Meditation and psychotherapy

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Psychological treatments are categorised into the major types: psychodynamic, interpersonal, behavioural and cognitive, the latter two usually now being considered together as cognitive–behavioural psychotherapy. Another system does not fit into any of these categories. It is the acquisition of personal or self-control, initially under the direction of a therapist but essentially conducted by the individual. One method for acquiring this skill is based upon some form of meditational practice. Apart from its everyday use to indicate pondering over some theme, the term meditation was not used in a clinical sense until the introduction to the West of a modified form of yoga practice called transcendental meditation. Otherwise it was generally considered in the context of various practices of a religio-mystical nature such as yoga, Zen and Sufism. The best overview of these practices and their origins is *The Varieties Of Meditative Experience* (Goleman, 1977).

If considered at all by Western therapists, meditation is generally thought of as a form of mental and physical relaxation, perhaps a method of shelving the psychological problem by retreat into some inner world. The word was avoided in one of the best known methods, that introduced by Benson and his colleagues in the USA who styled their procedure 'the relaxation response' (Benson *et al*, 1974). In that paper they considered meditational practices throughout the world and defined meditation by its characteristics: (a) a mental device for fixation of attention, (b) a passive attitude ("ignoring distracting thoughts"), (c) decreased muscle tonus, and (d) a quiet environment. This attempt is not entirely satisfactory since it ignores the fact that trance states may be induced by repetitive muscular activity (as in dance movements and repetitive sensory stimulation by noise or light). The term 'passive attitude' is also, perhaps, not best described in the above manner but by the allowance of some state (e.g. muscular relaxation or mental quietude) to occur rather than by the deliberate attempt to enforce it to come about.

There has been recent clinical attention to meditation. In 1987 the most prominent writers on the theme in Britain and America contributed individual chapters to a book, *The Psychology of Meditation* (West, 1987). In these surveys, definitions of the topic and aspects of physiological as well as psychological effects are considered. Reviews of the topic with particular relevance to psychotherapy include Smith (1975), West (1979), Shapiro & Giber (1978), Delmonte (1985) and Craven (1989).

DEFINITIONS

Can meditation be considered at all apart from the context of the cultic or religious usages, dedication to which usually results in a transcendence of conscious awareness, a state variously indicated by terms such as *nirvana* or *jhana*? The answer must be that lesser degrees of this transcendence may be experienced. The best non-cultic term which signifies such a state is 'trance'. Despite the various senses in which that term is used it may be defined by its two overriding characteristics: a *partial detachment* from immediate sensory experience and *increased susceptibility to suggestion*, whether made by oneself or by another person. The trance may be self-induced or induced by some other person, as in the practice of hypnosis.

I shall now briefly survey some of those forms of psychotherapeutic practice in which meditation (i.e. the induction of a trance state) plays a central role. Space precludes a comprehensive list of techniques. The order in which they are presented follows approximately the temporal sequence of their appearance.

AUTOGENIC TRAINING

Autogenic training was devised by a German physician (Schultz, 1932). It remained largely unknown in the anglophone countries until its introduction to North America by Luthe (1963). Schultz considered the method to be essentially one of acquisition of personal control over perception of somatic sensations, initially under suggestion of the therapist and later by auto-suggestion. He did not consider the method to be a form of hypnosis although he was not averse to the concept of auto-hypnosis. There are six 'standard' exercises, in the first of which the subject is advised to think of the dominant arm becoming heavy, the next stage being a sensation of warmth in the arm, then a steadiness of heartbeat, and so on. After the introduction of each exercise the subject is advised to practise regularly, at home, the induction of the sensation experienced with the aid of suggestion from the therapist. The progression to mastery of the exercises may take many weeks, but once this is achieved visual imagery may be incorporated leading up to some abstract concept such as 'happiness' and finally of a door the opening of which may lead to "hidden emotions or images". If the therapist lacks training and confidence to handle emotional disturbance, the therapy may terminate after the six 'standard' exercises.

It may be said that autogenic training represented a fundamental shift of approach to psychosomatic disorders. At the time psychotherapy was a new science and dominated by the psychodynamic approach. Medical practitioners had little treatment to offer once definitive somatic disease had been excluded since the current range of medicaments, sometimes effective in such disorders, had not then appeared. Hypnosis appeared to be in the domain of the charlatan and the showman although Schultz, like Charcot and a few others, belonged to the small band of physicians who did not entirely dismiss its potential. Interest in the concept of self-management by auto-suggestion was rare, Coué being one of the protagonists in the Western world. Schultz progressed from conventional hypnotherapeutic practice to a meditational method through which a person could begin to build up confidence in personal control. It is noteworthy that he was prepared to advocate the use of the method by those not trained in psychiatry. Outside Schultz's own entourage the method did not attract much interest.

Linden (1990), who has written one of the best summaries in English, considers that the language barrier was a major

obstacle since most of the literature was in German and few in the anglophone world at the time, apart from refugees from that disturbed region, were prepared to give much heed to any but one particular emigré, Sigmund Freud.

THE RELAXATION RESPONSE

This is the term selected by Herbert Benson and his colleagues. It is not a good term since it may readily be confused with Jacobson's 'relaxation training'. Benson made it clear that he had been influenced by the simplified yogic technique which was imported to the West by the Maharishi Mahesh Yogi in the 1970s and saw that there was an application of this 'transcendental meditation' to many of the health and personal problems that beset mankind, although it would need to be shorn of cultic associations and the smack of Eastern mysticism if it were to become a technique that was likely to be recommended by the medical and allied professions.

Benson certainly achieved this simplification. The directions make it clear that he claims "no innovation but a scientific validation of an age old wisdom" (Benson, 1976). The procedure (which I here abbreviate) provides the following instruction:

(a) sit quietly in a comfortable position;

(b) close your eyes;

(c) relax your muscles beginning with your feet;

(d) breathe through your nose, become aware of your breathing and each time you breathe out say the word 'one' to yourself;

(e) continue this for 10–20 minutes then sit quietly for a few minutes before you stand up;

(f) do not worry about the degree of your success in obtaining relaxation but maintain a passive attitude; practise once or twice daily.

The introduction of Benson's method led to a certain amount of research and certainly helped to increase interest in the topic. On account of its simplicity it may have become the standard technique but other authors do not always make the matter clear and are frequently content to use the term 'meditation' without further elaboration of method.

ANXIETY CONTROL TRAINING

The development of my technique of anxiety control training (ACT) (Snaith, 1981, 1991) was influenced by the foregoing procedures. Another influence was certainly the publication of *Psychotherapy by Reciprocal Inhibition* (Wolpe, 1958), which was a landmark in the development of clinical behaviourism. Looking for the briefest but most effective method to relieve anxiety, autogenic training seemed to me to fit with the developing psychological research and theories relating to self-control, and for a long-term benefit from any therapy self-control seemed to be of the essence. The problem with autogenic training was that it took rather a long time to master the exercises and many patients were discouraged when they perceived that they were unable to experience one or other of the bodily effects. Turning to Wolpe's work the setting up of hierarchies often appeared to be impractical. However, Wolpe did advocate the use of hypnosis to enhance imagery of a feared situation, a fact which was widely ignored. I set out to see whether I could be a successful hypnotist and found that my experience in application of standard induction techniques was in accord with accounts by others, that is, that many patients did not achieve a trance state and were declared to be unsuitable subjects for such an approach. However, I found that, with a rehearsal in the setting-up of a Benson-type meditative procedure, most patients reported that, allowed to choose for themselves, they were able to visualise some calm imagery. This appeared to be a step forward and the majority, with regular homework practice between weekly sessions with me, reported that they were able to visualise themselves in an anxiety-arousing situation and visible evidence of discomfort was apparent during the session. When this was observed I advised that the thought of some cue control calming device, usually of the words 'calm control', could be exercised in order to master the anxiety. This seemed to work although some patients reported that they re-substituted the calm imagery. I always explained that the success of the method depended upon regular twice daily (but brief) practise of the imagery and its control between the sessions with me, and I provided an explanatory leaflet (available from the author upon request) to enhance adherence.

Questions about this form of therapy immediately arise. Few have been answered to satisfaction but I shall describe the attempts which have so far been made.

At the time I was developing the ACT method the received wisdom about behavioural methods was that exposure to anxiety was the effective ingredient and without such exposure, in fact or at least in imagination, no benefit would result. The ACT procedure provided a paradigm for testing this view (Constantopoulos *et al*, 1982). Individuals suffering from phobic states were randomised to receive the ACT either with or without exposure to their anxiety-provoking stimulus. People in the first or 'standard treatment' group were introduced to the anxiety-provoking scenarios during the therapy session and were advised to attempt to introduce the same into their homework sessions; moreover, as the therapy progressed they were gently encouraged to approach the actual feared situation. The second group received no instruction concerning exposure to anxiety either in the therapy sessions or in daily life although they received the information that regular practise of the method to the level of induction of calming imagery would have benefit in terms of anxiety reduction. Contrary to expectation there was no difference between the groups. Both showed sustained reduction in anxiety at the final assessment.

The next point to be determined was whether the ACT had enduring effect or lasted only for so long as contact with the therapist was maintained. In order to investigate this (Snaith *et al*, 1992) people attending for treatment of phobic disorder were informed that they would receive the standard six therapist-directed sessions but one group retained contact with the therapist on a monthly basis for six months whereas the other group received no further appointment although, like the first group, they were informed that assessment of progress would be made at three months and a further six months after the six standard sessions. Assessments were made blind to the allotted group; assessments of level of both generalised anxiety and anxiety in the feared situation were made. There was no difference in outcome between the groups but the important finding was that anxiety reduction was progressive throughout the whole period, indicating that the patients had acquired a skill in personal self-mastery which they continued to exercise with increasing self-confidence.

SUMMARY VIEWS

This review of methods necessarily excludes some. For instance, the procedures of biofeedback are included by some reviewers as being basically a meditational approach. Despite the existing reviews of the topic (see above) meditation is a seldom-used therapeutic practice and the reasons for this neglect are worth consideration. Craven (1989) wrote:

> ". . . meditation has not been easily accepted as a psychotherapeutic modality on its own, or as an adjunct to psychotherapy. This is in part due to a paradigm clash between the disciplines from which the techniques of meditation and psychotherapy arise resulting in mutual misunderstanding between the adherents of the consciousness disciplines and adherents of modern psychological formulations".

Apparent simplicity is another factor and Smith (1975) wrote:

> "To the casual observer it may seem implausible that a simple mental exercise could have any effect on widespread problems of neurosis and anxiety".

However, all reviewers point to benefits reported in reduction in anxiety.

Meditational methods fall firmly into the realm of self-management and it may be supposed that few patients would be motivated to take over the major role in their own treatment. This supposition can be contested but careful explanation, preferably with some written guide, is necessary. The advantages of self-management, by meditation or other means, include the abbreviation of therapist time, which has not only financial implications but also confers the ability to offer help to large numbers of people. A further advantage is perceived self-efficacy (Bandura, 1977) and the importance to the individual of the realisation that he or she has played the major part in improvement, with consequent increase in self-esteem having wide implications for generalisation of the beneficial effect.

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(First received 18 May 1998, revised 9 June 1998, accepted 10 June 1998)

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