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Eastern and Western Approaches to Mindfulness

Similarities, Differences, and Clinical Implications

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As the efficacy of mindfulness training in reducing distress and increasing quality of life (QOL) has been demonstrated through well-controlled trials, an increasing number of mindfulness-based programs have sprung up designed for specific populations and circumstances. Summaries of their positive effects are covered in several reviews (Chiesa & Serretti, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Irving, Dobkin, & Park, 2009). While each of these programs has as its goal the reduction of mental suffering, descriptions of their training protocols reveal important divisions and variations between them in their conceptions of the construct of mindfulness and how it is best learned and taught.

The most widely studied programs are as follows:

1. The Buddhist-derived approach popularized by Kabat-Zinn in which the experience of mindfulness is to be found in the experience of meditation practice. This has found its most popular expression in mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT).
2. The conception described by Hayes in acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT) in which the approach to mindfulness is based upon the psychological processes involved in the domination of the literal and evaluative functions of human language and cognition (Fletcher & Hayes, 2005). These programs also draw upon cognitive behavioral therapy but have removed mindfulness from a meditation foundation and freely adapted their training protocols to suit the circumstances of their clinical populations.
3. The approach described by Langer, which derives from social psychological principles, implicitly draws upon elements of each, but approaches mindfulness as the desired end-result of an open and curious orientation to the environment. Its training protocols, described below, focus directly upon encouraging the cultivation of such a stance to experience.

Despite the apparent differences in their understanding and approach to mindfulness, each of these programs has been shown to improve one or more QOL-related variable. So, are these different conceptions and practices primarily semantic and merely ones of emphasis, or do they represent fundamentally different approaches to something they each call mindfulness that somehow arrive at a similar experiential end (Langer & Moldoveanu, 2000)?

The question of commonality is not without controversy. In the meeting of these approaches, discussions of mindfulness and mind–body medicine more generally become a confused and confusing interface between the parsimonious approach of science, and the narratives of religious/spiritual aspiration and meaning. For some clinicians and researchers, the clinical mindfulness training programs are an extension

of their own personal commitment and identification as dharma practitioners. They would claim that the Buddhist view brings a unique and “paradigm-changing” approach to the cultivation of well-being. From this perspective, approaches to mindfulness that do not derive their foundation from Buddhist principles and trainings would be seen as superficial and, at worst, denying patients the opportunity for a richer and more penetrating experience. This belief persists despite wide differences in approach and trainings within Buddhist traditions, and debate as to whether any of these clinical approaches can be said to exemplify the construct described in the Buddhist texts (Rapgay & Bystrisky, 2009). Such particular views stand in contrast with Langer’s more embracing contention that all mindfulness programs simply employ different means to get to a “there” that is the same for each (Langer, 2009). Since no universally agreed-upon criterion is on the horizon, it is unlikely that views on the “true” nature of mindfulness will be reconciled.

But focusing on the parochial question of what mindfulness is and which program most accurately reflects it does not get very far with the more essential question of how best to reduce mental suffering. Each of these programs focuses on qualities of the attending-to-experience that result in improvements in well-being. Therefore, it may be helpful to scrutinize the perceptual skills trainees are asked to cultivate in the training exercises. What is it that people are actually asked to do in the training? Comparisons of the training protocols may provide a more general knowledge of the qualities of attending to experience that facilitate well-being; knowledge that can only improve clinical efficacy, adaptability, and accessibility.

In this chapter, I discuss some issues that bear upon these qualities of attending, as well as similarities and differences between the “there” for the programs and, finally, the means by which they support getting “there.” I follow Langer’s lead in referring to the Buddhist-derived conceptions of mindfulness as Eastern, and the psychological understandings as Western. To provide a foundation for comparing and contrasting the approaches, I first summarize the fundamental features of the Eastern use of the term, and follow this with a description of Langer’s conception, since it is the most conceptually divergent in its approach to cultivating mindfulness. I then discuss the apparent similarities and distinctions between the two approaches and suggest that the clinical goal of both approaches would be better served by shifting the focus to the generalizable attending skills developed through each. Since both conceptions of mindfulness use a phenomenological approach, I use a psychological conceptual framework throughout.

The Eastern Conception and Approach to Mindfulness

The Eastern conception of mindfulness emerges out of the primarily introspective approaches to knowledge extant in India at the time of the Buddha that had the goal of reducing mental suffering. In this view, the root problem preventing mental peace is ignorance of the momentary construction of the sense of self and ownership in the mind, and the associated craving and aversion. The term mindfulness has come to be the accepted English translation of the Pali word “sati” (sometimes translated as awareness), which is one of the mental qualities whose cultivation is considered important in a larger systematic path to dispel that ignorance and the development of

mental peace. But since Pali is no longer a spoken language, and the teachings have undergone adaptations in each of the countries to which Buddhism spread, there is considerable variation in the ways different traditions approach and understand the construct described in the original texts.

As Eastern mindfulness is once again adapted, this time to Western clinical settings, the definitions and terms used to describe it have been cobbled together from traditional and contemporary constructs (Bishop et al., 2004; Brown & Ryan, 2004). And as might be expected, given its religious roots, there is ongoing debate as to where its “true” understanding is to be found (Grossman, 2011). That the word “mindful” had a pre-existing meaning in English has extended the confusion. Nevertheless, programs such as MBSR and MBCT were developed to reflect a spirit of mindfulness as it is generally taught in traditional Buddhist monastic settings. And even as they vary in detail, most definitions of mindfulness in the clinical literature center around that of Kabat-Zinn of “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1994; Shapiro, Carlson, Astin, & Freedman, 2006). A long list of additional descriptive expressions has also been used such as: beginner’s mind, being in the moment, present-centered awareness, embodiment, being rather than doing mode, etc.

Most programs adhering to the Eastern conception first ask the beginner to cultivate the capacity to deliberately redirect attention to an arousal-neutral mind object; most often the sensations associated with breathing. Not only does this exercise develop facility in the use of attention but directing it to this arousal-neutral object creates a relatively calm mental state that can be accessed anywhere and at all times. This mental calm can be cultivated both as an end in itself and as a mental state conducive to the process of further experiential discovery.

Beginning instruction with the realm of sensation in this way has a couple of other advantages. First, it is the realm of experience most easily recognized and perceptually distinguished from the thoughts and feelings that comprise the two other components of everyday experience (Carmody, 2009). As such, it is readily accessible to the beginner. It is also the realm in which delight is most acutely experienced. Second, it redirects attention away from the ongoing internal monologue with its judgments and their accompanying unpleasant affect and to which attention repeatedly defaults. The capacity to distinguish between sensations and cognitions in this way opens the possibility of being able to remain longer in the sensory realm before attention is once again overtaken by the cognition-based internal monologue categorizing (even in novel ways), judging and comparing the experience with imagined or remembered others.

These principles are exemplified in the use of the body scan as an initial mindfulness training exercise. Having established some facility in bringing attention to the sensations of the breathing, attention is moved in a systematic way through the entire body with the instruction to notice whatever sensations happen to be present in each part, and noticing the difference between the sensations, their associated feeling tone, and any cognitive commentary that is present. The instructions also ask participants not to try to change the sensation/thought/affect during the exercise, but simply to acknowledge and accept its presence. This process of perceptual differentiation and re-cognition of the components of experience is sometimes further

supported by giving cognitive labels to them as they are noticed, such as “this is a thought,” “this is a sensation,” etc., or “this sensation has an unpleasant feeling associated with it . . .,” or “this emotion is associated with these sensations, thoughts,” etc. As facility develops, recognition of the components as such becomes increasingly immediate, and some psychological distance from the content of cognitions is cultivated.

The Western Conception of Mindfulness

The approach extensively described and studied by Langer is probably the most radical departure from the Eastern approach in that it focuses upon the lived end-point of being more mindful. This is a mode of functioning that actively engages in reconstructing the environment by continually creating new categories or distinctions and thus directing attention to new contextual cues that may be controlled or manipulated as appropriate (Langer & Moldoveanu, 2000). Mindfulness is contrasted with the mindlessness characterized by processing environmental cues in an automatic and inflexible manner, and where cognition relies on preformed environments determined by automatic categories no longer consciously available for consideration. Approaching situations with curiosity and cognitive flexibility, on the other hand, reveals their novelty, keeping us in the present and open to new information. This mindful perspective-taking increases creativity and more fruitful behavioral responses to situations and problems. The whole individual is said to be involved in this process, and the felt sense of this is one of heightened wakefulness (Carson, Shih, & Langer, 2001)

Langer and colleagues have demonstrated that interventions manipulating the environment to increase awareness of these automatic mindsets, and stimulating new more fruitful perspectives (Langer, Bashner, & Chanowitz, 1985) result in remarkable increases in creativity, attending, and learning. In a widely cited study of longevity in nursing-home residents, (Alexander, Chandler, Langer, Newman, & Davies, 1989), the mindfulness intervention required them to engage in both a structured word-production task and an unstructured creative mental activity task. Subjects were required to think of a word, take its last letter, and find a new word beginning with that letter. They were not permitted to use any word more than once per session, and the level of demand of the program was continually increased to keep it novel and so more mindfulness inducing. Subjects were then instructed to produce words relating to specific categories such as animals, springtime, foods, places, etc. This task did not specify rules for thinking or particular target thoughts. Rather, the individual was asked to think about any topic in new and creative ways. Illustrations were provided such as thinking of unusual uses for common objects, or picking a controversial topic and arguing the side contrary to one’s established opinion. Subjects were asked not to lapse into daydreaming but to actively direct their thinking during the process. They produced words for approximately 6 min, engaged in creative mental activity for 6 min. and closed with another 6 min of word production followed by 2 min of rest.

Commonalities and Differences in These Approaches to Mindfulness

The most readily-apparent principle the approaches have in common is the foundational idea that our experience of the world is shaped in large part by the way we perceive it. In the Western understanding of mindfulness, this principle emerges out of ideas from attribution theory in social psychology in which our experience of the world is reconstructed in the mind by attributing to the objects of the world those qualities detected through our senses. But Langer's work challenged the notion that people act only rationally on their beliefs and are instead often guided by unconsciously processed information. Her mindfulness interventions encourage recognition of unconscious processes shaping inappropriate responding, replacing them with more appropriate ones. In the Eastern conception, the attribution principle is stated explicitly and radically in the Rohitassa sutra, a paraphrase of which reports the Buddha as having said: in this [fathom-long] body, with its senses and intellect, the entire cosmos is created along with the opportunity for its cessation. In this understanding, we are ignorant (unconscious) of the most fundamental processes shaping perception, and the training exercises are geared toward bringing them into awareness.

At this level, then, the two approaches have a good deal in common. In the Western conception, human suffering is created, or at least exacerbated, by people unconsciously employing outdated and inappropriate categories and mindsets in responding to everyday life situations (Langer et al., 1985). This results in lack of spontaneity and reduced awareness of the social and physical world and prevents the possibility of creative change. The training exercises to reduce this mindlessness such as the word "production" exercise or being challenged to think about a topic in a new and creative way by, for example, arguing the side contrary to one's usual opinion on a controversial topic, are designed to counteract this tendency. By intellectually challenging people to develop fresh, creative perspectives and explanations more appropriate to the situation at hand, the exercises make more apparent the automatic/unconscious categories that have been shaping responses. The language of these mindfulness instructions also reveals the influence of the classical Greek method of enquiry that it shares with cognitive therapy where solutions are sought through exposing conceptual flaws, and knowledge and happiness are furthered by creating a more rational and appropriate path. This is a training that is dynamic and values perspective taking as a way of better understanding the world.

The intellect-centered exercises, such as the word-production challenges, have features in common with exercises used in some Eastern approaches to mindfulness training. For example, one of the functions of the koans, used in some Zen traditions, is to foster curiosity about rational cognitive processes, albeit by frustrating their attempts to find a solution. Challenging the primacy they typically hold on attention exposes the perceptual filtering preventing more immediate experience of the world. The attribution principle is exemplified also in the "nine dots" puzzle, an exercise included in the MBSR class handbook and in management classes, to illustrate how the usual ways of thinking and perceiving can prevent us from recognizing that solutions to some problems emerge only when we "think outside of the box." Many MBSR programs also use the old/young woman trompe l'oeil picture from Gestalt psychology figure/ground experiments as a way of helping participants recognize the unconscious and automatic processes at work in shaping the way we typically perceive the world. Similarly, the compassion generating exercises commonly included in MBSR, MBCT, and DBT

(Birnie, Speca, & Carlson, 2010; Shapiro, Brown, & Biegel, 2007; Van Dam, Sheppard, Forsyth, & Earleywine, 2011) are another way of exposing, for some, the unrecognized judgment-related categories and negative affect they may hold toward their own self, or others.

In these ways, then, the training for both approaches can be said to promote a mode of functioning characterized by curiosity, recognition of preformed categories, appreciation of the novelty of every situation, and actively engaging in reconstructing the environment and stimulating new perspectives.

However, while the Western approach is said to involve the whole individual in the process of enquiry, the training focuses primarily on constructions of the intellect; fostering an intellectual curiosity about concepts being used and whether they are appropriate to the situation and challenging trainees to create new ones. The senses are employed in the service of stimulating the intellect. In the Eastern approach, trainees are similarly encouraged to be curious about old habits of attending and aware of the concepts shaping their perception, but the training exercises are more perceptually granular and direct attention to the sensory realm as an end in itself. Cultivating awareness of bodily sensations is foundational in the Eastern approach, including physical sensations unfiltered by conceptual categories. The body scan, for example, directs curiosity and attention toward bodily sensations, as sensations, throughout the body, especially those usually missed because of their subtlety or as a result of inattention to the body parts in which they are occurring. And even though both approaches encourage trainees not to lapse into daydreaming, the Western approach to training does not appear to give particular attention to cultivating awareness of when this has occurred.

Eastern instructions for developing the capacity to become aware of bodily sensations also include facility in redirecting attention to the sensations of breathing as an effective way of reducing arousal. In this respect, it is interesting to note that in the study of the nursing-home population referred to above, no differences were found in anxiety, depression, or appreciation of self and the environment following an intervention using the Western training exercises. Reductions in anxiety and depression are, however, a usual outcome following Eastern training and are related to the emotion regulation that is associated with attentional regulation.

Mindfulness training instructions can be said to provide both encouragement and the means to recognize and discern one or more of three features of everyday mental activity, and how they impact well-being (Carmody, 2009): first, by supporting recognition that the apparent seamlessness of everyday experience comprises three experiential components (thoughts/images, sensations, and their pleasant/unpleasant/neutral feeling tone) that can be perceptually discriminated and that these components form conditioned cycles of association. Second, facility in attention regulation provides the trainee the opportunity to notice which component of experience the attention is on at any moment and, if they so choose, to redirect it to a more neutral or positively valenced object. This experientially reveals to the person the principle that arousal levels follow the affective valence of the object of attention. The other option, of refraining from attempting to change what is noticed, gives the person an opportunity to develop tolerance for intense experience and emotion regulation. Third, in the process of this learning, the trainee recognizes that the three components

comprising experience are events occurring in the field of awareness, bringing about a decentering or meta-awareness that creates a psychological distance from the components' content.

How recognition of these three features is best internalized so as to obtain the gains in well-being resulting from them differs in the Eastern and Western approaches. The Eastern tradition emphasizes the necessity of the meditation practice characteristic of those programs, and reductions in distress are indeed related to practice (Carmody & Baer, 2008). And there is evidence that the learning results in a lasting increase in well-being (Pbert et al., 2012). Just how much practice is required remains an open question. The Western approach relies upon exercises that intellectually challenge existing categories or immersion in a structured environment that exposes them, and the derived benefits appear to be immediate. Proponents of meditation would contend that it provides deeper insight into the process by which all mental life is constructed from moment to moment, both the functional and less than optimal; and that this is a quite different approach to change than considering just the appropriateness of a category's content, or continually coming up with new, albeit creative and novel, cognitive categories and processing solutions to an ongoing and changing situation or problem. Whether the more perceptually detailed training of the Eastern approach, and the time spent in meditation practice, results in additional benefits not immediately apparent is an empirical question deserving of study. For the time required to complete these programs is a significant barrier to many people, not to mention the exotic associations meditation has in many people's minds.

Perhaps, however, the most important source of misunderstanding in the "there" between Eastern and Western approaches is in the Rohitassa sutra phrase that states not only is the entire cosmos created in the body, but also it contains the *opportunity for cessation of the entire cosmos*. As the Buddhist-derived practices have been integrated into Western programs, this radical notion of cessation often stands unstated in the background of discussions of clinical mindfulness. Cessation is the ultimate goal in the Buddhist system and comes through experiential recognition of the illusion of a permanent and unchanging self—the coalescing of experiential components comprising it are recognized as occurring in a more fundamental and unchanging field. This insight results from adherence to the prescribed eightfold system in which formal mindfulness practice plays an important role linking back to the "clear seeing" referred to in the traditional roots of mindfulness (Thera, 1992).

This cessation is, however, rarely the goal of trainees in clinical settings where mindfulness is introduced. Most patients are more interested in obtaining the situational relief from anxiety and depression that comes with the relatively limited amount of mindfulness practice recommended in the programs. This is illustrated in one of the few MBSR long-term follow-up studies (Kabat-Zinn, Lipworth, Burney, & Sellers, 1987) that found that the majority of participants did not maintain a regular meditation practice; the learned technique they used most frequently and found most helpful was the simple act of redirecting attention to the sensations of breathing at times of stress.

It may be that patients of certain temperaments will find one approach more attractive than the other. No doubt some people experience delight when engaging in challenging mental/conceptual activities characterized by Langer's and colleagues' training exercises, and through them learn to increase the opportunity for greater well-

being. Such people may flee from an exercise like the body scan, finding it exquisitely uncomfortable or boring. For others, it is the realm of sensation that holds most delight; a realm that often becomes neglected in the process of socialization. For them, this rediscovery is a revelation and a comfort. They may find conceptualizations boring and diminishing of their delight, and fear becoming “lost in their heads.” The different types do not often understand or appreciate the other, and although they can learn to appreciate the other better, and it sometimes becomes a source of enrichment, the fundamental difference remains.

In Conclusion

Eastern and Western approaches to clinical mindfulness programs appear to vary in their understandings of the construct. Training in each, however, results in improvements in well-being. Proponents of the Western approach contend that all mindfulness programs simply employ different means to get to a “there” that is the same for each. But without an agreed-upon criterion reference, the question of the conceptual independence of each, and which is the more “true” understanding of mindfulness is unlikely to be resolved. The more general and clinically profitable question to ask is what if any are the therapeutic properties they may have in common. And since programs ask participants to attend to their experience in particular ways, this question can be approached by examining the instructions trainees are asked to follow in their everyday lives, delineating the qualities of attending the programs share, and considering the ways each approach can complement the other. This approach can result also in a better understanding of processes that are common across many mind–body training programs.

References

- Alexander, C., Chandler, H., Langer, E., Newman, R., & Davies, J. (1989). Transcendental meditation, mindfulness, and longevity: An experimental study with the elderly. *Journal of Personality and Social Psychology*, *57*(6), 950–964.
- Birnie, K., Speca, M., & Carlson, L. E. (2010). Exploring self-compassion and empathy in the context of mindfulness-based stress reduction (MBSR). *Stress and Health*, *26*(5), 359–371.
- Bishop, S., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., . . . Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, *11*(3), 230–241.
- Brown, K. W., & Ryan, R. M. (2004). Perils and promise in defining and measuring mindfulness: observations from experience. *Clinical Psychology: Science and Practice*, *11*(3), 242–248.
- Carmody, J. (2009). Evolving conceptions of mindfulness in clinical settings. *Journal of Cognitive Psychotherapy*, *23*(3), 270–280.
- Carmody, J., & Baer, R. A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioral Medicine*, *31*(1), 23–33.

- Carson, S., Shih, M., & Langer, E. (2001). Sit still and pay attention? *Journal of Adult Development*, 8(3), 183–188.
- Chiesa, A., & Serretti, A. (2011). Mindfulness-based interventions for chronic pain: A systematic review of the evidence. *The Journal of Alternative and Complementary Medicine*, 17 83–93.
- Fletcher, L., & Hayes, S. C. (2005). Relational frame theory, acceptance and commitment therapy, and a functional analytic definition of mindfulness. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, 23(4), 315–336.
- Grossman, P. (2011). Defining mindfulness by how poorly I think I pay attention during everyday awareness and other intractable problems for psychology's (re) invention of mindfulness: Comment on Brown et al. (2011). *Psychological assessment*, 23(4), 1034–1040.
- Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 78(2), 169–183.
- Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary Therapies in Clinical Practice*, 15(2), 61–66.
- Kabat-Zinn, J. (1994). *Wherever you go there you are*. New York, NY: Hyperion.
- Kabat-Zinn, J., Lipworth, L., Burney, R., & Sellers, W. (1987). Four-year follow-up of a meditation-based program for the self-regulation of chronic pain: Treatment outcomes and compliance. *The Clinical Journal of Pain*, 2, 159–173.
- Langer, E. J. (2009). *Counter clockwise: Mindful health and the power of possibility* (Vol. 22). New York, NY: Ballantine Books
- Langer, E. J., Bashner, R. S., & Chanowitz, B. (1985). Decreasing prejudice by increasing discrimination. *Journal of Personality and Social Psychology*, 49(1), 113.
- Langer, E. J., & Moldoveanu, M. (2000). The construct of mindfulness. *Journal of Social Issues*, 56(1), 1.
- Pbert, L., Madison, J. M., Druker, S., Olendzki, N., Magner, R., Reed, G., . . . Carmody J. (2012). Effect of mindfulness training on asthma quality of life and lung function: a randomised controlled trial. *Thorax*, 67(9), 769–776.
doi:10.1136/thoraxjnl-2011-200253
- Rapgay, L., & Bystrisky, A. (2009). Classical mindfulness. *Annals of the New York Academy of Sciences*, 1172(1), 148–162.
- Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, 1, 105–115.
- Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology*, 62(3), 373–386.
- Thera, N. (1992). *The heart of Buddhist meditation*. Kandy: Bhuddist Publication Society.
- Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders*, 25(1), 123–130.