

## Meditation and Mental Health

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### ABSTRACT

*Meditation has contributed to mental health in India since the beginning of its civilization. It is now used along with psychotherapy in many places in the West. It should be studied by clinical psychologists in India, both theoretically and practically; the result of this work could be one of their important contributions to the emerging world psychology. The state of 'deep trance' is a single common basis for relaxation, hypnosis, mental imagery and meditation. The psychological mechanisms through which meditation heals the mind are studied in some detail. The indications of meditation for various psychopathological patients are suggested.*

**Key words :** Meditation, transpersonal psychotherapy, hypnotic trance, emotional abreaction.

It may seem paradoxical to see a Western psychiatrist write an article on meditation in an Indian journal; there should be more than enough Indian psychologists to treat this subject; but my itinerary for research has made me a resident in India for a decade.

The specificity of psychotherapy in India has already been dealt within publications like 'Psychotherapy in India' by H.G. Singh or 'Psychiatry in India' by De Sousa. In the West, the most active current for the meeting of East and West psychology is the Transpersonal Movement, with its journal which has been publishing good level articles on meditation research and psychology for over 25 years. They have held their first conference in Bombay in 1982. I went from India to France in 1991, to talk at the Conference of the European branch of the movement.

There are broadly four types of psychotherapies: inspired by psychoanalysis, behavioural, humanistic and transpersonal. Humanistic psychology was a reaction to psychoanalysis which had a tendency to reduce inner life to its verbal expression, and against

behavioural therapy which was reducing the richness of the psyche to elementary behaviours; humanistic therapies stressed the manifestation of emotions. But that was a kind of reductionism too, since emotions are not the whole picture. Transpersonal psychology emphasized the limitations of a psychology restricted to the ego and introduced the notion of a reality beyond ego and personality; this notion is indeed quite familiar to the implicit psychologies of various traditions. In India to my knowledge, humanistic psychotherapy is not much represented in its Western form, but the emotional therapy is quite well known in traditional setting through sessions of trance (not only in the famous Balaji temple between Agra and Jaipur, but all over the country). Taking into account the part of the individual which is beyond the ego, is done practically by quite a few psychotherapists in India when they practice, but they seldom care to give to this feeling a theoretical expression as it is done in the West. An exception to that are two books published first in the West but available in an Indian edition by late Swami Rama (of Indian origin, but who studied some psychology as well in the West)

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and Swami Ajaya (an American Ph.D. in psychology)'Yoga and psychotherapy' and 'Psychology East and West— A Unifying paradigm'.

We could define meditation in a broad way as it is done in Katha Upanishad (4-1) 'Turning one's sight towards oneself'. More specifically, meditation is a non-analytical, non-verbal method to look at oneself. It is an intuitive presence to the messages of the body from moment to moment and an attempt to perceive a steady consciousness above the continuous noise coming from automatic sensations and the thoughts they induce. There has been a number of scientific studies on meditation. Walsh and Shapiro (1984) in a kind of encyclopedia on the subject reproduced the integral text of fifty research papers or so, and quoted 700 other studies, 90% of them conducted after 1970. Since that time, research has continued, both in physiology and in psychology. Some years ago, in the United States only, there was more than 4000 thesis written on meditation. In my own book on meditation and psychology (1996), I try systematically to review the different levels of action of meditation: on the body (self-healing, placebo effect, etc....), **on the states of consciousness (deep trance, awoken dream and so on...)** on emotions, ego and mental imagery. I discuss the role of endorphins in the intense well-being experienced by advanced meditators, the mechanisms and results of attention and in a last chapter the perspective of pure consciousness.

I cannot easily summarize my ideas on these various subjects. I prefer to consider a particular theme and study it more in detail. For instance we could reflect on how deep trance is effective to change the mind. Deep trance is a stage reached by different means: relaxation, classical or Ericksonian hypnosis, in the wake of emotional abreactions, in the methods of creative visualization or mental imagery, and of course meditation. I came to the conclusion that whatever the technique, what they

have in common is a deep state of consciousness where mind and body communicate easily, where the unconscious clearly pops up in the conscious and where suggestions coming from outside or from oneself are well received and integrated. We will now focus on the mechanisms of this state which we choose to call deep trance. We will be particularly inspired by E.L. Rossi in this description, Milton Erickson's disciple, and his 400 pages comprehensive book on the psychobiology of healing (1993). As a conclusion, we will consider in which way some kind of simple meditation can be indicated for patients.

## MECHANISMS OF THE THERAPEUTICAL ACTION OF DEEP TRANCE

Memory is linked with mood : we better remember events which occurred in a sad state if we are sad. Experiments of memorization while drunk, or under the effect of amphetamins (exciting) or amobarbital (depressing) have been conducted. Subjects had to take the substance again to remember well what they had memorized in the same state (Rossi, 1993). This is also true for emotional states, body postures (see the memory of a dream which comes back when one takes the same posture than when it happened) or the memory linked to a place, even to a season. Some depressions, for instance, recur in the same period of the year regularly. This sort of conditioning linked with the state is used when meditators are advised to practice at same time of the day in the same place and in the same posture. To facilitate the integration of meditation to daily life, it is also recommended in some Buddhist school like Zen to meditate with open eyes. However, this memory linked to the state can be an obstacle as well and explains the difficulty for meditators to transfer the experiences they have had while practising into their daily life. There is no simple recipe for that, what matters is a global maturation.

Let us see now the main mechanisms of action involved in deep trance.

**1) Facing up to the symptom.** In this state, deep fears may arise, they must be faced. Fearlessness is basic quality of a meditator. Advising the patient to go 'in the sense of the symptom', to listen to it has often been called paradoxical injunction; but a symptom, when it arises, wants to tell us something, and the paradox is rather in the usual habit of silencing it rather than listening to it. The crux of the matter is to go progressively towards the place of suffering. We could speak of a mechanism of 'association-dissociation': by a chain of mnemonic associations, one comes back to the traumatic event and there, thanks to a deep relaxation, one dissociates the traumatic image from the negative underlying emotion, from the tension which was automatically associated with it, to replace it with a deep rest. Many therapies agree with this mechanism, each with its particular vocabulary: in psychoanalysis, they will speak of 'following the resistances', to be a mirror of the distortions of the patient' etc.... In behaviourism, they will evoke the implosion, the flooding by the symptom, the stimulus to satiety... In gestalt therapy, the patient will be asked to stress the symptom rather than to avoid it, and in the systemic therapies, they will speak of paradoxical injunctions, of prescribing the symptom or the relapse, or else of double bind.

In meditation, unlike in psychoanalysis, associations are only half-free, there is a thread (mantra etc..) and while following this thread, distractions arise, but the meditator dissociates from them and comes back repetitively to this basic state of well-being which characterises meditation. So, this mechanism is more of 'free dissociation' than of 'free association'. Meditation enables one to go into the symptom and into the dark side of his being thanks to the quality of fearlessness, as we mentioned earlier. Moreover, deep understanding of the functioning of the mind by pairs of opposites naturally leads to accept the symptom we would like to suppress and to acknowledge that it has

something to tell us, and may even suggest us a way out. Practically, the immobility of the meditator is a means to face up to the resistances, every small movement corresponding to the beginning of an escape. If one meditates for a minimum amount of time during each session and as a whole everyday, then one is prevented from running away from oneself by reducing the time of meditation. A method of *Vipassana* consists in sweeping each part of the body one after the other with consciousness, and to stop in front of insensitive, 'blind' parts until they become felt.

It allows the opening of a window on the unconscious, thanks to a suppressed sensation which shows us why it was suppressed: when it comes back, beginnings of images appear in the mind and by association give a clue to understand the lesson for the suppression.

In the life of *yogis*, we read that during their *samadhis*, the breath used to slow down, be superficial and even stop completely for some time. This appears to mean the *yogi* directly plunging into the fear of suffocation and death, and once in it, learn how to smile about the situation. Hypoxia (decreased oxygen in the blood) probably favours the release of hormones associated to euphoria (cortisol and perhaps endorphins) and thus creates a fundamental mechanism of desensitization. The basic fear of death (stopping of the breath) is associated with an intense well-being, hence the desensitization. In Tibetan tradition, the practice of *samadhi* and the preparation to death are considered as parallel process.

**2) Evaluating the symptom.** This method is related to the first point, inasmuch as it allows one to face up to the symptom: the patient is asked to rate on a scale from 1 to 100 the intensity of his symptom, and then to see how it evolves during a deep trance. This persuades him of its impermanence, because most of the time it eventually disappears, at least for a while. In this sense, that method can be compared to meditation

where one realizes the impermanence of the sensations, be they painful, pleasant or neutral, by simply observing them: thus, one gradually gets rid of their influence on the basis of the mind.

**3) Coming back to the resources which are already present in the subject.** This base for therapy is typically a foundation of meditation as well: resources permanently present at the core of ourselves correspond to the *Self*, or the true *Nature*, or the *Divine* according to the tradition we consider. It is interesting to note that the Alcoholic Anonymous (AA) ask the patients to use this power to detoxify themselves; and they are one of the most effective groups to cure addictions.

**4) Making the mental functions communicate between each other.** The lack of communication between the mental functions is one of the reasons of inner suffering. Too often, verbalization, mental imagery, emotions and sensations are like tight compartments, and therapy clearly aims at circulating information between them and meditation does that as well. In practice, regularly returning one's attention towards the body while the mind drives distractions, away from it as well makes a real communication between these different levels possible.

**5) Ultradian Regeneration.** Rossi stresses the global versus the specific efficiency of twenty minutes rest sessions when the need is felt during the day. He thus disagrees with the claim of various schools of psychotherapy which want to appear very specific to look as scientific as possible. In fact, this relationship between specific and scientific should be allowed to be questioned. Global efficiency, as soon as it is proved, is scientific. Moreover, behind claims of specificity of action, commercial vested interest may creep in: "Follow my method, they say, it is the most specific, the other ones will never give you such results". The interest of a general study on meditation and psychology is to show the common basis of different methods. To come back to the ultradian (i.e.,

recurring several times daily) rhythm, we may notice that it is often advised to retreatants in Tibetan Buddhism to start by repeating often during the day short sessions of meditation for fifteen or twenty minutes when they feel like. It seems they had discovered the process of ultradian regeneration a long time ago...

**6) Emotional abreaction.** Emotions are a basis of the psyche, and they have their place in therapy as well as in meditation. Emotions should not play with us, but we should play with emotions. Three types of abreactions can be distinguished: pathological, therapeutic and meditative.

The pathological abreaction corresponds to the hysterical fit, which is very theatrical and little therapeutic; however, it was noticed that until the beginning of this century, hysteria could be manifested physically without guilt and that at the same time psychosomatic diseases were little developed; now-a-days hysteria of conversion is less common but psychosomatic diseases are more so; and the latter, unlike hysteria, can kill (through high blood pressure, stress related diabetis, etc....)

Therapeutic abreactions occur during the sessions: they are effective, but they can nevertheless be suspected of theatralism, be it that the patient wants to please the therapist or frighten him.

Meditative abreactions: usually happen inside, although they may also manifest outside through what is called '*kriyas*' (spontaneous movements). They are subtle, but real. Their only witness is the Witness, i.e., the Self. The energy they release during meditation can be directly oriented towards inner evolution.

**7) Other mechanisms.** We will limit ourselves to enumerating them, because we cannot study them in detail in the context of this article. If deep trance is practiced for a long time, there is a sensorial deprivation effect. Going back to oneself regularly through the practice cuts the root of defence mechanisms like projection, transference, etc.... What is sown in meditation develops in the

mind, this corresponds to the mechanisms of positive biofeedback. In that state, psychic life is accelerated, inner conflicts are experienced more intensely, but solved more quickly. In the traditional context, even when the meditator practices alone, he feels one with others who meditate at the same time, and with those who have followed the same path before. There is definitely what could be called a group effect, even if the other members of the 'group' are not physically present: what matters in psychology is the strong belief that they are.

The last mechanism of that particular type of deep trance which is meditation, is the 'mechanism without mechanism': fortunately, everything is not reducible to mechanisms in meditation, which aims to manifest this very consciousness which perceives the play of mechanisms. The increasing importance given in psychology to the memory linked to the state of consciousness rediscovers three pillars of meditation: first, our ego is not the steady entity it appears to be, but a changing mosaic of variegated states; second, mental states evolve from moment to moment, according to the memories which are brought back by a particular state of consciousness or mood at that time, they do not have the continuity which is superimposed on them afterwards. Third, it may be noticed that what is liberating in therapy or meditation is not so much the depth of the 'trance' than the quality of the dissociation between psycho-physical phenomena and the one who observes them. Thanks to this dissociation, a subject can feel that his leg is being operated on but he is not identified to the pain. To take a concrete example of this, the well-known sage Ramana Maharshi had been operated for a tumor on his arm without anesthesia; it was at the end of his life. When he was asked how much pain he had, he answered peacefully: 'It is like the sting of a million scorpions, but it is for the body, not for my Self'. Until the end, he remained quiet and luminous. Then, when he passed away, his face expressed an intense pain. This means that as long as consciousness was there, the

dissociation was functioning, but once it left, the body followed its course. This dissociation between the observation and what is observed (*drishti and drishya*) is much more than a therapy. It is a spiritual path in itself, the path of *Jnana* (Knowledge).

Beyond the psychological mechanisms of deep trance and meditation, what is basically active in the process is attention; and above all, attention is a practice, not a theory; there ends psychology. This is exemplified in the following story: 'A Zen monk was unhappy because his meditation was not good. He approached his master who was observing silence at that time and explained his predicament to him. The master answered on a paper which he handed to the disciple. There was a single word on it: 'Attention'. He asked for further explanations, and the master added something on the paper. The disciple read 'Attention, attention'. Annoyed, he asked for further clarifications. The master wrote a little more on the paper, handed it back to the disciple who read: 'Attention, attention, and attention means attention'.

#### CAN MEDITATION BE USED WITH PATHOLOGICAL SUBJECTS?

To be clear, it is better to distinguish between meditation in the ordinary sense of the term which means a daily practice of fifteen minutes or one hour, and an intensive practice for the whole day during closed retreat, and may be for half the day during the periods between these retreats. In the second case meditation is definitely not indicated for psychopathological patients, because it intensifies everything, good or bad, and puts a strain on the weak points of the personality. Traditionally, an aspirant for intensive meditation must be '*adhikari*' (ready) and able to observe the rules of conduct (*yama-niyama*) rather well. In the case of patients, these prerequisites are not fulfilled. However, simple practices can be useful for them if performed for a short duration during brief sessions which can be repeated several times daily. What

happens during these sessions should be freely discussed with a therapist who has some experience of meditation. Thus, it will give the patient a habit of 'mental hygiene', which will be the best guarantee for the stability of his long term improvement. I have noticed that including some traditional practices in the therapy—however simple they may be—represent a clear encouragement for the patient, even in France where tradition is much less trusted than in India. Patients can find a way out of the psychopathological labeling and enter the general stream of humanity which is certainly suffering, but which has since long found ways out of suffering.

There are two types of meditation, the first where one concentrates the mind, the second where one observes it. Concentration is a basis for beginners and for patients as well. It gives some knowledge and capacity to master the mind, even if it does not solve every problem. Observation of the mind is more difficult for someone who has a strong tendency towards dispersion as most patients do, but can be done in a limited way with the help of the therapist. There must be a clear method for that: it may be observing sensations throughout the body in a regular order, or another method. Usually, coming back to the body is beneficial because it keeps one away from mental wandering, and in fact shows the basis of these wanderings which are the variations of sensations; but this method used for instance in *Vipassana* is not indicated for hypochondriac patients who have already a tendency to be focused on the smallest sensation and to interpret it as the beginning of a serious disease.

The main question is to know if the technique of meditation which is prescribed should go in the sense of the symptom or against it: let us consider an obsessional neurotic for instance. He likes repetitive and ritualized methods: should one give him this sort of technique to practice, or on the contrary insist on the spontaneous aspect of meditation? Or for a depressive who has a psychomotor inhibition: should one advice him relaxation

or on the contrary dynamic techniques? Perhaps a balanced attitude consists in advising first something which goes in the sense of the symptom—some very precise technique for the obsessional, relaxation for the depressive; in this way, they will get interested in the practice. And then, very gradually, one introduces an 'antidote' to the symptom, pure observation of the mind for the obsessional, technique with physical, dynamic movements for the depressive.

In any case, the therapist should be careful about the taste of the patient for these techniques: nothing can be done without his active interest and collaboration; the therapist should closely follow the experiences the patient gets. The real rule is 'try and see'; there is no need for the therapist to get a false feeling of security from simplistic recipes. The one who helps should have a personal experience of meditation besides his proficiency as a therapist; he should remember that helping someone else is not a mechanical work and that—fortunately—it remains an art.

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