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MINDFULNESS MEDITATION IN CLINICAL PRACTICE

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ABSTRACT: In modern clinical psychology, the practice of mindfulness is gradually being introduced. In the sense of psychotherapy and stress management, mindfulness meditation is emerging as a systemic therapeutic technique, based on Buddhist theory and subsequently incorporated into Western health care. As originally conceived and developed by Kabat-Zinn and colleagues, this article discusses stress-reduction applications of mindfulness meditation primarily in medical environments. The process factors associated with the time-limited, group-based format preferred by this model are identified and the results of early and more recent outcome studies are presented in tabular form.

KEYWORDS: Mindfulness ,meditation ,yoga, health .

INTRODUCTION

In clinical applications of meditation practise, there is growing interest. Despite the fact that Buddhist meditation treatises date back more than 3,000 years, systematic attempts to incorporate meditation and therapeutic treatments have only recently been made, a prime example of which is a recent special section of this journal dedicated to integrating Buddhist theory and clinical practise. Nevertheless, meditative practise is now being incorporated in both the fields of medical and mental health care, as well as in the recently emerging "positive psychology" subfield. Jon Kabat-Zinn and colleagues [1], who created a group-based stress reduction programme for chronically ill patients known as Mindfulness-Based Stress Reduction, were among the first implementations of mindfulness meditation. The nature of mindfulness is learning to concentrate one's attention in a non-judgmental way on the experience of the present moment. Learning to pay attention to the experience of the present moment provides an alternative to the endless anxiety for past and future events, which appears to decrease one's quality of life. The purpose of this article is to discuss the MBSR program in the context of clinical practice [2].

While Buddhism has the cultural and philosophical origins of mindfulness meditation, its basic tenets are similar to Western pragmatism, which emphasises the interdependence of actions

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(action), emotion, intellect, and memory. A capacity to observe actions, emotions, and feelings, combined with knowledge of their interconnections, is central to the practise of mindfulness. Goleman, for instance, described the meditative state as one in which attention to mental events that are spontaneously generated takes place in a state of deep physical relaxation, thus constituting a type of' global self-desensitization') [3]. Linehan described mindfulness as " learning to observe internal and external events without necessarily trying to terminate them when painful or prolong them when pleasant", a process she likened to no reinforced exposure to extinguish fear and avoidance. Core mindfulness skills comprise a key element in her treatment protocol for borderline personality disorder.

Teasdale and colleagues subsequently proposed a "attention control," paradigm that subsequently became the basis for their recent combination of cognitive therapy and meditation on mindfulness. Other mindfulness-based approaches include Hayes, Strosahl, and Wilson's (1999) Acceptance and Commitment Therapy (ACT) and Epstein's use of mindfulness in psychodynamic psychotherapy. ACT, based in radical behaviorism, has in common with mindfulness an emphasis on accepting things as one finds them, perceptual clarity, and freedom from the judgmental aspects of language [4]. Both mindfulness and ACT treat thoughts as '~just thoughts," as elements of consciousness that are not accorded any more status than other objects of sensory awareness.

The influence of Transcendental Meditation, including Benson's Relaxation Response and Carrington's Clinically Standardized Meditation, is demonstrated by early adaptations of meditation to clinical practise and is reminiscent of cue-controlled relaxation strategies in which a stimulus—the mantra—is associated with a sustained state of prolonged and deep relaxation. Meditation is increasingly seen as offering a unique way of seeing and reacting to one's environment in a way that is marked by a deepening of experience derived from being centered in the present moment [5], regardless of what forms one's practice may take. In this context, Horowitz commented on the potential of meditative practices to serve as a lens with which to view the business of the mind and modern-day life, potentially capable of "reworking... mental schemata and attitudes in a unique way".

It should be noted before continuing that two cautionary notes are posed by the translation and application of mindfulness to psychotherapy and health care. Next, meditation therapeutic applications emphasise realistic, goal-oriented approaches aimed at enhancing one's health or psychological well-being condition. In effect, meditation on mindfulness entered Western psychology primarily as a quest for realistic ways to alleviate illness-related pain and psychological distress. The Buddhist practice of mindfulness, in stark contrast, is more of a' way of being' or' being with' the pain that is an inevitable part of life in general. Second, the contemporary culture of Western psychotherapy emphasizes the concept of the self [6].

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In contrast, Buddhist psychology views the concept of self as an artificial, language-based construct that impedes, rather than fosters, the sort of perceptual clarity associated with mindfulness. Not only is the conceptual nature of self problematic, but the tendency to become overly attached to one's concept of self can result in psychological rigidity that makes change or adaptation difficult. According to the Buddhist perspective underlying mindfulness meditation practice, attachment in any context lies at the root of suffering, whether this involves a particular view of the self, pursuit of material possessions, personal relationships, or any other endeavor that becomes the object of deliberate attainment [7].

Nonetheless, the concept of self is so deeply ingrained in Western psychology that virtually all clinical techniques use this construct as a point of reference. Practically speaking, proponents of both traditional Western clinical interventions and meditation practices emphasize the gradual diminishing of "self-absorption" that is so characteristic of states of psychological distress. Being less defensive [8], more open to experience, more accepting, and less judgmental are all potential reflections of a tendency toward less personal rigidity that might indicate a "freeing-up" of the self. Becoming aware of and experiencing compassion for the suffering of others is another way in which the strength of the se/f concept may begin to be diluted, or at least become less of a constant preoccupation.

Mindfulness refers to a tradition of meditation practice emphasizing the cultivation of moment-to-moment attention, based on Buddhist vipassana or insight meditation. Consciously directed attention is a key element in virtually all forms of meditation practice. In this context, Massion et al. (1995) define mindfulness meditation as "the intentional self-regulation of attention in the service of self-inquiry." In addition, many authors of both popular and scholarly texts on mindfulness, such as Boorstein (1995), Gunaratana (1991), Kabat-Zinn (1990) and others, emphasize the importance of acceptance, implying the adoption of an open, impartial, and nonjudgmental stance to the process of self-observation. The intention of mindfulness is to heighten self-awareness, become more aware of factors that influence behavioral tendencies, and act in ways that reflect skill and compassion toward oneself and others [9].

Kabat-Zinn (1990) explained how, by contributing to the "appraisal" portion of the stress/coping model of Lazarus and Folkman (1984), the attentional element of mindfulness can be applied to stress management. Detecting signs of stress is a required prerequisite for the implementation of successful coping responses, according to this model. Absent a capacity to detect signs of stress, the effects tend to accumulate gradualist, often remaining undetected until a major health problem such as a heart attack or ulcer occurs.

As practised in the MBSR programme, mindfulness offers a way of identifying the often subtle psychological reactions and physiological changes that in the classic fight-or-flight response sequence, if undetected, contribute to overactivation of the autonomic nervous system. A pattern

of increasingly unstable reactions and behaviours is set in motion without any regulatory oversight, ultimately resulting in systemic breakdown. In response to perceived stress, this continual modification and readjustment of "set points" for physiological parameters such as breathing and heart rate favours short-term adaptation at the cost of long-term physiological wear and tear. Allostatic load has been called the cumulative expense. Regulatory mechanisms tend to lose their versatility and responsiveness as allostatic load accumulates. Stress response mechanisms may lead to and hasten the development of stress-related diseases as a result of chronic activation. According to KabatZinn, mindfulness meditation can help de-automate this cycle of reactivity by enhancing detection of stress symptoms at comparatively low activation levels, providing the individual with an opportunity to implement responses that are more deliberate and less reflexive.

In general, applications of mindfulness meditation in health-care settings, reflecting the significant influence ofKabat-Zinn's MBSR program, are intended to help participants detect and respond skillfully to illness-induced stress in the context of time-limited, group-based intervention programs. In general, clinically based mindfulness practice incorporates the following components: (a) conscious allocation of attention in the service of (b) nonjudgmental awareness; ideally cultivated (but not necessarily limited to) a state of (c) physiological hypo-arousal; with the intention of (d) enhancing present-moment awareness and (e) diminishing habitual patterns of cognitive, behavioral, and physiological reactivity.

In meditation practice, management and distribution of attention is paramount. Instead of trying to regulate or change the precise content of thoughts or beliefs, as is the case in cognitive therapy, the practice of meditation, including mindfulness, starts simply by experiencing fundamental phenomena, such as breath. While at first glance this can seem of little value, breath observation shows the difficult essence of regulation of attention and offers a way to practise focused attention. The belief in mind completeness is that it takes dedicated practise to turn one's focus inward in a concentrated, conscious way. From a hierarchical viewpoint, breath-watching practise will lead to direct or conscious observation of other objects of attention—other stimuli, including sounds, visual objects, and eventually thoughts. Knowledge uses a wider observational stance that involves patterns of thinking and other mental activities instead of more narrow thought monitoring in cognitive approaches. In this position, it is tacit to be able to detach from one's ideas and make them subjects of basic attention rather than examination. Thoughts are viewed like any other feeling in this sense sounds and sights, for instance—rather than as special occurrences to which we attach specific significance [10]. Six, not five, senses were positioned in the Buddhist philosophical system on which mindfulness meditation is based; these included hearing, vision, touch, taste, smell, and mental phenomena.

CONCLUSION

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To conclude, mindfulness meditation appears to represent a positive trend in clinical practise on the basis of the literature reviewed here. The practise of mindfulness meditation has been shown to have a beneficial impact on pain, anxiety, depression, and other medical symptoms, especially in the context of outpatient behavioural medicine applications. This article represents an attempt to integrate mindfulness as a means of developing additional testable research hypotheses regarding its effectiveness as a therapeutic intervention technique in a broad, contemporary context of stress reactivity. In order to bring this approach further into the mainstream of clinical practise, such research is needed. Growing recognition in clinical applications of meditative and contemplative activities makes it possible that the influence of mindfulness will continue to grow, provided that supporting validation continues to be offered by clinical studies.

REFERENCES

[1] A. Ross and S. Thomas, "The health benefits of yoga and exercise: A review of comparison studies," *Journal of Alternative and Complementary Medicine*. 2010.

[2] R. Desai, A. Tailor, and T. Bhatt, "Effects of yoga on brain waves and structural activation: A review," *Complementary Therapies in Clinical Practice*. 2015.

[3] T. R. Carei, A. L. Fyfe-Johnson, C. C. Breuner, and M. A. Brown, "Randomized Controlled Clinical Trial of Yoga in the Treatment of Eating Disorders," *J. Adolesc. Heal.*, 2010.

[4] A. Diamond and K. Lee, "Interventions shown to aid executive function development in children 4 to 12 years old," *Science*. 2011.

[5] A. Büssing, A. Michalsen, S. B. S. Khalsa, S. Telles, and K. J. Sherman, "Effects of yoga on mental and physical health: A short summary of reviews," *Evidence-based Complementary and Alternative Medicine*. 2012.

[6] H. Cramer, R. Lauche, J. Langhorst, and G. Dobos, "Is one yoga style better than another? A systematic review of associations of yoga style and conclusions in randomized yoga trials," *Complementary Therapies in Medicine*. 2016.

[7] K. Davis, S. H. Goodman, J. Leiferman, M. Taylor, and S. Dimidjian, "A randomized controlled trial of yoga for pregnant women with symptoms of depression and anxiety," *Complement. Ther. Clin. Pract.*, 2015.

[8] L. A. Uebelacker, G. Epstein-Lubow, B. A. Gaudiano, G. Tremont, C. L. Battle, and I. W. Miller, "Hatha yoga for depression: Critical review of the evidence for efficacy, plausible mechanisms of action, and directions for future research," *Journal of Psychiatric Practice*. 2010.

[9] J. J. Noggle, N. J. Steiner, T. Minami, and S. B. S. Khalsa, "Benefits of yoga for psychosocial well-being in a us high school curriculum: A preliminary randomized controlled trial," *Journal of Developmental and Behavioral Pediatrics*. 2012.

[10] I. Stephens, "Medical Yoga Therapy," *Children*, 2017.

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