Comenzar por uno mismo

Introducción a Mindfulness para Profesionales de la Salud

Coordinado por la Lic. María Noel Anchorena

Buenos Aires, Argentina

Sociedad Mindfulness y Salud

Mindfulness y Psicoterapia:
Un nuevo camino hacia la integración

Por la Lic. María Noel Anchorena -
Fundadora y Directora General de la Sociedad Mindfulness y Salud

Un Modelo Emergente

por Christopher Germer (*)

¿Hacia donde se dirige el interés actual en Mindfulness?

"Tal vez estemos siendo testigos del comienzo de un modelo más unificado en la psicoterapia. Es muy probable que leamos cada vez más investigaciones que identifican a Mindfulness como un elemento clave en los protocolos de tratamiento, un elemento crucial en la relación terapéutica y una nueva herramienta para los psicoterapeutas para cultivar cualidades terapéuticas personales y bienestar general. Mindfulness puede convertirse en un constructo que une y conecta aún mas la teoría, la investigación y la práctica clínica y ayuda a integrar la vida personal y profesional del terapeuta".

(*) Christopher Germer Ph.D. Director del Área de Educación Continua del Institute for Meditation and Psychotherapy, en Boston, Massachussets. Co-editor del libro Mindfulness and Psychotherapy. Desde hace 20 años es Instructor Clínico de Psicología en Harvard Medical School.

El Profesional Atento (Mindful Practitioner)

por Ronald Epstein, M.D.(**)

"Mindfulness es una extensión lógica del concepto de práctica reflexiva. El profesional atento (mindful practitioner) está presente en su experiencia de todos los días, en todas sus manifestaciones, incluyendo acciones, pensamientos, sensaciones, imágenes, interpretaciones y emociones. Mindfulness lleva a la mente desde las teorías, posturas y abstracciones de vuelta a la experiencia en sí misma, lo que nos evita caer presos de nuestros propios prejuicios, opiniones, proyecciones y expectativas y nos permite liberarnos del chaleco de fuerza de la inconciencia. [...] Mindfulness es lo opuesto a la multitarea (multitasking). Es una cualidad del médico como persona, sin límites entre los aspectos técnicos, cognitivos, emocionales y espirituales de la práctica."

(**) Ronald M. Epstein, M.D. es Profesor de Medicina de Familia, Psiquiatría, Oncología y Enfermería en el Centro Médico de la Universidad de Rochester y un médico certificado en Medicina Familiar y Medicina Paliativa. Es un experto en y ha escrito numerosos artículos acerca de la comunicación entre médicos, pacientes y parientes.

Breve Historia de Mindfulness y su Integración en la Salud

En las últimas décadas se ha profundizado el **diálogo entre las prácticas contemplativas como Mindfulness, la Psicoterapia y la Salud,** explorando como el desarrollo de la conciencia que emerge a partir de la práctica de Mindfulness puede integrarse en la práctica clínica y enriquecer el encuentro humano entre el profesional y el paciente. Esta nueva integración incluye a **psicólogos, psiquiatras y otros profesionales de la salud como investigadores y educadores** que están interesados en las ciencias del comportamiento y buscan sentirse más integrados en su vida personal y profesional.

En el campo de la Salud actual se está desplazando desde el foco en el tratamiento y la patología a la comprensión de las necesidades de apego, los efectos de la conexión con otro ser humano en el desarrollo de la mente y el cerebro y otras vías de la curación emocional. **Las investigaciones actuales apuntan a comprender como la mente, el cerebro y el cuerpo trabajan en forma conjunta de manera que favorecen el crecimiento y la sanación.**

Los cambios que se están produciendo permiten la **integración de Mindfulness en el cuidado de la Salud, en el cultivo de la relación profesional-paciente y en el profesional mismo.** Particularmente las teorías cognitivas conforman un terreno fértil sobre el cual la práctica de Mindfulness ofrece grandes posibilidades terapéuticas y prometedores avances. Esta práctica se incluye en las llamadas terapias cognitivas de tercera generación y las denominadas neurociencias contemplativas.

El entrenamiento en Mindfulness ha demostrado ser una práctica efectiva y poderosa, basada en la evidencia científica, para mejorar la salud mental.

Está empíricamente validada como una intervención efectiva en una amplia variedad de cuadros clínicos como el dolor crónico, enfermedad cardiovascular, los trastornos de ansiedad, la depresión, el trastorno por estrés postraumático, el trastorno obsesivo compulsivo, el abuso de sustancias y el trastorno limite de la personalidad, entre otros.

Mindful Practitioner:

El cultivo de Mindfulness en el Profesional de la Salud

Aunque la mayor cantidad de estudios publicados y modelos desarrollados son de orientación cognitiva, es importante destacar que la integración de Mindfulness a la teoría y práctica clínica **no es exclusiva de una orientación teórica en particular**, ya que los beneficios que brinda tienen que ver con el cultivo de cualidades primordiales para cualquier tipo de proceso terapéutico exitoso.

Su integración cubre un amplio rango de orientaciones ya que **Mindfulness se trata de una capacidad humana universal** y puede incluirse en diferentas campos de la psicología y de la ciencia como la terapia cognitivo-comportamental, el psicoanálisis, la psicoterapia humanística, la neurociencia, la ética, la espiritualidad, la psicología de la salud y la psicología positiva.

Para el profesional de la Salud es un gran desafío poder permanecer atento, plenamente presente y conectado con el paciente, momento a momento. Esta práctica mejora la calidad de la atención, profundizando la presencia y la compasión hacia el paciente en cualquier intervención clínica y marco teórico con el que se trabaje; apuntando a la integración de diferentes disciplinas que enriquecen la mirada y el abordaje terapéutico.

Según Ellen Langer:

"...el uso de Mindfulness en la psicoterapia sostiene la perspectiva que busca una visión más amplia en lugar de un tratamiento eterno en la patología del pasado."
E. Langer (1989)

El cambio de paradigma también se apoya en resultados significativos hallados en investigaciones acerca del proceso terapéutico. Estos estudios indican que lo mas importante no es la orientación teórica del terapeuta *per se*, sino la calidad del vínculo terapéutico, siendo éste el factor esencial para el éxito terapéutico. Esto es también cierto no solo para profesionales del ámbito de la psicología, sino también para los profesionales de la Salud en general: la presencia del profesional tiene una gran influencia en las posibilidades de sanación del paciente.

La integración de Mindfulness en el contexto clínico permite el desarrollo de una Presencia Compasiva en la práctica clínica, enriquecido y profundizando el vinculo y la empatía. Esta integración en la psicoterapia se vincula directamente con los factores comunes en la práctica que subyacen a un tratamiento exitoso, y amplían y enriquecen desde una nueva perspectiva la

concepción de sufrimiento y bienestar. Tiene que ver con una actitud del profesional, una forma de estar en el encuentro con el paciente. **Surge a partir de la práctica personal del profesional, desarrollando luego habilidades clínicas para su integración**.

Gay y Kathlyn Hendricks dicen:
"La estrategia de sanación más importante es la de Estar Presente. Para todos nosotros, pero mas específicamente para los profesionales de la salud, el brindar a una persona el espacio para sentir lo que sea que esté sintiendo es la técnica de sanación mas importante. Todo lo que hacemos mejora o interfiere con nuestra habilidad para poder estar con lo que está sucediendo en nosotros mismos". Hendricks G. y Hendricks K.(1993)

Una práctica atenta:

Los beneficios de Mindfulness

Los beneficios de la práctica de Mindfulness tienen una gran importancia tanto para el profesional como para el paciente. De alguna manera el profesional modela Mindfulness para el paciente en la medida que le muestra la atención plena que él mismo tiene de sus procesos al mismo tiempo que lo hace con los procesos del paciente. Todo lo que pueda fortalecer y profundizar una conexión sana y genuina entre el paciente y el profesional tendrá una influencia positiva en el proceso del paciente, lo que lo conducirá a resultados positivos.

- Cultiva cualidades humanas como la autenticidad y el calor humano
- Cultiva la empatía y la compasión
- Facilita el desarrollo de la capacidad de escuchar con un interés genuino por el paciente
- Favorece la capacidad de mantener el foco en el presente, aun cuando el paciente no lo pueda hacer.
- Permite que se pueda permanecer centrado, equilibrado y tranquilo, aún en momentos en que el paciente tiene una alternación emocional intensa
- Permite mantener una actitud saludable hacia los resultados
- Ayuda a mantener la dirección y foco en el tratamiento
- Aumenta las habilidades para observar las respuestas del paciente.

¿Qué es Mindfulness o Atención Plena?

La palabra **"Mindfulness"** ha sido traducida al español de muchas maneras: Conciencia plena, Presencia mental, Mente Plena y Atención Plena, entre otras. Nosotros utilizaremos el término **Atención Plena.**

Mindfulness puede definirse como:
"Prestar atención de manera intencional al momento presente, sin juzgar"
Jon Kabat Zinn.

Este tipo de atención nos permite **aprender a relacionarnos de forma directa con aquello que está ocurriendo en nuestras vidas, aquí y ahora, en el momento presente**. Es una forma de tomar conciencia de nuestra realidad, dándonos la oportunidad de trabajar conscientemente con nuestro estrés, dolor, enfermedad, pérdida o con los desafíos de nuestra vida. En contraposición, una vida en la que no ponemos atención, en la que nos encontramos más preocupados por lo que ocurrió o por lo que aun no ha ocurrido, nos conduce al descuido, el olvido y al aislamiento, reaccionando de manera automática y desadaptativa.

La práctica de Mindfulness nos ayudará a recuperar la conexión con los sentidos, con las sensaciones físicas, desarrollando una mayor la capacidad de percibirnos momento a momento, para **autorregularnos, tomando así un rol ACTIVO en el proceso de mejorar la salud y calidad de vida en general.**

La atención plena nos ayuda a **recuperar nuestro equilibrio interno**, atendiendo de forma integral a los aspectos de la persona; cuerpo, mente y espíritu. Practicando la atención plena desarrollamos una **mayor capacidad de discernimiento y de compasión**. La práctica de esta atención abre la puerta hacia nuevas posibilidades, nos trae al "aquí y al ahora", nos invita a vivir una vida de manera mas plena y presente.

¿Cuál es la importancia de Mindfulness?

Durante la última década, Mindfulness ha tenido una **influencia significativa en la psicoterapia contemporánea y en el cuidado de la Salud en general**. Es una forma simple, pero increíblemente efectiva para relacionarse con la experiencia y para aliviar el sufrimiento humano.

Con su origen en prácticas de Meditación de más de 2500 años, la ciencia y los profesionales están comenzando a descubrir de manera notable que Mindfulness es una gran promesa, no solo para el desarrollo personal, sino también para mejorar la relación entre el profesional y el paciente.

Mindfulness está demostrando ser un abordaje muy poderoso para enriquecer cualquier forma de tratamiento y constituye un **componente central en muchos de modelos de tratamiento** empíricamente validados.

La práctica de Mindfulness permite profundizar la **aceptación de si mismo**, que lleva a un mayor sentido de bienestar mental y emocional en el profesional, aprendiendo a reducir y manejar su nivel de estrés. Permite también profundizar **cualidades esenciales de la presencia terapéutica** como la empatía y la ecuanimidad.

La integración de Mindfulness en la práctica clínica surge a partir de una **práctica continua por parte del profesional. No es posible incluir esta práctica sin que el profesional experimente por si mismo, en el marco de una práctica diaria personal y sostenida**, lo que implica la observación ecuánime y disciplinada de los movimientos de la mente, las emociones y las sensaciones.

Todos los modelos que integran Mindfulness en su tratamiento coinciden que una de las **condiciones necesarias para aplicar Mindfulness en la práctica profesional, es la práctica personal del profesional** para poder luego integrar gradualmente y naturalmente estas capacidades en la práctica clínica.

Entre los requisitos propuestos por el Center for Mindfulness en los Professional Training Programs (programas de entrenamiento para profesionales) para aceptar a los candidatos que allí se forman incluyen una **extensa práctica personal de meditación, realización de varios retiros prolongados y capacidad para expresar la esencia de la práctica que debe venir de la propia experiencia.**
Al respecto **Jon Kabat-Zinn** refiere que:

"no se puede pedir al paciente que haga por si mismo algo que no hayamos hecho nosotros por nosotros mismos."

Reconociendo este aspecto fundamental para la integración, se propone **comenzar el cultivo de Mindfulness** a través del desarrollo y el cultivo de la propia práctica y poder así desarrollar con el tiempo una práctica estable, integrando la vida personal y profesional.

Fundamentos de la práctica: Actitud y Compromiso.

Pilares y actitudes básicas que sostienen la práctica de Mindfulness.

Por Jon Kabat-Zinn

- **No juzgar**
  Testigo imparcial, poder ver a través de los juicios
- **Paciencia**
  Una forma de sabiduría, aceptar los tiempos, aquel que se puede conectar con las cosas tal cual son
- **Mente de Principiante**
  Cada momento es nuevo, poder ver más allá de los pensamientos, las expectativas, estar abierto a la experiencia, a nuevas posibilidades
- **Confianza**
  En un mismo, en los propios sentimientos, en la intuición
- **No forzar**
  No querer llegar ningún lado, SER en el momento presente, conectarse con las cosas tal cual son ahora sabiendo que cambian.
- **Aceptación**
  Crea las precondiciones para la sanación, para el cambio. Estar receptivo y abierto para actuar apropiadamente, claramente, sin estar nublados por nuestros juicios, expectativas, reacciones emocionales.
- **Desapego, soltar, dejar ir.**
- **Sentido del humor.**
- **Compromiso, autodisciplina, intención.**

Acerca de la Lic. Maria Noel Anchorena

La Sociedad es impulsada por **María Noel Anchorena**, es **Licenciada en Psicología** y ha sido entrenada como **Instructora de MBSR por Instructores Senior del Center for Mindfulness, en el Centro Medico de la Universidad de Massachusetts.**

María Noel fue integrante del Servicio de Psiquiatría del Hospital Italiano de Buenos Aires en los equipos de Evaluación y Asistencia Psicológica durante 5 años.
Durante 3 meses participó **en Programas de entrenamiento y capacitación de instructores - Professional Training Programs -** en el Center for Mindfulness, del Departamento de Medicina Preventiva y del Comportamiento del Centro Médico de la Universidad de Massachusetts. Se formó en el **NICABM - National Institute for the Clinical Application of Behavioral Medicine- de los Estados Unidos** especializándose en la integración de Mindfulness y Psicoterapia y su aplicación en la Medicina y el Cuidado de la Salud.

Desde hace varios años dicta regularmente **Programas de Reducción de Estrés basados en Mindfulness** (MBSR, Mindfulness-based Stress Reduction) en diversos ámbitos de intervención. Se desempeña como **Psicóloga Clínica** brindando asistencia con una Orientación basada en Mindfulness (Minfulness-based Psychotherapy), **investigando y aplicando diferentes modelos de intervención clínica basados en Mindfulness y Aceptación.**

Dicta cursos de entrenamiento y capacitación en el **ámbito Empresarial y Corporativo** para la Reducción y el Manejo del estrés laboral y en la formación de profesionales de la salud.

Realiza entrenamientos y presentaciones en el **ámbito académico y científico en Congresos Internacionales y Conferencias** realizadas en la Argentina, otros países de Latinoamérica y en los Estados Unidos.

En este emprendimiento, María Noel busca **profundizar y ampliar la expansión de Mindfulness, haciéndola accesible a diversos ámbitos**. El desarrollo de la Sociedad está firmemente enraizado en la **Ciencia y en la Práctica y Enseñanza de Mindfulness, para crear puentes entre las disciplinas científicas y contemplativas.**

Desde los 21 años, María Noel lleva adelante una práctica personal de Mindfulness, participando regularmente en Retiros de Meditación en las tradiciones Zen y Vipassana y continúa dictando programas MBSR y distintos formatos de intervenciones basadas en Mindfulness.

Acerca de la Sociedad Mindfulness y Salud

Misión y Objetivos

La **Sociedad Mindfulness y Salud** es una iniciativa para la integración y desarrollo de Mindfulness:

1. **En el ámbito Científico**, a través de la investigación y estudio de modelos de aplicaciones clínicas en la Medicina y en el campo de la Psicoterapia;
2. **En el ámbito Asistencial**, generando intervenciones en el campo de la Psicoterapia, en el cuidado de la Salud y la asistencia en la Enfermedad;
3. **En el ámbito Organizacional**, brindando recursos y aplicaciones prácticas para la inclusión de Mindfulness en diversas Instituciones.

La práctica de Mindfulness (Atención Plena) propone la **toma de un rol activo** y la incorporación de herramientas que permiten reducir y manejar el estrés de manera diferente y más eficaz.

Por lo tanto es necesario el **estudio, la práctica, la transmisión y la continua investigación y aplicación de Mindfulness** en el manejo del estrés, la enfermedad y el cuidado de la Salud, llevada a cabo con **seriedad académica y rigurosidad científica,** incluyendo aportes de diversas áreas y/o disciplinas.

Las actividades que se desarrollan con este fin incluyen el Programa de Reducción y Manejo del Estrés (MBSR) basado en la práctica de Mindfulness (atención plena), como así también workshops, talleres y cursos orientados a pacientes, profesionales de la salud y a empresas. Se centra también en la aplicación en el ámbito de la Psicología ampliando y profundizando la práctica de la Psicoterapia, el vínculo terapéutico y el cuidado y bienestar del profesional de la salud.

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Un cambio Atento: el desarrollo y cultivo de Mindfulness en la regulación del estrés y la ansiedad.

Lic. María Noel Anchorena, Lic. Javier Cándarle.

Trabajo basado en la presentación que realizó el Lic. Javier Cándarle en el marco de la **Jornada de Aceptación** del **XI Congreso Internacional de Estrés Traumático y Trastornos de Ansiedad** realizadas el 23, 24 y 25 de Junio de 2010 en Buenos Aires, Argentina.

Resumen:
En este trabajo se presenta una de las modalidades de intervención que realiza el Equipo de la Iniciativa Mindfulness en la Salud en la Argentina, dirigida por la Lic. María Noel Anchorena, con diez años de experiencia en la práctica, estudio y enseñanza de Mindfulness. Esta presentación se referirá específicamente al aporte que realiza el Programa de Reducción de Estrés (MBSR) en la regulación del estrés y de la ansiedad.

En las últimas dos décadas ha habido un creciente interés en el estudio e integración de prácticas contemplativas en Occidente. El abordaje tradicional de la medicina y la psicología de occidente se integra con prácticas contemplativas, desarrollando así nuevos modelos de intervención basados en Mindfulness. Estos modelos abordan de manera más integrada y humanizada los diferentes aspectos asociados a la salud, la enfermedad, el dolor, el sufrimiento y el cuidado de las personas.

Dentro de las intervenciones que se han desarrollado en el contexto de la Medicina Mente-Cuerpo (Mind-Body Medicine) una de los modelos más aplicados e investigados en los últimos 30 años es el modelo **MBSR**.

Este modelo invita a la persona a conocer a través de la propia experiencia directa, en qué consiste la práctica de Mindfulness para poder así integrarla en el cuidado de su salud y calidad de vida.

Las investigaciones demuestran que este enfoque es efectivo en la reducción del estrés, el alivio del malestar psicológico, la reducción de los niveles de depresión y ansiedad, y en la mejora en el estado de ánimo y el bienestar general.

MBSR es la sigla en inglés para **Mindfulness-based Stress Reduction** y cuya traducción al español es **Reducción de Estrés basada en Mindfulness** (Atención Plena). El Modelo MBSR es un modelo con un enfoque psico-educativo, sistemático y bien definido, centrado en la persona, en el que cada participante toma un **rol activo en el cuidado y/o restablecimiento de su salud.** El MBSR se desarrolló en el **Center for Mindfulness**, en la División de Medicina Preventiva y del Comportamiento del Centro Médico de la Universidad de Massachusetts. Fue creado por el **Dr. Jon Kabat-Zinn** en el año 1979.

Inicialmente Jon Kabat-Zinn piensa este programa como una red de contención para pacientes que *"caían por las grietas del sistema"*. Aquellos pacientes que presentaban cuadros de dolor crónico, enfermedades terminales o cuadros de ansiedad y depresión resistentes al tratamiento entre otros.

Al no encontrar alivio en los tratamientos habituales que llevaban a cabo, eran derivados a la Clínica de Reducción de Estrés en el Centro Médico de la Universidad de Massachussets para complementar su tratamiento médico, psicológico o psiquiátrico, pudiendo así desarrollar un rol activo y participativo en el cuidado de su salud.

También asisten al programa MBSR personas que presentan cuadros de estrés crónico, tensión y malestar y que deciden generar un cambio profundo en su modo de vida y la manera de estar presente.

El MBSR invita a la persona a tomar conciencia de la manera en que se relacionan con su experiencia en el momento presente. Se invita a explorar la conexión mente-cuerpo así como también el rol de los pensamientos, emociones, reacciones y patrones de conducta en la salud y calidad de vida.

Hoy en día este abordaje se desarrolla en más de 260 centros a nivel mundial. Se calcula que 16.000 personas han realizado el entrenamiento y unos 6.000 profesionales de la Salud han sido entrenados como instructores de Mindfulness, aplicándose actualmente en ámbitos diversos tales como empresas, deportes de alto rendimiento, educación (docentes y alumnos) y cárceles entre otros.

Estos son algunos de los resultados que reportan las personas que completan el programa MBSR

- Desarrollo de habilidades para **manejar de manera más efectiva situaciones de estrés y ansiedad** a corto y largo plazo.
- Una mayor **habilidad para relajarse.**
- Una **disminución sostenida de síntomas físicos y psicológicos** y una mayor habilidad para **mantener el equilibrio** bajo situaciones de estrés.
- Una **disminución en los niveles de dolor** y una mayor habilidad para **afrontar síntomas de dolor crónico o irreversible.**
- Un mayor nivel de **entusiasmo y energía.**
- Mejoría en la **respuesta inmunológica.**
- Mayor **activación cerebral en el área pre frontal izquierda**; asociada a una respuesta más adaptativa frente al estrés.

¿Qué es Mindfulness?

Este término no tiene una traducción exacta al español. Algunas de las traducciones que se han utilizado en la bibliografía castellana son "presencia mental" "mente plena" o "atención plena".

Elegiremos la acepción "Atención Plena" como la más cercana al concepto en inglés que posee una riqueza de significación difícil de hallar en nuestra lengua.

Jon Kabat-Zinn define Mindfulness o Atención Plena como:

"Prestar atención deliberadamente, al momento presente con aceptación".

Lo que aparenta ser extremadamente sencillo reviste paradójicamente una gran dificultad. La misma genera un desafío que consiste en la práctica de la atención plena con curiosidad acerca de uno mismo.

La mente suele perderse en hechos pasados o futuros, razona, calcula, especula, juzga….

Rara vez estamos en el momento presente, abiertos y receptivos a lo qué este nos pueda traer. Solemos apegarnos a ciertos aspectos de nuestra experiencia y a rechazar otros, cerrándonos a la experiencia más inmediata y generando un **patrón de desatención** casi permanente.

Desde esta comprensión, **la práctica de Mindfulness no intenta ir a ningún sitio, ni sentir algo especial.**

No propone retirarse a una montaña para aislarse en soledad, ni exige pertenecer a una secta o religión. Ni siquiera busca alcanzar algún estado excepcional.

Jon Kabat-Zinn describe la Práctica de Mindfulness como el simple (y a la vez complejo) proceso de ***"observar expresamente cuerpo y mente permitiendo que nuestras experiencias se vayan desplegando de momento en momento y de aceptarlas como son".***

Así, la práctica disciplinada de Mindfulness **cultiva la capacidad de darse cuenta de lo que sucede mientras sucede,** invitando a entrenar la mente para mantenerla en calma y tornarla progresivamente más atenta y concentrada para poder así desarrollar un cambio en la relación con la propia experiencia momento a momento.

Un componente central y a la vez transformador de la práctica de Mindfulness es la actitud con la que la persona atiende a la experiencia momento a momento. Esta actitud se refiere al cultivo de aspectos compasivos, afectuosos y cálidos manteniendo apertura, amabilidad e interés hacia lo que se atiende.

Cultivar estas cualidades atendiendo a la experiencia interna y externa implica que la persona no permanezca atrapada en los juicios, evaluaciones y análisis de la experiencia, sino que

reconoce y acepta con amabilidad y apertura lo que está sucediendo en el campo de la experiencia un momento tras otro.

Mecanismos de activación del estrés y la ansiedad

El **estrés** es la respuesta generalizada e inespecífica del organismo ante la ***Percepción*** de una amenaza o de demanda incrementada. La percepción de una demanda ambiental activa el organismo para resolverla. Dicho mecanismo es por lo tanto adaptativo e imprescindible para la supervivencia.

Dicha activación **aguda** está diseñada para aumentar las probabilidades de supervivencia frente a una amenaza a corto plazo y no para que se la mantenga indefinidamente.

Cuando la persona habitualmente no puede volver al nivel basal de equilibrio, desarrolla un cuadro de **estrés crónico**, que puede no ser intenso pero sí prolongado en el tiempo, exigiendo una adaptación permanente. En estas condiciones se sobrepasa el umbral de resistencia de la persona, provocando lo que se conoce como **enfermedades de adaptación**.

Algunas de las consecuencias evidenciadas ante el Estrés Crónico:

- Disminución de las defensas inmunológicas dejando a las personas con mayor exposición a las enfermedades.
- Alteraciones funcionales de los órganos que más tarde se pueden convertir en daños orgánicos.
- Influencias sobre el sistema endócrino modificando y hasta anulando la secreción de algunas hormonas.
- Aparición de conductas compensatorias que intentan regular el nivel de estrés pero generan más daño tales como exceso de alcohol, café, tabaco, trabajo, etc.
- Alteraciones del sueño, del apetito, del carácter y la **aparición de ansiedad.**

¿Qué es exactamente la Ansiedad?

La **ansiedad** es una respuesta automática que se produce en nuestro cerebro más primitivo y en el sistema límbico al reconocer la existencia de un **peligro inminente**. Es también un recurso adaptativo ante la precepción de una amenaza. Cuando se "desafina" dicho mecanismo se genera un estado crónico de alerta o de respuesta exagerada ante estímulos que el mismo sujeto considera como menores.

Si el organismo se activa **de manera crónica**, produce una suma de tensiones y sobrecargas musculares por la hiperactivación permanente del sistema simpático-adrenérgico que hacen que el **cuerpo se vuelva cada vez más sensible a estímulos menores**.

Se genera una hipersensibilidad que produce una respuesta excesiva. La persona se encuentra bajo "alertas permanentes" producidas por los **automatismos perceptivos de los que tiene poca distancia crítica.**

En este estado de hiperactivación permanente decimos que la persona actúa en "**Piloto Automático",** es decir, permanece atrapada en los **patrones de pensamiento**, **conducta y emoción**, sin lograr una **perspectiva** que **evalúe con claridad y equilibrio** la demanda ambiental.

Desarrollar este recurso es lo que le permitiría **poder elegir de manera conciente** la respuesta necesaria a tales demandas.

¿Cómo actúa Mindfulness?: El rol de Mindfulness en la regulación del estrés y la ansiedad

La terapia Cognitiva y las Neurociencias han estudiado como la **desatención sistemática y la reacción de evitación** producen ansiedad, siendo ésta unas de las respuestas más comunes para intentar regularla.

La persona **evita conectarse cognitiva, afectiva o conductualmente** con la experiencia que le genera estrés o ansiedad subyaciendo la lógica infantil de que *"lo que no se ve, no existe*".

Dicha evitación ocasionalmente impide un incremento puntual de la ansiedad pero contribuye a mediano y largo plazo a su **sostenimiento y perpetuación** al **impedir la habituación y el aprendizaje**.

Se desarrolla una **adaptación a la cronicidad del estrés** que incluye la **desatención a las señales del cuerpo**, **a los estresores internos o externos, y a las consecuencias tóxicas de ese modo de vida.**

Este es justamente uno de los puntos donde opera la práctica de Mindfulness: **La observación atenta y sin juzgar** de los estresores y de las sensaciones de ansiedad **sin intentos de escapar o rechazarlas** va generando una **desensibilización** a dicha ansiedad que logra una **disminución de los mecanismos evitativos** que subyacen al fenómeno ansioso.

El **registro atento y con aceptación** de Emociones/Sensaciones Físicas y Pensamientos genera **un espacio** para percibir los patrones de percepción, afectivos y de la conducta permitiendo a la persona pasar de la **reacción automática a la respuesta elegida**.

Se logra una **perspectiva que sitúa un distanciamiento crítico** respecto de las variables del mundo y de las reacciones. Este es uno de los mecanismos a través del cual se cree que pueden estar asociados los cambios que se observan con la práctica.

La presencia de esta **capacidad metacognitiva** permite la auto-observación de los procesos mentales en la medida que suceden, notando los propios pensamientos y emociones como un testigo imparcial, sin identificarse con los mismos.

Esta **capacidad metacognitiva** abre un espacio para que la persona deje de actuar en forma automática y en cambio pueda tener un distanciamiento a través del cual tiene mayor libertad para dar una **respuesta** diferente a la situación, tanto interna como externa.

Este mecanismo permite que se genere un cambio en la **relación que la persona establece con la experiencia**. El reconocimiento y la aceptación de las sensaciones de malestar, tensión y ansiedad, sin tener que hacer nada para modificarlas, evitarlas o huir de ellas es en si mismo un cambio radical en la manera de afrontar la experiencia, generando una modificación en la percepción y de la intensidad de las mismas.

Este nivel de conciencia y aceptación de la experiencia del momento presente desarrolla la **flexibilidad psicológica** necesaria para ensayar nuevos mecanismos de afrontamiento y dar nuevas respuestas .

Al ampliar la capacidad de percibir los estresores y su impacto sobre el cuerpo y la mente **mientras suceden,** se abre un espacio para **desarrollar una visión más clara** y de esta manera lograr una **mayor capacidad auto-regulatoria**.

La capacidad **de auto-regulación** es otro de los mecanismos que nos permite comprender los cambios que se generan con la práctica de Mindfulness.

A través de la atención plena a las sensaciones del cuerpo, los pensamientos y emociones junto con una mayor conciencia de la información del entorno, la persona puede identificar de manera más temprana y precisa las señales de la ansiedad y de la activación del estrés en el cuerpo.

A través de mecanismos retro-alimentación o *feedback* el organismo logra regularse y adaptarse a la nueva situación, debido a que logró generar un espacio entre la percepción de la experiencia y la respuesta.

Esta pausa que se genera entre el estímulo y la respuesta es central al momento de generar cambios en la conducta y en los patrones de funcionamiento habitual y automático que mantienen el nivel de ansiedad y estrés activados y que generan sufrimiento. De esta manera disminuye la rumiación propia de los estados de ansiedad, en donde la mente queda atrapada en evaluar, juzgar, anticipar y controlar eventos en el futuro, impidiendo así un contacto directo con la experiencia del momento presente.

En síntesis, podemos decir que la práctica sostenida de Mindfulness cultiva:

- Habilidades de **autorregulación** que implican un **mayor equilibrio y balance emocional** para manejar y afrontar el estrés, el dolor y las demandas de la vida cotidiana.

- Una mayor **toma de conciencia** de la **relación entre el cuerpo, la mente y las emociones** dándose cuenta de como éstas influyen en el manejo del estrés, la salud y la calidad de vida.

- Un **rol activo y responsable** en el mejoramiento de la salud y calidad de vida.

La práctica de mindfulness permite que la persona desarrolle una mayor flexibilidad psicológica, para poder conectarse con la realidad del momento presente de manera más integrada y consiente. Así la persona desarrolla recursos internos y nuevas maneras de responder a las situaciones, que la llevan a una regulación de sus reacciones y dan lugar a una respuesta mas consiente y elegida.

Los abordajes basados en Mindfulness y Aceptación nos permiten tener una comprensión más amplia de la manera en que se genera y se perpetúa el sufrimiento en la mente, abriendo la posibilidad de explorar cómo a través el desarrollo de la conciencia, la aceptación y la compasión podemos recuperar el bienestar y el equilibrio momento a momento.

Mindfulness-Based Interventions in Context: Past, Present, and Future

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For Francisco Varela, 1945–2001

Baer's review (2003; this issue) suggests that mindfulness-based interventions are clinically efficacious, but that better designed studies are now needed to substantiate the field and place it on a firm foundation for future growth. Her review, coupled with other lines of evidence, suggests that interest in incorporating mindfulness into clinical interventions in medicine and psychology is growing. It is thus important that professionals coming to this field understand some of the unique factors associated with the delivery of mindfulness-based interventions and the potential conceptual and practical pitfalls of not recognizing the features of this broadly unfamiliar landscape. This commentary highlights and contextualizes (1) what exactly mindfulness is, (2) where it came from, (3) how it came to be introduced into medicine and health care, (4) issues of cross-cultural sensitivity and understanding in the study of meditative practices stemming from other cultures and in applications of them in novel settings, (5) why it is important for people who are teaching mindfulness to practice themselves, (6) results from 3 recent studies from the Center for Mindfulness in Medicine, Health Care, and Society not reviewed by Baer but which raise a number of key questions about clinical applicability, study design, and mechanism of action, and (7) current opportunities for professional training and development in mindfulness and its clinical applications.

Key words: **mindfulness, meditation, mind/body medicine, mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT).** ***[Clin Psychol Sci Prac 10: 144–156, 2003]***

I appreciate the opportunity to comment on Baer's (2003; this issue) review of mindfulness training as clinical intervention and to add my own reflections on the emergence of mindfulness in a clinical context, especially in a journal explicitly devoted to both science and practice. The universe of mindfulness[1] brings with it a whole new meaning and thrust to the word *practice,* one which I believe has the potential to contribute profoundly to the further development of the field of clinical psychology and its allied disciplines, behavioral medicine, psychosomatic medicine, and health psychology, through both a broadening of research approaches to mind/body interactions and the development of new classes of clinical interventions.

THE GROWING INTEREST IN MINDFULNESS

I find the Baer review to be evenhanded, cogent, and perceptive in its description and evaluation of the work that has been published through the middle of 2001, work that features mindfulness training as the primary element in various clinical interventions. It complements nicely the recent review by Bishop (2002), which to my mind ignores some of the most important, if difficult to define, features of such interventions in its emphasis on the perceived need

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to reduce to a clinical algorithm the complexity of the practice and nuanced delivery of mindfulness-based stress reduction (MBSR).

Both Baer and Bishop pose important questions that require addressing if researchers and clinicians are ultimately to understand mindfulness and its clinical utility. Both reviews agree that the scientific study of mindfulness and MBSR to date suffers from a range of methodological problems, a view with which I concur. When a field is in its infancy, it is not uncommon for the first generation of studies to be more descriptive of the phenomenon rather than definitive demonstrations of efficacy. Attempts at the latter tend to evolve over time after the potential value of a new approach has been at least tentatively established. This now appears to be the case with mindfulness-based interventions. Both Baer and Bishop conclude that enough evidence has now accumulated to warrant the development of more methodologically rigorous investigations of both the clinical efficacy of mindfulness training in various specific disorders and the possible mechanisms and pathways through which it might exert characteristic effects within those specific disorders.

The very fact that an increasing number of studies on mindfulness and its clinical applications are being funded and published and that an increasing number of doctoral theses on mindfulness are appearing in Dissertation Abstracts suggests that this is an area that is currently sparking considerable interest, perhaps driven primarily by the intuition that new dimensions of therapeutic benefit and novel insights into mind/body interactions might accrue through its exploration. Because interest in mindfulness and its applications to specific affective conditions is likely to increase even further, particularly within the cognitive therapy community with the development of mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) and with the use of mindfulness within dilectical behavior therapy (DBT; Linehan, 1993), it becomes critically important that those persons coming to the field with professional interest and enthusiasm recognize the unique qualities and characteristics of mindfulness as a meditative practice, with all that implies, so that mindfulness is not simply seized upon as the next promising cognitive behavioral technique or exercise, decontextualized, and "plugged" into a behaviorist paradigm with the aim of driving desirable change, or of fixing what is broken.

WHAT EXACTLY IS MINDFULNESS, AND WHERE DOES IT COME FROM?

As pointed out by Baer, mindfulness has to do with particular 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. Historically, mindfulness has been called "the heart" of Buddhist meditation (Thera, 1962). It resides at the core of the teachings of the Buddha (Gunaratana, 1992; Hanh, 1999; Nanamoli & Bodhi, 1995), traditionally described by the Sanskrit word *dharma,* which carries the meaning of *lawfulness* as in "the laws of physics" or simply "the way things are," as in the Chinese notion of *Tao.* One might think of the historical Buddha as, among other things, a born scientist and physician who had nothing in the way of instrumentation other than his own mind and body and experience, yet managed to use these native resources to great effect to delve into the nature of suffering and the human condition. What emerged from this arduous and single-minded contemplative investigation was a series of profound insights, a comprehensive view of human nature, and a formal "medicine" for treating its fundamental "dis-ease," typically characterized as the three "poisons": greed, hatred (aversion), and ignorance/delusion (unawareness).

Of course, the Buddha himself was not a Buddhist. One might think of dharma as a sort of universal generative grammar (Chomsky, 1965), an innate set of empirically testable rules that govern and describe the generation of the inward, first-person experiences of suffering and happiness in human beings. In that sense, dharma is at its core truly universal, not exclusively Buddhist. It is neither a belief, an ideology, nor a philosophy. Rather, it is a coherent phenomenological description of the nature of mind, emotion, and suffering and its potential release, based on highly refined practices aimed at systematically training and cultivating various aspects of mind and heart via the faculty of mindful attention (the words for mind and heart are the same in Asian languages; thus "mindfulness" includes an affectionate, compassionate quality within the attending, a sense of openhearted, friendly presence and interest). And mindfulness, it should also be noted, being about attention, is also of necessity universal. There is nothing particularly Buddhist about it. We are all mindful

to one degree or another, moment by moment. It is an inherent human capacity. The contribution of the Buddhist traditions has been in part to emphasize simple and effective ways to cultivate and refine this capacity and bring it to all aspects of life. In this regard, mindfulness certainly received its most explicit and systematic articulation and development within the Buddhist tradition over the past 2,500 years, although its essence lies at the heart of other ancient and contemporary traditions and teachings as well, approaches that can be of great value in refining one's own practice, insight, and teaching (see, for example, Chuang Tsu, 1964; Krishnamurti, 1999; Lao-tsu, 1988; Maharaj, 1973; Maharshi, 1959; Thakar, 1972; Tolle, 1999).

Mindfulness is the fundamental attentional stance underlying all streams of Buddhist meditative practice: the Theravada tradition of the countries of Southeast Asia (Thailand, Burma, Cambodia, and Vietnam); the Mahayana (Zen) schools of Vietnam, China, Japan, and Korea; and the Vajrayana tradition of Tibetan Buddhism found in Tibet itself, Mongolia, Nepal, Bhutan, Ladakh, and now large parts of India in the Tibetan community in exile. It should be noted that these traditions all have various schools, subtraditions, and particular texts that they revere more than others, so the actual practices and emphases regarding mindfulness can vary considerably, even within one tradition, such as Theravada or Zen (Goldstein, 2002). Nevertheless, mindfulness, as elucidated by the Buddha in two discourses, the Anapanasati Sutra (Rosenberg, 1999) and the Satipathana Sutra (Thera, 1962), is the core teaching and constitutes the foundation upon which all of these various forms and traditions rest. In these traditions the actual practice of mindfulness is, however, always nested within a larger conceptual and practice-based ethical framework oriented towards nonharming (an orientation it shares with the Hippocratic tradition of Western medicine). This "view" includes a skillful understanding of how unexamined behaviors and what Buddhists would call an untrained mind can significantly contribute directly to human suffering, one's own and that of others. It also includes the potential transmutation of that suffering through meditative practices that calm and clarify the mind, open the heart, and refine attention and action.

Over the past 40 years or so all of these Buddhist traditions have taken root in the West to one degree or another (Bachelor, 1994; Fields, 1992), and have by this time been taken up by several generations of Westerners, who practice these methods in their own lives on a daily basis as well as through participation in periodic teacher-led, intensive meditation retreats, which can last from a weekend to 3 months or more (see, for example, Goldstein, 1987; Goldstein, 2002; Goldstein & Kornfield, 1987; Walsh, 1977, 1978). This phenomenon represents a cultural shift that may be only in its infancy. Nevertheless, it provides a range of rich resources for personal practice and dialogue that can contribute toward the training and development of a cohort of highly competent teachers, from a wide variety of professional backgrounds, committed to the effective delivery of authentic mindfulness-based interventions in various settings.

Mindfulness is often spoken of synonymously as "insight" meditation, which means a deep, penetrative nonconceptual seeing into the nature of mind and world. This seeing requires a spirit of perpetual and persistent inquiry—as in, "What is this?"—toward whatever arises in awareness, and toward "who is attending," "who is seeing," "who is meditating." Its role in deep inquiry and the cultivation of insight have led some to argue that that mindfulness provides a unique perspective that can inform critical issues in cognitive science, neurophenomenology, and attempts to understand the cognitive underpinnings of the nature of human experience itself (Varela, Thompson, & Roach, 1991).

CROSS-CULTURAL AND PARADIGM ISSUES IN WORKING WITH THE CONSCIOUSNESS DISCIPLINES

From the perspective of the behavioral sciences, mindfulness can be thought of as a "consciousness discipline," as described by Walsh in a seminal paper (Walsh, 1980) that explicates the generic paradigm of the meditative traditions and their associated disciplines and shows how such disciplines might be approached empirically by the behavioral sciences without falling into paradigm clash or a range of category errors, which can unwittingly ignore or dismiss the deepest and most subtle features of such practices, thereby predisposing investigators to draw erroneous conclusions. Thus, in encountering the consciousness disciplines and the question of their possible adaptation and application in secular clinical or medical contexts, it is critically important to treat mindfulness and the traditions that have articulated it much as a respectful anthropologist would treat an encounter with an indigenous culture (Davis, 1998) or a different epistemology (Zajonc, 2000). This intimate sensitivity will be necessary to understand, evaluate, and preserve essential elements of the universal

dharma dimension of mindfulness practice as it is analyzed by and incorporated into Western science. It in no way contradicts the call by Hayes (2002) to find ways to fit practices and knowledge from spiritual traditions into the theoretical matrix of scientific psychology. The challenge is to find a fit that honors the integrity of what may be different but complementary epistemologies.

It should be noted in this regard that, in the cross-cultural context of scientific studies of Tibetan monks practicing meditation, sensitivity to differences in orientation and motivation between neuroscientists and meditators around both the meditation practices and the set and setting in which they are investigated is essential for the investigation to have integrity and to be interpretable and valid from the perspective of both the scientists and the meditators (Houshmound, Harrington, Saron, & Davidson, 2002). In a recent "cross-cultural" development of note, EEG, fMRI, and PET studies of brain activity in the evocation of specific meditative states and positive feelings, such as compassion and devotion, in a highly trained long-term monastic practitioner (a Western Lama in the Tibetan tradition with a doctorate in molecular biology) have engaged the meditator not merely as subject but as a full collaborator in the design and interpretation of these investigations with his scientific counterparts, capitalizing as well on his highly developed ability to give a precise account of his mental activity during various practices. These investigations show a range of stable patterns of brain activity ("neural signatures of different mental states") that have never been observed in naive subjects, patterns that can be replicated by the subject at will, depending on his choice of meditative practice. Such studies have multiple implications for research in affective neuroscience, neuroplasticity, and our understanding of what might be possible through specific kinds of training regarding the ways we process and express emotion (Goleman, 2003). They assume practical relevance in light of brain changes reflecting enduring shifts in the processing of negative emotion under stress, which have been observed in novice meditators following training in MBSR in an 8-week worksite intervention (Davidson, Kabat-Zinn, Schumacher, Rosenkranz, Muller, Santorelli, et al., in press).

THE MEANING OF "PRACTICE" IN THE CONTEXT OF MINDFULNESS MEDITATION

If we hope to understand mindfulness meditation, it behooves us to examine the use of the word practice and its meaning as it refers to the meditative traditions and the consciousness disciplines that form their core. We speak of the "practice" of meditation, and the "practice" of mindfulness, meaning the actual engagement in the discipline, the inward gesture that invites and embodies it (Depraz, Varela, & Vermersch, 2000). It is not used in the common sense of "rehearsal" for some future performance. The "performance" is always this moment unfolding (Kabat-Zinn, 1994). This engagement takes a variety of forms, from a range of formal practices that are undertaken for varying periods of time on a regular basis, to informal practices that are aimed at cultivating a continuity of awareness in all activities of daily living. However, mindfulness meditation practice, whether within the various Buddhist traditions or within the context of MBSR, for instance, is not limited to the operationalization of particular techniques, which, however important and essential, which they are, are also merely launching platforms or particular kinds of scaffolding to invite cultivation and sustaining of attention in particular ways. They are the menu, so to speak, not the meal; the map, rather than the territory, the traditional admonition being not to mistake the finger pointing at the moon for the moon.

In a recent commentary in this journal on the subject of mindfulness and generalized anxiety disorder, Borkovec (2002) describes in whimsical but cogent and insightful detail the emotional consequences of living with a trust that, he says, "allows me to let go of the illusory future and past and to focus on the nonillusory present." Using examples of washing the dishes and of writing a National Institute of Mental Health (NIMH) grant, he unpacks various cognitive sets that either create anxiety about future outcomes, or keep him grounded in the process itself (the present moment) and its intrinsic meaning and pleasures. He states,

If a focus on the outcome and the extrinsic aspects of an activity are conducive to anxiety and depression, then the objective quality of my work, whether washing dishes or writing grant proposals, will likely be lowered, given what we know about the adverse effects of negative emotion on performance. So seeking the extrinsic outcome makes the failure to achieve that outcome more likely. A focus on the process and intrinsic qualities of an activity reduces the likelihood of anxiety and depression (thus eliminating their negative impact on performance), increases the pleasure of joy during the process, and thus increases the likelihood of achieving the extrinsic outcome. I have to let go of the desired outcome

in order to acquire it. What a paradoxical and strange way to live. (pp. 79–80)

I would add only that it is perhaps a sane way to live that may not be so strange once one begins to inhabit that landscape in a more regular way. Perhaps it is only strange in a society that persists in devaluating the present moment in favor of perpetual distraction, self-absorption, and addiction to a feeling of "progress." Although Borkovec's descriptions of his inner process are compelling, it is unlikely that such process would be sustained or developed over time in most of us without some element of intentional practice (it is not enough as a rule to remind oneself to "just let go," especially when one is little aware of how attached one may be and, also, how blind to being caught up in habitual patterns of thinking and emotional expression). It is here that the cultivation of the inner orientation of which Borkovec speaks is important. Mindfulness is not merely a good idea such that upon hearing about it, one can immediately decide to live in the present moment, with the promise of reduced anxiety and depression and heightened performance and satisfaction, and then instantly and reliably realize that state of being. Rather, it is more akin to an art form that unfolds over time, and it is greatly enhanced through formal disciplined practice, both formally and informally on a daily basis.

This challenge is posed to our patients in the Stress Reduction Clinic at the very beginning, and with the introduction of the body scan meditation, or even the process of eating one raisin mindfully: namely, to let go of their expectations, goals and aspirations for coming, even though they are very real and valid, to let go—momentarily, at least—even of their goal to feel better or to be relaxed in the body scan, or of their ideas about what raisins taste like, and to simply "drop in" on the actuality of their lived experience and then to sustain it as best they can moment by moment, with intentional openhearted presence and suspension of judgment and distraction, to whatever degree possible. Mindfulness develops and deepens over time but invariably requires an ongoing commitment to its practice and cultivation in any and every moment.

PRACTICE WITHOUT ATTACHMENT TO OUTCOME

In fact, the term "practice" used in this way is better understood as a way of being, a way of seeing, which is embodied, inhabited, grown into through the implementation of the methods and techniques that comprise the discipline (Kabat-Zinn, 2003). There is a major role for paradox here, so Borkovec's noting of it is quite relevant. Indeed, paradox is built in, since the ultimate understanding one encounters through paying attention transcends even conventional subject-object duality. From the outset of practice we are reminded that mindfulness is not about getting anywhere else or fixing anything. Rather, it is an invitation to allow oneself to be where one already is and to know the inner and outer landscape of the direct experience in each moment. This implies waking up to the full spectrum of our experience in the present moment, which, as we engage in mindfulness practice, we rapidly discover is severely edited and often distorted through the routinized, habitual, and unexamined activity of our thoughts and emotions, often involving significant alienation from direct experience of the sensory world and the body.

In my experience, an understanding of these considerations is critical, both to the development of clinical interventions that authentically nurture mindfulness and speak with compelling, sustained relevance to the lives and needs of potential participants, and to the scientific paradigm for its study. This emphasis on nonattachment to outcome is a radical departure from most clinical interventions. Yet it can be found at the heart of Jacobson's pioneering work (1938), which emphasized learning to recognize and trust the direct proprioceptive experience of the landscape of sensation within tension rather than striving to achieve a more desirable state, such as relaxation. It was only when his method was condensed into progressive muscle relaxation (PMR) in the service of systematic desensitization (Wolpe, 1958) that the nonstriving, slow, mindful element was, ironically, abandoned—probably unwittingly—in favor of time efficiency and, with it, the primacy of the experiencing of the sensations themselves, without judgment or editing (see Woolfolk & Lehrer, 1984).

ORIGINAL VISION AND RATIONALE FOR MBSR

The intention in developing MBSR in 1979 and offering it through an outpatient stress reduction clinic at the University of Massachusetts Medical Center was twofold, as explained below.

MBSR as a training vehicle for the relief of suffering. The primary intention was to see if it were possible to create a vehicle for the effective training of medical patients in rel-

atively intensive mindfulness meditation (including mindful hatha yoga) and its immediate applications to the stress, pain, and illness people were grappling with in their lives. The intervention needed to be free of the cultural, religious, and ideological factors associated with the Buddhist origins of mindfulness, because the objective was not to teach Buddhism or even "to make great meditators" out of people, but to offer an environment within which to experiment with a range of novel and potentially effective methods for facing, exploring, and relieving suffering at the levels of both body and mind, and understanding the potential power inherent in the mind/body connection itself in doing so. At the same time, the program needed to remain faithful in both spirit and substance to the universal dharma dimension alluded to, which, as noted, lies at the very core of the gesture of mindfulness. The task, which is always ongoing and immediate for the MBSR instructor, is to translate the meditative challenges and context into a vernacular idiom, vocabulary, methods, and forms which are relevant and compelling in the lives of the participants, yet without denaturing the dharma dimension. This requires some degree of understanding of that dimension, which can come about only through exposure and personal engagement in practice—learned or deepened either though meditation retreats at Buddhist centers or through professional training programs in MBSR with teachers who have themselves trained in that way, or, ideally, both.[2] The Stress Reduction Clinic requires extensive grounding in mindfulness practice as one criterion in hiring new teachers. The standards we employ are outlined in a series of recommendations for assessing teaching readiness and competency in MBSR instructors in general (Santorelli, 2001).

The Stress Reduction Clinic, embedded within a department of medicine and a division of preventive and behavioral medicine, was originally designed to serve as a referral service for physicians and other health providers, to which they could send medical patients with a wide range of diagnoses and conditions who were not responding completely to more traditional treatments, or who were "falling through the cracks" in the health care system altogether and not feeling satisfied with their medical treatments and outcomes. MBSR was thus framed from the beginning as a generic challenge to each patient to train in ancient and potentially transformative meditative practices *as a complement* to his or her medical treatments (Kabat-Zinn, 1993). The clinic, in the form of an 8-week course for outpatients, was meant to serve as an educational (in the sense of inviting what is already present to come forth) vehicle through which people could assume a degree of responsibility for their own well-being and participate more fully in their own unique movement towards greater levels of health by cultivating and refining our innate capacity for paying attention and for a deep, penetrative seeing/sensing of the interconnectedness of apparently separate aspects of experience, many of which tend to hover beneath our ordinary level of awareness regarding both inner and outer experience (Kabat-Zinn, 1990; Santorelli, 1999).

MBSR as a model. If the experience was "successful" in terms of acceptability of the process to the participants and the referring physicians, and in terms of attaining measurable outcomes of clinical significance, the second intention in developing MBSR was that the program might serve as a model for other hospitals and medical centers, which indeed has proved to be the case, and would be adaptable to other contexts in which stress, emotional and physical pain, or illness and disease were primary concerns. To this end, the clinic eventually developed a range of professional training programs in MBSR.[3] Mindfulness-based programs are now offered in hospitals and clinics around the world, as well as in schools, workplaces, corporate offices, law schools, adult and juvenile prisons, inner city health centers, and a range of other settings.

SOME CHALLENGES ASSOCIATED WITH TEACHING MINDFULNESS-BASED INTERVENTIONS

It should be clear from what has been said that mindfulness, from our point of view, cannot be taught to others in an authentic way without the instructor's practicing it in his or her own life. Mindfulness meditation is not simply a method that one encounters for a brief time at a professional seminar and then passes on to others for use as needed when they find themselves tense or stressed. It is a way of being that takes ongoing effort to develop and refine, in T. S. Eliot's apt phrase, "A condition of complete simplicity / (Costing not less than everything)" (Eliot, 1943). It is both the work of a lifetime and, paradoxically, the work of no time at all—because its field is always this present moment in its fullness. This paradox can be understood and embodied only through sustained personal practice over days, weeks, months, and years.

Recall that practice as we have been using the word is not a mechanical self-repetition of meditation instructions (although it can sometimes subtly feel that way), but a commitment to reside as best one can from moment to moment in awareness with an open heart, a spacious, nonjudging, nonreactive mind, and without trying to get anywhere, achieve anything, reject anything, or fall into either the stream of conceptual thought or what the Dalai Lama calls "afflictive" or "unwholesome" emotions (Goleman, 1997, 2003). Since it is virtually inevitable that people will fall into both the stream of conceptual thought and afflictive emotions (and potentially unwise actions) over and over again, the practice involves working intimately and compassionately with whatever arises in the field of awareness, so that whatever arises is seen and known (recognized) in the field of awareness as it arises (or as soon as one can). Thus, mindfulness can always be large enough to include whatever arises if it can be seen, felt, and known nonconceptually, directly apprehended through the five senses (including proprioception) and through the mind, which in Buddhism is considered another sense door. However, it takes personal commitment and perseverance in formal practice gradually to establish a degree of stability in one's capacity to attend, especially to stressful or aversive objects, including severe emotional turbulence or enduring dysphoria, and to see beneath the surface of the phenomena themselves as they arise in the field of experience. Classes and periodic retreats form a supportive group environment within which practice can develop and deepen over time for both teachers and students of mindfulness. A working principle for MBSR teachers is that we never ask more of our patients in terms of practice than we ask of ourselves on a daily basis. Another is that we are all students and the learning and growing are a lifelong engagement.

The decision to teach mindfulness, even among those teachers with many years of personal meditation practice, whether they be trained as psychologists, physicians, surgeons, or other health professionals, can at times be intimidating and humbling, and understandably so. One needs to be well prepared to take on such a challenge, and that usually includes feeling that one is nowhere near ready to begin teaching. In our experience, unless the instructor's relationship to mindfulness is grounded in extensive personal practice, the teaching and guidance one might bring to the clinical context will have little in the way of appropriate energy, authenticity, or ultimate relevance, and that deficit will soon be felt by program participants. For how can one ask someone else to look deeply into his or her own mind and body and the nature of who he or she is in a systematic and disciplined way if one is unwilling (or too busy or not interested enough) to engage in this great and challenging adventure oneself, at least to the degree that one is asking it of one's patients or clients? How will one know how to respond appropriately and specifically to their questions if one cannot draw on one's own lived experience, not just on book knowledge and concepts, when the practice itself is all about seeing clearly and transcending (not getting caught up in and blinded by) the limitations of the conceptual mind while, of course, not rejecting the conceptual mind or the power and utility of thought within the larger context of awareness?

Since people with stress, pain, and medical conditions of all sorts invariably and quite naturally come to stress reduction or to various forms of therapy with agendas and goals (and, in fact, are encouraged to define realistic goals for themselves in MBSR), how will a teacher skillfully reconcile their motivation to achieve these perfectly sensible goals with the orientation of nonstriving, nondoing, and letting go that must inform the meditation practice and the entire program if it is to be mindfulness? It can be done only if one feels a deep experience-based confidence in the practice and an equally deep humility in offering it to others, developed through one's own intimate engagement and struggles with it. Ultimately, one teaches out of one's own passion for the practice itself, keeping things grounded in the actuality of present-moment experience. Of course, a skillful teacher will bring in any number of things as appropriate to inform and round out the teaching, dialogue, and practice itself, drawing on his or her extensive professional and personal knowledge base, temperament, and skills. However, without the foundation of personal practice and the embodying (a preferable term to "modeling," which carries the unfortunate connotation of intentionally acting in a particular way for the sake of appearances) of what it is one is teaching, attempts at mindfulness-based intervention run the risk of becoming caricatures of mindfulness, missing the radical, transformational essence and becoming caught perhaps by important but not necessarily fundamental and often only superficial similarities between mindfulness practices and relaxation strategies, cognitive-behavioral exercises, and self-monitoring tasks.

Over the past 10 years numerous health professionals have taken on the teaching of mindfulness-based stress reduction and have developed well-established clinical and

research programs. Although there is no formal vehicle for assessing competency of MBSR teachers at this time, nor a professional credentialing mechanism,[4] the feedback from the people coming out of these programs, when we have occasion to meet them, tends to be highly enthusiastic and positive. They themselves tend to speak of the experience as transformative. There is a sense among those of us teaching mindfulness that we continue to be nurtured personally and professionally by the work itself and by the practice. This, and a sense of connectedness with local and global communities of colleagues who do this work are constant reminders of the importance of staying true to the spirit of mindfulness practice.

RECENT RESULTS FROM THE CENTER FOR MINDFULNESS AND THEIR IMPLICATIONS FOR THE SCIENCE OF THE MIND/BODY CONNECTION AND FURTHER STUDIES

From a research perspective, work at the Center for Mindfulness and the Stress Reduction Clinic has attempted to provide various platforms upon which increasingly rigorous explorations of aspects of mindfulness and its clinical and social applications could ultimately be built. A number of early descriptive studies, reviewed by Baer (2003), 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, 1982; Kabat-Zinn, Chapman, & Salmon, 1997; Kabat-Zinn & Chapman-Waldrop, 1988; Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn, Lipworth, Burney, & Sellers, 1986; Kabat-Zinn et al., 1992; Salmon, Santorelli, & Kabat-Zinn, 1998; Miller, Fletcher, & Kabat-Zinn, 1995;). This work eventually led us to undertake several small randomized trials, one with patients with moderate to severe psoriasis undergoing ultraviolet phototherapy treatments (Kabat-Zinn et al., 1998), the other a worksite intervention in which we delivered the 8-week MBSR program to company employees and monitored quantitative EEG and immune responsivity at various times, as well as a range of psychosocial measures (Davidson et al., in press). These studies demonstrated clinical effectiveness with two very different mindfulness-based interventions: one delivered in isolation solely by audiotaped instructions; the other, in the group context of MBSR. Their designs may serve as models in the design of further and larger studies of the potential healing and restorative effects of mindfulness and MBSR for different classes of individuals with different life situations in different environments. These studies are described below in some detail.

Skin Clearing in Psoriasis

In the psoriasis study we asked if mindfulness could influence a healing process that we could see and photograph in people with a skin disease that has a strong relationship with psychological stress, namely, psoriasis. Thirty-seven patients with moderate to severe psoriasis who were candidates for treatment with phototherapy (UVB) or photochemotherapy (PUVA) were randomized into two groups. One group (meditators) followed guided mindfulness meditation instructions delivered by audiotape during their ultraviolet (UV) treatments (either PUVA or UVB) on a 3-times-per-week protocol. (For full study design and methods, see Kabat-Zinn et al., 1998). This tape included a guided visualization in which the subject visualized the ultraviolet light slowing down and then stopping the rapidly growing cells in the epidermis. The other group (usual care) received the light treatments (either PUVA or UVB) without listening to a tape. The skin status of each patient was monitored by clinic nurses at each treatment session and documented periodically by photography. The photographs were rated in terms of skin status by dermatologists blind to the identity and group assignment of the patients. These ratings were then used to validate or invalidate the nurses' necessarily unblinded ratings. A Cox proportional hazards analysis of the photographically validated data showed that the meditators' skin cleared at about 4 times the rate of the nonmeditators' (usual care group) during the 12-week study period (p = .033). An earlier and smaller study (Bernhard, Kristeller, & Kabat-Zinn, 1988) also found that the meditators' skin cleared more rapidly than that of the nonmeditators.

Although both studies suffer from a small sample size, the replicability of the finding suggests that the effect is real and merits further research. We cannot conclude from these observations that it is the mindfulness practice per se that is responsible for the fourfold rate of skin-clearing in the meditation cohort, although that is our hypothesis. However, the finding does lead to a number of potentially important, if currently tentative conclusions: (1) that some factor or combination of factors having to do with the activity of mind can positively influence a healing process in a specific disease; (2) that psychological participation of this sort on the part of the patient during the light treatments can lead to reduced time to clearing in at least some

patients, and thus to fewer treatments, and thus to potential cost savings; (3) that the need for fewer light treatments also reduces the risk of basal cell carcinoma associated with ultraviolet light treatment; (4) that social support—minimal in this intervention because the patient is isolated in the light box, there is no group experience, and all the instruction in the meditation is by audiotape—cannot be a major factor in the observed outcome; (5) that the experimental design itself is well suited for studying the role of the mind (intention, attention, belief, expectation, psychological conditioning, meditation, visualization) in a readily observable healing process for a specific disease down to the level of gene expression, including concurrent investigation of appropriate biological mediators associated with psoriasis, such as cytokines, transforming growth factor (TGF-α), and Bcl-x protein; (7) that, since psoriasis is an uncontrolled cell proliferation, although not oncogenic, such investigations may shed light on the potential for positive psychological involvement in oncogenic processes, such as basal cell carcinoma, which shares some molecular characteristics with psoriasis; and (8) that this design is an example of both integrative (Snyderman & Weil, 2002) and participatory (Kabat-Zinn, 2000) medicine: integrative because the meditative (unconventional) intervention is coextensive in time and place with the allopathic treatment, and participatory because the full engagement of the patient's mind and body is a critical part of the psychological intervention. All of these areas suggest further studies that might illuminate critical issues in mind/body medicine and adjunctive psychological approaches to patient care and treatment, including mindfulness-based approaches with specific diseases.

Our 1998 study was criticized by Relman on various methodological grounds, including the small sample size, the way we accounted for dropouts, the effectiveness of the blinding of physician-evaluators, and our statistical treatment of the data. He also took umbrage at our conclusions. While recognizing the validity of some of his criticisms, we were able to respond to each one, refuting their criticality either to the basic observation or to our conclusions (see Relman, Riley, Kabat-Zinn & Hosmer, 2001). I cite this interchange because it highlights the degree of controversy that occasionally arises, particularly regarding the quality of the evidence in studies investigating mind/body phenomena. Such controversy extends beyond the psoriasis study. Relman also challenged the validity of the findings and conclusions of much larger clinical trials and epidemiological studies that are widely accepted in behavioral medicine (see "The Great Debate": Relman & Angell, 2002; Williams and Schneiderman, 2002).

Debates of this kind are welcome and healthy for any field of research. They certainly underscore the importance of larger and better designed studies to further establish or dispute findings in the nascent field of mindfulness-based clinical interventions and their potential therapeutic effects in people with specific medical and psychological conditions, as called for by Baer (2003) and Bishop (2002). They also illuminate the degree to which well-trained scientists can and should disagree about the evidentiary status underpinning even widely accepted of phenomena in the behavioral and human sciences.

Brain, Immune Changes, and Emotional Processing in a Work Site MBSR Program

In another study (Davidson et al., in press) 41 employees of a biotechnology company were randomized to either an MBSR condition ($n = 25$) or a wait-list condition ($n = 16$). The MBSR subjects participated in an 8-week program during working hours. All subjects underwent extensive laboratory testing on three occasions, pre and post the 8-week intervention period and at 4-month follow-up, including EEG to measure brain electrical activity in response to various emotional challenges. All subjects were also vaccinated with influenza vaccine at the end of the 8-week intervention period and subsequently tested for antibody titer.

As originally hypothesized, we found significant increases in left-sided activation in the anterior cortical area in the subjects who had undergone MBSR training as compared to the wait-list controls. Left-sided activation in several anterior regions has been observed during certain forms of positive emotional expression and in subjects with more dispositional positive affect (Davidson, 1992; Davidson, Ekman, Saron, Senulis, & Friesen, 1990), as well as in studies of the highly trained Tibetan monk cited earlier, in whom the effect was of remarkable magnitude (Goleman, 2003). Right-sided activation is usually associated with negative emotional expression such as anger, anxiety and depression (Davidson, 2000; Davidson & Irwin, 1999).

We also found that the meditators displayed a significantly greater rise in antibody titers from the 4-week post-vaccination to the 8-week blood draw as compared to control subjects. Moreover, among the subjects in the MBSR group, those who showed the greatest pre-to-post

increase in left-sided activation displayed a significantly larger rise in antibody titers, whereas there was no significant relationship for control subjects. This study suggests that MBSR training can lead to brain changes consistent with more effective handling of negative emotion under stress. These changes endured for at least 4 months after the intervention.

To our knowledge, this study is the first to demonstrate a reliable effect of meditation on an in vivo measure of immune function and on anterior activation asymmetry in the brain. The results suggest that there may be multiple biological consequences of mindfulness training relevant to emotional and physical health, and that such an intervention can be delivered effectively in a work setting to a broad spectrum of employees and influence psychological and emotional health under stressful conditions. In light of the findings of Teasdale et al. (2000) and the development of MBCT for relapse prevention in the treatment of depression (Segal et al., 2001), mindfulness/acceptance-based treatments for generalized anxiety disorder (Roemer & Orsillo, 2002), DBT for borderline personality disorder (Linehan, 1993), and mindfulness-based therapy for obsessive-compulsive disorder (Schwartz, 1996), these results suggest that it would be fruitful to explore mindfulness-based interventions in various affective disorders, using an approach that maps potentially relevant underlying neurobiological mechanisms and pathways together with affective behavior change measures, taking advantage in the study design of the intrinsic adaptability of mindfulness-based approaches to different life circumstances and conditions.

A New Prostate Cancer Intervention Combining MBSR and Dietary Intervention

In addition to these studies, a recent uncontrolled pilot study (Saxe et al., 2001) combined and expanded MBSR training with a low-fat vegetarian dietary intervention to explore the effectiveness of this new 12-week intervention, which included spouses and significant others, in slowing, arresting, or reversing prostate-specific antigen (PSA) velocity in men with prostate cancer who had previously undergone prostatectomies and who subsequently proved to have rising PSA levels, indicating metastatic spread. In a series of 10 patients, we found that the rate of PSA increase decreased in 8 of the 10 patients, while 3 had a decrease in absolute PSA (signed rank test $p = .01$). Estimated median PSA doubling time increased from 6.5 months before the intervention to 17.7 months after the intervention. This study demonstrates the potential feasibility and utility of using the cultivation of mindfulness within the context of MBSR to achieve behavior changes, such as dietary compliance, that are frequently difficult to attain and maintain with use of strictly behavioral motivators. In this case the mindfulness training and application was extended to include bringing mindfulness to shopping and food selection, cooking, and eating in ways that can enhance dietary adherence. This remains an area of ongoing investigation.

CONCLUSION

Baer's conceptual and empirical review of mindfulness-based interventions points toward the potential promise of further and increasingly methodologically rigorous studies of mindfulness-based clinical interventions. This commentary highlights and contextualizes some of the fundamental issues, opportunities, and challenges facing both clinicians and researchers alike, in the design, delivery, and evaluation of such a deceptively simple yet highly complex intervention approach and its effective integration, at the level of theory as well as treatment, with other therapies and practices in medicine and psychology. It necessarily glosses over or leaves undescribed the nature, spirit, and substance of the curriculum of mindfulness-based interventions; the inherent flexibility of the curriculum in terms of both content and delivery and yet its reliance on essential core meditative practices grounded in silence, stillness, self-inquiry, embodiment, emotional sensitivity, and acceptance of the full gamut of emotional expression held in awareness (all practices that shape and inform the intervention and its unfolding at every level); and, finally, its acknowledgment of the universal longing in people for happiness, well-being, resilience, and peace of mind, body, and soul, and how that longing might be effectively met, honored, and mobilized for transformation among program participants (Kabat-Zinn, 1990; Santorelli, 1999). This commentary has perforce also ignored the poetry of mindfulness, and the appropriate uses of the poetic imagination within mindfulness-based interventions.

NOTES

1. Following Baer, I will not discuss the social-psychological construct that Langer (1989) has termed "mindfulness," but focus on the traditional usage stemming from Buddhist meditation practices that have been adapted to one degree or another and

integrated within the mainstream of medicine over the past 20-plus years.

2. Note that while this perspective may seem commonsensical, if not axiomatic—just as surgeons who want to perform an unfamiliar complex procedure would first need to acquire, from those who developed it or their designees, first-person, hands-on experience through specialized postgraduate training before becoming competent in performing it—this proposition has not been subject to empirical testing in the case of mindfulness. Hayes (2002) has emphasized that methods involving acceptance and mindfulness must be separated from their religious and spiritual traditions so they can be conceptualized and studied from a scientific perspective and integrated into Western psychological understanding. Of course, any true integration of a new and fundamental element into psychology is likely to contribute to a broadening of the field itself and its perspective on alternative epistemologies, in this case those epistemologies lying at the interface of meditative experience itself, influenced in some measure by cultural and contextual considerations, and empirical science, as suggested by Walsh (1980). This area is one for fruitful research and deserving of rich debate and dialogue, which can only deepen the profession's ultimate understanding of what works, for whom, and why. I am merely delineating in this article the bare outlines of a perspective that my colleagues and I have developed from both our own firsthand experience of meditation practice and teaching, and our clinical experience with medical patients undergoing training in MBSR in the context of mainstream medicine and health care. Of course, it is important to point out that research has yet to probe systematically the relationship between specific outcomes of MBSR and the degree and depth (difficult to measure) of formal practices engaged in by participants, either in the classes themselves or between sessions, to achieve optimal clinical effects.

3. Further information on MBSR and its professional training opportunities, standards of practice, guidelines for providers, background bibliographies on mindfulness, and ongoing projects can be obtained by contacting the Center for Mindfulness in Medicine, Health Care, and Society at University of Massachusetts Memorial Medical Center, Shaw Building, Worcester, MA 01655-0267, or accessing the Web site: http://www.umassmed.edu/cfm. There are also training opportunities in MBCT. Information for these can be obtained by contacting Zindel Segal, Center for Addiction and Mental Health, Clarke Division, University of Toronto, Toronto, Ontario M5T 1R8, Canada, for training programs in North America; and John Teasdale, Medical Research Council, Cognition and Brain Sciences Unit, 15 Chaucer Road, Cambridge CB2 2EF, U.K., for training programs in Europe. For mindfulness meditation retreats in the Buddhist Theravada tradition (vipassana), see the Web site: http://www.dharma.org. The Center for Mindfulness requires that prospective interns have experienced at least one and preferably two teacher-led 10-day vipassana retreats (or an equivalent) before enrollment.

4. *Note added in proof:* The Center for Mindfulness in Medicine, Health Care, and Society has recently initiated a multistage credentialing process, teacher certification in MBSR. See www.umassmed.edu/cfm for details.

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