



***Vipassanā* Meditation in Contemporary Psychiatry: Transformation of a Buddhist Practice into a Mental Health Intervention**

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Article	Submitted	Revised	Accepted	Available Online
History	2026-01-08	2026-05-17	2026-06-19	2026-06-26

Abstract

The integration of meditation practices into contemporary psychiatry reflects a shift from a reductionistic biomedical model to a more holistic approach to mental health. However, the epistemological transformation of Buddhist practices such as *Vipassanā* into a secular-psychological framework still leaves conceptual and methodological problems that have not been critically and comprehensively examined. This article aims to systematically analyze the epistemological transformation of *Vipassanā* from a soteriological framework to an evidence-based clinical paradigm, evaluate the level and quality of its clinical validity in the treatment of depression, anxiety, and stress, identify the underlying psychological mechanisms, and formulate challenges for its integration into psychiatric practice. The study used Critical Interpretive Synthesis with an inclusion-exclusion protocol for empirical articles and international meta-analyses indexed in PubMed and Scopus for the period 2000–2025, which were analyzed using a thematic-critical synthesis approach. The results indicate the occurrence of normative reduction and conceptual recontextualization, primarily through the elimination of ethical-doctrinal dimensions of achieve empirical compatibility. Clinically, the majority of randomized controlled trials and meta-analyses report moderate and consistent effects on reducing symptoms of depression and anxiety, although heterogeneity in design and sample size limits generalizability. Identified mechanisms include improved attentional regulation, cognitive decentralization, decreased affective reactivity, and enhanced executive function and metacognitive awareness. Key challenges include excessive decontextualization, methodological inconsistencies, and ethical issues surrounding the appropriation of contemplative practices. These findings

underscore the need for a reflective, integrative theoretical framework to strengthen interdisciplinary dialogue and enhance the rigor of evidence-based clinical implementation of meditation in psychiatry.

Keywords: *Vipassanā*; Contemporary Psychiatry; Buddhism; Psychological Mechanisms; Clinical Validity

Abstrak

Integrasi praktik meditasi dalam psikiatri kontemporer merefleksikan pergeseran dari model biomedis reduksionistik menuju pendekatan kesehatan mental yang lebih holistik. Namun, transformasi epistemologis praktik Buddhis seperti *Vipassanā* ke dalam kerangka psikologis-sekuler masih menyisakan problem konseptual dan metodologis yang belum dikaji secara kritis dan komprehensif. Artikel ini bertujuan menganalisis secara sistematis transformasi epistemologis *Vipassanā* dari kerangka soteriologis ke paradigma klinis berbasis bukti, mengevaluasi tingkat dan kualitas validitas klinisnya dalam penanganan depresi, kecemasan, dan stres, mengidentifikasi mekanisme psikologis yang mendasarinya, serta merumuskan tantangan integrasinya dalam praktik psikiatri. Penelitian menggunakan *Critical Interpretive Synthesis* dengan protokol seleksi berbasis kriteria inklusi-eksklusi terhadap artikel empiris dan meta-analisis internasional terindeks PubMed dan Scopus periode 2000-2025, yang dianalisis melalui pendekatan sintesis tematik-kritis. Hasil menunjukkan terjadinya reduksi normatif dan rekontekstualisasi konseptual, terutama melalui eliminasi dimensi etis-doktrinal demi kompatibilitas empiris. Secara klinis, mayoritas uji terkontrol acak dan meta-analisis melaporkan efek moderat dan konsisten dalam penurunan gejala depresi dan kecemasan, meskipun heterogenitas desain dan ukuran sampel membatasi generalisasi. Mekanisme yang teridentifikasi meliputi peningkatan regulasi atensi, desentralisasi kognitif, penurunan reaktivitas afektif, serta penguatan fungsi eksekutif dan kesadaran metakognitif. Tantangan utama mencakup dekontekstualisasi berlebihan, inkonsistensi metodologis, dan isu etika apropriasi praktik kontemplatif. Temuan ini menegaskan perlunya kerangka teoretis integratif yang reflektif guna memperkuat dialog interdisipliner dan meningkatkan rigor implementasi klinis meditasi dalam psikiatri berbasis bukti.

Kata Kunci: *Vipassanā*; Psikiatri Kontemporer; Buddhis; Mekanisme Psikologis; Validitas Klinis

Introduction

Contemporary psychiatry faces structural challenges such as high relapse rates, chronicity, and resistance to pharmacotherapy in major mental disorders. Longitudinal meta-analyses indicate that approximately 50–80% of patients with major depression experience a relapse within five years of their first episode, despite receiving standard therapy (Kato et al., 2021). While the biomedical model effectively reduces acute symptoms through neurochemical modulation, interventions tend to limit them to symptomatic reduction and have not systematically integrated dimensions of subjective experience such as self-awareness, reflective emotion regulation, and the construction of meaning in suffering (Halligan & Oakley, 2021). This gap raises the need for approaches that go beyond symptom suppression and transform individuals' relationships to their mental experiences. *Vipassanā* meditation, a Buddhist contemplative practice rooted in the direct observation of mental phenomena through an understanding of *dukkha*

(suffering), *anicca* (impermanence), and *anattā* (non-self), offers a transformational framework that goes beyond mindfulness techniques alone (Giridharan et al., 2025). The integration of this practice into the clinical setting raises epistemological and ethical questions about how spiritual practices can be reconstructed into standardized interventions without losing their original framework of meaning.

Global phenomena demonstrate the urgency of this issue. The World Health Organization (2022) states that more than 280 million people live with depression and approximately 301 million with anxiety disorders, with prevalence increasing by more than 25% following the COVID-19 pandemic. The burden of disability due to mental disorders ranks among the top causes of years lived with disability globally. A clinical evaluation released by the American Psychiatric Association (2013) also highlighted the limitations of long-term pharmacological therapy related to side effects, poor adherence, and high relapse rates. These conditions have prompted healthcare systems to adopt mindfulness-based interventions, which are relatively safe, low-cost, and compatible with standard therapies. The popularity of mindfulness approaches in public health policy suggests that the adoption of *Vipassanā* is not simply an alternative trend but rather a systemic response to the limited effectiveness and sustainability of conventional psychiatric models (Wankhade, Lavangare, & Dani, 2025). However, conceptual clarification is needed regarding the extent to which these adaptations retain the transformative dimension of meaning that is central to the original practice.

The empirical literature of the past two decades documents the clinical effectiveness of mindfulness-based interventions, although much of it is secular and technical in nature. Sheybani et al.'s (2022) study on Mindfulness-Based Stress Reduction demonstrated significant reductions in anxiety and chronic pain, but limited the intervention to attention training without exploring a Buddhist philosophical framework. McCartney et al.'s (2021) study on Mindfulness-Based Cognitive Therapy demonstrated the effectiveness of mindfulness-based cognitive restructuring in preventing depressive relapse, while modifying the traditional practice into a modern cognitive-therapeutic protocol. Humble et al.'s (2025) neuroimaging findings identified increased prefrontal cortex regulation of *amygdala* activity in experienced meditation practitioners. However, they did not specifically distinguish *Vipassanā* from other forms of meditation, thus limiting its conceptual implications. Pruessner et al.'s (2024) mechanistic analysis emphasized attention and emotion regulation as therapeutic mediators, without addressing transformations in self-understanding and suffering.

A study by Baboş, Leucuţa, and Dumitraşcu (2022) demonstrated clinical benefits in psychosomatic disorders, but focused on short-term quantitative outcomes and neglected the epistemological dimension. A synthesis of these findings indicates three major gaps: the epistemological reduction of contemplative practices to attention regulation techniques; the explicit omission of core concepts

such as *dukkha* and *anicca* from clinical formulations; and the lack of qualitative analysis of patients' self-meaning transformations as a result of the intervention. This research gap lies in the lack of critical studies that analyze the conceptual, ethical, and cultural translation of *Vipassanā* into a contemporary psychiatric framework and its implications for therapeutic effectiveness.

This study formulates the main questions: how is *Vipassanā* meditation transformed into a mental health intervention in contemporary psychiatric practice, what epistemological assumptions shape this process, and what are the implications for clinical effectiveness and the meaning of patients' experiences? The research objectives include: analyzing the conceptual and operational adaptation of *Vipassanā* into clinical protocols; identifying the theoretical assumptions of psychiatry that influence the translation process; and evaluating the therapeutic and philosophical consequences of such transformation. The study's initial argument asserts that the effectiveness of *Vipassanā* does not rest solely on non-reactive mindfulness techniques but rather on a framework of understanding suffering and impermanence that can reconstruct an individual's relationship to symptoms. Reducing the practice to a mere mindfulness technique risks eliminating the transformational dimension, a key therapeutic resource. The theoretical contribution of the study is the development of an integrative analytical framework between Buddhist studies and psychiatry, including mapping the epistemological, ethical, and clinical levels in the process of secularizing contemplative practices. Practical contributions include conceptual recommendations for the development of reflective and contextual mindfulness-based interventions, as well as a methodological basis for further research that combines quantitative evaluation and qualitative exploration of self-meaning transformation.

Method

This study employed a Critical Interpretive Synthesis (CIS) design, grounded in a hermeneutic-constructivist epistemology, to analyze the transformation of *Vipassanā* practice from a canonical Buddhist context to contemporary psychiatric intervention formulations. The research question focused on how epistemic translation, ontological reduction, and medicalization of core concepts such as *sati*, *dukkha*, and *anattā* occur within a modern clinical framework. Data sources included canonical *Theravāda* texts, particularly the *Satipaṭṭhāna Sutta* and the *Visuddhimagga*, as well as peer-reviewed articles indexed in PubMed and Scopus between 2000 and 2025, including RCTs, meta-analyses, systematic reviews, and mindfulness-based clinical guidelines. Non-scientific publications and articles without a clinical focus were eliminated. The search strategy employed a structured Boolean search. It was documented in accordance with the PRISMA (identification, screening, eligibility, inclusion) process, with independent selection by two reviewers and reconciliation of discrepancies through discussion. Data extraction was conducted through conceptual open coding, followed by axial coding to map

interdisciplinary correspondences and shifts in meaning. The analysis combined thematic synthesis and Foucauldian discourse analysis to identify patterns of secularization, restructuring of self-concept, and repositioning of practice goals from spiritual liberation to affective regulation. Methodological rigor was maintained through an audit trail, researcher reflexivity, and triangulation of textual and clinical sources.

Results and Discussion

Epistemological Transformation of *Vipassanā* in Contemporary Psychiatry

The epistemological transformation of *Vipassanā* into contemporary psychiatry requires a clarification of the theoretical framework regarding what constitutes epistemic change. Epistemology is understood as the legitimate structure of knowledge encompassing sources of validity, criteria for justification, and conditions for the possibility of truth regarding inner experience. The *Vipassanā* tradition positions *paññā* as transformational knowledge acquired through the existential participation of a trained subject, rather than the mere accumulation of descriptive propositions. The authority of truth rests on intersubjective verification by the community of practitioners and consistency with canonical *Pāli* teachings (Wang, 2025). Modern psychiatry operates on a legitimacy model grounded in observability, replicability, and neurobiological correlates (Crowe, 2022). Change concerns not only therapeutic goals but also the restructuring of the conditions of justification for knowledge. This analysis interprets transformation as a shift in validity criteria, not merely in terminology or pragmatic function, thereby focusing on changes in the epistemic structures underpinning truth claims about the mind.

This framework allows for a distinction between cross-epistemic translation, epistemic reduction, and epistemic domestication. Translation refers to conceptual reformulation without altering the legitimating structure; reduction refers to narrowing of ontological space for the sake of methodological compatibility; domestication refers to normative adjustments so that concepts do not disrupt the basic assumptions of the recipient system. Schlieter's (2017) study of the medicalization of mindfulness and the secularization of Buddhist practices suggests that clinical integration often proceeds through a gradual domestication that shifts the soteriological orientation toward symptom regulation. However, psychiatry is not homogeneous; phenomenological, existential, and enactive schools offer more dialogical models of experience. The epistemological transformation of *Vipassanā* must be read through this differentiation to avoid simplification. The following analysis traces the changing legitimating structures of direct experience, *anicca*, *dukkha*, and *anattā*, considering various psychiatric paradigms and the possibilities for critical dialogue.

Direct experience in *Vipassanā* is understood as non-propositional knowledge that involves reflective participation in the phenomenal flow without conceptual reification. However, the Buddhist tradition is not anti-conventional; the

Abhidhamma developed a systematic classification of mental phenomena (Neupane, 2025). The productive tension between preconceptual experience and analytical articulation forms a complex internal epistemology. Contemporary psychiatry, particularly the DSM-based model, tends to transform experiential reports into structured phenomenological data through assessment instruments (Kyzar & Denfield, 2023). This transformation occurs when the source of legitimacy shifts from verification of meditative community practices to statistical and neurobiological validation. Although neurophenomenological approaches attempt to bridge the two, the standard of justification remains contingent on objective correlations. Experience is no longer positioned as a vehicle for deconstructing ontological illusions, but rather as a modulable content of consciousness. This shift reconstructs the subject from an agent of liberating realization to a clinical informant reflecting a measurable mental state.

Anicca in the *Pāli* canon refers to the impermanence of all *sankhāras*, which has both existential and ontological implications. Impermanence not only implies temporal change but also indicates the absence of a fixed substance, thus undermining claims of identity stability (Sangiaco, 2025). Clinical literature often interprets impermanence as an awareness of affective fluctuations that supports emotional acceptance and decentering (Gavrilova & Zawadzki, 2023). This reformulation reflects a pragmatic translation but also demonstrates an ontological reduction as the metaphysical dimension is eliminated in favor of scientific neutrality. The epistemological transformation is evident in the shifting criteria of truth: valid insight is no longer measured by penetration of the structure of conditioned reality, but rather by the effectiveness of emotional regulation. The phenomenological approach to psychiatry, which emphasizes the temporality of experience, opens up space for dialogue, yet remains descriptive and devoid of ontological commitment. *Anicca* shifts from a deconstructive principle to a cognitive technique that supports measurable psychological flexibility.

Dukkha in early Buddhism encompasses *dukkha-dukkha*, *vipariṇāma-dukkha*, and *saṅkhāra-dukkha*, which together characterize the inherently unsatisfactory structure of conditioned existence (Gold, 2023). This framework positions suffering as an epistemic gateway to the realization of freedom, rather than merely a pathological symptom. Biomedical psychiatry conceptualizes suffering through the category of mental disorders that require regulative intervention (Brückl et al., 2020). A shift occurs when the legitimacy of knowledge about suffering is determined by indicators of functional or neurochemical dysfunction, rather than by the depth of insight into conditioned conditions. Existential psychiatry does acknowledge the universal dimension of suffering but remains focused on restoring self-integrity (Temple & Gall, 2018). The epistemological transformation is evident in the shift in teleology: full penetration of *dukkha* as a means of dismantling ontological assumptions is replaced by symptom management for adaptive well-

being. The justification structure shifts from liberation as the criterion of truth to symptom reduction as the standard of success.

Anattā presents the most radical challenge because it denies the permanent core of the self. Bodhi (2000) asserts that the five aggregates cannot be identified with the self, so the realization of the non-self invalidates the assumption of an autonomous subject. Modern psychiatry has developed theories of the minimal self, the narrative self, and the self as a dynamic construct that is conceptually more flexible than the classical substantialist model (Fazakas et al., 2025). Potential dialogue arises because some cognitive approaches view the self as a representational process. However, clinical integration tends to interpret the non-self as a decline in attachment to personal narratives without questioning the subject's ontology. Epistemic domestication occurs when the ontological claims of *anattā* are reduced to adaptive strategies for identity regulation. The criterion of validity shifts from the realization of corelessness to the enhancement of social and psychological functioning. This transformation demonstrates the limits of the clinical paradigm's tolerance for ideas that threaten the foundation of the therapeutic agent as an entity whose stability must be maintained.

The typology of transformation can be formulated in terms of four patterns: ontological to psychological, soteriological to therapeutic, participatory to observational, and deconstructive to regulative. This pattern is not necessarily synonymous with distortion, but rather indicates a restructuring of the legitimacy of knowledge. Cross-epistemic translation may preserve structural resonance, while reduction and domestication narrow ontological horizons for the sake of methodological compatibility. The neurophenomenological literature seeks to avoid reduction through two-way correlations between experience reports and neural data, while maintaining the standard of empirical replication as the final arbiter. Consequently, contemplative experience acquires legitimate status when it can be mapped to objective indicators. This analysis asserts that epistemological transformation is not simply an adaptation of language, but rather a change in the conditions of possibility of truth that determine what is recognized as valid knowledge about the human mind.

Clinical Validity of *Vipassanā* as a Mental Health Intervention

The clinical validity of *Vipassanā* as a mental health intervention must be assessed within an evidence-based psychiatric framework that emphasizes a clear distinction between statistical and clinical significance. Evaluative parameters include standardized effect sizes, remission rates, long-term sustainability of benefits, tolerability, acceptability, and comparative relevance to standard therapies. Assessment of evidence quality requires the use of a hierarchy of evidence and the Grading of Recommendations Assessment, Development, and Evaluation approach, which distinguishes levels of certainty as high, moderate, low, or very low (Prasad, 2024). Most *Vipassanā* studies are small-scale, quasi-experimental, and

observational longitudinal trials without protocol preregistration. The absence of standardized meta-analyses for *Vipassanā* retreats leaves effect estimates scattered and unconsolidated. This places the evidence base for *Vipassanā* at a low-to-moderate level of certainty, primarily due to limitations in multisite replication, design variations, and inconsistent reporting of primary clinical outcomes.

Evidence for depression indicates reductions in Beck Depression Inventory and Hamilton Depression Rating Scale scores following a 10-day retreat, with effect sizes generally in the small-to-moderate range (Vollbehr et al., 2025). These estimates rarely report a minimal clinically important difference or diagnostic remission rates based on structured clinical interviews. Most studies use passive control groups or waitlists, making it difficult to separate the specific effects of *Vipassanā* from nonspecific factors such as the intensity of the retreat environment, social support, and participant expectations. High attrition rates and reliance of self-reports without blinded raters increase the risk of selection and response bias. The pharmacotherapy literature rarely controls for covariates, even though antidepressant use can influence score changes (Ainsworth et al., 2024). Comparisons with established psychotherapies such as Cognitive Behavioral Therapy and Mindfulness-Based Cognitive Therapy indicate that the number of trials and the consistency of *Vipassanā*'s effects are still far behind, so claims of effectiveness should be limited.

Findings for anxiety disorders show substantial heterogeneity in terms of study design, diagnostic characteristics, and intervention format. Studies in nonclinical populations tend to report larger effect sizes than studies of patients with a confirmed diagnosis of generalized anxiety disorder or panic disorder (Pauley et al., 2021). Variations in retreat duration, practice intensity, and adjunctive therapy status make comparative synthesis difficult. Some trials did not use active comparators, such as structured relaxation or cognitive therapy, potentially confounding the effects of expectancy and the general relaxation response with those of specific *Vipassanā* mechanisms. Blinding of outcome assessors was rarely reported, despite standards in anxiety research requiring independent evaluation (Niu et al., 2021). Meta-analyses of mindfulness for anxiety demonstrated modest effects with moderate certainty; *Vipassanā*'s position remains unconfirmed due to a lack of consistent replication, reporting of adverse events, and the absence of moderator analyses to explain the sources of heterogeneity.

The stress domain showed relatively stronger consistency, particularly reductions in Perceived Stress Scale scores and indicators of emotional exhaustion among healthcare workers and students. Several studies have used active comparison groups and mid-term follow-up, although reporting of objective biomarkers, such as salivary cortisol and heart rate variability, remains limited (Kushwaha et al., 2024; Mani & Mishra, 2023). *Vipassanā* retreats are complex interventions involving sleep regulation, controlled diet, communication restriction,

and digital detoxification; each component has the potential to contribute independently to stress reduction (Giridharan et al., 2025). The Medical Research Council framework for complex interventions requires separating the active components to allow for more precise causal inference. Without a dismantling or factorial trial design, attribution of benefit solely to the bodily sensation observation technique remains inferential. Generalizability of the results is also hampered by the selection of highly motivated volunteer participants, which can inflate effect estimates through self-selection and expectancy bias.

Methodological assessments across studies revealed a recurring pattern of weaknesses, including small sample sizes, lack of transparent randomization, and lack of an active comparison group with comparable therapeutic standards. The risk of publication bias is evident in the predominance of reports of positive findings, while studies with neutral results are rarely published. Researchers' ideological affiliation with meditation traditions has the potential to introduce allegiance bias, a phenomenon well-documented in psychotherapy research. Application of the GRADE framework to the *Vipassanā* evidence likely resulted in low-certainty categories for depression and anxiety and moderate for stress, primarily due to limitations in precision and inconsistency. Multisite cross-cultural replication remains limited, resulting in inadequate external validity. Standards for preregistration of clinical trials and CONSORT reporting have not been consistently adopted, compromising the transparency and reliability of scientific syntheses.

Comparative analyses of established psychotherapies highlight disparities in the level of evidence. Cognitive Behavioral Therapy is supported by hundreds of large-scale randomized controlled trials, with meta-analyses demonstrating moderate-to-large effect sizes and formal recognition in international clinical guidelines. Interpersonal Therapy and Mindfulness-Based Cognitive Therapy have standardized manualization, structured therapist training, and data on the sustainability of effects for twelve months or longer. *Vipassanā* lacks an adapted clinical protocol that allows for individualized flexibility for complex comorbidities, and it has not been extensively tested as monotherapy or adjunctive therapy in severe clinical populations. Comparisons of effect sizes suggest partial equivalence for stress, but not for major depression or diagnostic anxiety disorders. The imbalance in the number of trials and the consistency of replications necessitate positioning *Vipassanā* as a complementary intervention.

The safety and adverse effects dimensions require explicit attention. Ekici, Garip, and Van Gordon (2020) reported the potential for depersonalization, derealization, trauma resurfacing, and increased anxiety during intensive meditation practice, particularly in individuals with psychopathological vulnerabilities. Most *Vipassanā* studies do not report systematic monitoring of side effects or criteria for discontinuation. The lack of tolerability data complicates risk-benefit evaluation, an essential component of clinical validity. Guidelines for

psychological intervention research require reporting of adverse events to a standard comparable to that for pharmacological trials. Without comprehensive documentation of safety, broad recommendations cannot be justified. Integration of *Vipassanā* into mental health services requires professional supervision, early risk screening, and crisis management protocols to minimize the potential for symptom exacerbation.

Psychological Mechanisms of *Vipassanā* in Psychiatric Perspective

The psychological mechanism of *Vipassanā* can be explained as a process of training attention and awareness that changes the dynamics of an individual's relationship with their mental experiences. Sumantry and Stewart (2021) define mindfulness meditation as a practice that modifies attentional regulation by improving attentional monitoring, sustained attention, and the ability to disengage from distracting cognitive stimuli. Ding et al. (2025) demonstrate that mindfulness training improves attentional stability and reduces susceptibility to cognitive distraction. This mechanism is understood as strengthening attentional control, enabling individuals to continuously monitor mental activity without becoming entangled in automatic thought processes. Rahrig et al. (2022) assert that mindfulness practice integrates the attentional system with the cognitive control network so that mental experiences no longer operate entirely reactively. *Vipassanā* utilizes the process of experiential monitoring, treating the mind as an object of observation and recognizing mental activity that normally occurs automatically as a transient phenomenon open to conscious reflection.

These changes in attentional patterns contribute to increased metacognitive awareness, often referred to as meta-awareness or decentering. Lange (2025) identified metacognition as a core mechanism of mindfulness meditation because it allows individuals to observe thoughts without identifying with their cognitive content. A cognitive psychiatry perspective views this process as a form of mental monitoring that increases the flexibility of information processing. Bennett et al. (2021) demonstrated that decentering allows individuals to view thoughts as transient mental events, rather than representations of reality that must be automatically followed. This mechanism is relevant for understanding mental disorders involving cognitive fusion or rigid beliefs about thought content. Nordahl, Anyan, and Hjemdal (2023) assert that psychological disorders are often maintained by metacognitive beliefs that drive rumination and repetitive worry. *Vipassanā* practice modifies this pattern through direct experience, separating the observer's awareness from the stream of cognition, so that mental activity no longer automatically controls psychological responses.

The process of nonreactive observation of mental experiences has important implications for emotion regulation. Modern emotion psychology explains emotion regulation through a process model proposed by James J. Gross (2015), which includes the stages of situation selection, attention shifting, cognitive appraisal

changes, and emotional response modulation. *Vipassanā* operates primarily through strengthening conscious attention and acceptance of affective experiences without impulsive reactivity. This allows emotional regulation to occur through changes in how individuals deal with emotional experiences. This mechanism neither suppresses emotions nor forces cognitive reinterpretation; rather, it allows emotions to be processed openly, gradually decreasing the intensity of affective reactions. A therapeutic approach developed by Zindel Segal et al. (2001) through mindfulness-based cognitive therapy suggests that nonreactive awareness can reduce the tendency to rumination, which often triggers recurrent depressive episodes. This relationship confirms that mindfulness meditation modifies emotional regulation by increasing affective tolerance and the ability to maintain attention to emotional experiences without the urge to avoid.

Emotion regulation through nonreactive observation is also closely related to an emotional learning mechanism known as extinction learning or inhibitory learning. Clinical psychology understands the formation of maladaptive emotional responses as the result of conditioning between internal stimuli and affective reactions that are repeatedly reinforced (Trentini & Dan-Glauser, 2025). De Jong et al. (2024) explain that anxiety reduction occurs when individuals confront emotional stimuli without engaging in avoidance responses, gradually weakening old associations. The inhibitory learning model developed by Michelle Craske (2012) asserts that new exposure experiences can form alternative memories that inhibit previous fear responses. *Vipassanā* practice creates a similar psychological state through continuous observation of bodily sensations, emotions, and thoughts without defensive reactions. Affective experiences that typically trigger avoidance are held as objects of attention, thus weakening the automatic association between internal stimuli and emotional responses.

Transformation of an individual's relationship with mental experience is also related to changes in self-processing. Contemporary psychiatry views self-experience as a cognitive construct involving self-referential processing networks and autobiographical narratives (Brewin, 2023). Ganesan et al. (2023) demonstrated that mindfulness meditation practice reduces the activity of brain networks associated with self-referential processing, particularly the default mode network. This decrease in network activity correlates with a reduced tendency to rumination and attachment to negative self-narratives. Bortolan (2020) distinguishes between minimal, direct self-experience and narrative self-construction formed through cognitive reflection. *Vipassanā* focuses attention on direct experience, thereby weakening identification with self-narratives. This transformation enables individuals to recognize that thoughts, emotions, and bodily sensations are constantly changing phenomena, so that psychological distress is no longer perceived as a threat to a fixed self-identity.

This change in self-processing is related to the concept of psychological flexibility, a focus of various modern therapeutic approaches. Fuochi and Voci (2024) emphasize that mental health is influenced by an individual's ability to detach from the content of their thoughts and maintain openness to internal experiences. The concept of cognitive defusion explains that thoughts need not be treated as literal facts that determine behavior. *Vipassanā* cultivates similar skills through observing mental experiences without conceptual attachment, thus depriving the mind of its normative authority over behavioral responses. Research by Öztekin, Gómez-Salgado, and Yıldırım (2025) shows that increased psychological flexibility correlates with decreased symptoms of anxiety, depression, and chronic stress. This relationship demonstrates that the mechanisms of mindfulness meditation are not only introspective but also have clinical implications that can be explained through evidence-based psychotherapy models. This approach positions *Vipassanā* as a practice that expands an individual's ability to manage mental experiences without relying on rigid cognitive control.

The integration of phenomenological and mechanistic approaches is crucial for a comprehensive understanding of the mechanisms of *Vipassanā*. Meditation traditions emphasize the direct experience of awareness, often described through phenomenological accounts of changes in the quality of attention and in the relationship to experience. Abdoun et al. (2025) demonstrate that subjective reports of meditation practitioners can be combined with neurocognitive measurements to explain the dynamics of awareness more accurately. This perspective rejects reductionism, which assumes that mental experience can be fully explained by neural activity, while still recognizing the contribution of empirical methods. The dialogue between phenomenology and neuroscience allows for a deeper understanding of the transformations of consciousness that occur during *Vipassanā* practice. This integrative approach demonstrates that the psychological mechanisms of meditation involve a complex interaction between attentional processes, emotion regulation, metacognition, and the formation of self-experience, so that mental changes cannot be reduced to a single mechanism.

Conceptual and Clinical Challenges of Integrating *Vipassanā* in Psychiatry

The integration of *Vipassanā* meditation into contemporary psychiatry raises fundamental epistemological issues stemming from the differences in ontological and teleological orientations between the Buddhist tradition and modern medical frameworks. Tensions arise when practices historically geared toward soteriological realization are framed as psychological regulation techniques to achieve affective stability or adaptive functioning. Joshi (2025) has highlighted this instrumentalization process as a reduction of meditation to a utilitarian strategy for stress management or emotion regulation. This transformation creates epistemic ambiguity because clinical frameworks tend to abstract the practice from the

transformational goals central to the Buddhist tradition, raising questions about the conceptual appropriateness of such integration.

The issue of decontextualization of Buddhist practice adds to the complexity of integrating *Vipassanā* into modern clinical settings. The meditation tradition in Buddhism developed as part of an interconnected system of ethics, mental disciplines, and philosophical perspectives. This structure is reflected in the eightfold path framework, which positions mindfulness practice as part of a process of moral and cognitive transformation (Wang, 2025). Adaptations of meditation to clinical contexts often diminish ethical and cosmological dimensions to enhance compatibility with secular medical institutions. Gokhale (2020) highlights this phenomenon as a form of reinterpretation that shapes what has been called modern Buddhism. This process is also observed in the development of secular mindfulness practices that separate mindfulness practice from its religious framework of origin, a transformation described by Jeff Wilson (2012) in his analysis of the evolution of contemporary mindfulness. When *Vipassanā* practice is presented as a neutral, value-free technique, its underlying anthropological assumptions become less visible. This value mismatch can create interpretive conflicts among individuals with differing religious or cultural frameworks, leading to ambiguity in the therapeutic experience.

Meditation-based clinical approaches also face limitations related to their suitability for patient populations. *Vipassanā* practice demands intense observation of mental phenomena through a nonreactive attitude that maintains sustained awareness of the flow of subjective experience. This demand can be problematic for individuals with certain psychiatric conditions who are vulnerable to cognitive disorganization or affective deregulation. Kirberg and Chadha's (2024) study on the side effects of meditation suggests that intense introspective experiences can sometimes trigger depersonalization, derealization, existential anxiety, or disruption of self-integration in some practitioners. Empirical research by Crosswell et al. (2024), conducted on difficult meditation experiences, demonstrates that contemplative practices do not always produce universal therapeutic effects. These risks are particularly significant in populations with a history of psychotic disorders, dissociative disorders, or complex trauma, who may experience increased distress through exposure to unstructured mental experiences. This situation demands more systematic clinical attention to participant selection processes, monitoring of meditation experiences, and the development of clearer contraindications for the application of contemplative practices in psychiatric settings.

The methodological framework for clinical interventions also faces challenges in standardizing *Vipassanā* practice. Meditation traditions have evolved through various schools of interpretation, emphasizing different instructional methods and phenomenological orientations (Joshi, 2025). This variation reflects the flexibility of contemplative traditions in adapting to specific cultural and pedagogical contexts.

Modern psychiatry, on the other hand, requires intervention protocols that can be replicated, documented, and evaluated through experimental research methodologies (Yaqub et al., 2025). Efforts to bridge these two approaches are evident in the development of mindfulness-based intervention programs such as Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy. These programs attempt to formalize meditation practice in the form of manualized interventions that allow for systematic clinical evaluation. However, this manualization process presents a conceptual dilemma because reducing the complexity of contemplative practices to standardized protocols could alter the phenomenological character of meditation and limit the instructional flexibility that characterizes the *Vipassanā* tradition.

Another challenge arises in relation to scientific evaluation based on the evidence-based psychiatry paradigm, which demands clarity of intervention constructs and methodological validity of research. The evidence-based approach places randomized controlled clinical trials as the gold standard in evaluating the effectiveness of mental health interventions (Ariansyah et al., 2025). Research on mindfulness and meditation has grown rapidly through numerous clinical trials and meta-analyses demonstrating moderate benefits for conditions such as depression, anxiety, and chronic stress. Methodological heterogeneity remains a significant issue in this field. Variations in intervention definitions, differences in training intensity, and the diversity of facilitator training backgrounds make it difficult to establish a consistent intervention construct. A study by Davidson and Kaszniak (2015) showed that meditation research often faces publication bias, limited control over contextual variables, and difficulty isolating the causal mechanisms underlying therapeutic effects. These challenges have led some researchers to emphasize the need for a more rigorous evaluation approach to ensure that claims of meditation's clinical benefits are not based on generalizations that go beyond the available empirical evidence.

Epistemological criticism has also been directed at the tendency toward reductionism that arises when contemplative practices are translated solely into psychological or neurobiological frameworks. Attempts to naturalize meditation through scientific language often focus on mechanisms of attention regulation, neural plasticity, or stress response modulation without considering the existential, transformative dimension central to *Vipassanā* practice. A critical analysis of this phenomenon demonstrates that the process of conceptual translation can lead to simplifications that obscure the original purpose of contemplative practice. Kirberg and Chadha (2024) emphasize that meditation aims not simply to produce a specific mental state but to transform how individuals perceive their identity and experiential reality. When these dimensions are reduced to techniques for enhancing psychological well-being, meditation practices risk losing the philosophical depth that is the source of their transformational meaning.

Conclusion

Contemporary psychiatry demonstrates the increasing integration of contemplative practices across traditions in response to the need for a more holistic, experience-centered approach to mental health. The analysis demonstrates the transformation of *Vipassanā* from a soteriologically oriented Buddhist practice into a structured psychological intervention, adapted within a clinical mindfulness framework and amenable to scientific evaluation. Key findings indicate that *Vipassanā*-based practice is associated with reduced symptoms of depression, anxiety, and stress, improved emotion regulation, and enhanced metacognitive awareness that facilitates the observation of mental experience without automatic reactivity. Frequently reported psychological mechanisms include restructuring of attentional patterns, increased decentering abilities, and reduced affective rumination, all of which contribute to psychological stability. Theoretically, these findings extend models of emotion regulation and the clinical mindfulness framework through a less reductionist, inner-experiential approach to mental phenomena. Practical implications include the potential integration of *Vipassanā* practice as a complementary intervention to cognitive-behavioral therapy, particularly for affective disorders. Key limitations include the predominance of short-term quantitative studies, the heterogeneity of operational definitions of *Vipassanā*, and the concentration of Western research samples. Future research agendas require longitudinal designs, mixed methodologies, analyses of neuropsychological mechanisms, and cross-cultural studies to strengthen the clinical validity and conceptual consistency of integrating contemplative meditation practices into modern psychiatric practice.

Acknowledgments

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Author Contribution Statement

DW contributed to the conceptualization of the research, the formulation of the theoretical framework, the development of the methodology, data analysis, the writing of the main draft, the substantive revision of the manuscript, and correspondence with the editor and publisher. AM contributed to data collection and verification, literature search, preparation of part of the literature review, and review of the manuscript's content. MR contributed to data analysis, interpretation of findings, strengthening academic arguments, and editing the manuscript. YD contributed to data validation, critical review of the article's substance, alignment of the writing structure, and final proofreading of the manuscript.

Conflict of Interest

There are no conflicts of interest with respect to the preparation, execution, analysis, interpretation of data, writing, or publication of this manuscript. The authors have no financial, professional, institutional, or personal interests that could

affect the objectivity, integrity, or independence of the research and the presentation of the results reported in this article.

AI Usage Statement

Artificial intelligence (AI) technology was used only to a limited extent to assist with language editing, grammar correction, improving manuscript readability, and supporting document formatting. AI was not used in problem formulation, conceptual framework development, data collection, data analysis, interpretation of results, argument development, formulation of findings, or drawing research conclusions. All ideas, concepts, methodologies, analyses, research results, discussions, and conclusions presented in this manuscript are the author's intellectual work and are the sole responsibility of the author.

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