foundations or domains of mindfulness

In traditional Theravadin Buddhist teachings there are four foundations or domains of mindfulness. These are mindfulness of body, feelings, mind states and mind objects (Nyanapodika Thera, 1962).

1. Mindfulness of body includes, among other things, being aware of postures, physical sensations as well as sight, sounds, smell taste and the breath.
2. Mindfulness of feelings refers to being attentive to qualities of pleasantness, unpleasantness and neutrality that arise in the mind in relationship to sensory perceptions or mental processes.
3. Mindfulness of mind states refers to being attentive to the states of mind that may colour the mind such as a distracted mind, an angry mind, a wanting mind, a happy mind, a guilty mind and so on. Being mindful of thoughts and emotions, as we normally understand them could be included in this domain.
4. Mindfulness of mental objects refers to being aware of phenomena in general. Thoughts may also be included in this domain as well as the influence of the content of mind such as thoughts, on physical and mental processes (Nyanapondika Thera, 1962). Being aware of how some mental, emotional and behavioural tendencies may perpetuate mental distress while other tendencies alleviate or uproot mental distress is also included in this domain of awareness.

Mindfulness in contemporary psychology

The practice of sati or satipatthana is not limited to Buddhism as it best considered as a universal skill or healthy tendency (Kabatt-Zinn, 1990). Without recognising the connection to Buddhism, mindfulness or aspects of this practice may be found in many different contemporary psychological paradigms often under different names such as:

- self monitoring in Behavioural Therapy (BT) (Mahoney and Thoresen, 1974),
- being in the now in Gestalt Therapy (Pearls, 1970),
- present centeredness in Gestalt therapy (Naranjo, 1970),
- listening to oneself in Client Centred Therapy (Rogers, 1962),
- listening to automatic thoughts in Cognitive Behavioural Therapy (CBT) (McKay, Davis and Fanning, 1981),
- self awareness in Emotional Intelligence (Salovey, Bedell, Detweiler and Mayer, 1999),
- meta-mood and meta-cognition (Goleman, 1995),
- free association and hovering attention in Psychodynamic therapy (Epstein, 1995; Speeth, 1982), and
- acceptance in Acceptance and Commitment Therapy or ACT (Hayes et al., 1999).

ACT provides one example of how mindfulness is incorporated into a contemporary psychology. ACT is a therapeutic approach to a variety of mental health issues including depression. Through paradox, metaphor and experiential exercises, ACT aims towards "de-literalising" language and the promotion of health and vitality (Hayes et al., 1999). One of the main factors considered as aetiological for mental suffering in the ACT model of psychopathology is emotional avoidance (Stroshahl, Hayes, Bergan, & Romano, 1998). Willingness to experience, or acceptance, is indicated as a way to overcome emotional avoidance (Hayes et al., 1999). In this therapeutic approach acceptance refers to:

> "the willingness to experience a full range of emotions, thoughts, memories, bodily states, and behavioural predispositions, without necessarily having to change them, escape from them, act on them or avoid them" (Hayes, 1995 cited in Paul, Marx, & Orsillo,1999, p.150).

Here, the definition of acceptance seems parallel to the definition of mindfulness. Recently Hayes (2002) has acknowledged strong similarities between ACT and Buddhist practices. However, ACT was developed as

radical behaviourism without reference to Buddhism. In other contemporary psychological approaches mindfulness-based practices have been directly adapted from Buddhist traditions. Dialectical Behaviour Therapy (DBT), for example, one of the few empirically supported approaches for the treatment of Borderline Personality Disorder, (BPD) teaches and uses mindfulness as the key coping skill (Linehan, 1993).

Another example is Mindfulness Based Cognitive Therapy (MBCT) (Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Segal et al., 2002). This approach utilises mindfulness practices to help clients with a history of depression prevent relapse.

Parnell (1999) has drawn parallels between mindfulness based (MB) practices and Eye Movement Desensitising and Reprocessing (EMDR; Sharpiro, 1989) and suggests mindfulness as an adjunct to this widely used technique for post traumatic stress disorder.

Empirical evidence that satisfies contemporary scientific standards is accruing and supports the use of mindfulness for the management of depression. Of particular interest is the work described in Segal, et al., (2002) with MBCT. They described how, in a randomised control study individuals with a history of three or more depressive episodes significantly reduced the risk of relapse after participating in MB training.

Segal et al., (2002) emphasise that MBCT is particularly helpful for relapse prevention with depression. They were, however, uncertain of its value for the treatment of depression because they felt that when in an severe episode those who are depressed cannot concentration enough to make the practice beneficial. When suffering with severe symptoms of depression they recommended medication coupled with or preceding conventional CBT.

Another study that should be mentioned is one conducted by the author in conjunction with Bankstown clinic for anxiety and traumatic stress (Huxter, 2001). Basically this study compared two eight-session stress management programs for Generalised Anxiety Disorder. One program utilised MB strategies and the other program Cognitive Therapy cognitive restructuring strategies. The results showed that measures of stress, depression and anxiety symptoms in participants of both programs fell significantly, from within pathological ranges to non-pathological ranges over the period of their participation. Changes noted in those who participated in the MB program were maintained for two months after the program finished.

For more detailed reviews of MB practices in contemporary settings see Huxter (2001) or Huxter (2002). (For discussion of the similarities and differences between MB practices and conventional CBT practices see Appendix A. Also see De Silva, 1984; Fenner, 1995; Kabat-Zinn et al., 1992; Linehan, 1993; Segal et al., 2002; Teasdale et al., 2000; 2002; and the Special series-Integrating Buddhist Philosophy with cognitive and behavioural practice. Cognitive and Behavioral Practice. Volume 9, Number 1, Winter 2002, pp 38-79)

Mindfulness may have numerous therapeutic functions for the management of depression. Some of these functions may include that they can: counter, short circuit or reciprocally inhibit worry and rumination, cultivate meta-cognitive insight, reduce "cognitive fusion" and help to "let go" of painful emotions by providing a function similar to exposure or response prevention in CBT practices.

Short circuiting worry and rumination

Worry and rumination are two features of depression. Worry generally refers to thinking excessively about solutions to a problem where there may be a number of negative outcomes. Rumination is similar to worry except that it is more passive. That is, one mulls or "chews" over an issue but does not think

of any solutions. When ruminating one generally focuses repeatedly upon one's distress and its circumstances. It is easy to fall into automatic patterns of thought that perpetuate one's distress when worrying or ruminating. (Borkovec, 1994; Nolen-Hoeksema, 2000; Salovey, Bedell, Detweiler & Mayer 1999)

Teasdale, Segal and Williams (1995) described a ruminative tendency called "depressive interlock" which refers to how individuals may regenerate and maintain their depressed state. With depressive interlock, depressed individuals continue to circulate around a cognitive loop dominated by depressive content. When someone is suffering with depression not only do they have negative thoughts about themselves the world and future, they also seem unable to short circuit these habitual negative thinking processes.

According to Teasdale et al., (2000, p. 618) a core feature of mindfulness based practices involves "facilitation of an aware mode of being, characterised by freedom and choice, in contrast to a mode dominated by habitual, over-learned, automatic patterns of cognitive-affective processing". Thus, mindfulness may provide a space to break habits of clinging to views, concepts and experience and a tool to disengage from unhealthy thinking patterns.

<u>Developing metacognitive insight</u>

Buddhists claim that experience can be illusionary. Just as many frames of a motion picture create the illusion of life on a screen, we usually compound and solidify experience with our views and conceptual thinking processes. However, if we look and see the moment-to-moment nature of experience we can see that things are not always as they appear.

When depressed it is easy to believe negative thoughts, such as "I'm a failure" "life is hopeless" "I'm worthless, helpless, useless" etc., as truth. However, when we bring attention to the nature of thought with mindfulness it is possible

to realise that thoughts can be illusionary and are not always what they advertise themselves to be (Hayes, et al., 1999). An interpretation of something may not reflect the truth. In other words, thoughts are not facts (Segal, et al., 2002). Thoughts are thoughts and they do not necessarily define who or what we are.

Mindfulness helps to develop what Teasdale, Moore, Hayhurst, Pope, Williams and Segal (2002) have called “metacognitive insight”. Metacognitive insight is similar to what Beck (1976) described as “decentring” and “distancing”.

Metacognitive insight refers to “experiencing thoughts as thoughts (that is as events in the mind rather that direct readouts on reality).” (Teasdale et al., 2002, p.286).

Shifting perspective and freeing cognitive fusion

Focusing on ones problems can fuel and fertilise these problems. Being mindful of a problem does not mean one focuses upon it. Rather, mindfulness provides the capacity to shift attention. When depressed it is easy to confuse the contents of thoughts and emotions as who and what we are. This has been called “cognitive fusion” (Stroshahl, Hayes, Bergan, & Romano, 1998). Identifying with negative thoughts or painful emotions is inherently dukkha. In addition, if one identifies with a conceptual self based upon pleasant emotional or thought content one is vulnerable to suffer as these experiences change. ACT (Hayes, et al., 1999) emphasises a shift in identification to an “observer self”. The “observer self” provides a more stable realm of consciousness where individuals are more readily able to tolerate inevitable change. Mindfulness or observing thought and emotions has also been compared to “stepping back” (Linehan, 1993). Stepping back is not dissociation but considered as observing from a place that seems deep and still within one’s being or centre.

Linehan (1993, p.67) used the following metaphor to explain the difference between going outside oneself and observing. “Imagine that the place you go outside your self is a flower. The flower is connected to your centre by a long stem. The centre is the root of the flower. Imagine coming down the stem to the root”.

Letting go of painful emotions

Despite sometimes being distressing, emotions have a function. Sadness, the core emotion of depression, for example, may be needed to alert us to something that needs attention in our lives. It may point to something in our relationships or in our environment that needs adjustment. If we deny or suppress this emotion we may also fail to understand its function. Depression can be a compounding and perpetuation of a number of distressing emotions that may also have a function. According to Welwood, (2000, p.180) “depression is the loss of heart that results from turning against the unfathomable flux of life” and “it is an opportunity to awaken our heart and deepen our connection with life.”

The Buddhist approach to emotions is to use them as a means to awakening. If they are distressing, emotions are not suppressed or denied but are transmuted into something that is of value. Mindful inquiry can assist this process. Investigation is a factor of awakening that helps to dispel confusion (Pandita, 1992). This type of spiritual inquiry can be discursive or non-discursive (Rothberg, 2000). At a discursive level investigation may be similar to rational reflective or problem solving processes used with Cognitive Therapy (e.g., Ellis, 1962). It may involve objectively thinking something through in a rational manner. This type of reflection is different to mulling over or ruminating in that it is more focused and controllable (i.e., we can choose to engage or disengage with it).

Non-discursive inquiry may be more penetrative and can be used with mindfulness. For example, with distressing emotions one could ask, “what is

really happening here?" Or "how am I really experiencing this emotion?" With penetrative inquiry we can see that emotions are, in fact, a conglomeration of thoughts, stories, physical sensations, learned or conditioned reactions, feelings and so on. By inquiring into the nature of our emotional "monsters", such as depression, instead of avoiding them we can see that that they are not as frightening as they first appear. In this manner the compounded perception and identification with an emotion may be dismantled.
When distressing emotions associated with depression arise, Buddhists recommend facing them, feeling them and letting them be (Trungpa, 1973). Emotions can be felt at a physical level and in this way the stories that often fuel distressing emotions are allowed to run their course and extinguish naturally. Allowing emotions to be and not react to them is similar to the process of operant extinction through exposure or response prevention as it is often explained with learning theories (Craighead, Craighead, Kazdin & Mahoney, 1994). By being mindful of the physical sensations of an emotion we are less likely to be caught up in stories and more likely to perceive the illusionary nature of these experiences.

By understanding the interdependence of emotions individuals are also less likely to take these experiences personally. Not taking emotions personally has been compared to riding a horse. We must not identify with the horse (or emotion) in order to direct it. At the same time we must be able to feel at one with the horse to ensure the function of riding occurs efficiently and effectively (Linehan, 1993). Mindfulness provides us with the ability to utilise emotions rather than be controlled by them. Mindfulness gives more capacity to nurture helpful thoughts and emotions whilst also giving more ability to let go of unhelpful thoughts and emotions.

<u>The practice of mindfulness in therapeutic settings</u>

Psychotherapeutic paradigms that emphasise the use of mindfulness practices have detailed guidelines for their use (e.g. Hayes et al., 1999; Kabat-Zinn, 1990; Linehan, 1993; Segal, et al., 2002). As mindfulness has

been utilised by Buddhists for thousands of years, details about the practice are sophisticated and voluminous, and can be found in many contemporary texts (e.g. Fryba, 1995; Goldstein, 1976; Nyanaponika Thera, 1962; Pandita, 1992; & Thich Nat Hahn, 1975; 1999). The reader is referred to these texts for details of the practice. In addition, simple basics of mindfulness practice can be found in a workbook attached to this discussion or given upon request (Huxter, 2002b). However, in order to clarify some aspects of this practice a few points will be made.

One danger when using mindfulness with those who are experiencing depression is that sometimes mindfulness is confused with self-focussed attention. Self-focussed attention refers to focusing upon ones distress and failing to perceive its interdependent context or the bigger picture (Ingram, 1990). Self- focussed attention can exacerbate depressive symptoms. Thus clinical discretion, clear instructions and adapting the practice to suit the individual are needed.

In my experience those who are depressed tend to think excessively or seem to "be in their heads". All areas of mindfulness are important but mindfulness of body practices can be a way to get those who are prone to ruminations "out of their heads" and experience life in an alternative mode. Mindfulness of body provides an experiential base rather than a thinking verbal base for processing problems. The shift in attention away from thinking can some times reduce "thinking" problems such as worry and rumination.

Physical movement such as yoga or Tai Chi or dance as well as body oriented therapies such as massage or acupuncture can have numerous psycho-emotional connections and therapeutic benefits for managing depression. More active aerobic exercise is also helpful to manage depression. This has been my observation and I am aware of more scientifically validated research that supports this observation (e.g., Babyak, Blumenthal, Herman, et al., 2000). Not only does such activity initiate physical

and bio-chemical changes that can shift depressive moods but they can also provide very tangible experiences to be mindful of.

Emphasising how mindfulness can be integrated into daily activities and being creative in the ways mindfulness can be used with many activities may also be particularly helpful to individuals with depression. Encouraging depressed clients to develop mindfulness during enjoyable activities can, for example, enhance these clients' ability to focus on the task and disengage from negative thinking patterns. Encouraging those suffering with depression to be attentive to the process of thoughts and emotions can enhance their capacity for detachment and humour and reduce the tendency to take these events personally. The wisdom generated by mindfulness can empower positive change by encouraging acceptance and liberating attitudes towards life.

Cultivating the wholesome, cultivating Joy

The individual suffering with depression will often be caught a negative concept of self, nihilistic views of the future and negative interpretations of life's events (Beck, 1976). If these habits can be abandoned joy may arise. Consistent with a Cognitive Behavioural approach (e.g. Thase, 1995) Buddhist meditation teachers explain that joy can arise if we reflect our positive qualities as well as wholesome themes such as those associated with truth and awakening to truth (Pandita, 1992).

Joy is naturally opposite to feeling miserable. In traditional Buddhist practices mood is uplifted and joy naturally arises when the mind becomes concentrated (Fryba, 1995: Pandita, 1992). Classic Buddhist texts (e.g., The Path of Purification, Buddhagosa, 1976.) describe, in detail, different types of joy and how joy can be subtly refined to varying degrees with concentration practices.

The joyous effect of being focused or concentrated has also been acknowledged in contemporary psychology and called "flow". Goleman

(1995) in reference to the development of emotional intelligence has discussed the ecstatic nature of “flow” when he described how some sports people, professionals and artists become so absorbed in what they are doing that they forget themselves.

> “Flow is a state of self-forgetfulness, the opposite of rumination and worry: instead of being lost in nervous preoccupation, people in flow are so absorbed in the task at hand that they lose all self consciousness, dropping the small preoccupations ---health, bills, even doing well---of daily life” (Goleman. 1995, p.91).

Those who are experiencing depression are miserable, distracted and generally unable to concentrate. If, however, depressed individuals can, in some way or other, begin to focus attention, joy may arise.

Research indicates that when people who are prone to experience depression participate in pleasant activities and/or activities that give a sense of achievement or mastery this participation can influence a lift in their mood. Psychologists often ask people suffering with depression to complete daily activity schedules that include activities that are pleasant and that give a sense of achievement (e.g., Beck, 1976; Lewinsohn, Munoz, Youngren & Zeiss 1986).

Though it may be a far cry from the refined concentrated states described in “The Path to Purification” participating in enjoyable activities can nurture joy. Simply participating in enjoyable activities may be one way to forget worry and rumination and be a little bit happier.

I often ask those who feel depressed to list some simple thing that they may enjoy and then consider how participating in these activities may be possible. As mindfulness can lead to concentration I then discuss how these activities may be practiced in a mindful manner. I also encourage them to simply enjoy

what they may be doing or "get into it". According to Hahn (1998, pp.173-174):

> "many small things can bring us tremendous joy, such as the awareness that we have eyes and we can see the blue sky, the violet flowers, the children, the trees and so many other kinds of forms and colors. Dwelling in mindfulness, we can touch these wondrous and refreshing things and our minds of joy arises naturally. Joy contains happiness and happiness contains joy".

The four divine abodes

The four divine abodes are other core Buddhist meditation practices and ways of being. Cultivating the qualities of love, compassion, joy or sympathetic and equanimity are referred to as the four divine abidings because "being" in these states of mind is god-like or divine. Not only do these mind states counter tendencies that lead to depression but they also become a way to relate to oneself and other beings in a manner that is consistent with the truth or the way things are. According to Hahn (1998, p.170) "Love, compassion, joy and equanimity are the very nature of an enlightened person. They are the four aspects of true love with ourselves and within everyone and everything".

Cultivating equanimity

Cognitive models of depression highlight how early childhood learning influences the way we see the world, the self and the future. This in turn impacts upon attitudes and the way we cope with stressful events including difficult interpersonal interactions. When we can't cope we may slip into automatic thought processes with negative content. When depressed, thought processes may be distorted which further influences the way events and interactions are appraised and interpreted (Thase, 1995). Cognitive therapy often addresses cognitive distortions. Some cognitive distortions include: drawing unrealistic conclusions about oneself and how others think about oneself from minimal evidence; "catastrophising" all negative life

events; misinterpreting negative events as indicative of a negative aspect of self; misinterpreting positive events as irrelevant and; taking, very personally, negative criticism from others (McKay, Davis & Fanning, 1981).

Equanimity is a “quality of mind that remains centred without inclining towards extremes” (Pandita, 1992, p.291). It is a quality of non-attachment or even mindedness (Hahn, 1998). Equanimity naturally counters the tendency for those who feel depressed to react to and “catastrophise” difficult life events as well as personalise destructive thoughts and emotions. Equanimity also helps one to cope and manage with difficult interpersonal interactions. With equanimity one can see natural cause effect relationships and realise that each and every different individual must be responsible for their own actions.

In Buddhist philosophy, equanimity provides the emotional stability to not be affected or blown around by “the eight worldly winds”. The eight worldly winds are praise and blame, loss and gain, pain and pleasure and fame and disgrace.

Equanimity can counter distorted thinking patterns, negative attribution, personalising or taking personally negative life events. Wise reflection and developing mindfulness are, perhaps, the best ways to cultivate equanimity.

Sympathetic Joy

When individuals are overwhelmed with depression or anxiety it is common to devalue their own attributes and exaggerate inadequacies. If their perception is tainted with negative self-evaluation and someone else is successful or skilful at something a common tendency, with depression, is to compare and further exaggerate and highlight personal failings and inadequacies. Sympathetic joy directly counters this tendency. With sympathetic joy one is not threatened by the success of others because they realise that the happiness of others is not separate from one’s own (Salzberg & Goldstein, 2001).

Sympathetic joy is said to be the hardest divine abodes to practice consistently (Fryba, 1995). This is possibly because it is counter to the ego's desire to compete and be better than others. In some cases, sympathetic joy requires that an ego understand the nature of change, surrender it's attachment to permanence and status and allow another to take over and have their time. Being able to rejoice in the joy of others requires a maturity of wisdom. Such equanimity understands, at a deep level, that each and everyone's success is not because of "luck" but because of effort with particular actions. Sympathetic joy is an appreciation of that effort. Appreciations of an artist's skill or celebrating when a child succeeds at a new task are examples of sympathetic joy. More powerful examples may involve the happiness experienced when someone else overcomes suffering or how some individuals live in a manner that is free from stress, virtuous and for the benefit of others.

Cultivating love and compassion

When I talk to people who are afflicted with depression they seem to be discontent and unsatisfied with most aspects of their lives. They generally express, sometimes overtly, self-hatred. Not only do they dislike themselves but they also feel alone, alienated, isolated, disconnected and generally imprisoned in a mind made solitary confinement. When depressed it is easy to confuse our identity with a separate self and loose our sense of belonging to our society or community. Moreover, depression often occurs when there is interpersonal disharmony. Interpersonal Psychotherapy (IPT) is a psychotherapeutic approach that is gaining scientific credence for the management of depression (Markowitz, 1998; Mufson, Moreau, Weissman, & Klerman, 1993). With the treatment of depression IPT emphasises accepting role changes and resolving interpersonal conflict. Interpersonal relationships and being part of a community are important considerations for the management of depression. According to one discourse the Buddha stated

that being supported in a spiritual community was the most important aspect of the spiritual life.

Love is a panacea for hate and loneliness. The meaning of love may be limited by attempts to define it. Nonetheless when Buddhists talk about love they generally mean, what in Pali is called, metta. Metta refers to heart felt care, friendliness, concern or kindness for oneself and other beings. It is not sentimental good will, or sensual personal love. It is not the type of love related to attachment or the type of love one exchanges for comfort or security. Rather, it is the cultivation of and capacity to offer unconditional care. Metta is an acknowledgment of the interconnection of all living things. Metta has the power to melt divisions or feelings of separateness, both within ourselves and to the world around us. Metta is the binding element of a harmonious community.

Compassion is often considered as synomymous with loving-kindness (Kumar, 2002). There are, however, some minor distinguishing features. According to Pandita (1992, p.284) compassion is "the quivering of the heart in response to others' suffering; the wish to remove painful circumstances from the lives of other beings". Compassion arises when we realize the interconnectedness of all beings and how, like ourselves, other being may also suffer. Compassion is not pity or sympathy but a quality of active caring.

As previously discussed (under the heading "therapeutic relationships"), truly communicating with and listening to another person's expression of pain has the power to transmute this suffering. Further to this, if an individual can generate, at the time of their suffering, a quality of tolerant compassion and love towards themselves it can be miraculously transformative, healing and liberating. His Holiness the Dalai Lama when asked if he ever felt lonely without hesitation simply replied "No". His Holiness added that when one cultivates compassion there is less fear and apprehension. In addition,

compassion allows openness with others and generally creates a positive friendly atmosphere. (HH the Dalai Lama and Cutler, 1998)

The evidence to support the above claims is not based upon randomised controlled trials or other scientifically validated experimental procedures. They are nonetheless empirical in that they are based upon personal experience, anecdotal reports and the wisdom generated by human beings over thousands of years. According to Buddhists metta can promote health, beauty, restful sleep, the ability to fall asleep easily, pleasant dreams, peace, concentration, interpersonal harmony, psychic protection and greatly undermine ill will. Intuitively, most people know that love is healing.

If depression is a "loss of heart" (Welwood, 2000), then the challenge of being afflicted with depression is to awaken or reawaken a heart filled with love, compassion, joy and equanimity. There are many ways to nurture love and compassion and traditional Buddhist meditation teachings have specific instructions (e.g., Fryba, 1995; also see Huxter 2002b). Sometimes, after some preparation, I introduce clients to these practices as they are explained in Buddhist traditions. Often, these traditional and formal practices are utilised enthusiastically and successfully by people overcoming depression. At other times, however, self-dislike is so ingrained that attempts to purposefully practice metta or compassion back fire. Unfortunately these attempts become yet another opportunity for self derogating thoughts and destructive emotions to emerge.

If purposeful attempts to generate love and compassion fail, I generally encourage being mindful with an emphasis upon acceptance, soft openness and gentle kindness with oneself.

Other ways to generate these qualities are by increasing the probability that they arise spontaneously. These mind states may arise naturally when individuals are in situations or around people who can remind them of them. I,

for example, have a picture of His Holiness the Dalai Lama in my office. His warm, kind and smiling face reminds me of the qualities of kindness and acceptance that are potentially deep within the hearts of all beings including myself. According to records of his discourses the Buddha recommended avoiding the company of the unwise, rude, abusive, and unkind and keeping company with wise, kind, supportive, compassionate, joyous, and/ or calm. Such company can naturally resonate with or awaken these wholesome qualities in oneself (Pandita, 1992).

Engaging in social activities and or meaningful occupations can engender love and compassion. Sometimes I ask those who are experiencing depression to purposefully place themselves in situations where wholesome social contact can increase the possibility of metta arising spontaneously. Cultivating "right" livelihood or participating in activities or occupations which provide an opportunity to share, work towards team goals, be kind and generous are ways that we can connect with other beings.

Being part of a community can melt alienation and engender a sense of belonging and connection. It can also dispel identity confusion and nurture awareness that we are something greater than an isolated self.

The four divine abodes are practices that can become a way of being, a way of interaction with the world and a path to liberation from the suffering of depression.

Summary and conclusion

In contemporary psychology depression is viewed as a disorder that impacts upon physical health and function, mood, behaviours, thinking, and motivation. Depression may be chronic or, if not, it tends to be episodic and recurring. The management of depression refers to treatment when it is present and prevention of further relapses when it is not. The application of Buddhist principles for the management of depression has been briefly

discussed and, in the authors view, involves the understanding of how mental and physical phenomena interact and a way to be free from mental suffering or dukkha.

Depression, as it is understood in contemporary psychology, is a manifestation of dukkha. It is perennial and pervasive. Buddhism and Buddhist practices are directed at alleviating, ameliorating and ultimately uprooting dukkha and its causes. Thus, these practices may be helpful for the management of depression.

Buddhism may provide an overarching philosophical paradigm and pragmatic approach to understand and practice of the healing process. The eight-fold path is the essential practice of Buddhism. Therapists as well as those who are depressed may appreciate the usefulness of this path and recognise the connection to Buddhism. However, this connection need not be acknowledged or recognised, as the structure of the Buddhist pathway can be understood as reflecting natural cause effect relationships.

Providing a sense of hopefulness that freedom from depression is actually possible is, perhaps, the most important first step in considering Buddhist practices for the management of depression. Consideration of hindrances on the path to wisdom and awakening followed by the active removal of these hindrances are more preliminary steps on the way to be free from depression. After this, exploring and understanding those cognitive affective and behavioural tendencies that 1/lead to becoming depressed 2/perpetuate the depressive phenomena and 3/trigger relapses of depression are the next steps in managing depression. With this understanding “letting go” of or disengaging from unhealthy tendencies and engaging with or nurturing healthy tendencies then become the ongoing treatment and relapse prevention strategies for depression.

The management of depression is an ongoing process. It is possible, however, in this author's opinion, to completely abandon the suffering of depression and be liberated from this burden. This liberation could be understood as an awakening of the heart to our true nature as well as a clear perception of how phenomena interact. This awakening is a deep acknowledgement and acceptance of ourselves and the inter-connection and interdependence of all sentient beings. This awakening is also a shift in perspective from one of an isolated, alienated, disconnected, fixed, centralised self to one of an integrated, open, inter-connected, decentralised being, free from dukkha. This process is ultimately the confluence of love and awareness.

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Appendix A: CBT and MB approaches compared

Similarities

- Both CBT and mindfulness based practices centre around the understanding that there is a functional relationship between thought content, thought process, overt behaviours, and mood disturbances (Teasdale et al., 1995).
- Both CBT and mindfulness focus on dealing with issues that arise in a current time context.
- CBT and mindfulness training share the emphasis of monitoring thoughts and perceptions in a realistic and accurate manner and not viewing mental and physical experiences in a catastrophic manner (Kabat-Zinn, Massion, Krieteller, Peterson, Fletcher, Pbert, Lenderking & Santorelli 1992).
- CBT and mindfulness practices both emphasise the need for practice in the form of homework (Kabat-Zinn, et al., 1992).
- Some strategies that are used with CBT that over lap and may also be part of mindfulness include relaxation training, breathing techniques, distraction, focusing attention upon an object or an activity, and increasing awareness of the environment (Manicavasagar & Blaszczynski, 1995).
- Distancing or decentring procedures where individuals are encouraged to view their thoughts in a detached manner and as representations of reality rather than facts that should be "believed" are a feature of both mindfulness based practices and CBT practices (Teasdale et al., 2000; 2002; Zettle & Rains, 1989). Teasdale et al., (2002) have distinguished the difference between metacognitive awareness and metacognitive knowledge. Metacognitive knowledge refers to thinking about thoughts or knowing on an intellectual level that thoughts are not facts. Metacognitive awareness or insight on the other hand refers to "experiencing thoughts as thoughts (that is as events in the mind rather that direct readouts on reality)." (p.286). MB practices are directed towards developing metacognitive insight. This insight, however, can also develop with CT practices. (Teasdale et al., 2002). With CT, metacognitive insight is implied but with MB practices it is explicit (Segal et al., 2002).

Differences

- The emphasis in CT is distinguishing between the faulty and non-faulty content of thoughts. CBT approaches generally emphasise rationally analysing the content of thoughts and purposefully or deliberately changing the content of irrational or dysfunctional thoughts and thinking patterns. Mindfulness practices may draw attention to content of thoughts and there may be some rational analysis of the thoughts as healthy or unhealthy. However, the emphasis with mindfulness is upon perceiving the process of thoughts (i.e., their changing and interdependent nature) and "just" acknowledging thoughts as thoughts (Kabat-Zinn, 1995). With MB practices healthy thoughts may be encouraged or promoted and unhealthy thoughts may be discouraged but the change mechanism is not wilful or forceful. Mindfulness may change the relationship between thought and the thinker and by doing so the content of toxic thoughts may also change. (Fenner, 1995). In general, mindfulness practices encourage a willingness to allow thoughts and emotions to be and let change in a natural manner (Teasdale, et al., 1995).
- As mindfulness can be considered as one defining aspect of Buddhist psychology and there are some fundamental ontological differences with Buddhist psychology and CBT (Fenner, 1995). "Western" psychologies such as CBT emphasise rapid and specific change. Buddhist psychology, on the other hand, emphasises contentment and acceptance with the way things are, change that may occur over many years and a generic holistic perspective about life rather than the elimination of specific symptoms.
- From a philosophical perspective, causality in CBT is considered as linear where thoughts or beliefs often mediate psychological consequences. In practices that utilise mindfulness (such as Buddhism, DBT and ACT) causality is considered as interdependent, contextual and contingent. CBT generally adopts linear causality to explain pathology and the treatment of pathology. CBT, for example, adopts the "ABC of thinking" to rationalise how distorted thinking pattens (B) may mediate negative emotional

consequences (C). With treatment modalities that adopt linear causality "A" leads to "B" leads to "C". If "C" is a problem then it can be resolved by changing "B" or "A". With interdependent notions of causality "A, B, and C" are interdependent. If there is no "B" then "C " does not arise. However, as "C" is part of system that cannot be separated from the whole, the arising or nature of "A" is dependent upon the nature of "C" or "B". In other words, the interdependent co-arising of self and the world (represented by A B and C) are reciprocally modified by their interaction.

- Mindfulness is more generic in nature than CBT. CBT tends to target specific disorders, problems, situations or thinking styles whereas this does not occur with mindfulness practices. Mindfulness is taught as a "way of being" that can be used as a generic skill in all situations and not only when an individual is experiencing distress. Teasdale et al., (1995) commented that this feature of mindfulness might increase its practice effect and enhance a prophylactic function.
- With CBT practices individuals may be systematically exposed to specific anxiety provoking situations or cues. Systematic desensitisation is not directly or purposely practiced with mindfulness-based approaches, and situations or anxiety provoking stimuli are generally addressed as they arise. Practitioners of MB skills can, however, choose to expose themselves to anxiety provoking situations, thoughts or emotions if they wish.
- Identifying with thoughts and emotions is only considered a problem when they are negative in CBT practices. With MB practices the tendency to identify with any thought or emotion is considered problematic. Within an ACT model of psychopathology, for example, behavioural disorders are considered to arise from a number of contextual factors including "cognitive fusion". Cognitive fusion is explained as a failure to distinguish self from the content of thoughts and feelings (Stroshahl et al., 1998). If one identifies with a conceptual self based upon emotional or thought content one is vulnerable to suffering as these experiences change. ACT emphasises identification with an "observer self". The "observer self"

provides a more stable realm of consciousness where individuals are more readil able to tolerate inevitable change.

- Clinicians who utilise CBT need not themselves personally use CBT. MB practices, however, require that the clinician utilise and maintain a personal practice in order that MB practices are taught authentically (Segal et al, 2002)