An Application of Buddhist Mindfulness Meditation as a Complementary Approach to Depression Care

Ven. Nguyen Huu Anh[1] Phramaha Nantakorn Piyabhani[2]
Ven. Nguyen Anh Tuan[3]
International Buddhist Studies College. Mahachulalongkornrajavidyalaya University[1,2,3]

Corresponding author email: nguyenhuuanh020902@gmail.com[1]
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Abstract

Depression affects approximately 332 million people worldwide and can substantially impair emotional, cognitive, social, and physical functioning. Although effective psychological and pharmacological treatments are available, recurrent depression and residual symptoms remain important clinical challenges. This qualitative study explored the potential role of Buddhist mindfulness meditation as a complementary approach to depression care. Data were drawn from documentary analysis of selected canonical and interpretive Buddhist texts, particularly the Satipaṭṭhāna Sutta and Ānāpānasati Sutta, and from in-depth interviews with three adults who had lived experience of depression and three experienced meditation teachers. Qualitative content analysis identified emotional, cognitive, behavioral, and somatic dimensions of depression, together with Buddhist interpretations involving greed (lobha), hatred (dosa), delusion (moha), craving, clinging, and mental proliferation. Participants described perceived improvements in emotional regulation, cognitive clarity, sleep, self-understanding, and sense of meaning associated with sustained mindfulness practice. The study's principal contribution is the STOP model, a preliminary four-stage framework—Stop, Transform, Observe, and Practice—that integrates breath awareness, body-based mindfulness, contemplation of feelings and mental states, loving-kindness, and daily-life practice. The model is intended as a culturally and spiritually informed complement to professional depression care rather than as a substitute for clinical assessment, psychotherapy, medication, or crisis intervention when these are indicated. Because the study used a small purposive sample, relied on retrospective self-report, and did not assess clinical outcomes, its findings are interpretive and exploratory. Further empirical evaluation is required before claims can be made regarding the model's safety, effectiveness, or comparative clinical value.

Keywords: Buddhist mindfulness meditation; Depression; STOP model; Complementary care

Introduction

Depression is a common mental disorder that can affect mood, interest, concentration, sleep, energy, relationships, and daily functioning. The World Health Organization estimated in 2025 that approximately 332 million people worldwide experience depression and emphasized that effective psychological and pharmacological treatments are available (World Health Organization, 2025). Depression results from complex interactions among biological, psychological, and social factors rather than from a single cause. Accordingly, research on complementary approaches should avoid presenting any one practice as a universal or standalone cure.

Evidence-based care includes psychological interventions, such as cognitive behavioral therapy and behavioral activation, as well as antidepressant medication when clinically appropriate. These treatments can be effective, but recurrent episodes, residual symptoms, access to treatment, adverse effects, and individual preferences remain important considerations. Mindfulness-based cognitive therapy has shown value in preventing relapse among some people with recurrent depression, particularly when delivered as a structured clinical intervention (Kuyken et al., 2016). Buddhist mindfulness meditation should therefore be examined as a possible complement to established care rather than as a replacement for it.

Buddhist mindfulness meditation offers a contemplative framework with both traditional and contemporary relevance. Mindfulness (sammā-sati) is a central component of the Noble Eightfold Path and is cultivated together with ethical conduct, concentration, and wisdom (Bodhi Bhikkhu, 2010). The Satipaṭṭhāna Sutta and Ānāpānasati Sutta provide systematic instructions for observing the body, feelings, mind, and mental phenomena, as well as for developing mindfulness of breathing (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995). Contemporary research has associated mindfulness training with changes in attention- and emotion-related processes, although such findings should be interpreted with caution and not treated as direct evidence of clinical efficacy (Hölzel et al., 2011).

Despite growing scientific interest, a gap remains between classical Buddhist accounts of mindfulness and contemporary clinical applications to depression. Secular mindfulness protocols often emphasize attentional and

cognitive skills, whereas Buddhist sources situate mindfulness within ethical restraint, compassion, insight, and liberation from suffering (Bodhi Bhikkhu, 2011). Conversely, classical texts were not written as modern clinical manuals. Few studies have integrated canonical interpretation, contemporary psychological literature, and the lived experiences of people with depression and experienced meditation teachers into a single, explicitly preliminary framework. This study addressed that gap by examining Buddhist mindfulness meditation through documentary analysis and qualitative interviews and by developing the STOP model—Stop, Transform, Observe, and Practice. The model was designed as a conceptual framework for supporting depression care through staged, body-based, and compassion-oriented mindfulness practices. It does not constitute a validated clinical treatment protocol, and its application should remain consistent with professional assessment, informed consent, risk management, and referral when symptoms are severe or persistent.

Research Objectives

1. To examine the manifestations and perceived contributing factors of depression from Buddhist and contemporary psychological perspectives.
2. To analyze the principles of Buddhist mindfulness meditation and their potential therapeutic relevance to depression care.
3. To develop a preliminary Buddhist mindfulness framework, the STOP model, as a complementary approach for supporting people experiencing depression.

Literature Review

1. Canonical Foundations

Early Buddhist canonical sources provide the doctrinal foundation for understanding mindfulness meditation. The Satipaṭṭhāna Sutta and Ānāpānasati Sutta describe the Four Foundations of Mindfulness (kāyānupassanā, vedanānupassanā, cittānupassanā, and dhammānupassanā) and sixteen contemplations of breathing (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995). These texts present mindfulness as part of an integrated training in ethical conduct, concentration (samādhi), and insight (vipassanā), rather than as an isolated attentional technique.

2. Modern Buddhist Interpretations

Contemporary Buddhist masters have adapted canonical teachings for modern practitioners. Zen Master Nhat Hanh's The Miracle of Mindfulness (1975) provides systematic instruction on mindfulness in everyday life, while his Breathe, You Are Alive! (1988) introduces breath as a medium between body and mind, demonstrating how mindful breathing fosters emotional control and inner tranquility. His development of mindfulness verses (gāthās) for daily activities illustrates how traditional practice can address modern suffering. Buddhadasa Bhikkhu's Mindfulness with Breathing (1988) further codifies Ānāpānasati through progressive stages building mindfulness, concentration, and insight according to practitioners' advancing capacity.

3. Clinical and Therapeutic Applications

The integration of mindfulness with contemporary psychological therapy has expanded its clinical relevance. Mindfulness-based cognitive therapy combines mindfulness practices with cognitive therapy to help participants recognize ruminative patterns and relate to thoughts as mental events rather than facts (Segal et al., 2013; Williams et al., 2007). Evidence suggests that structured MBCT can reduce relapse risk among some people with recurrent depression, although it is not a universal treatment and should be delivered with appropriate clinical safeguards (Kuyken et al., 2016). Neuroscientific and psychological studies may help explain potential mechanisms, but they do not replace direct evidence of safety and effectiveness for a newly proposed model.

The literature shows a progression from canonical Buddhist instruction to modern therapeutic applications. However, much scholarship focuses either on doctrinal foundations or on standardized clinical interventions. Less attention has been given to frameworks that integrate canonical sources, contemporary clinical evidence, and lived experience while retaining explicit safeguards against overgeneralization. The present study addresses this gap by developing a preliminary, culturally informed model grounded in documentary and qualitative evidence.

Conceptual Framework

The conceptual framework is organized around input, process, and output. Inputs comprise selected canonical Pāli texts, interpretive Buddhist works, contemporary clinical literature, and qualitative accounts from adults with lived

experience of depression and experienced meditation teachers. The process consists of documentary analysis, semi-structured interviews, qualitative content analysis, and iterative synthesis across the two data streams. The output is the preliminary STOP model—Stop, Transform, Observe, and Practice—together with cautious implications for complementary care, Buddhist education, and future empirical research. The framework does not assume clinical effectiveness; rather, it specifies concepts and practices that require subsequent evaluation.

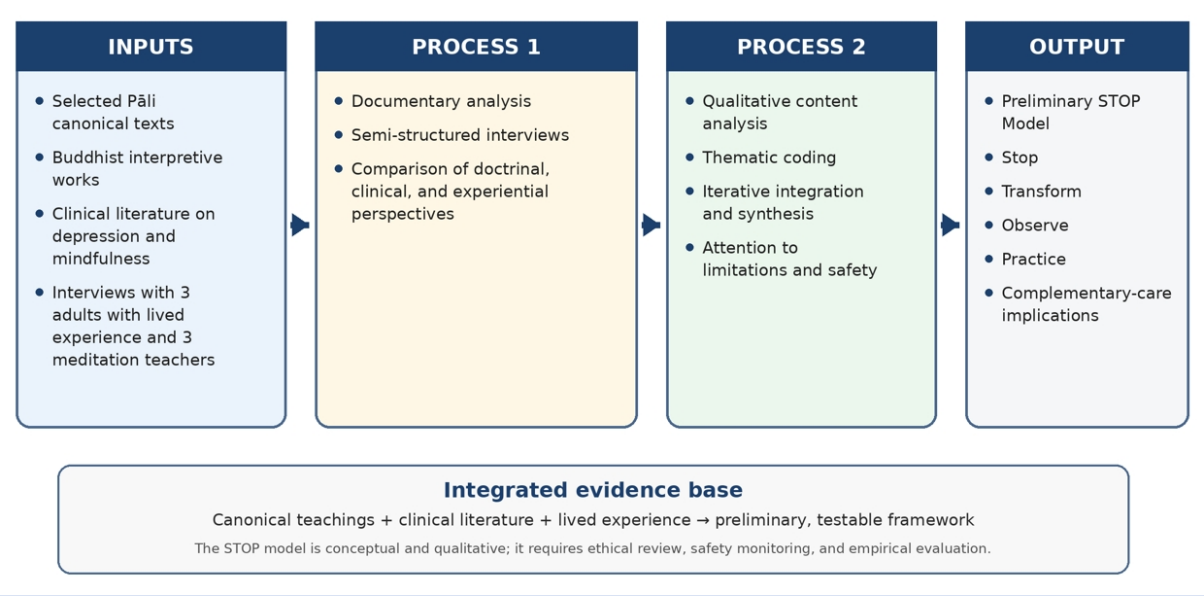

Figure 1. Conceptual Framework of the Study

Research Methodology

This study employed a qualitative research design combining documentary analysis and semi-structured interviews. The design was appropriate for exploring doctrinal concepts, lived experience, perceived mechanisms, and practice adaptations; it was not designed to test clinical effectiveness or establish causal outcomes.

Data Collection

Primary sources. Documentary data were drawn from English translations of selected Pāli canonical texts, with particular attention to the Satipaṭṭhāna Sutta and Ānāpānasati Sutta. Interpretations were compared with modern Buddhist commentaries and scholarly works to reduce reliance on a single translation or teacher perspective.

Secondary sources. Additional materials included Buddhist commentaries, scholarly books, peer-reviewed articles, clinical literature on depression and mindfulness, and works by contemporary meditation teachers. Sources were

selected for relevance to the research objectives and were used to contextualize, rather than clinically validate, the interview findings.

In-Depth Interviews

The interview component involved two purposively selected groups chosen for direct lived experience or established practice expertise:

Group 1—Participants with lived experience of depression. Three Vietnamese women who had recovered from or were recovering from depression were interviewed. Each reported using Buddhist mindfulness meditation as one element of her recovery process. Their accounts provided case-based insights into perceived causes, symptoms, obstacles, and changes associated with practice. The accounts should not be interpreted as representative of all people with depression.

Group 2—Meditation teachers and experienced practitioners. Three participants were selected based on at least 10 years of sustained mindfulness practice or formal teaching experience in a recognized Buddhist tradition. Two were senior monks affiliated with Plum Village, and one was a faculty member in a doctoral program in mindfulness studies. They contributed perspectives on doctrinal principles, practice adaptations, limitations, and referral considerations.

Semi-structured interviews were conducted by video call using a prepared interview guide with flexibility for open-ended follow-up. Interviews were conducted in Vietnamese or English and lasted approximately 60–90 minutes. Interview recordings were transcribed for qualitative analysis.

Data Analysis and Synthesis

Data were analyzed using qualitative content analysis. Interview recordings were transcribed, coded, and compared to identify recurring themes related to depression, mindfulness practice, perceived mechanisms, obstacles, and contextual adaptations. Documentary sources were analyzed for canonical and clinical concepts relevant to the emerging themes. Findings were synthesized iteratively to develop the STOP model. Interview accounts functioned as illustrative cases rather than representative or causal evidence.

Research result

The research findings are presented according to the three primary objectives: examining depression's problematic situations and causes, studying Buddhist mindfulness meditation principles and therapeutic benefits, and applying mindfulness meditation as a therapeutic approach for depression treatment. Interview data presented throughout should be understood as

illustrative case-based insights from a small purposive sample rather than as statistically representative evidence.

1. Depression: Problematic Situations and Causes

1.1 Manifestations from Dual Perspectives

The study found that depression manifests through three interconnected dimensions that Buddhist and therapeutic perspectives illuminate in complementary ways. Emotionally, depression presents through persistent sadness, hopelessness, and anhedonia—manifestations the Buddha identified as dukkha arising from the three unwholesome roots: greed (lobha), hatred (dosa), and delusion (moha) (Beck, 1979; Ñāṇamoli & Bodhi, 1995). Interview data confirmed these theoretical frameworks through lived experience. Ms. Nguyen Xan articulated the cognitive-emotional entanglement characteristic of her depression: thinking negatively, feeling resentful, and magnifying suffering in ways that created self-perpetuating cycles. Most significantly, Ven. Chan Troi Dat Nguyen identified a debilitating psychosomatic feedback loop—negative thoughts producing stomach pain, chest tightness, exhaustion, and insomnia, which in turn intensified the negative thoughts—demonstrating depression's integrated nature across psychological and somatic domains and validating the Buddhist concept of mind-body interdependence (nāma-rūpa).

Cognitively, depression involves systematic distortions including catastrophizing, overgeneralization, and harsh self-criticism—patterns Beck (1979) termed the "cognitive triad" of negative views about self, world, and future. Buddhism identifies these as "wrong view" (micchā-diṭṭhi) and "mental proliferation" (papañca), arising from delusion about reality's nature (Payutto, 2021). The Satipaṭṭhāna Sutta addresses these distortions through contemplation of the mind (cittānupassanā), teaching practitioners to observe thoughts as mental events rather than as representations of reality (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995). Interview findings confirmed this mechanism's therapeutic potential: Ms. Tran Nhat Quynh Nhi reported that mindfulness practice helped her identify and observe negative thoughts instead of being swept away by them, illustrating the shift MBCT terms "decentering."

Behaviorally and physically, depression produces withdrawal, motivational deficits, chronic fatigue, and somatic pain. Buddhist psychology explains these through the mental factors of sloth-torpor (thīna-middha) and

restlessness-worry (uddhacca-kukkucca)—two of the Five Hindrances that obscure mental clarity (Gunaratana, 2012). All three participants with lived experience of depression reported severe somatic symptoms, including rapid heartbeat, palpitations, severe headaches, chest heaviness, difficulty breathing, and prolonged insomnia. These symptoms validate the mind-body interdependence (nāma-rūpa) central to Buddhist psychology (Payutto, 2021).

1.2 Causal Factors: Buddhist and Therapeutic Convergence

From Buddhist perspectives, depression's root causes lie in the three unwholesome roots (akusala-mūla): greed manifesting as desperate clinging, hatred appearing as self-loathing and resentment, and delusion clouding perception of reality (Nārada, 1987). The doctrine of dependent origination (paṭicca-samuppāda) explains the self-perpetuating nature of depression: ignorance (avijjā) leads to craving (taṇhā) and clinging (upādāna), thereby generating continued suffering through attachment to impermanent phenomena (Payutto, 2021). Interview data illustrated these mechanisms: one participant's depression arose from the collapse of deep trust in a spiritual teacher, demonstrating how shattered attachment (upādāna) gives rise to intense aversion (dosa).

From therapeutic perspectives, depression arises from neurobiological factors (neurotransmitter imbalances, genetic predisposition), psychological factors (cognitive distortions, learned helplessness), and environmental stressors (trauma, chronic stress, social isolation) (Korb, 2015; World Health Organization, 2025). Interview data corroborated environmental stressors' role: cited causes included pressure from a child's serious illness, family conflict and parental divorce, childhood trauma, prolonged trauma in a romantic relationship, work pressure, the COVID-19 pandemic, and academic stress. This accumulation of stressors, combined with a lack of effective social support, created fertile ground for depressive episodes.

The comparison identified partial conceptual correspondences between Buddhist and contemporary psychological accounts while preserving their distinct aims and explanatory frameworks. The three unwholesome roots may be compared cautiously with maladaptive patterns of craving, aversion, and distorted appraisal; dependent origination offers an interpretive account of self-reinforcing processes; and mind-body interdependence may be placed in dialogue with psychosomatic perspectives. These correspondences may broaden conceptual

understanding, but they do not establish equivalence between Buddhist doctrine and clinical constructs or demonstrate the superiority of an integrated treatment approach.

2. Buddhist Mindfulness Meditation: Principles and Therapeutic Benefits

2.1 Core Principles from Canonical Sources

The Satipaṭṭhāna Sutta establishes the Four Foundations of Mindfulness as systematic training in present-moment awareness. Contemplation of the body (kāyānupassanā) begins with breath awareness, establishing stable attention by observing inhalation and exhalation without manipulation, a foundation that is particularly crucial for depression, as Ven. Dr. Thich Chan Phap Tu explained: "The body is the foundation because when the body relaxes, the feelings and mind also become calm." Contemplation of feelings (vedanānupassanā) trains practitioners to observe pleasant, unpleasant, and neutral sensations without reactive craving or aversion, directly addressing depression's characteristic emotional dysregulation. Contemplation of mind (cittānupassanā) develops metacognitive awareness, enabling practitioners to observe mental states with clear recognition but without identification. Contemplation of mental objects (dhammānupassanā) investigates phenomena, including the Five Hindrances, which are particularly relevant to depression: sloth-torpor, causing lethargy; restlessness-worry, producing agitation; and doubt, undermining confidence (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995).

The Ānāpānasati Sutta presents sixteen contemplations that progress from basic breath observation to increasingly subtle awareness, systematically developing both concentration (samādhi) and insight (vipassanā). The progressive structure, beginning with recognition of breath length, expanding to whole-body awareness, and then observing feelings, mind states, and phenomena, provides a graduated approach suitable for practitioners of varying capacities, including those with depression-related cognitive impairments (Buddhadāsa Bhikkhu, 1988).

Contemporary meditation masters have adapted traditional teachings for modern contexts while maintaining doctrinal integrity. Zen Master Nhat Hanh's development of gāthās (mindfulness verses) for daily activities, waking, eating, walking, and working, demonstrates how mindfulness extends beyond formal meditation into every moment of life. His teaching to "embrace" difficult

emotions with mindfulness rather than struggling against them, using the metaphor of a mother holding a crying baby, offers a profound therapeutic principle. Ven. Dr. Thich Chan Phap Tu articulated this: "Depression is seen as a form of energy. Instead of fighting or trying to eliminate it, mindfulness teaches how to transform this energy. The energy of mindfulness is invited to embrace the energy of depression, much like a mother embracing her crying baby."

2.2 Therapeutic Benefits: Evidence from Multiple Sources

Emotional regulation emerges as mindfulness meditation's primary therapeutic benefit for depression, based on both literature and participant accounts. The practice cultivates non-reactive awareness of emotions, creating psychological space between feelings and responses. Ms. Nguyen Pho Hoa's experience, despite not achieving complete recovery, illustrates this mechanism: she reported greater self-understanding, growing empathy toward others, and a gradual reduction in anger energy, a shift from reactive aversion toward acceptance that aligns with what mindfulness cultivates in theory. Neuroscientific research supports these experiential reports, as regular mindfulness practice has been associated with increased prefrontal cortex activity and decreased amygdala reactivity (Hölzel et al., 2011). It should be noted, however, that neuroimaging findings support only part of this interpretation and do not by themselves fully explain the experiential or doctrinal dimensions under discussion.

Cognitive benefits, drawing primarily from clinical literature, include breaking ruminative cycles and developing metacognitive awareness—the capacity to observe thoughts as transient mental events rather than self-defining truths (Segal et al., 2013). Ven. Dr. Thich Chan Phap Tu identified temporal displacement as depression's core mechanism: "Suffering and depression primarily stem from a mind stuck in the future (creating anxiety) and the past (creating regret). Mindfulness helps let go of the future and the past to return to the present moment, thereby stabilizing the mind and reducing suffering."

Behavioral and physical improvements were reported by all three participants with lived experience of depression, who described reduced physical tension, better sleep, and calmer mental states through mindfulness practice. The gradual calming of physiological arousal through breathwork and body scanning may interrupt the stress response maintaining depression, creating an upward spiral as reduced physical tension facilitates mental clarity (Korb, 2015). These reports illustrate individual trajectories rather than evidence of uniform outcomes.

Clinical literature suggests that mindfulness-based approaches may be relevant to relapse prevention for some people with recurrent depression, while the interviews emphasized the perceived importance of continued practice (Kuyken et al., 2016). One teacher described a single case in which mood improved during approximately three months of twice-daily guided meditation and worsened after practice was discontinued for more than a month. This retrospective account cannot establish causation, relapse-prevention efficacy, or the safety of medication changes. Another participant described improvements in mood, concentration, and sense of meaning during six months of sustained practice; this likewise represents an individual trajectory rather than a generalizable outcome.

3. Application: The STOP Model Framework

3.1 Model Development and Rationale

The study's principal contribution is the STOP model, Stop, Transform, Observe, and Practice, a preliminary framework that organizes breath awareness, body-based practice, contemplation of feelings and mental states, loving-kindness, and integration into daily life. The model is grounded in documentary and qualitative evidence and has not been tested as a clinical intervention.

The model emerged from synthesizing canonical teachings (Satipaṭṭhāna Sutta, Ānāpānasati Sutta), contemporary clinical insights (MBCT principles, neuroscience), and experiential wisdom from interviews. Ven. Chan Troi Dat Nguyen's identification of "stopping" as the essential therapeutic factor, stopping thoughts about the past and the future, and truly dwelling in the present moment, provided the foundational insight for Stage 1. Ven. Dr. Thich Chan Phap Tu's teaching about "embracing" depression rather than fighting it informed Stage 2's transformation approach. Ms. Tran Nhat Quynh Nhi's articulation that mindfulness helps identify and observe negative thoughts without being swept away by them validated Stage 3's focus on observation. The integration of all practices into daily life, emphasized by all meditation teachers, shaped Stage 4.

3.2 Stage 1: STOP — Developing Concentration

The initial stage addresses depression's characteristic temporal displacement, rumination about the past, and catastrophizing about the future by developing the capacity to interrupt these automatic patterns and anchor attention

in the present moment. Theoretical foundation draws from the Buddha's teaching in the Bhaddekaratta Sutta: "One should not chase after the past or place expectations on the future... Whatever phenomenon is present, one clearly sees right there, right now" (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995). This mechanism interrupts ruminative thought cycles identified as central maintaining factors in depression (Williams et al., 2007).

Core practice uses mindfulness of breathing (ānāpānasati) with simple verbal cues that support awareness of inhalation and exhalation (Hanh, 1975). One interview-informed adaptation involved attending to the abdomen's rise and fall rather than to sensations at the nostrils. The teacher presenting this approach regarded the lower-body focus as more grounding for people prone to intense rumination. This adaptation remains an experiential recommendation and requires evaluation for safety, feasibility, and acceptability.

3.3 Stage 2: TRANSFORM — Cultivating Awareness

The second stage shifts from interrupting negative patterns to transforming the relationship with difficult emotions through acceptance and compassionate awareness rather than elimination or suppression. Theoretical foundation draws from Ven. Dr. Thich Chan Phap Tu's teaching: "Depression is seen as a form of energy. Instead of fighting or trying to eliminate it, mindfulness teaches how to transform this energy. The energy of mindfulness is invited to embrace the energy of depression, much like a mother embracing her crying baby." This approach distinguishes Buddhist mindfulness from suppression-based coping strategies, offering a more sustainable path toward psychological health.

Core practice draws on contemplation of feelings (vedanānupassanā) in the Satipaṭṭhāna Sutta, in which pleasant, unpleasant, and neutral feeling tones are observed without immediate craving or aversion. Nhat Hanh (1988) similarly presents mindful breathing as a way to recognize and gently calm painful feelings rather than suppress them. Additional practices include body scanning to notice somatic tension and loving-kindness meditation (mettā) to cultivate self-compassion.

A participant account illustrates this transformation-oriented approach. One participant described greater self-understanding, increased empathy, and a gradual reduction in anger during ongoing recovery. This account suggests a

possible process of change but cannot establish that mindfulness caused the improvement or that similar outcomes would occur for others.

3.4 Stage 3: OBSERVE — Developing Right Understanding

The third stage deepens practice by cultivating observation of mental processes themselves, developing what Buddhist psychology terms "clear comprehension" (sampajañña) and leading toward right understanding (sammā-diṭṭhi). The theoretical foundation implements contemplation of the mind (cittānupassanā) and mental objects (dhammānupassanā) from the Satipaṭṭhāna Sutta. Practitioners observe mental states, distracted or concentrated, constricted or expansive, with clear recognition but without identification, thereby loosening the rigid fusion between the sense of self and depressive content (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995).

Core practice involves recognizing mental states as they arise and meeting distraction with awareness rather than self-criticism (Hanh, 1988). More advanced practices include observing rumination, catastrophizing, and self-critical thought patterns; investigating the Five Hindrances (nīvaraṇas); and recognizing individual mind-body cycles. The proposed mechanism is metacognitive awareness: shifting from automatic identification with thoughts toward observing them as transient mental events. One participant's account illustrated this perceived shift, but the study cannot establish that it caused clinical improvement.

3.5 Stage 4: PRACTICE — Integration into Daily Life

The fourth stage extends mindfulness from formal meditation into all life domains, recognizing that depression affects all activities and therefore healing must similarly pervade all moments. The theoretical foundation follows the Buddha's teaching that mindfulness should encompass all postures and activities (Ñāṇamoli Bhikkhu & Bodhi Bhikkhu, 1995). This stage incorporates elements of behavioral activation, a key evidence-based component of depression treatment, through mindful engagement with daily tasks (Lejuez et al., 2001).

Core practice incorporates Nhat Hanh's gāthās, or mindfulness verses, as brief reminders during routine activities such as waking, eating, walking, and responding to stress (Hanh, 1990). Rather than functioning as clinical

prescriptions, these verses are used to reconnect attention with the body, breath, present activity, gratitude, and a gentler orientation toward experience.

Additional elements include mindful communication through deep listening and loving speech, establishing a sustainable daily practice rhythm (formal practice in the morning and evening, plus informal integration), and participating in sangha or community support. Ms. Nguyen Xan's recovery involved not merely symptom reduction but restoration of motivation, meaning in life, and love for life, existential dimensions that conventional treatments often address less directly. Her transformation illustrates the potential of integrated practice, though her account reflects one individual's trajectory.

3.6 Strengths and Limitations

Potential strengths of the proposed approach include its emphasis on present-moment awareness, self-compassion, ethical reflection, body-based practice, daily-life integration, and community support. These features may be relevant to rumination, harsh self-criticism, and loss of meaning. However, the present study cannot determine effectiveness, side-effect frequency, relapse prevention, or comparative value because it did not use clinical outcome measures, a control group, or longitudinal follow-up. Participants' concerns about medication were individual experiences and should not be interpreted as evidence against pharmacological treatment.

Limitations acknowledged include: (1) initial difficulty and potential intensification of difficult feelings—Ven. Dr. Phramaha Weerasak Abhinadavedi noted many find it painful to sit quietly because difficult emotions arise strongly; (2) sustained commitment requirements—Ven. Chan Troi Dat Nguyen identified lack of determination and patience as a major obstacle; (3) cultural and religious barriers, Ven. Dr. Thich Chan Phap Tu observed many people assume meditation is only for Buddhists; and (4) difficulty maintaining practice during acute episodes, when depression worsens, motivation and concentration decline, creating a therapeutic paradox that patients need practice most when they can do it least.

These limitations suggest that mindfulness may be more feasible for some individuals as an adjunctive or maintenance-oriented practice after acute symptoms have been clinically assessed and stabilized. The study does not support replacing psychotherapy or medication with meditation, changing

medication without medical supervision, or using the STOP model during acute risk without qualified mental-health support. The appropriate timing, intensity, and integration of mindfulness require empirical evaluation.

Discussions

This research demonstrates meaningful convergence between Buddhist contemplative psychology and contemporary therapeutic approaches to depression. The Buddhist identification of three unwholesome roots—greed, hatred, and delusion—parallels Beck's cognitive model identifying maladaptive schemas as maintaining factors in depression (Beck, 1979; Nārada, 1987). Interview data provided compelling illustrative evidence: one participant's vivid description of a self-reinforcing mind-body cycle—negative thoughts producing physical symptoms, which in turn intensified negative thinking—echoes both Buddhist mind-body interdependence (nāma-rūpa) and contemporary psychosomatic understanding. Neurobiological findings showing that mindfulness practice is associated with increased prefrontal cortex gray matter density and decreased amygdala reactivity (Hölzel et al., 2011) provide partial biological support for observed experiential changes; however, neuroimaging data alone do not fully explain the doctrinal or phenomenological dimensions discussed in this study.

The STOP model offers an explicitly Buddhist and clinically informed structure for organizing practices discussed in the texts and interviews. Its sequence—Stop, Transform, Observe, and Practice—was designed to respond gradually to difficulties involving rumination, emotional reactivity, cognitive fusion, and disruption of daily functioning. The model's current support is conceptual and qualitative; clinical trials and safety monitoring are required before it can be recommended as an intervention.

A recurring theme in the teacher interviews was the value of beginning with body-based practices, such as breathing, walking, and body scanning, before moving to direct observation of complex thought patterns. This sequencing may be helpful for some people who find cognitive observation overwhelming, but the study cannot determine for whom it is appropriate. The approach is broadly consistent with body-oriented and trauma-informed perspectives that emphasize physiological stabilization, although direct extrapolation from trauma literature should remain cautious (van der Kolk, 2014).

Important limitations include the effort required for sustained practice, the possibility that quiet meditation may intensify difficult emotions, cultural or religious barriers, and reduced motivation or concentration during severe depressive episodes. These concerns reinforce the need for screening, informed consent, gradual instruction, qualified supervision, crisis procedures, and referral pathways. Mindfulness should be positioned as one possible component of integrated care rather than as a time-limited cure.

In interpreting findings, it is important to distinguish between conclusions supported by the existing clinical literature and those derived from this study's small qualitative sample. Broad claims about therapeutic mechanisms draw primarily from canonical texts, neuroscientific studies, and established clinical research. Claims about individual experience, transformative outcomes, specific coping strategies, and the subjective sense of recovery derive from the accounts of three patients and three meditation teachers and should be understood as interpretive, case-based findings rather than generalizable clinical evidence.

Knowledge from Research

This study generated a preliminary body of theoretical, practical, and methodological knowledge by integrating selected Buddhist texts, contemporary clinical literature, and six qualitative interviews.

Theoretical knowledge. The analysis identified points of dialogue between Buddhist psychology and contemporary models of depression. The three unwholesome roots (lobha, dosa, and moha), dependent origination (paṭicca-samuppāda), and mind-body interdependence (nāma-rūpa) offer interpretive perspectives on craving, aversion, distorted appraisal, and self-reinforcing cycles. These parallels should be treated as conceptual correspondences rather than claims that Buddhist and clinical constructs are equivalent.

Practical knowledge. The STOP framework organizes practice into four progressive stages and highlights several adaptations raised in the interviews: beginning with brief body-based practices, emphasizing gentleness, using walking meditation and mindfulness verses, integrating practice into daily routines, and drawing on community support. These elements may improve accessibility, but each requires empirical testing for safety, feasibility, and effectiveness.

Methodological knowledge. Combining documentary analysis with qualitative interviews enabled comparison among doctrinal principles, clinical concepts, teacher perspectives, and lived experience. This triangulated approach enriched conceptual development, but the small purposive sample, lack of independent coding information, possible translation effects, and absence of clinical outcome measures limit transferability.

Implications. The STOP model may be useful as a hypothesis-generating framework for Buddhist education, clinician-researcher collaboration, and pilot studies of culturally adapted complementary care. It should be implemented only with a clear scope, appropriate training, professional referral pathways, and explicit acknowledgment that it is not a substitute for evidence-based treatment.

Figure 2. The STOP model as a hypothesis-generating framework

Conclusion

This study explored Buddhist mindfulness meditation as a possible complementary approach to depression care by integrating selected canonical sources, contemporary clinical literature, and interviews with three adults with lived experience of depression and three experienced meditation teachers.

The analysis described depression across emotional, cognitive, behavioral, and somatic dimensions and considered Buddhist interpretations involving the three unwholesome roots, craving, clinging, and mental proliferation. The

comparison with contemporary psychological models identified potentially useful conceptual parallels, but it did not establish equivalence between Buddhist doctrine and clinical constructs.

The primary contribution of this study is the STOP model—a structured four-stage framework (Stop, Transform, Observe, Practice) designed to apply Buddhist mindfulness meditation to the treatment of depression. The model synthesizes canonical teachings, clinical insights, and lived experience to provide a graduated, accessible pathway. Critical depression-specific adaptations include directing breath attention to the abdomen, emphasizing body-based practices as entry points, and using mindfulness verses for daily life integration. The model addresses both symptomatic and existential dimensions of depression. However, its current support is conceptual and qualitative; it has not yet been evaluated in clinical trials, and its claims should be interpreted accordingly.

Interview participants described perceived changes in emotional regulation, cognitive clarity, sleep, self-understanding, and sense of meaning. These reports are individual, retrospective accounts and do not demonstrate clinical effectiveness or support medication changes. Mindfulness may be considered as a complement to professional care when appropriately adapted, supervised, and integrated with clinical assessment and treatment.

Future research should examine the STOP model through feasibility studies, explicit safety monitoring, standardized outcome measures, comparison conditions, and longitudinal follow-up. Research should also investigate cultural adaptation, participant selection, contraindications, teacher competence, and integration with evidence-based care. The present study provides a foundation for further inquiry rather than a conclusive demonstration of therapeutic efficacy.

Suggestion

Based on these research findings, the following suggestions are offered. Given the study's qualitative design, these recommendations are framed as proposals for consideration, pilot evaluation, and further investigation rather than as evidence-based directives for immediate adoption of the protocol.

For mental-health professionals. The STOP model may be considered for carefully designed pilot work as an adjunct to established care, not as a replacement. Any application should include clinical screening, suicide-risk

procedures, informed consent, qualified supervision, adverse-event monitoring, and coordination with existing treatment. Medication decisions must remain under the supervision of an appropriately licensed prescriber.

For Buddhist institutions and meditation centers. Programs addressing depression should be developed collaboratively with mental-health professionals. Teachers should receive mental-health literacy training, understand the limits of their role, use clear referral pathways, and avoid promising recovery or advising participants to discontinue treatment. Crisis and safeguarding procedures should be established before implementation.

For participants and families. Mindfulness may be explored as a supportive practice with realistic expectations regarding gradual learning and variable response. People experiencing severe, persistent, or worsening symptoms, functional impairment, or thoughts of self-harm should seek professional help promptly. Meditation should not be used to delay assessment or replace indicated treatment.

For researchers. Initial work should prioritize feasibility, acceptability, safety, and fidelity before comparative-effectiveness trials. Future studies should use transparent recruitment criteria, validated depression measures, adequate sample sizes, longitudinal designs, adverse event reporting, and clearly specified integration with psychotherapy or medication.

For policymakers and healthcare administrators. Support should focus on rigorous evaluation, ethical governance, workforce standards, referral systems, and equitable access. Decisions about coverage or implementation should follow sufficient evidence of safety, effectiveness, and cost-effectiveness rather than precede it.

Implementation should proceed thoughtfully, respecting the integrity of traditional teachings and contemporary clinical standards, while always prioritizing participant welfare and evidence-based practice.

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