SPECIAL ARTICLE: SPIRITUAL THOUGHTS IN PSYCHIATRY-I

Practical and Theoretical interactions of Buddhism and Psychiatry: a view from the West.

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ABSTRACT

One of the greatest religions in the world, Buddhism and its tenets have been used for understanding the pain and human emotions. Using these tenets of social and psychological development of the individuals can be encouraged. Key constructs of Buddhism can be employed in cognitive therapy. In this paper we provide an overview of the key principles embedded in Buddhism and also place these in the context of Western concepts of psychotherapy. We link the Buddhist concepts with anxiety, obsessive compulsive disorders, addictions and chronic illness.

Key words:

INTRODUCTION

Buddhism is often classified as one of the great religions of the world. However, Buddhism is different from other great faiths in that it does not propose the existence of a central God or creator. Some scholars see Buddhism as a philosophy, and others as a way of life, but to pigeonhole it in this way is somewhat academic.

Buddhism can be seen as a set of beliefs which alleviates suffering by encouraging and motivating the follower onto a path of beneficial psychological and social development. When regarded in these terms, it is easy to see how over two millennia of Buddhist teachings could prove a fertile ground for those in the West attempting to develop psychological therapies for improving mental health. Yet only relatively recently has the West begun to realise how rich a harvest Buddhism may impart.

Over the past two decades a rapidly growing body of work has amassed which explores the commonalities of Buddhism and Western psychological therapies. This body of work is the subject of this review.

A brief background is given to some of the key constructs of Buddhism — providing the framework upon which the remainder of the discussion is built. Western models of anxiety states are briefly discussed with a view to highlighting the similarities with the Buddhist view of the mind. The Buddhist technique of mindfulness meditation is considered as a possible intervention for a number of anxiety disorders. The potential benefits of Buddhist psychology to those suffering from addiction problems, chronic pain, and chronic illness such as HIV are also discussed. Finally, the application of Buddhist psychology as an adjunct to psychotherapy is considered, with reference to the potential therapeutic benefit of the Buddhist no-self.

Before embarking upon an account of Buddhism's historical and philosophical constructs, it is important to note that an array of different schools of Buddhism exist the world over. The basic tenets presented here are central to all of them, but are by no means exhaustive to any. Described here are only those facets of Buddhism relevant to the present discussion.

For a more comprehensive account, see Morris (1993), and for a more detailed account with reference to western therapeutics see Kumar (2002).

BACKGROUND

Buddha delivered the Four Noble Truths, and thereafter was known as the Buddha, or Awakened One.

The First Noble truth states simply that dukkha (suffering) is an inevitable part of human existence. Dukkha encompasses all forms of pain, misery, discontent, emptiness, dissatisfaction or any other negative emotional experience. Since suffering is an existential fact, not an evil, it should not be feared — nothing is gained from responding to suffering with impatience.

The Second Noble Truth describes that the source of suffering is tanha (thirst or craving). Tanha is born from our sensations and perceptions of the world, and is "bound up with pleasures, lusts, the desire to become more, to grow" (Morris, 1993). Craving results in attachment to objects, ideas and desires, which ultimately leads to suffering. Suffering can, however, be overcome by eliminating its cause (craving) through the self-regulation of desires and emotions. This is the Third Noble Truth. Finally, the Fourth Noble Truth proposes how this is achieved: by following the Eightfold Path to Enlightenment.

A detailed description of the Eightfold Path is not required here. Its broad aim is to alleviate dukkha (suffering) through the practice of mindfulness meditation.

Mindfulness meditation is a Buddhist technique for training the mind through a combination of focussed attention and breathing techniques. The meditator develops a heightened awareness of all mental and bodily sensations as they occur and cease to occur. To the Buddhist, thoughts are to the mind as sounds are to the ear — the mind is a sense organ whose stimuli are the concepts and thoughts passing through it. As such, when a thought enters the mind it is subject to the same interpretations as any other stimulus. Consider the psychological events that occur when listening to a piece of music. The experience is far more complex that simply...
that of an auditory stimulus – the input is distorted by an array of perceptions and memories (beautiful, calming, powerful etc). Similarly, when a thought enters the mind, that thought is subject to an equal number of distortions and interpretations. Mindfulness meditation trains the mind to strip away these distortions, allowing cognitions to be objectified as they pass through consciousness, with no emotional response generated towards them.

Mindfulness precipitates particular insight into the Buddhist principle of impermanence (anicca). This notion suggests that all things – be they objects, people, sensations, or beliefs – are transient; nothing everlasting, nothing everlasting. This makes Buddhism quite unique amongst the great faiths in that, when applied to the self, the notion of impermanence postulates that there is no everlasting soul. This is the Buddhist principle of anatta, or no-self. Anatta is realised though meditation – in the moment-to-moment bare attention of mindfulness, the Buddhist ceases to identify with sensations and feelings as his/her ‘self’. As concentration intensifies the sense of self dissipates, and is replaced instead by the notion of anatta. This principle is succinctly described by Morris (1993): ‘There is no immutable core of being, no eternal soul, either within the individual person or in the world. Existence is, for the Buddha, impermanent, conditioned, and essentially transient and in flux’.

The principles of dukkha, anicca and anatta (suffering, impermanence and no-self) are termed the three pillars of Buddhism.

An important point to note with regard to mindfulness is that each thought is regarded as distinct from the emotional response to it.

This is not dissimilar to the metacognitive framework used in the West to model anxiety states. A metacognition is a belief or attitude towards one’s own cognitions, or ‘a reflective process directed at one’s own cognitive activity’ (Allen & Armour-Thomas, 1991). This framework is a useful platform from which to cast light on some of the similarities between the Buddhist and the cognitive therapist’s views of the mind. We shall begin by considering Western metacognitive modelling of obsessive compulsive disorder (OCD).

Buddhist Psychology and Anxiety Disorders

The American Psychiatric Association’s Diagnostic and Statistical Manual (APA, 1994) defines obsessions (of OCD) as ‘recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress’. Resistance to these intrusive thoughts is another important (almost defining) property of OCD. That is to say that the sufferer attempts to ignore or suppress intrusions with some other thought or action (the compulsion).

Anxiety (the metacognition) in OCD arises from two sources – from the content of the obsession (“I must clean the kitchen ten times or I will die”), but also from the perceived threat of a repetitive cyclical thought that refuses to disappear from consciousness. Mindfulness meditation could potentially train the mind to objectify the obsession as it passes through consciousness, without generating the pathological anxiety-response. Furthermore, a realisation of anicca (impermanence) can promote a sense that the cyclical thoughts will eventually cease, since all things are transient. This provides a reassuring sense of order and control over a chaotic thought process previously viewed as threatening.

Currently, the aim of cognitive-behavioural therapy in OCD is to modify the anxiety-response by direct exposure to feared cognitions (e.g. to show that cleaning the kitchen only once does not result in death), and through systematic deconstruction and rationalisation of false beliefs. These two approaches reduce anxiety by directly attacking the obsession itself. That is they try to prevent the undesired metacognition (anxiety) by obliterating the intrusive obsession. Interestingly, however, it has been shown that intrusive thoughts indistinguishable in content from clinical obsessions occur in nearly 90% of the general population (Rachman and de Silva, 1978; Salkovskis and Harrison, 1984). This suggests that it is the response to the obsession which is pathological in OCD, not the obsession itself. It could be argued, therefore, that the ideal intervention for OCD would seek only to modify the (pathological) anxiety-response, whilst allowing the (‘normal’) intrusive cognitions to continue. This is exactly what is achieved in mindfulness – a training of the mind which adapts only the emotional response to thoughts, and not the thoughts themselves.

Similar claims can be made with regard to the role of mindfulness in other anxiety disorders. Evidence suggests that the perception of threat arising from the content/occurrence of intrusive cognitions is also important in the psychopathology of generalised anxiety disorder (GAD) (Beck et al 1995, Freeston et al 1994). A comparable model of panic disorder is proposed by Clark (1985), who suggests that panic attacks occur in response to the catastrophic interpretation of bodily sensations such as palpitations and breathlessness (as opposed to the pathological interpretation of cognitions in OCD and GAD). Similarly, Barlow (1986) proposes a model of sexual dysfunction based on the notion of ‘negative automatic thoughts’. In this model, sexual dysfunction is maintained by cognitive interference from intrusive thoughts occurring during sex. An important commonality of all these models is the notion of a pathological reaction to intrusive thoughts or bodily sensations. The detached observation of mindfulness may therefore provide relief from all of these pathologies.

Only a limited amount of research is available to empirically verify the efficacy of mindfulness in the treatment of mental disorder. Kabat-Zinn et al (1992) studied the effectiveness of a mindfulness meditation-based stress reduction program for the treatment of GAD and panic disorder. They observed significant reductions in subjective and objective measures of anxiety following eight weeks of meditation training. 91% of subjects showed significant reductions in Hamilton and Beck Anxiety (and depression) scores post intervention and at three month follow-up. Significant reductions were also observed in the severity and frequency of panic attacks.

A 3-year follow-up study of the same cohort (Miller et al, 1995) showed that meditation practice was maintained in at least 77% of subjects (although some were untraceable), and that all therapeutic benefits
of mediation were also maintained in this group. It should be noted, however, that the samples used in this research were too small to permit definitive conclusions (n=22). The results are however promising, and indicate the need for more thorough investigation - with a view to a potential integration of Buddhist techniques into western therapeutics.

The possibility of such integration was first conceived by Mikulas, in a number of pioneering papers marrying Buddhism to behavioural techniques (Mikulas, 1978; Mikulas, 1981). An important commonality of Buddhist psychology and cognitive behavioural therapy is that both stress the importance of modifying maladaptive/erroneous cognizing of the internal and external environment. For example, behavioural techniques which train patients to objectify behaviour may later be helpful in training the mind to objectify thoughts during meditation. Similarly, learning to relax through behavioural techniques may contribute to self-regulation and the cultivation of meditative states for overcoming attachments. An important addition that Buddhism could make to the west is through a more satisfactory explanation of the nature of suffering. The Buddha taught that suffering is a natural and normal state of being. Given that the mind is a sense organ, all cognitions, good or bad, have value. As described by Toneatto (2002):

"[Buddhist psychology teaches that] unpleasant cognitive states serve the same function, psychologically, as does pain for our physical wellbeing. Physical pain, while undeniably unpleasant, is a harmless but potent motivator in seek and resolve source of pain. Similarly, unpleasant cognitive states serve to motivate changes in our behaviour, lifestyle, social relationship, interpersonal behaviour, and so on. All experiences, desirable or not, have value for increasing self-knowledge and self-understanding."

Mindfulness goes above and beyond cognitive therapy - doing much more than simply seeking out and modifying maladaptive behaviours. It is a "way of thinking", a paradigm shift which provides a new way of relating to suffering. As such, mindfulness has been recruited by some to help develop effective coping strategies in those suffering from the often devastating impact of chronic pain, and terminal illness.

**MINDFULNESS IN CHRONIC AND TERMINAL ILLNESS**

Data have indicated that mindfulness meditation can deliver effective long term reductions in both the severity and frequency of chronic pain. Kabat-Zinn et al (1985) took 90 people for whom conventional hospital-based management had failed to effectively treat their pain. They were entered into a ten-week mindfulness-based stress reduction program, and showed significant reductions in measures of present-moment pain, negative body image, inhibition of activity by pain, physical symptoms, mood disturbance, and psychological symptomatology, including anxiety and depression. All improvements were maintained at 15 month follow-up, and the majority of patients continued to use meditation in their daily lives. Mindfulness achieved these results by detaching physical pain from the psychological response to it. Mindfulness helps to break down this belief, to "cause an 'uncoupling' of the sensory dimension of the pain experience from the affective/evaluative alarm reaction, and reduce the experience of suffering via cognitive reappraisal." (Kabat-Zinn, 1982).

Kabat-Zinn et al (1985) outline a number of unique features which recommend mindfulness as an intervention for chronic pain. (1) In the current climate cost effectiveness, meditation is much less expensive than complex behaviour modification programs. It can be taught in groups of up to thirty individuals, and has shown good compliance rates long after training has ceased. (2) The emphasis placed on self observation can help build healthier models of disease in the mind of the patient, and give insight into maladaptive behaviour patterns resulting from the illness. (3) Insight into the nature of consciousness can be generalised to other behavioural contexts, outside the arena of pain management. (4) Meditation can help reduce secondary psychopathologies such as depression, and help patients to develop on a personal level (see 'Buddhist Psychology and Psychotherapy' below). (5) Meditation has become less of a quintessentially Eastern phenomenon in recent years. As such it has fewer religious and ideological overtones - increasing acceptability in the West. (6) The neurophysiology of meditation is becoming a field of empirical research. This may one day unravel the biological processes which underpin the ability of meditation to cultivate feelings of well-being and self-worth, even in the midst of suffering.

Similarly promising results have been reported for the use of mindfulness meditation in the management of oncology patients. Specia et al (2000) applied Kabat-Zinn's meditation program to patients with a range of cancer diagnoses, and observed significant reductions in measures of depression, anxiety, anger and confusion. Moreover, the program brought about physical benefits of reduced gastrointestinal and cardiopulmonary symptoms.

Such 'organic' benefits of meditation may be of particular value to those suffering from HIV and AIDS. Taylor (1995) investigated the effect of a stress reduction program (involving meditation) on HIV-positive men, noting that anxiety reduction is particularly important since the immunosuppressive effect of stress is more pronounced in HIV/AIDS. Participants in the treatment group showed improvements in overall self-esteem, and even in T-cell count. A detailed review of mindfulness in the treatment of HIV/AIDS is given by Logsdon-Conradsen (2002). She cites a preliminary study (Kelly, 1989) showing that mindfulness was able to reduce psychological stress, enhance positive outlook and promote a sense of control in HIV-positive men. However, the sample size was small (n=4), and as such further research is required. Logsdon-Conradsen (2002) also notes that a host of new long-term problems have emerged and these include coping with medication side-effects, disclosing diagnosis, changes in social relationships, survivor guilt, re-entering the workforce and financial worries, to name only a few. This highlights that the Western approach to tackling such devastating illnesses as HIV or cancer is largely through a detailed understanding of only organic pathology. This understanding of how illness occurs has been enormously
successful in extending life, but does little to answer the question "why me?" Mindfulness may give some comfort here by providing a refreshing perspective on the nature of suffering.

Acceptance of impermanence and the resulting release from attachments can be enormously liberating, providing relief from the anguish and uncertainty of chronic or terminal illness.

**BUDDHISM AND ADDICTION**

Groves and Farmer (1994) discuss the Buddhist perspective on drug addiction within the framework of the Four Noble Truths.

They stress that the universality of dukkha/suffering (the First Noble Truth) encompasses "being attached to the unloved or separated from the loved, as well as not getting what one wants or getting what one doesn't want; all common features of addiction". Moreover, dukkha can be the fear of potential suffering, or future displeasure ("where will my next fix come from?").

The Second Noble Truth (that dukkha results from tanha/craving), is discussed with reference to the three sources of craving: kama, bhava and vibhava. Kama is sensory experience, as may be offered by drugs, food or sex — all objects of addiction.

Bhava implies the craving for a state of mind — searching for a mindset of self-confidence and security — such as a cocaine high. Vibhava is nothungness, emptiness, non-existence — analogous to alcohol and opiate use to eclipse real feelings. From a Buddhist perspective, therefore, addiction represents a false refuge from the pain and suffering of real life. The addict is trapped in a controlling attachment to the addictive behaviour. The drug provides a rapid but short-lived relief from the ever powerful craving and suffering of withdrawal.

The Third Noble Truth (that suffering can be overcome though the extinction of craving and attachment), makes the crucially motivating assertion that there is an alternative to suffering — it is possible to be liberated from both suffering and craving.

Finally, the Fourth Noble Truth postulates a 'way out' for addicts: The Eightfold Path to Enlightenment (involving mindfulness and meditation). It has already been discussed how constructive mindfulness can be to those suffering from anxiety, depression and feelings of low self-worth. It is easy to see the potential value in such technique in freeing people from addictive behaviours and their psychopathological consequences. Moreover, the Buddhist stance on addiction avoids the moralistic approach sometimes adopted in the west. As noted by Marlatt (2002), the choice between total abstinence ('success') and relapse ('failure') can lead patients into a never-ending cycle of restraint and relapse. By contrast, the Buddhist approach places emphasis on compassion. The Eightfold Path promotes the development of a new set of attitudes and beliefs in a non-judgmental context of detached observation and positive personal development.

**BUDDHIST PSYCHOLOGY AND PSYCHOTHERAPY**

The West often perceives the self not only as a stable entity, but a strong ego is regarded as the key to a successful life (at work, in interpersonal relationships, etc). To this end, Western psychotherapy often seeks to strengthen the ego, to correct low self esteem.

Similarly, psychologists may treat psychotic or character disordered patients by building a stronger self, resulting in a sense of 'ongoingness' and stability in the midst of profound psychological chaos. It would seem therefore that psychotherapy and Buddhist mindfulness are diametrically opposed in their service of the ego (mindfulness promotes the dissolution of the self into anatta). This apparent divergence of the two disciplines is discussed by Michalon (2001), who argues that the two are not opposed, but that ideas of the self and the no-self lie on the same continuum of development. The West focuses on an earlier stage of development, with the later stages being mapped out by Buddhist teachings. Michalon gives the example of individuals who spend the first third of their lives forming attachments to such things as education, work, marriage and children. Opposing the development of the self at these stages of development could be potentially damaging.

Later on in life, however, individuals are more prone to disillusionment with the unsatisfactory nature of existence (the mid-life crisis). It is at this point that the Buddhist approach could provide tremendous insight into, and perhaps relief from, the nature of existential suffering.

**CONCLUSION**

It is only recently that the West has come to realise the wealth of therapeutic promise contained within Buddhist teachings. In recent years, attempts to integrate the Buddhist approach and Western psychological therapies have begun. The possible therapeutic benefits of Buddhist Psychology are very diverse, and can be brought to bear on different levels of psychological functioning. Mindfulness may be effective in a range of pathologies. These include anxiety disorders, addictive behaviours, chronic pain, and terminal illness such as cancer and HIV — traditionally tackled in the West through a purely organic understanding of disease. Moreover, a deeper penetration of the Buddhist doctrines of anicca and anatta can promote profound person development, providing new ways of relating to suffering. We return then to the question of how to define Buddhism; is it a religion, a philosophy, or a way of life? Perhaps a more fitting definition to the current discussion would be that Buddhism is a form of psychological medicine — a compassionate and highly sophisticated set of psychological constructs whose key concern is the abolition of suffering.

**REFERENCES**

Allen BA & Armour-Thomas E. (1991) Construct validation of metacognition. Journal of Psychology. (272): 203-211.

American Psychiatric Association. (1994) Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM-IV). Washington, DC: American Psychiatric Press.

Barlow DH. (1986) Causes of sexual dysfunction: the role of anxiety and cognitive interference.
Journal of Consulting & Clinical Psychology. 54(2): 140-8.

Clark DM. (1986) A cognitive approach to panic. Behaviour Research & Therapy. 24(4): 461-70.

Groves P & Farmer R. (1994) Buddhism and addictions. Addiction Research. 2(2): 183-194.

Kabat-Zinn J. (1982) An outpatient program in behavioural medicine for chronic pain patients based on the practice of mindfulness meditation: theoretical considerations and preliminary results. General Hospital Psychiatry. 4(1): 33-47.

Kabat-Zinn J, Lipworth L & Burney R. (1985) The clinical use of mindfulness meditation for the self-regulation of chronic pain. Journal of Behavioural Medicine. 8(2): 163-190.

Kabat-Zinn J, Massion AO, Kristeller J, Peterson LG, Fletcher KE, Pbert L, Lenderking WR & Santorelli SF. (1985) Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. American Journal of Psychiatry. 149(7): 936-43.

Kabat-Zinn J. (1994.) Wherever you go, there you are. New York: Hyperion.

Kelly PJ. (1989) Evaluation of a meditation and hypnosis based stress management program for men with HIV. Proceedings of the Fifth International Conference on AIDS, Montreal.

Kumar SM. (2002) An introduction to Buddhism for the cognitive-behavioural therapist. Cognitive & Behavioural Practice. 9(1): 40-43.

Logsdon-Conradsen S. (2002) Using mindfulness meditation to promote holistic health in individuals with HIV/AIDS. Cognitive & Behavioural Practice. 9(1): 67-71.

Marlatte GA. (2002) Buddhist philosophy and the treatment of addictive behaviour. Cognitive & Behavioural Practice. 9(1): 44-49.

Michalon M. (2001) "Selflessness" in the service of the ego: contributions, limitations and dangers of Buddhist psychology for western psychotherapy. American Journal of Psychotherapy. 55(2): 202-18.

Mikulas WL. (1978) Four noble truths of Buddhism related to behaviour therapy. Psychological Record. 28(1): 59-67.

Mikulas WL. (1981) Buddhism and behaviour modification. Psychological Record. 31(3): 331-342.

Miller JJ, Fletcher K & Kabat-Zinn J. (1995) Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. General Hospital Psychiatry. 17(3): 192-200.

Morris B. (1993) Buddhism and the Doctrine of No-Soul. In 'Anthropology of the Self: The individual in cultural perspective': Pluto Press, 49-69.

Rachman SJ & de Silva R. (1978) Abnormal and normal obsessions. Behaviour Research and Therapy. 16:233-238.

Salkovskis PM & Harrison J. (1984) Abnormal and normal obsessions - a replication. Behaviour and Research Therapy. 22:549-552.

Salkovskis PM & McGuire J. (2003) Cognitive-Behavioural Theory of Obsessive Compulsive Disorder. In 'Obsessive-Compulsive Disorder: Theory, Research and Treatment': Wiley & Sons, 59-78.

Speca M, Carlson LE, Goodey E & Angen M. (2000) A randomized, wait-list controlled clinical trial: the effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. Psychosomatic Medicine. 62(5): 613-22.

Taylor DN. (1995) Effects of a behavioural stress-management program on anxiety, mood, self-esteem, and T-cell count in HIV-positive men. Psychological Reports. 76(2): 451-7.

Toneatto TA. (2002) A metacognitive therapy for anxiety disorders: Buddhist psychology applied. Cognitive & Behavioural Practice. 9(1): 72-78.