Buddhism and psychiatry: confluence and conflict

Graham Meadows

Objective: To describe the relationship between Buddhism and psychiatry, from a personal perspective.

Conclusions: The present paper introduces Buddhist thought for those unfamiliar with it, then describes some of the sites of confluence and conflict between this tradition and those of Western mental health care. It does so from the perspective of a Westerner who has made some exploration of Buddhism, mainly within one of the Tibetan traditions.

Key words: Buddhism, psychiatry, religion.

HISTORY OF BUDDHISM

The historical Buddha lived in Northern India approximately 2500 years ago, and so was a contemporary of Pythagoras. He taught for many years, extensively sharing his personal experience with a wide range of audiences. The teachings spread widely, being locally interpreted in transmission, with, broadly speaking, two routes of development. One was north of the Himalayas, including the Tibetan group, eastward into China finally into Japan and Vietnam; there was also a southerly route including Sri Lanka, Thailand, Burma and Cambodia. Latterly, there has been an explosion of teachings in the West, with increased travel, availability of more and better translations, of accessible presentations by Westerners, and, in the case of Tibetan teachings, the effect of the outflow of teachers consequential on the Tibetan diaspora. Australia and New Zealand have a surprising number of these refugees and migrants, with many very senior teachers providing teachings in a wide range of traditions. The recent Australian Census identified Buddhism as the fastest growing spiritual tradition in the country.

BUDDHIST THOUGHT

We are what we think
All that we are arises within our thoughts
With our thoughts we make the world
Speak or act with an impure mind
And trouble will follow you
As the wheel follows the ox that draws the cart

(Tibetan Dhammapada)

Buddhist thought is very psychological in nature; a great deal of the content of Buddhist teachings has to do with promoting more positive states of mind. Included within these states of mind are states that are free of afflicting emotions such as anger, despair, and negative types of desire.

Codification of Buddhist teachings

The Buddha's presentation of his teachings varied somewhat according to the audience and the context. Because he taught in many settings over a large number of years, this could be a source of confusion. During the spread of Buddhism in Tibet, there were efforts made to reduce possible harm from this. Arising out of these efforts we have a number of versions of teachings called the 'Graded Path'. Tibetan Buddhism also commonly makes use of a figure the Buddha composed within his lifetime, that of the 'Wheel of Life' (Figure 1).
The wheel of life (e.g. http://www.buddhanet.net/wheel1.htm for a guided tour and http://www.digitaldharma.org/g15.asp for an extended explanation) depicts a wrathful figure grasping a large plate-like image. Around the edge of this are images depicting the ‘links of independent origination’ – from one o’clock onwards:

1. At the base of all problems is ignorance of the true nature of reality, depicted by a blind man.

Then a further series of images conveys concepts that build on this:

2. because of ignorance, we create karma;
3. because of karma, we create consciousness;
4. because of consciousness, we create ‘the aggregates’;
5. because of the aggregates, we create the senses;
6. because of the senses, we create contact;
7. because of contact, we create suffering;
8. because of suffering, we create craving;
9. because of craving, we create grasping;
10. because of grasping, we create conception;
11. because of conception, we create rebirth;
12. because of rebirth, we create death.

Within this circle are the six realms. These images can be taken as signifying actual environments for rebirth; metaphors for different aspects of the human condition; or in more subtle interpretations, as different states of mind that lead to different kinds of suffering, which involve the subjective perception of different environments. Clockwise from the top we have the God Realms, the Human Realm, the Hungry Ghosts, the Hell Realms, the Animal Realm and the Jealous Gods. Within this we have a depiction of the rising and falling of mental states with the alternation of positive and negative mental states, then in the centre we have the three root poisons of anger, desire and ignorance symbolized by the snake, the rooster and the pig. The whole of this space – psychic existence or Samsara – is embraced by Yama, the Lord of Death. Within the frame but outside Samsara is also a Buddha, illustrating that escape to enlightenment outside this constricted universe is possible.

Plainly, this presentation is greatly abridged. Concepts such as ‘the aggregates’ require substantial exposition, and many of the terms that appear familiar are being used here in quite specific ways. What may be clear, however, from this summary is the extent to which the doctrines of Buddhism place a great deal of close emphasis on the nature of internal states. Allied with the doctrinal teachings are extensive meditative techniques that encourage the practitioner to become very much aware of internal states and the way in which mental states are created out of our habitual ways of perceiving things. ‘Habitual ways of perceiving things’ in fact is one way of looking at the whole concept of karma within Buddhism. Our accustomed and habituated ways of construing the world will tend to influence how we experience it and how we respond to it.

CONNECTIONS BETWEEN BUDDHISM AND MENTAL HEALTH CARE

Theoretical connections and the nature of consciousness

Western psychology is currently grappling mightily with the nature of consciousness. Although it has made little impact yet into the thinking around clinical mental health care, where a number of conventional assumptions regarding cognitive-behavioural and psychodynamic psychology stand centre stage, waiting in the wings as it were are some radical reformulations of the nature of personhood and the mind. Consciousness theorists and investigators preoccupy themselves with issues such as the ‘binding problem’ whereby disparate sensory inputs arriving at different times in the sites through which awareness might be coordinated seem to be experienced as simultaneous. They concern themselves also with speculations on the nature of ‘zombies’ or non-conscious humans – whether such creatures might exist and indeed if you were one whether you would know it or not.
Workers in this field have had a couple of reasons to become interested in Buddhist thinking. First, Buddhism contains some highly developed models of mind based on the fruits of extended contemplative exploration of the nature of mental self. Second, the techniques of meditation offer some promise in opening up the possibility of more intensive exploration of mental phenomena. Buddhist techniques offer to consciousness study investigators the possibility of, to borrow a phrase from Guy Claxton, ‘sharpening the gizmo’ in relation to introspection on the origin and nature of conscious experience.

Practical utility of mindfulness and other Buddhist techniques for therapists

Training in psychiatry in particular presents some psychological and mental challenges for the practitioner. Phenomenological mental state examination requires the development of a particular observing faculty: a capacity to create a representation in one’s own mind of the events in another, and then cogently describe this. This is a developed form of empathy that requires a certain kind of mental poise and pliancy. This in itself represents a reason for seeking out techniques that may sharpen the introspective faculties.

Further reasons for seeking out techniques that may support mental health and stability include: dealing with the day-to-day stresses of work, with the impacts of transference and counter transference on our own psychologies, as well as the stress of making often painful and risky decisions. My own encounters with Buddhism came in part from this root, starting out in psychiatry and feeling that some kind of relaxation practice might be beneficial in containing stresses of this type of work. This along with encounters with some other political writings from a Buddhist orientation were part of my own early journey into contact with Buddhism.

Buddhist meditation techniques emphasize the importance of a concept known as ‘mindfulness’. To illustrate the centrality of this concept: a story is told of the Buddha being stopped on the road by a group of soldiers who were going to battle, telling him that they might die that day and that they needed to know what teaching he could give them that was at the core of his spiritual lessons. He is said to have replied with one word: ‘awareness’. Meditation techniques, by encouraging the strengthening of the capacity to focus single-pointedly on an indicated object, with the gentle but progressive development of self-accepting strategies for dealing with intrusions on that concentration, provide important resources for the clinician in dealing with the at times bewildering array of influences and stresses that confront us in clinical mental health practice. Also within Buddhist practice are extensive techniques for cultivating positive attitudes towards others. I remember encountering as a trainee psychiatrist the Rogerian proposition that ‘unconditional positive regard’ was a desirable feature to be cultivated by an effective therapist. However, this was in the context of not being provided with any very clear directions as to how to develop such a desirable state. Buddhist teachings and meditation aspects have their place here.

Buddhism as a source for therapeutic techniques

There has long been a degree of cross-fertilization of ideas between Buddhism and psychological therapies. There is a substantial school of Tibetan psychological strategies taught within Buddhism described as ‘thought transformation’ training, many of which have similarities with reframing strategies in cognitive restructuring and other cognitive–behavioural techniques. A large number of mental health practitioners also make some use of meditative techniques and there is extensive evidence of their psychological helpfulness. One recently published treatment manual illustrates well the potential for cross-over in this area. In seeking to develop a maintenance form of cognitive therapy for depression, Segal et al. decided, after going considerable distances up some blind alleys, that one of the key aspects of mental function that they wish to promote in helping people to maintain the gains achieved during cognitive therapy was the ability to de-centre or distance from one’s own thinking; the ability to look at it from an observing posture without being overly engaged with thoughts as the central definition of self. This they saw as an important vehicle in the ability of people to be able to apply lessons learned in cognitive therapy on a continuing basis. In their quest to find effective and cost-effective ways of promoting such an attitude, they found themselves exploring mindfulness-based approaches. This led to them completely revising their treatment directions and developing a package of mindfulness-based cognitive therapy for depression that integrated Buddhist notions of mindfulness and mental awareness with Western notions of cognitive therapeutic techniques. This was then manualized, trialled, and produced good outcomes, particularly with people with multiple depressive relapses. This whole exercise was funded by the National Institute of Mental Health in the USA.

CONFLUENCE AND CONFLICT

It seems clear then that there are a number of points where there may be confluence between Buddhist thinking and Western psychology and mental health practice. Many of the accessible and now (thanks to a wide range of translations) readily available presentations of Buddhism will provide material that will be of relevance as a resource in cognitive and behavioural therapeutic settings. Buddhist techniques have a role in collaborative work on understanding of the nature of mind. Practitioners may benefit from the
mental stability and awareness developed through meditative practices, and others are likely to find their own sources of convergence that I have not presented.

We might now move on to some of the areas of difference. In traditional presentations of Buddhism, there are teachings that are open (exoteric) and teachings that are secret (esoteric). The teachings so far alluded to are substantially within the open group; within the traditionally secret group are in-depth teachings on ‘emptiness’ and also most of the teachings of tantra. Here we might find some of the divergences.

Tantric techniques involve among other things extensive use of visualization practices and these are something that generally receive little attention or exploration in Western clinical mental health practice. Teachings on ‘emptiness’ may seem to stand at odds with many of the tenets of cognitive therapy. Within cognitive therapy, the negative automatic thought is often presented as something to be faced, engaged with, addressed, challenged, debated, and thereby overcome. Beginning with mindfulness teachings but then developed further with notions of emptiness, Buddhism suggests different routes than these to dealing with negative thoughts. In emptiness teachings, the nature of selfhood is explored closely and in depth; the features of the self, including thoughts, are seen as ‘dependant arisings’: products of causes and conditions and not with inherent existence.

Mindfulness traditions in meditation encourage the idea that troublesome thoughts can be simply allowed to pass, and not necessarily engaged with on their own terms. Emptiness teachings go further than this, promoting the ability to respond to such thoughts by invoking the understanding of their essentially impermanent, conditioned, and evanescent nature. In this respect the invoking of emptiness to deal with frustrating or distressing thoughts does not involve engaging with the thoughts and grappling with them; rather, it involves applying a particular mental posture to the experience of a thought, in response to which the distress associated with the thought is undermined, by the application of an attitude that holds that this troublesome thought really has no existence. The full fruits of the experiential understanding of emptiness is a far from easy thing to achieve. I would certainly not claim it. However, even in partial forms, the use of the concepts and the reflection on them as antidote to adverse situations can be powerful. Emptiness is one instance where, to my understanding, Buddhist thought would diverge from most applications of cognitive therapy. Indeed, Buddhism may be in some degree of tension with any psychological therapy that works in modalities that strongly intensify the notion of a sense of self and selfhood. The Buddhist approach may be described as rather generating a more diffuse and distributed, looser sense of self, which, in turn, is seen as freer, more flexible and more spacious than is a self identified as local, enduring, and inherently existent.

As noted in the introduction, Buddhism is Australia’s fastest growing religion; a lot of this growth is in new converts to Buddhism among previously non-Buddhist Australians. Increasingly, people working in clinical practice may encounter Buddhists, including Buddhists of Australian origin. As with any of the many cultural settings of practice, it may be important to understand the cultural context when conceptualizing their problems. This may have particular importance in Buddhism wherein the nature of the cultural content has so much in the way of material that is closely related to the application of psychological techniques.

The present paper can have only scratched the surface on an enormous set of topic areas. Presented here are some suggested areas of convergence and divergence between two substantial bodies of thought and practice. Others may find that parallels or distinctions I have attempted to make are not persuasive, and there are often multiple valid ways to present the kinds of concepts referred to in the paper. If this is so, I at least hope that this contribution will serve to promote discussion and debate about the areas of common ground and constructive collaboration between two very important traditions of philosophical and psychological thinking, and their associated bodies of practical psychological techniques.

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REFERENCES


