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BUDDHIST PHILOSOPHY AND PSYCHIATRY

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ABSTRACT

Buddhism has been described as one of the great religions in the world. Like any other religion, Buddhism also may seem to be in conflict with any science including psychiatry. But Buddhism is more than a religion; it is a philosophy of life. Its tenets not only help us in understanding the origins of various psychiatric disorders but also help in treatment. Technique of mindfulness meditation can be an effective treatment of various anxiety disorders. Further this article looks at the usefulness of basic tenets of Buddhism in understanding the day to day problems and to promote positive mental health.

BUDDHIST PHILOSOPHY AND PSYCHIATRY

Buddhism as a religion to about 350 million people around the world, came into existence about 2500 years ago when Prince Siddharth Gautam attained Nirvana after six years of rigorous study and meditation and was known to be Buddha (which comes from the word "Budhi" meaning "to awaken") After enlightenment, Buddha spent next 45 years of his life teaching the principles of Buddhism- known as Dhamma (Truth).

Buddhism actually goes beyond being a religion and provides with a philosophy of life. The basic tenets of Buddhist philosophy, which were initially inscribed in Pali language, can be summarized as:[1]

1. The original Buddhist canon which was put together soon after the Buddha's death and put into written-form in the first century B.C., consists of three parts:

a. Sutta Pitaka, containing the discourses delivered by Buddha throughout his preaching life;
b. Vinaya Pitaka, containing the rules of discipline for the monks;
c. Abhidhama Pitaka, containing highly systematized philosophical and psychological analyses and constructs, which were finalized in their present form about 250 B.C.

2. The early Pali commentaries on the canon that were in their present form by the end of the fifth century A.D.; and
3. Other Pali texts of the same period which are best described as expository and interpretive works.

The main teachings of the Buddha are contained in the Four Noble Truths, that:

- life is characterized by "suffering" (dukkha);
- the root cause (samudaya) of the suffering is craving or desire (tanha);
- this suffering can be abolished (nirodha), via the cessation of craving or desire leading to the state of Nibbana; and
- there is a way (magga) to achieve this cessation, which is called the Noble Eightfold Path.

The Noble Eightfold Path is also called the Middle Path, said to have been discovered by Gautama Buddha prior to his enlightenment, is an important guiding principle of Buddhist practice and a path of moderation away from the extremes of self-indulgence and self-mortification. This Eightfold Path consists of the following:

1. Right view is the true understanding of the Four Noble Truths, especially that the things are imperfect, impermanent and insubstantial.
2. Right aspiration is the true desire to free oneself from attachment, ignorance, and hatred.

   These two constructs are referred to as prajña, or wisdom.
3. Right speech involves abstaining from lying, gossiping, or hurtful talk.
4. Right action involves abstaining from hurtful behaviors, such as killing, stealing, and indiscriminate sexual activity.
5. Right livelihood means making your living in honest and non-hurtful manner.

   These three are referred to as shila, or morality.
6. Right effort is taking control of mind and the contents thereof. Bad thoughts and impulses are abandoned by watching them without attachment, while good ones are imbibed.
7. Right mindfulness is the focusing of one's thoughts and percepts without attachment in such a way as to overcome craving, hatred, and ignorance.
8. Right concentration is meditating in such a way so as to overcome attachments, fears and ignorance, and to realize a true understanding of imperfection, impermanence, and insubstantiality of life.

The last three are known as samadhi, or meditation.

But what Buddhism has to do with psychiatry?

Our interest in Buddhist text becomes entirely understandable when it is realized that there is a great deal of psychological content in parts of the canonical texts, as well as later Buddhist writings. For example, the Abhidhamma Pitaka contains a highly systematized psychological account of human behavior and mind. The Noble Eightfold Path, which guides Buddhism, involves steps which can only be described as psychological (e.g. right thought, right understanding). Buddhism further emphasizes on the importance of one's constant efforts and practice to bring about these changes. So it is not surprising that Buddhism has much to say about one's thinking and behavior.

Further, the concept of ignorance helps us to understand nature of various neurotic disorders. All of us have our belief systems, personal and social, that remain untested by direct experience, and which stay even on being challenged. It is because of a built-in circular logic, which says that evidence or reason threatening the belief system is, ipso facto, incorrect. Understanding of Noble Truths helps us to return to a direct awareness of reality and to face the reality as it is, without the essential distortions and avoiding denial and suppression at all times.

Next question which comes to mind is that **why to turn**

towards a religion, not science. Science is the systematized knowledge which depends upon seeing and testing facts, and then stating general natural laws. The core of Buddhism fits into this definition, because the Four Noble truths can be tested and proven by anyone. In fact the Buddha himself advised a group of disciples not to accept anything on hearsay, authority or pure argument, but to accept only what can be empirically and experientially verified.[2] Based on experiments and empiricism specific behavior modification techniques were recommended in Early Buddhism. We will discuss them in brief and see how similar they are to modern day cognitive/behavior therapy.

BEHAVIOR MODIFICATION STRATEGIES

Early Buddhist literature contains a wide range of behavior modification strategies other than meditation, which have been discussed in detail by Mikulas.[3] These strategies are remarkably similar to several modern behavior therapies in areas such as: the rejection of the notion of an unchanging self or soul; focus on observable phenomena; emphasis on testability; stress on techniques for awareness of certain bodily responses; emphasizing the "here and now"; and dissemination of teachings and techniques widely and publicly.

For the control of unwanted, intrusive cognitions, several strategies are recommended and are presented in a hierarchical fashion, each to be tried if the preceding one fails, based on the Vitakkasanthana Sutta of the Majjhima Nikaya (1888-1902).[4]

1. Switching to an incompatible thought: This means that if the unwanted cognition is associated with lust, one should think of something promoting lustlessness; and if it is associated with hatred, one should think of something promoting loving kindness (metta). This helps in controlling intrusive thoughts.
2. Pondering on harmful consequences: If the first technique is not helpful, one is advised to think about the harmful consequences of the intrusive, unwanted thought. This would help to rid oneself of that thought.
3. Ignoring and distraction: If that, too, fails, the technique of ignoring an unwanted thought is recommended. Various distracting techniques recommended include: concentrating on actual concrete objects such as flower, recalling of something one has read recently or engaging in some unrelated physical activity.
4. Reflect on root cause: If the problem still persists, reflect on the removal or stopping of the causes of the target thought. This is explained with the analogy of a man walking briskly who asks himself "Why am I walking briskly?," then reflects on his walking and stops and stands; then reflects on his standing and sits down, and so on.
5. Forceful control: If this strategy, too, fails, then a strategy involving forceful restrain and domination of the mind by another thought is advocated. This use of effort is likened to "a strong man holding and restraining a weaker man." One is to use the "effort of one part of the mind to control the other."

Further the popular technique of habituation training (instructing the client to expose himself to the thought repeatedly and/or for prolonged periods) finds a parallel in the Satipattthana Sutta[5], also part of the Majjhima Nikaya (1888-1902), and the Mahasatipattthana Sutta of the Digha Nikaya.[6] These discourses describe an important meditation technique named mindfulness. "Correct" or "right" mindfulness (samm -sati,) is the seventh element of the noble eightfold path. The Buddha advocated that one should establish mindfulness (satipatthana) in one's day-to-day life maintaining as much as possible a calm awareness of one's bodily functions, sensations (feelings), objects of consciousness (thoughts and perceptions), and consciousness itself.[7] If an unwanted thought arises, one is advised to face it directly and continuously, and dwell on it. Gradually the thought will lose its intensity, and will disappear.[8]

Mindfulness practice is being employed in Western psychology to alleviate a variety of mental and physical conditions, including obsessive-compulsive disorder, anxiety, and in the prevention of relapse in depression and drug addiction.[9] Now let us see how this knowledge helps us to understand various psychiatric disorders.

BUDDHISM AND GENERALISED ANXIETY DISORDERS

Generalized anxiety disorder (GAD) is a chronic condition, characterized by pervasive, excessive and free-floating worry. GAD is associated with high rates of comorbidity, significant functional impairment and health-care costs/utilization.[10] Several theories highlight the role that avoidant, negative responses to internal experiences seem to play in GAD.[11] Mindfulness and emotion regulation deficits are two constructs that may be relevant to understanding avoidance in GAD.

While Kabat-Zinn[12] defines mindfulness as "paying attention, in a particular way: on purpose, in the present moment, non-judgmentally", Bishop et al proposed a two-component definition: self-regulation of attention toward immediate experience, with that attention characterized by openness, curiosity, and acceptance.[13] This open, curious, accepting quality of attention has also been characterized as non-entangled or compassionate.[14] Both of these aspects may be relevant to our understanding and treatment of GAD. Individuals with GAD characteristically focus their attention on potential future catastrophes, leading to decreased awareness in the present moment.[15] Further, these individuals seem to judge, or evaluate their internal experiences—both their worry and their emotional responses negatively, suggesting that low levels of both components of mindfulness may be associated with GAD.[16] They may also interfere with individuals' adaptive learning in the present moment and amplify their emotional responses, thus perpetuating avoidance. Hence, the relationships between aspects of mindfulness and GAD symptoms are likely bidirectional; worry may reduce present-moment awareness and acceptance/self-compassion, and these reductions may perpetuate worry and other symptoms of GAD.

To date, cognitive behavioural treatments for this disorder have demonstrated efficacy, but a large proportion of treated individuals fail to meet criteria for high end-state functioning.[17]

Mindfulness with focus on the present moment and an attitude of openness, acceptance, and compassion toward the experience, may be help the patient to control the unnecessary anxiety.

BUDDHISM AND OBSESSIVE-COMPULSIVE DISORDER

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV-TR) [18] defines obsessions 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 property of OCD, which refers to the 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. A realization of annica (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.[19]

BUDDHISM AND SEXUAL DYSFUNCTION

Barlow proposes a model of psychosexual 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.[20] The detached observation of mindfulness may therefore provide relief from all of these pathologies.

BUDDHISM AND ADDICTION

Similar to existentialism, Buddhism regards suffering as a spiritual phenomenon, an integral part of an individual's daily existence (samsara) with no beginning and no end.

Buddhist philosophy views suffering as an emotional condition rooted in two primary causes; attachment (upadana) and craving (trsna). Attachment is an emotional state that leads to craving, and results from the desire to achieve the object craved.21 Craving is an attitude of possessiveness, emotional clinging and inability to accept change as reality. Coping is possible when an individual relinquishes craving and all forms of attachment resulting from lack of knowledge about the impermanence of the objects (avidya) they crave. Buddhism presents an optimistic, spiritual approach to coping with suffering and may provide the answer to the existential dilemma of suffering. Individuals are perceived as having the ability to choose and assume responsibility for their actions.

SUFFERING AS BOTH A CAUSE OF DRUG ADDICTION AND A MOTIVATION IN RECOVERY (FIG. 1)

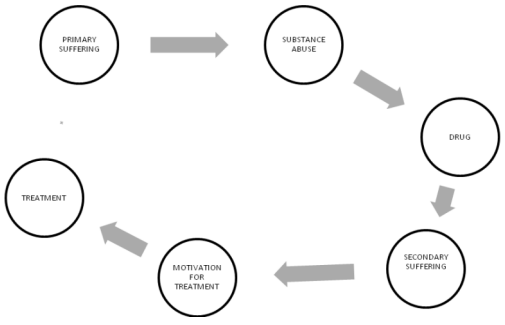

Fig 1: Self-medication Hypothesis

Khantzian proposed the self-medication hypothesis.22 According to this hypothesis primary suffering is defined as the range of an individual's emotional deficiencies, needs and stresses motivating him toward substance abuse. Secondary suffering is defined as the unbearable suffering of drug addiction e.g., the 'hitting bottom' that forces one to reassess his life and seek help. Emotional deficiencies which cause primary suffering, along with one's rejection of assistance from others, may motivate individuals to seek solace through substance abuse - a form of self-treatment. Over time, the destructive aspects of addiction cause secondary suffering—a multidimensional phenomenon affecting all aspects of one's physical, emotional and social existence. Studies reveal that upon reaching this stage of unbearable suffering, addicts tend to seek external help.[23]

Based on these studies it may be assumed that at this stage,

(a) addicts realize that using drug exacerbates, rather than balances their deficiencies through emotional regulation;
(b) their suffering becomes unbearable;
(c) they are powerless to cope with their suffering alone.

Therefore, one can assume that secondary suffering may motivate addicts to seek external assistance through a recovery program.

Motivation for treatment is a key factor in the initiation of, and involvement in treatment as well as in determining its outcome.[24] Recovery is contingent upon the addict's motivation to self-change and cannot be imposed. Hence, motivation is a self-change approach[23] and can be expressed in acknowledgement of addiction as a severe problem, readiness to seek help and to participate in treatment.

Self-help programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), known as 12 step programs, constitute a spirituality model for understanding the experience of addiction suffering and recovery.[25]

MINDFULNESS IN CHRONIC AND TERMINAL ILLNESS

Studies indicate that mindfulness mediation can deliver effective long-term reduction, in both severity and frequency, of chronic pain. Mindfulness detaches physical pain from the psychological response to it, or precisely, "causes 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."[26]

Kabat-Zinn et al [27] outline a number a unique features which recommend mindfulness as an intervention for chronic pain:

(1) In the current climate of cost effectiveness, meditation is much less expensive than complex behavior-modification programs. It can be taught in groups of thirty, and has shown good compliance rates long after training ceases.
(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 behavioral-patterns resulting from the illness.
(3) Insight into the nature of consciousness can be generalized to other behavioral 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.
(5) Meditation has become less of a quintessentially Eastern phenomenon in recent years. As such it has fewer religious and ideological overtones thereby 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 wellbeing and self-worth, even in the midst of suffering.

MINDFULNESS AND ONCOLOGY

Promising results have been reported for the mindfulness meditation in the management of oncology patients. Speca et al applied Kabat- Zinn's meditation program to cancer patients and observed significant reductions in measures of depression, anxiety, anger and confusion.28 Moreover, the program brought about physical benefits of reduced gastrointestinal and cardiopulmonary symptoms.

MINDFULNESS AND HIV

Taylor investigated the effect of a stress reduction program (involving mediation) 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.[29]

Apart from these areas a further possible application of Buddhist psychology lies in the area of prophylaxis of certain kinds of psychological disorders. For example, training in meditation, leading to greater ability to achieve calmness and tranquility, may help enhance one's tolerance of the numerous inevitable stresses in modern life. Further learning not to develop intense attachments to material things and to those around, makes one less vulnerable to psychological distress and disorders arising from their loss, including pathological grief reactions. The facility and skill in self-monitoring one acquires with mindfulness meditation, could provide a valuable means of self-control and may help in various addictive disorders such as substance dependence, eating disorders, impulse control disorders.

CONCLUSION

Buddhism one of the oldest religions in the world, actually goes beyond being a religion and provides with a philosophy of life. The main teachings of the Buddha are contained in the Four Noble Truths and Eightfold Path. Our interest in Buddhist text becomes entirely understandable when it is realized that there is a great deal of psychological content in Buddhism pertaining to human behavior and mind. The practice of Buddhism, emphasizes on the importance of one's constant efforts and practice to bring about psychological changes. The similarities between some of the Early Buddhist strategies and the techniques used in modern behavior therapy are only too obvious. Mindfulness practice, inherited from the Buddhist tradition, is being employed in Western psychology to alleviate a variety of mental and physical conditions, including GAD, obsessive-compulsive disorder, chronic pain, HIV and cancer as well as depression and addiction. A further possible application lies in the prevention of certain kinds of psychological disorders and numerous inevitable stresses in modern life.

We are what we think
All that we are arises within our thoughts
With our thoughts we make the world
Speak or act with a pure mind
And happiness will follow you
As your shadow, unshakable.

Tibetan Dhamammapada[30]

REFERENCES

1. Silva, P. (1990). Buddhist psychology: A review of theory and practice. Current Psychology, (9), 236-54.
2. Morris, R. E., & Hardy, E. (1922-1938). Anguttara Nikaya. Vol (I-V). London: Pali Text Society.
3. Mikulas, W. L. (1981). Buddhism and behavior modification. Psychol Record, 31:331-42.
4. Treckner, V., & Chalmers, R. (1888-1902). Majjhima Nikaya , Vol (I-III). London: Pali Text Society.
5. Rachman, S. (1978). An anatomy of obsessions. Behav Analysis and Modification, 2: 253-78.
6. Davids, T. W., & Carpenter, J. E. (1889-1910). Digha Nikaya, Vol (I-III). London: Pali Text Society.
7. Wynne, A. (2007). The origin of Buddhist meditation (p.73). Routledge.
8. Gunaratna, V. F. (1981). The Satipatthana Sutta and its application to modern life. Kandy: Buddhist Publication Society.
9. Siegel, D. J. (2007). Mindfulness training and neural integration: Differentiation of distinct streams of awareness and the cultivation of well-being. Social cognitive and affective neuroscience, 2(4), 259-263.
10. Greenberg, P. E., Sisitsky, T., Kessler, R. C., Finkelstein, S. N., Berndt, E. R., Davidson, J. R., ... & Fyer, A. J. (1999). The economic burden of anxiety disorders in the 1990s. The Journal of clinical psychiatry.
11. Roemer, L., & Orsillo, S. M. (2002). Expanding our conceptualization of and treatment for generalized anxiety disorder: Integrating mindfulness/acceptance–based approaches with existing cognitive–behavioral models. Clinical Psychology: Science and Practice, 9(1), 54-68.
12. Kabat-Zinn, J. (1994). Wherever you go there you are. New York: Hyperion.
13. Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., ... & Devins, G. (2004). Mindfulness: A proposed operational definition. Clinical psychology: Science and practice, 11(3), 230-241.
14. Germer, C. K., Siegel, R. D., & Fulton, P. K. (2005). Anxiety disorders: Befriending fear. Mindfulness and psychotherapy (p.152-72). New York: Guilford Press.
15. Borkovec, T. D. (2002). Life in the future versus life in the present. Clinical Psychology: Science and Practice, 9(1), 76-80.
16. Heimberg, R. G., Turk, C. L., & Mennin, D. S. (2004). Generalized anxiety disorders: Advances in research and practice (p.164-86). New York: Guilford Press.
17. Waters, A. M., & Craske, M. G. (2005). Generalized anxiety disorder. Improving outcomes and preventing relapse in cognitive behavioral therapy, 77-127.
18. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.
19. Osborne, T. R., & Bhugra, D. (2003). Practical and Theoretical interactions of Buddhism and Psychiatry: a view from the West. Indian journal of psychiatry, 45(3), 142.
20. Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. Journal of consulting and clinical psychology, 54(2), 140.
21. Burton, D. (2002). Knowledge and liberation: Philosophical ruminations on a Buddhist conundrum. Philosophy East and West, 326-345.
22. Khantzian, E. J. (1987). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. In The cocaine crisis (pp. 65-74). Springer, Boston, MA.
23. Nwakeze, P. C., Magura, S., & Rosenblum, A. (2002). Drug problem recognition, desire for help, and treatment readiness in a soup kitchen population. Substance Use & Misuse, 37(3), 291-312.
24. Webster, J. M., Rosen, P. J., Krietemeyer, J., Mateyoke-Scrivner, A., Staton-Tindall, M., & Leukefeld, C. (2006). Gender, mental health, and treatment motivation in a drug court setting. Journal of psychoactive drugs, 38(4), 441-448.
25. DuPont, R. L., & McGovern, J. P. (1992). Suffering in addiction: Alcoholism and drug dependence. The hidden dimension of illness: human suffering. New York: National League for Nursing Press.
26. Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. General hospital psychiatry, 4(1), 33-47.
27. Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. Journal of behavioral medicine, 8(2), 163-190.
28. Speca, M., Carlson, L. E., 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), 613-622.
29. Taylor, D. N. (1995). Effects of a behavioral stress-management program on anxiety, mood, self-esteem, and T-cell count in HIV-positive men. Psychological Reports, 76(2), 451-457.
30. Kornfield, J., & Fronsdal, G. (2012). Teachings of the Buddha. Boston: Shambhala.