The Effect of Home Buddhist Mindfulness Meditation on Depressive Symptom in Major Depressive Patients

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Background: *Major depressive disorder (MDD) is the important cause of disability in the world. Major depressive patients that are not respond to the first and second drugs are about 67% and 33%, respectively. Therefore the effective treatment is urgently needed.*
Objective: *To examine the effect of Buddhist mindfulness meditation combined with standard treatment on depression and quality of life in major depressive patient compared to the control group.*
Material and Method: *It was a quasi experimental study. The subjects with age ranged 20-70 years old and had Thai Hamilton rating scale for depression 13-29 scores were divided in two groups, each group contained 30 persons. The intervention was Buddhist mindfulness meditation which meditated everyday at least 5 days/week, 15 minutes each time, for six weeks. Both groups were treated with standard treatment. All subjects were tested using Thai Hamilton rating scale for depression, and WHOQOL-BREF-THAI questionnaire at baseline and every week for six weeks. Compare the result of Buddhist mindfulness meditation by independent t-test and Chi-square.*
Results: *The difference between the average of Thai Hamilton rating scale for depression (17.33$\pm$5.22 in meditation group and 17.67$\pm$6.33 in control group) and WHOQOL-BREF-THAI questionnaire (29.97$\pm$15.95 in meditation group and 31.33$\pm$12.12 in control group) before and after meditation was not statistically significantly among the two groups ($p>0.05$). However, it found that at the 6th week, 28 patients from the meditation group (93.3%) and 22 patients (73.3%) from the non-meditating group improved from depression. When examining by the Chi-square, the meditating group had a statistically significantly different in the number of patients that improved from depression (p-value = 0.04).*
Conclusion: *At the 6th week of Buddhist mindfulness meditation, significant number of patients were improved from depression. Thus, Buddhist mindfulness meditation should be included in the treatment of depression.*

Keywords: *Depression, Buddhist mindfulness meditation, Quality of life*

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Buddhist mindfulness meditation stop all thinking that cause stress and can decrease plasma cortisol[1]. Therefore, the Buddhist mindfulness meditation together with standard treatment (SSRI and psychoeducation) may improve depression more than the standard treatment alone.

Major depressive patients do not respond to the first drug about 67% and do not respond to the second drug 33%. There are resistant depression about 33%[2]. The Buddhist mindfulness meditation can improve depression and may decrease the opportunity to turn to resistant depression[3-5].

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The researchers in the past found that persons who always practice mindfulness meditation have lesser stress[6]. There are evidences that plasma and salivary cortisol can be decreased by mindfulness meditation[1,7]. Several studies have observed at immune parameters in patients with cancer, the mindfulness meditation tended to restore cytokine levels and natural killer cell activities toward normal levels[8]. In healthy people, meditation increased the antibody titer to influenza vaccine[9], lowered the stress-induced increase in interleukin-6[10] and decreased C-reactive protein[11]. In addition, a person who practice meditation has a lower level in cortisol compared to whom that does not practice[10]. The effects of mindfulness meditation on stress and serum cortisol level which regulate the stress pathways including hypothalamic-pituitary-adrenal axis which functions by releasing corticotrophin-releasing hormone (CRH) from

the hypothalamus to stimulate the pituitary gland to release adrenocorticotropic hormone (ACTH). Then, ACTH stimulates the adrenal cortex to release cortisol. The activation of this stress pathway from psychological stressors as well as physical stressors stimulates noradrenalin secretion[12,13]. Both pathways cause several physiological changes. For example, changes in cortisol, ACTH and noradrenalin in the blood stream activate the sympathetic system resulting in an increase in pulse rate and blood pressure which can cause hypertension related to depression[14,15].

The reason explaining the beneficial effect of mindfulness meditation is that it stop all thinking activated by external stimuli that cause stress, anxiety, depression, and discomfort. Mindfulness meditation is mind development, make immune for mind, peaceful mind that increase quality of how to solve problem. Mindfulness meditation improve physiology of body[16,17], and health[18].

The meditation consists of focusing the attention on the breathing, observing the breath as it enters and leaves the nostrils[19], and at the same time, trying to notice any sensations felt at the points of entry and exit. The goal of mindfulness meditation is to reach a state of thoughtless awareness, during which a person is aware of sensations at the present moment.

The aim this study is to investigate the effect of Buddhist mindfulness meditation on depression and quality of life of major depressive patient compared to control group.

Material and Method

Study design and participants

This study was approved by the Human Ethics Committees of the Faculty of Medicine, Srinakharinwirot University, Bangkok, Thailand. It was a quasi experimental study. All subjects signed informed consent prior to participated the study. The subjects were new cases which required to meet the DSM-IV-TR criteria for MDD and have Thai Hamilton Rating Scale for depression in the range of 13-29 scores. They were divided into two groups by Lottery Method of Sampling. They received the standard treatment (SSRI and psychoeducation), no co-intervention (massage, musictherapy, aromatherapy) and have completed a questionnaire of personal information and the Thai Hamilton rating scale for depression, and WHOQOL-BREF-THAI questionnaire. The intervention group received mindfulness meditation. SSRI dosing was depended on clinicians' judgment for efficacy and tolerability.

Participants

Selection of volunteers to join the project, volunteers that willing to participate in the project comprised of 60 person with age ranged 20-70 years old.They were major depressive patients of HRH Princess Maha Chakri Sirindhorn Medical Center, Faculty of Medicine, Srinakharinwirot University, Thailand. Selected patient fulfilled the inclusion criteria and have a score in the Thai Hamilton rating scale for depression in the range of 13-29 points. Inclusion criteria included the following; 1, people who were able to practice mediation as specified; 2, major depressive patients that have score in the Thai Hamilton Rating Scale for depression in the range of 13-29 points and they were new case. Exclusion criteria included the following: 1) have auditory or visual hallucinations; 2) a history of schizophrenia, organic mental disorder, schizo-affective disorder, current abuse of alcohol or other substances, bipolar disorder, diagnosis of obsessive-compulsive disorder; 3) regular meditation practice (meditating more than three times per month; 4) taking any other psychotropic medications with in six weeks prior to study; 5) persons who dislike meditations; 6) alcohol or substance abuse or dependence; 7) had significant or unstable medical illnesses. Discontinuation criteria included the following: 1) people unable to practice meditation for 15 minute, 5 days in a week; 2) persons who have incomplete data before or after the treatment.

Methods

Step 1

Study depression and quality of life of major depressive patients by psychiatric assessment as follows: Thai Hamilton rating scale for depression, this questionnaire was translated into Thai by professor Manot Lortrakul et al[20]. The test consists of 17 items concerning depression in many aspects. Each item consists of 4 choices. From the research, the questionnaire was tested in 50 depressed patients using the Hamilton Rating Scale for Depression as an external standard. The internal reliability and concurrent validity were good (Cronbach alpha = 0.858; r = 0.72).

The subjects were evaluated using the Thai Hamilton rating scale for depression every week for 6 weeks. Improvement was indicated by Thai Hamilton rating scale for depression which score = 0 (Table 1).

The Thai version of the brief form of the WHO quality of life assessment instrument (WHOQOL-BREF-THAI) was developed from WHOQOL-100. This questionnaire is objective test that was translated into

Table 1. Depression levels of HAMD score

Depression level	HAMD score
No depression	0-7
Mild depression	8-12
Less than major depression	13-17
Major depression	18-29
Severe major depression	30+

Thai by Suvat Mahatnirunjul et al[21]. The test consists of 26 items, each with 5-point Likert scales including 4 domain, physical domain (7 items), psychological domain (6 items), social relationships domain (3 items), and environment (8 items). From the research, the questionnaire was tested with the samples (208 men and 459 women) using WHOQOL-100 as an external standard. The internal reliability and concurrent validity were good (Cronbach alpha = 0.8921 and 0.8406; r = 0.6516). This study, the WHOQOL-BREF-THAI questionnaire was used to evaluate every week (week 1-6).

Step 2

Buddhist Mindfulness mediation practice consists of sitting right foot on left foot, close the eye focusing the attention on the breathing, observing the breath as it enters and leaves the nostrils[19], and at the same time, trying to notice any sensations felt at the points of entry and exit. The goal of mindfulness meditation is to reach a state of thoughtless awareness.

In this study, basic Buddhist mindfulness mediation that everyone can do was used. The achievement of meditation was that they can meditate for 15 minutes focusing the attention on the breathing, observing the breath as it enters and leaves the nostrils[19]. If it failed, try again by focusing the breath as it enters and leaves the nostrils in the same position (sitting right foot on left foot, close the eye). In the first session, the subjects were taught by a meditation instructor who had 6 years of experience. The meditation instructor was satisfied with the subject's mindfulness mediation and the subject who satisfied with mindfulness meditation were included in this study.

All subjects receiving Buddhist mindfulness mediation were asked to practice for five days per week and to complete a daily home practice schedule in which they recorded whether or not they had done mindfulness mediation. The schedule must be taken with him/her every week. Home practice schedule were brought to the meditation instructor at the end of each week so that any difficulties with home practice could be advised.The experimental group practised meditation for 15 min, daily before sleeping for 5 days in a week, for 6 weeks, otherwise the data were removed from the experimental group.

Statistical analysis

Sample size was calculated by using N4 studies program. The mean outcome of Hamilton rating scale in the treatment group and control group was 4 and 7, respectively. The type I and type II errors were 0.05 and 0.1. Descriptive statistics were used to summarize baseline characteristics as percentages or mean $\pm$ standard deviation (SD). The Chi-square, Fisher's exact test, and independent t-test were used to compare the groups on demographic and depression and quality of life measures at baseline. The Chi-square and independent t-test tests were used to compare the result of the intervention. A p-value of <0.05 was considered statistically significant. Analysis was done using the SPSS software version 19.0.

Results

Subject characteristics

Demographic and the mean scores for depression and quality of life measures at baseline of enrolled subjects are shown in Table 2. Most of them aged between 41-60 years old (43.3% in meditation group and 46.7% in control group), female (76.7%), married (63.3%), and employed (96.7%, 93.3%). It was found that the personal data of the two groups does not have a statistically significant difference, except the education. The meditation group was more educated than the control group ($p = 0.04$).

However, when the education was sub-grouped and analysed with the treatment, it was found that education does not influence the treatment ($p>0.05$) (Table 3).

When consider to the differences in the Thai Hamilton rating score (before intervention minus the result at the last treatment session), it was found that a difference was 17.33 ± 5.22 points for the meditation group whereas the non-practice meditation was 17.67 ± 6.33 points. After analysing the differences by independent t-test, it revealed that the differences in the Thai Hamilton rating score between the two groups are not statistically significant (p-value = 0.83) (Fig. 1).

Similarly, the differences between WHOQOL-BREF-THAI score (before intervention minus the result at the last treatment session) in meditating group and

Table 2. Demographic data of samples in this study

	Meditation group (n = 30)	Control group (n = 30)	*p*-value
Age			0.83[a]
20-40 years	9 (30.0%)	10 (33.3%)	
41-60 years	13 (43.3%)	14 (46.7%)	
61-70 years	8 (26.7%)	6 (20.0%)	
Gender			1.00[a]
Male	7 (23.3%)	7 (23.3%)	
Female	23 (76.7%)	23 (76.7%)	
Education			0.04[a]
Higher or equal bachelor degree	16 (53.3%)	8 (26.7%)	
Lower than bachelor degree	14 (46.7%)	22 (73.3%)	
Status			0.23[a]
Single	3 (10.0%)	7 (23.3%)	
Married	19 (63.3%)	19 (63.3%)	
Divorce and widow	8 (26.7%)	4 (13.4%)	
Occupation			1.00[b]
Unemployed	1 (3.3%)	2 (6.7%)	
Employed	29 (96.7%)	28 (93.3%)	
Income			0.30[a]
Less than 20,000 bath	14 (46.7%)	18 (60.0%)	
≥20,000 bath	16 (53.3%)	12 (40.0%)	
Stressor			0.20[a]
No	8 (26.7%)	4 (13.3%)	
Yes	22 (73.3%)	26 (86.7%)	
Hobby			0.43[a]
No	10 (33.3%)	13 (43.3%)	
Yes	20 (66.7%)	17 (56.7%)	
Chronic disease			0.30[a]
No	11 (36.7%)	15 (50%)	
Yes	19 (63.3%)	15 (50%)	
Relationship with family			0.49[a]
Bad	6 (20.0%)	4 (13.3%)	
Good	24 (80.0%)	26 (86.7%)	
Hamilton score base line	19.70±5.75	20.67±5.54	0.51[c]
Thai quality of life score base line	74.43±14.75	74.43±13.47	1.00[c]

[a] = Chi-square; [b] = Fisher's exact test; [c] = Independent t-test

Table 3. The number of subjects that improved in each level of education

	Meditation group	Control group	*p*-value
Education higher or equal bachelor degree			
The number of subject that improved/all subjects in this group	16/16 (100%)	7/8 (87%)	>0.05
Lower than bachelor degree			
The number of subject that improved/all subjects in this group	12/14 (85%)	15/22 (68%)	

the non-mediating groups were 29.97±15.95 and 31.33±12.12 points, respectively, which are not statistically significant (*p*-value = 0.71) (Fig. 2).

At the 6th week, 28 persons (93.3%) from the meditating group and 22 persons from the non-meditating group (73.3%) improved from depression

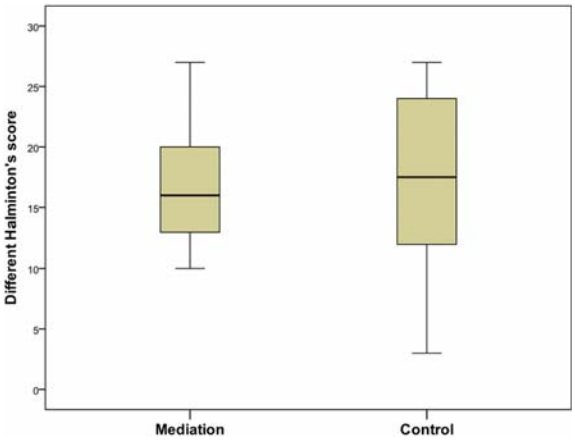

Fig. 1 Comparison of the differences in the Thai Hamilton rating score for depression between meditated group and control group.

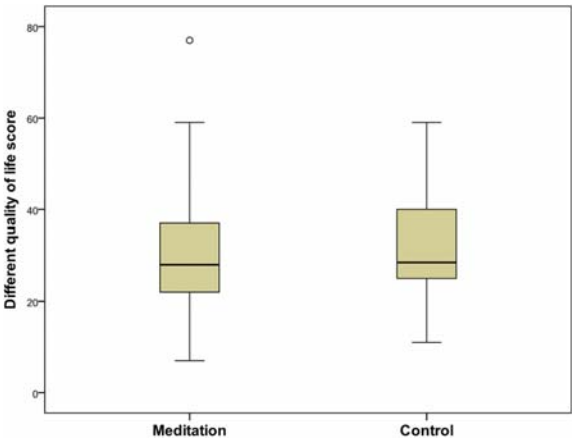

Fig. 2 Comparison of the differences of WHOQOL-BREF-THAI score between meditated group and control group.

(Thai Hamilton rating scale for depression = 0). When examining by Chi-square test, it shown that the differences in the percentage of the number of subjects that improved from depression were statistically significant (*p*-value = 0.04) (Table 4).

Discussion

The primary aim of the study was to assess the efficacy of Buddhist mindfulness meditation on depression treatment. Results showed that both treatments (standard treatment combined or uncombined with Buddhist mindfulness meditation) were effective in reducing depressive symptom ratings. There were no statistically significant differences in the Thai Hamilton rating score (before intervention minus the result at the last treatment session). The most interesting finding is that at the 6th week, 28 persons (93.3%) from the meditating group and 22 persons from the non-meditating group (73.3%) improved from depression. After examining by the Chi-square test, it was found that the differences in the percentage of the number of subjects that improved from depression were statistically significant (*p*-value = 0.04). This study suggest that the Buddhist mindfulness meditation can shorten the duration of depressive symptom. Furthermore, the Buddhist mindfulness meditation may be particularly well suited for individuals who open to learn a useful skill to manage their depression.

The reason that the differences in the Thai Hamilton rating score between the two groups were not statistically significant (*p*-value = 0.83) may be that the two groups received the standard psychiatric treatment and meditation was only an additional activity. This result is disagreement with the study of Delui MH et al[22] who investigated 45 cardiac patients divided into three groups (relaxation, meditation and control). They found that meditation was able to reduce depression more effectively than in the relaxation group and the difference was statistically significant ($p<0.05$). Our study, however, agrees with that of Williams JMG et al[23] who found that meditation does not relieve depression compared to a control group.

There were also no significant differences in the WHOQOL-BREF-THAI score between the two groups (*p*-value = 0.71). The reason was as above, in addition, the patient preference and perceptions of treatment plausibility were indirect effects on patient outcome. This results does not agree with that of Chiesa A et al[24] who reported that meditation was able to significantly improve the quality of life.

The most interesting finding is that Buddhist mindfulness meditation can cut down the duration of depressive symptom. The reason was that practising Buddhist mindfulness meditation is a way to strengthen the mind in order to be able to cope with disease, to make the mind quiet and useful, distress relief, mood stability, result in efficacy at the workplace, improve health and sound sleep[18]. Koolschijn PC et al[25] found that mindfulness meditation can make biological changes (functional MRI brain). Meditation can regulate of ventral affective processing areas (ventrolateral prefrontal cortex and the amygdala), enhance executive control areas (dorsal anterior cingulate and dorsolateral prefrontal cortex). The results

Table 4. The percentage of the number of subjects that improved from depression at the 6th week

Result of treatment	Meditation (n = 30)	Control	*p*-value
Improvement	28 (93.3%)	22 (73.3%)	0.038
Non-improvement	2 (6.7%)	8 (26.7%)	

of the present study agrees with that of Kim YH et al[26] who studied 102 breast cancer patients. They were divided into 2 groups of 51 persons. One group was treated with meditation 12 times during 6 weeks and the other group received only radiation therapy. It was found that meditation was able to reduce depression more than the control group. Chiesa A et al[24] found that MBCT was more efficacious in reducing residual symptoms after initial antidepressant treatment than psychoeducation.

Hamidian S et al found that augmentation with MBCT increase improvement in dysthymia much more than imipramine alone[27]. Barnhoffer T et al[28] and Kingston J et al[29] found that MBCT augmentation could improve outcomes in reducing the residual symptoms of chronic depression compared with typically antidepressant management. This study suggest that the basic home Buddhist mindfulness meditation can shorten the duration of depressive symptom that may provide a psychotherapeutic option for the treatment of acute depression and may be cost effective in comparison to maintenance medications over time if supported by further randomized controlled trials. Limitation of this study was the small sample size that limits generalizability, and the quantifying of mindfulness meditation at home which we hope to address in our future work. Strength of this study was the patients in both group were treated by standard treatment so they had not lost their opportunity to improve.

Conclusion

At the 6th week, practising Buddhist mindfulness meditation increases the number of patients that improved from depression (Thai Hamilton rating scale for depression = 0) and the difference is statistically significant (*p*-value = 0.04). Thus, Buddhist mindfulness meditation should be included in the treatment of depression.

What is already known on this topic?

Mindfulness base cognitive therapy is effective for improving depression.

What this study adds?

At the 6th week, the home Buddhist mindfulness meditation increases the number of patients that improved from depression, shorten the duration of depressive symptom in Thai people.

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Potential conflicts of interest

None.

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ผลของการทำสมาธิที่บ้านแบบสติระลึกรู้แนวพุทธต่ออาการซึมเศร้าในผู้ป่วยโรคซึมเศร้า

วันเพ็ญ ธุรกิตตวัณณการ, ปฏิรพ ปองประพฤทธิ์, เมธาพันธ์ กิจพรธีรานันท์

ภูมิหลัง: *โรคซึมเศร้าเป็นสาเหตุสำคัญของการไม่สามารถดำเนินชีวิตตามปกติได้ ผู้ป่วยโรคซึมเศร้าไม่ตอบสนองต่อยาชนิดแรก 67% และไม่ตอบสนองต่อยาตัวที่สอง 33% มี จึงมีความจำเป็นต้องหาวิธีการรักษาแบบอื่น*

วัตถุประสงค์: *เพื่อศึกษาผลการนั่งสมาธิแบบสติระลึกรู้แนวพุทธ ร่วมกับการรักษาตามมาตรฐาน ต่ออาการซึมเศร้าและคุณภาพชีวิตของผู้ป่วยที่มีภาวะซึมเศร้าที่มีคะแนน Thai Hamilton Rating Scale for depression ในช่วง 13-29 คะแนน เปรียบเทียบกับกลุ่มควบคุม*

วัสดุและวิธีการ: *เป็นการวิจัยแบบกึ่งทดลอง กลุ่มตัวอย่างอายุ 20-70 ปี ที่มีคะแนน Thai Hamilton rating scale for depression ในช่วง 13-29 คะแนน โดยแบ่งเป็น 2 กลุ่ม กลุ่มละ 30 คน กลุ่มทดลอง นั่งสมาธิแบบสติระลึกรู้แนวพุทธ ทำทุกวันอย่างน้อยอาทิตย์ละ 5 วัน แต่ละครั้งนาน 15 นาที เป็นเวลา 6 สัปดาห์ ทั้ง 2 กลุ่ม รักษาด้วยการรักษาตามมาตรฐาน ผู้เข้าร่วมศึกษาได้รับการทำแบบทดสอบ Thai Hamilton Rating Scale for depression และ WHOQOL-BREF-THAI questionnaire ในครั้งแรกที่มาพบแพทย์และติดตามอาการทุกอาทิตย์เป็นระยะเวลา 6 สัปดาห์ เปรียบเทียบผลการรักษาโดยการวิเคราะห์ข้อมูลด้วย independent t-test และ Chi-square test*

ผลการศึกษา: *คะแนนเฉลี่ยก่อนและหลังการทำสมาธิจาก Thai Hamilton rating scale ในกลุ่มทดลองและกลุ่มควบคุมเท่ากับ 17.33±5.22 และ 17.67±6.33 ตามลำดับและคะแนนจาก WHOQOL-BREF-THAI ในกลุ่มทดลองและกลุ่มควบคุมเท่ากับ 29.97±19.95 และ 31.33±12.12 ตามลำดับ ซึ่งคะแนนดังกล่าวนี้ไม่แตกต่างกันอย่างมีนัยสำคัญทางสถิติ (p>0.05) แต่พบว่าในสัปดาห์ที่ 6 ผู้ป่วยจำนวน 28 คน (93.3%) ในกลุ่มนั่งสมาธิและจำนวน 22 คน (73.3%) ในกลุ่มที่ไม่นั่งสมาธิหายป่วยจากอาการซึมเศร้า ซึ่งมีความแตกต่างอย่างมีนัยสำคัญทางสถิติ (p-value = 0.04)*

สรุป: *การทำสมาธิแบบสติระลึกรู้แนวพุทธเพิ่มจำนวนคนหายป่วยจากอาการซึมเศร้าใน 6 สัปดาห์ อย่างมีนัยสำคัญทางสถิติ ดังนั้นควรมีการเพิ่มการนั่งสมาธิแบบสติระลึกรู้แนวพุทธร่วมกับการรักษาตามมาตรฐาน เพื่อเป็นแนวทางการรักษาโรคซึมเศร้า*