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SPIRITUAL SILENCE PRACTICES AS AN INTERVENTION TOOL FOR IMPROVING META-COGNITION AND EMOTIONAL STATE OF THE INDIVIDUALS WITH THE SIGNS OF MOOD DISTURBANCE

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Abstract
The proposed research is designed to explore the effect and effectiveness of Spiritual Silence Practices (Hinduism & Buddhism Perspective) as an intervention tool for improving Neurocognitive functioning of patients of mood disorders. The major focus of the study is on contemplating this technique as a major Participants are selected from Art of living 'silence course' centers who have been diagnosed with mood disorder and sought refuge in these courses. This course was held for 5 days and encompassed yogic asans, pranayama, panchkosh kriya,
Sudarshan kriya and hollow-and-empty meditation. The meta-cognition questionnaire and The Emotional State questionnaire was administered on participants to measure their meta-cognition, and emotional state 5 days after completing the course and returning back to home. The scores of anxiety, depression, fatigue, insomnia and metacognition are checked for pre and post intervention. The Wilcoxon signed rank test is used to find the relationship between the pre and post intervention data. It was found that spiritual silence has significantly decreased the anxiety, depressive symptoms, agoraphobia, panic like symptoms and insomnia.

Keywords: Spiritual silence, depression, meta-cognition, anxiety, fatigue, insomnia

Introduction

Silence leads to a stillness of the mind,
Then to introspection,
Then to self-cleansing, Finally to liberation.

Silence is the absence of noise. This word is conceptualized in many ways in different cultures. It is commonly used as a tool to reach the Divine Truth. In paving the way to the truth within, silence is observed to be able to penetrate the layers of conditionings of the mind. In Rig Veda it is considered to be the platform for sounds to arise and play their symphony. While Kena Upanishad describes silence as the gap between the knower and the knowledge. In the background of the profoundness established by Sanatan Dharma, Buddhism, Jainism and
Christianity, some researches on its neuropsychological aspects have confirmed the assertions.
According to Leonardo Bernandi (2009), silence seems to intensify the arousal. The longitudinal study on the jhana practice of Khema practitioner has found that the mindfulness-based silence provides volitional control over the thought process and thereby increases meta-awareness. Silence

has been found to be the default state of human brain wherein even in the absence of external stimulation, the brain shows activity. The proposed study proposes Spiritual Silence as an intervention tool for emotional regulation for mood disturbance. Indian Psychological Concepts are gaining attention worldwide. This very important area of Indian Psychology is still untouched. Whether it is Buddhist or Hindu philosophy Silence has been given high importance. Indian Psychology has taken great strides in connecting the eastern wisdom with psychology and transform therapeutic modalities into holistic packages to deal with multitude of psychological issues. This study is an extension of the same with specific focus on emotion regulation using Spiritual silence. Below is the list of the aspects or variables that are part of the study along with their operational definitions.

Operational Definition:

Meta Cognition: Meta cognition is "cognition about cognition" or "Thinking about Thinking". Thus, in other words it is process of being aware of your own thought process.

Emotional State: Here Emotional state indicates "a state of emotional arousal when an individual experiences a particular emotion to the extant where it can influence his/her mental well-being".

Spiritual Silence: 'Maun', 'Golden Silence', 'Nobel Silence', Meditative Silence' and so many names but one destination that is your journey towards inner self or higher self. It is not a new concept, in fact being practiced since long time back. Our sages and saints used to practice it thousands of years back. Its importance is clearly mentioned in various epics; various saints like Mehar Baba, Mauni Baba and thousands of Kashtha Maun practicing saints made this kind of practice as their life ritual. These are extreme cases but so many worldly people are also practicing such spiritual silence on short term basis as well. Classic examples of such practices are Time Bound Kashtha Maun, Kalpvas, Vipasyana, Advance meditation Silence course of Art of Living and many more.

Almost all cultures are practicing it but its importance is yet to be discussed. This proposed research is trying to explore this untouched area of Indian Psychology as an intervention tool for improving emotional state and meta-cognition.

"Spiritual Silence is kind of silence practice when a person drops all the words to communicate to the external world, but rather strives to communicate to the inner most layer of his divine existence, through spiritual techniques."

Anxiety: It is the characterized by tension in the body and feelings along with physiological changes like increased blood pressure, dilated pupils and dizziness, sweating and trembling.

Agoraphobia: Intense fear of being in open spaces and in crowds with little to no means of escape without help.

Panic like symptoms: Intense fear that reaches a peak within minutes.

Depression: a negative affective state with feelings of despondency, pessimism, sadness and unhappiness

Fatigue: It is a state of reduced physical and mental state leading to decrease in performance.

Insomnia: It is regarded as sleeplessness where the person has trouble with sleeping leading to irritability, low energy, depressed mood and sleepiness during the daytime.

Review of Related Literature:

1.VanMeter, Jeffrey B; McMinn, Mark R; Bissell, Leslie D; Kaur, Mahinder; Pressley, Jana D**,** studied spiritual silence in Christian community they divided participant into two groups. One was given psychotherapy with the silence practice and another group was allowed to speak. The consequence was, the group which was more extraverted in nature did not show significant changes in therapeutic silence during the training

2. Shafii, M, discussed silence and quiescence in meditation as a temporary and controlled but deep regression in the service of ego. This, according to him, helps individual to re-experience and union with earlier love object on a preverbal level of psychosexual development.

METHOD

The proposed research will be based **Pre-Post Research design** with sample size **30.**

Process of Intervention

A 5-day spiritual silence course named Advanced Meditation Course or Silence course of Art of Living. This course was conducted by 2 trained senior trainers Ms. Namita Upadhyaya and Mr. Anurag Arora in Rishikesh, Uttaranchal. It entailed yogic postures (asan), dhyan and pranayama along with various healing processes like nature walk, musical satsang and catharsis-inducing activities. Around 85% people came from various ages, gender and culture participated from various regions of India. Out of which researchers deliberately chose 30 participants having signs of mood disturbance with the help of Screening tool-MINI Various processes practiced in this course were :-

1. Sudarshan kriya
2. Padma sadhana
3. Hollow and empty meditation
4. Panchkosh meditation
5. Pranayam like- Vastrika, Mudra pranayama, 3 stage pranayama, ujjaiyani breathing

And more everyday while observing silence along with avoidance of eye contact with other participants.

This was a complete package of dhyan, samadhi, asan and pranayama along with knowledge discussion and Discourses from Spiritual Verses to encompass, gyaan, gaan and dhyan into the spiritual practice.

Objective

1. To see the effect of Spiritual silence practice on the level of meta-cognition of the participants
2. To see the effect of Spiritual silence practice on the level of over all emotional state of the participants.
3. To see the effect of Spiritual silence practice on the level of Anxiety of the participants.
4. To see the effect of Spiritual silence practice on the level of Depression of the participants.
5. To see the effect of Spiritual silence practice on the level of Fatigue of the participants.
6. To see the effect of Spiritual silence practice on the level of Insomnia of participants .
7. To see the effect of Spiritual silence practice on the level of Agoraphobia/Panic like symptoms of the participants.

Hypothesis: On the basis of objectives following hypothesis is formed:

1. There will be a significant improvement in meta-cognition post intervention.
2. There will be a significant improvement in overall emotional state post intervention
3. There will be a significant improvement in Anxiety level post intervention.
4. There will be a significant improvement in Depression post intervention.
5. There will be a significant improvement in Insomnia post intervention.
6. There will be a significant improvement in Fatigue post intervention.
7. There will be a significant improvement in Agoraphobia and panic-like symptoms post intervention

Sample size: 30
Sampling: Simple Random Sampling**.**

Description of the tools:

1. **M.I.N.I. International Neuropsychiatric Interview** (For Diagnosis of Mood Disorders) assesses 17 common disorders that include 9 psychotic disorders. MINI showed similar reliability and validity to SCID-P and CIDI within a shorter period of time with time (mean 18.7 ± 11.6 minutes, median 15 minutes).

2. **The Meta cognition questionnaire-30 (MCQ -30)**(For measuring status of metacognition) which assess the individual differences in the metacognitive model of psychological disorders along 5 major factors contributing to it. The 5 subscales are : Cognitive confidence, cognitive self-consciousness, negative beliefs about uncontrollability of thoughts and danger, positive belief about worry and beliefs about the need to control thoughts.

3. **Emotional state questionnaire by** Anu Aluoja, Jakov Shlik, Veiko Vasar, Kersti Luuk, Mall Leinsalu created a self-report questionnaire with 5-point Likert scale that was administered on 194 patients with depressive and anxiety disorders around 5 sub scales of Depression, Anxiety, Agoraphobia–Panic, Fatigue, and Insomnia. The internal reliability of the total scale and subscales was assessed was found to be having a Cronbach's alpha reliability coefficients in patient group. The total EST-Q had an apha of 0.88, the Depression scale, 0.87; Anxiety, 0.69; Agoraphobia–Panic, 0.82; Fatigue, 0.77; and Insomnia, 0.76. This study has found high correlations between depression and anxiety. The scales of fatigue and insomnia have similar items and hence the both act as comorbidity showing high correlation as well.

Statistical tool:
Descriptive- The difference in pre and post intervention results on anxiety, metacognition, insomnia, agoraphobia, depression and fatigue is found to be non-parametric in nature.
Inferential: Pre and Post Wilcoxons Sign Rank test was done on the non-parametric data set.

Inferential Analysis
The data set was non-parametric and so Wilcoxons signed rank test was conducted on the pre and post data set. The sum of the ranks for post-meta and pre-meta , post-dep and pre-dep , is 465.00, for post-dep and pre-dep, post_anx - pre_anx, post_agpac - pre_agpac, Post_fat - pre_fat and post_ins - pre_ins is 465.00 with negative mean rank being 15.50 in a sample size of 30. The null hypothesis that the median scores of pre and post intervention scores are equal is not accepted. This depicts that there was a post-intervention scores are less than pre-intervention score showing significant decrease in all the subscales. The Z scores are negative and lie beyond 3.50 in a 2-tailed test of a non-normal data set, which implies that these scores are outliers in a sample size of 30.

Result and Interpretation Table 1.0

Table 1.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of meta-cognition.

Metacognition	Mean	SD	z
Pre	75.5667	5.51914	4.791^{b*}
Post	66.7667	4.18275	

*p < .05

As it is evident from table 1.0, that value of z is 4.791^{b} meaning that there is a significant difference between the group means pre and post meditation. This means there is a notable improvement in meta-cognition of the participants. Thus First Directional Hypothesis is Accepted.

Table 2.0

Table 2.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of overall emotional state

	Mean	SD	z
Pre	89.700000	6.406624	4.786951^{b*}
Post	40.633333	8.269109	

*p < .05

Table 2.0 shows mean, SD and z score of overall emotional state of the participants, pre and post intervention . Value of z is 4.786951[b] , meaning that there is a significant difference between the groups pre and post meditation. This means there is a notable improvement in the overall emotional state of the participants. Thus, the second Directional Hypothesis is Accepted.

Table 3.0

Table 3.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of anxiety

	Mean	SD	z
Pre	19.4333	2.8245	4.791[b]*
Post	8.4667	3.2455	

*p < .05

With z value of -4.791[b] the pre and the post data for anxiety showed significant difference suggesting decrease in anxiety. Thus ,the third hypothesis is accepted.

Table 4.0

Table 4.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of depression

	Mean	SD	z
Pre	29.2333	2.40235	4.789[b]*
Post	15.933	4.733384	

*p < .05

The z score for the pre and post scores of depression indicates decrease in the depression with 4.789 . Thus, the fourth hypothesis is accepted.

Table 5.0

Table 5.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of insomnia

	Mean	SD	z
Pre	8.5333	1.3060	4.806[b]*
Post	3.100	1.7685	

*p < .05

As it is evident in the table 5.0 that the z value is 4.806 . The pre and the post data for insomnia showed significant difference suggesting decrease in insomnia. According to the result the fifth hypothesis is accepted.

Table 6.0

Table 6.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of fatigue

	Mean	SD	z
Pre	17.9000	1.3060	4.800[b]*
Post	4.9667	1.7685	

*p < .05

In table 6.0, it is visible that the z scores is 4.800, which indicates decrease in the fatigue post intervention. Consequently, the sixth hypothesis is also accepted.

Table 7.0
Table 7.0: showing Pre and Post Mean, SD and Wilcoxon's paired t-test score of agoraphobia/panic like symptoms

	Mean	SD	z
Pre	14.4667	2.528	4.796[b]*
Post	8.1667	4.1860	

*p < .05

As shown in the table 7.0, the z value of Wilcoxon signed rank test is 4.796[b,] Suggesting significant improvement in agoraphobia and panic like symptoms. Thus seventh hypothesis is accepted.

DISCUSSION

The data collected was found to be a non-parametric in nature that did not abide by the laws of normality. The data was hence inferentially analyzed using the Wilcoxon signed rank test and the results are showed a significant difference in the means of the pre and post scores.

The non-parametric inferential statistics showed a significant decrease in anxiety, depression, fatigue, insomnia, agoraphobia and panic like symptoms after spiritual silence and sustained even after the course was completed. There was a significant improvement in the sleep cycle and general fatigue that had a lasting effect even after the termination of the intervention.

Conclusion:

The study shows that spiritual silence has significant effect on depression, anxiety, insomnia, fatigue which is found to be decreasing within 5-days of practice. It has significantly increased metacognition within the same period, giving volitional control over the thought process where in the practitioners could analyze and dispute their belief systems. A subjective review of each participant had common changes as in the quality of sleep has improved, found themselves more emotionally stable, and they reported they are able to be happy, blissful and light from within, without any reason.

The post data has been collected after 5-days of completion of the course, especially after participants have returned to their original habitats and acclimatized back again. This step was done to avoid dispute of the environmental and conditional effects of Spiritual culture and to acknowledge the lasting effects of the course. But due to the negative Z score lying well beyond3.50, the sample was non-normal and showcased outliers.

Delimitation:

1.The gender differences can be studied.
2. Sample size can be increased.
3. The qualitative aspect of spiritual silence on depression, fatigue, insomnia, agoraphobia and panic like symptoms can be studied.
4. The correlation between the differences of each dependent variable can be checked to find and establish relationships in this study.
5. The proposed study is confined to Indian community only, can be administered outside country to see the global impact of silence. Cross cultural study can also be conducted to see the cultural impacts.

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