

# Within pali was the language of buddhist psychology

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Within the past few decades, there has been an increase in the interest of investigating mindfulness as a psychological concept and as a form of clinical intervention. Our current knowledge regarding the use of mindfulness within the scope of clinical psychology has derived from recent discussion with Buddhist traditions. According to current research, mindfulness practices offer psychotherapists a way to positively influence angles of treatment that contribute to overall effective care (Germer, 2012). However, recent dialogue has suggested that mindfulness has lost its Buddhist roots, ultimately signifying that mindfulness is not as good as advertised. Counter arguments have attempted to prove that mindfulness brings about various psychological and health benefits.

The ultimate question we face now is this: What evidence and research can support the alleged benefits of mindfulness to prove its effectiveness? To properly understand the topic, it is necessary to know the proper definition of mindfulness and its origination. Mindfulness has to do with qualities of attention and awareness that can be cultivated and developed through meditation. An operational working definition of mindfulness is: the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment (Kabat-Zinn, 2003). Historically, mindfulness has been called “the heart” of Buddhist meditation. The term mindfulness is an English translation of the Pali word *sati* (Germer, 2016).

Pali was the language of Buddhist psychology 2,500 years ago and mindfulness was the core teaching of this tradition (Germer, 2016). *Sati*

connotes awareness, attention and remembering. Mindfulness continues to rest at the center of Buddhist psychology. Psychotherapists are likely to find early Buddhist psychology compatible with their interests because it shares the common goal of alleviating suffering. The historical Buddha (563-483 B.

C. E) is understood to have been a human being, not a god, and he dedicated his life's work to alleviating psychological suffering (Germer 2016). After the Buddha's enlightenment, he did not seem quite like other men. When they asked him who he was, he replied that he was "Buddha" which simply meant "a person who is awake" (Germer 2016). He spoke in simple language using stories and ideas from popular Indian culture. The Buddha could be described as a physician whose primary work was identifying the condition that affected humankind, discovering its causes, finding a cure and designing a plan through which each person could attain healthiness.

He first demonstrated these steps himself. According to tradition, Siddhartha began his journey to becoming the Buddha one night when he finally saw clearly how the mind and body create their own suffering. After this realization, he was able to transform himself such that suffering entirely ended for him. Having cured himself, he then went on to help others. In his first sermon on the Four Noble Truths, he put a brief list of foundational ideas.

Firstly, the human condition involves suffering. Secondly, the conflict between how things are and how we desire them to be causes this suffering.

Furthermore, suffering can be reduced or even eliminated by changing our attitude toward unpleasant experiences. Lastly, there are eight general strategies to bring suffering to an end (The Eightfold Path). Even in the earliest path of development in Buddhist tradition, it was understood that different people have different strengths and weaknesses, different capabilities, and find themselves in a variety of worldly circumstances.

The Buddha understood that the healing process involves far more than just medicine. The starting point for the program of healing prescribed by the Buddha was mindfulness meditation. Since 1979, mindfulness-based stress reduction (MSBR) has become widely accepted (Kabat-Zinn, 2012). The MSBR program essentially aims to create an environment where people can learn to slow down in their lives and train themselves to calm the body, examine what is occurring in both the mind and body and build a relationship with the present moment.

It is currently being used and studied within conventional medicine and psychiatry. Recent work at the Center for Mindfulness and the Stress Reduction Clinic at the University of Massachusetts Medical Center has attempted to provide various proposals upon which features of mindfulness and its clinical and social applications could ultimately be developed. Many early descriptive studies attempted to investigate the validity and short- and long-term clinical effectiveness of the MBSR intervention in patients with a wide range of medical conditions (Kabat-Zinn, 2003). Furthermore, a series of studies were done at this clinic to demonstrate clinical effectiveness of MSBR. One study looked at whether meditation could influence the healing process

in psoriasis, which is a skin disease that is an uncontrolled cell proliferation of the epidermis (Kabat-Zinn, 2012). Psoriasis can cover the whole body and stress can make this condition much worse. Psoriasis tends to flare up under high emotional stress and often disappears when one is not under a considerable amount of stress. The ultraviolet light in sunlight is quite effective for this condition, therefore the treatment for psoriasis is ultraviolet phototherapy.

The initial idea behind this study was that while patients were standing under ultraviolet light under very stressful conditions, perhaps it would be useful to guide them in mindfulness meditation. Possibly through this process, they would develop calmness and gradually become less stressed. In the psoriasis study, thirty-seven patients with moderate to severe psoriasis were chosen as candidates and randomly separated into two groups. One group (meditators) followed guided mindfulness meditation instructions delivered by audio-tape during their ultraviolet treatments on a 3-times-per-week protocol (Kabat-Zinn, 2003). This tape included a guided visualization in which the patient visualized the ultraviolet light slowing down and stopping the rapidly growing cells in the epidermis (Kabat-Zinn, 2003). The other group (usual care) received the light treatments without listening to a tape. The status of each patient was monitored by nurses at each treatment session and was documented periodically by photography during the twelve-week study (Kabat-Zinn, 2003). The study was done twice and during both studies, it was shown that the meditators healed at a much faster rate than the non-meditators.

The statistical analysis showed them healing at approximately four times the rate of those who were receiving the light treatments but were not meditating (Kabat-Zinn, 2012). The findings strongly suggest that the effects are real and deserves further research. The implication of these findings is that something occurring in the mind is greatly influencing the healing process of the skin. However, we cannot solely conclude from these observations that it is the mindfulness practice specifically that is responsible for the increased rate of the clearing of the skin. Overall, one can say that mindfulness-based interventions such as MSBR prove to be effective in their attempt to incorporate Buddhist meditative techniques into clinical medicine.

In another study, a small randomized trial of MSBR was conducted in a work setting to investigate how the brain and the immune system change as people regulate emotion when they are under work or life stress. Forty-one employees of a biotechnology company were randomly assigned to either an MBSR training or a wait-list condition. The MBSR subjects participated in an 8-week program during working hours (Kabat-Zinn, 2003).

All subjects underwent extensive laboratory testing on three occasions, pre and post the eight-week intervention period and at a four month follow-up, including EEG to measure brain electrical activity in response to various emotional challenges (Kabat-Zinn, 2003). All subjects were also vaccinated with influenza vaccine at the end of the 8-week intervention period and subsequently tested for antibody titer (Kabat-Zinn, 2003). The flu vaccine was designed to detect how well the immune system of the participants were functioning. In the findings, testing showed an increase in left prefrontal

activity in the brain among those who had done the meditation training. The control group showed an increase in activity on the right side of the prefrontal cortex (Kabat-Zinn, 2003). Left-sided activation in several anterior regions has been noted to possess forms of positive emotional expression while right-sided activation is usually associated with negative emotional expression such as anger, anxiety and depression (Kabat-Zinn, 2003). Regarding the flu vaccine that was given, it revealed that the meditation group showed an increase in the number of antibodies produced in response to the vaccine compared to the control group.

These changes endured for at least 4 months after the intervention (Kabat-Zinn, 2003). This study insinuates that the use of MSBR can lead to brain changes depending on more effective handling of negative emotion under stress.