The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 1, January- March, 2024
DIP: 18.01.150.20241201, DOI: 10.25215/1201.150
https://www.ijip.in

Article

The Buddhist Perspective of Mental Health: Destigmatization and Relevance in Psychotherapy

Pallavi Srivastava[1]*, Dr. Manini Srivastava[2]

ABSTRACT

Buddhism is one of the major religions of the world with over 520 million followers. It is based mainly on the teachings of its propounder "the Buddha" or the Enlightened One. Buddhism is often regarded as the most psychological religion in its approach. In fact, the origin of Buddhism was a quest to understand pain and suffering and to end that pain and suffering. Even though Buddhism was founded many years ago, its principles are a lighthouse for modern day psychological theories, breaking boundaries of time, region and religion. For example, the Buddhist concept of mindfulness amalgamated with western concepts has led to the evolution of novel techniques like mindfulness based stress reduction and mindfulness based cognitive therapy. The time period of Buddhist thriving was around 6th century B.C.E. It was a time when people were highly ignorant of the true nature of mental illnesses. Numerous stereotypes and stigmas were associated with mental problems including witchcraft and demonic possessions. In such times of ignorance, Buddhism had the intrepidity to give a new vision to the world in regards to the acceptance and management of mental illnesses. The teachings and principles of Buddhism even after centuries have not lost their luster. The preaching of Buddha in its crude or refined form is still relevant in the modern lives and lifestyles. This paper attempts to throw light on teachings of Buddha that are so pliant and malleable that even after hundreds of years they still hold pivotal place in our therapeutic and ameliorative regime.

Keywords: *Buddhist Perspective, Mental Health, Destigmatization, Psychotherapy*

Buddhism, since its conception has allured people all over the world irrespective of their faith and nationality. It is an intellectual tradition that combines Philosophy, religion and Psychology to give rise to an outlook that has withstood time and will continue to hold its vitality and pertinence for ages to come. The earliest and foremost teachings of the Buddhist school can be traced back to Gautam Buddha or Siddhartha who was born in the fifth century B.C.E. into a noble family. As a prince and the future ruler of the kingdom of Sakyas (in modern Nepal) Siddhartha had every luxury imaginable at his command. But at a very young age, despite all the charms of an affluent life, Siddhartha left his wife, his child, his family, his riches and luxuries and his kingdom to understand the

[1]Research Scholar, Department of Psychology, University of Lucknow.
[2]Assistant Professor, Department of Psychology, University of Lucknow.
*Corresponding Author

Received: January 28, 2024; Revision Received: March 01, 2024; Accepted: March 04, 2024

essence of life and to eradicate the plight and suffering of humankind. He was only 29 years old when he became an ascetic in search of truth.

For many years the ascetic Siddhartha Gautama wandered from one place to another, meeting famous religious teachers, studying and practicing their methodology and committing himself into rigorous ascetic practices. But these teachers and their preaching could not quench Siddhartha's quest for knowledge nor could they relieve him of his dilemma. Thus, he took his own path to search for answers to his questions. At the age of 35 years, Siddhartha attained Enlightenment under a peepal tree on the bank of the river Neeranjara at Bodh Gaya (modern day Bihar). From then onwards, he came to be known as Buddha or "The Enlightened One".

After attaining enlightenment, Buddha gave his first sermon at Isipatana (modern Sarnath) to group of five ascetics. From that day for almost forty-five years, he taught all classes of men and women alike- kings and peasants, revered and outcasts, priests and miscreants- without making the slightest distinction between them. He did not believe in or practice any sort of classifications and distinctions based on caste or societal stereotypes etc. His preachings were open to all men and women of all castes, colors and backgrounds. In fact, Buddha believed that even the mentally ill or the insane, who were highly stigmatized and considered unworthy at that time, were worthy of getting love, care and attention. Buddha in his teachings has greatly emphasized and has described the true nature of illnesses- both physical and mental and the right attitude towards them.

Expounding and maneuvering mental illness in Buddhist philosophy

Buddha was considered a great physician and psychotherapist due to his compassion and wisdom to diagnose and treat the root cause of all mental and physical malaise (Aich, 2013). The Medicine Buddha, Bhaisajyaguru, Yakushi Nyora, i or the Buddha of Healing is described in Mahayana Buddhist texts and usually represented seated with his right hand raised in vadra mudra (the hand and finger gesture symbolizing giving and compassion), and the left hand rested on his lap, holding a jar of medicine (Kalra et.al.,2018). Although the meaning of illness is primarily associated with the physical body, there is evidence in the Pali cannotation that the Buddha has distinguished between two kinds of illness: physical illness (kayiko rogo) and mental illness (cetasiko rogo). According to the literature, physical illness is attributed to eight different causes-

(1) caused by bile (pittasamutthana)
(2) caused by phlegm (semhasamutthana)
(3) caused by wind (vatasamutthana)
(4) caused by an imbalance of humors (sannipatika)
(5) caused by change of weather, seasons (utuparinamaja)
(6) caused by a lack of care of the body (visamapariharaja)
(7) caused by external, sudden attack (opakkamika)
(8) caused by the result of kamma (kammavipakaja).

But the Buddha has attributed mental illness to only one cause: the manifestations of mental defilements in the minds of beings. According to the abhidhamma these mental defilements or the kleshas cloud the mind and result in unwholesome actions. In the contemporary Mahayana and Theravada Buddhist traditions, the three kleshas of ignorance (moha), attachment (raga) and aversion (dvesha) are identified as the roots of all other kleshas. These are referred to as the three poisons in the Mahayana tradition or as the three unwholesome

roots in the Theravada tradition. Since these mental defilements or kleshas are the root cause of mental illnesses, they can be understood and pacified by means of meditation and insight.

Gautam Buddha's take on mental illness, its nature, its cause and its treatment can be understood by the story of his encounter with a greatly disturbed and grieving mentally ill woman, Patacara. Patcara was the daughter of a very wealthy merchant of Savatthi. As she grew up her parents arranged her marriage with a groom who was at par with their social standing. However, Patacara rejected this union and eloped with one of her servants whom she loved. They both went to a far-off village, married and began to live a life of hard work. After some time, Patacara became pregnant. She decided that she needed care during this time and hence asked her husband to take her to her parents' home. However, her husband feared that they might be tortured and imprisoned at her parents' house and so he refused to take her. Hence, Patacara left alone for her parents' house. Her husband followed her, trying to dissuade her but Patacara was adamant and did not turn back. During the journey itself, Patacara gave birth to a boy. As there was no need to go to her parents' house anymore, Patacara returned to her home with her husband. A few years later Patacara was about to have another child and same thing happened, she wanted to go to her parents' house but her husband was not willing to take her. Patacara once again started off for the journey alone. Seeing his wife leaving with their son, her husband followed her. On the way, they were struck by a storm, there was thunder and lightning. It was not possible to move ahead and so her husband started to make some temporary shelter for her. However, while collecting and chopping wood, a poisonous snake bit him and he died. Meanwhile Patacara gave birth to another son. On seeing her husband's lifeless body, she was grief stricken. She decided to continue her journey to her parents' house with her elder son and the newborn baby. However, on the way she had to cross a river which was in full spate due to the heavy rains. Patacara realized that she will not be able to cross the river with both the children at once. So, she decided to take them one by one. She left her elder son behind on the bank of the river and took her newborn to the other side. As she was returning for her elder son she saw an eagle swoop down on her newborn child and take him away. She started yelling and crying in sorrow seeing which her elder son got worried and tried to enter the water but was swept away by the currents of the river. Patacara was now completely shattered and devastated. Having lost everything, she continued to her parents' house. As she was reaching her village, she met an old acquaintance who informed that her family house had collapsed due to heavy rains and her parents were dead.

On hearing this, she completely lost her sense and began to tear her clothes and started to roam about naked in the entire village. People threw stones at her and made fun of her. Then one day Buddha came to her village to give sermons in the monastery. Patacara too went there but was stopped by the disciples and people. She was not considered worthy enough to attend Buddha's lectures. She was dirty, naked and not of sound mental condition. But Buddha let her come to him. As she approached him, Patacara started to regain some sanity. She became aware that she had no clothes on and so she sat down on the ground in shame. A cloak was given to her. Then she recounted her tragic life story to him. Buddha listened to her with compassion, free from any stereotypes and prejudices. He took up an empathetic approach to her and helped her to understand the impermanence of worldly possessions, relationships and experiences. Then one day while Patacara was washing her feet she observed three streams of foot water flowing as she poured water. As the water trickled, it dawned upon her like the shortest stream of water, some people live for short period like her children, some for medium length of time like her husband and looking at the longest stream of water she realized that some people live for longer periods like her parents. This enlightenment helped Patacara attain total detachment. Later Buddha made her one of his

major disciples, Bhikkuni Patacara. She was called "the keeper of vinaya". Bhikkuni Patacara helped many people as a disciple of Buddha.

This story describes how Buddha understood the concept of mental health and broke the then prevalent stereotypes associated with mental health and taught the importance of an empathetic and compassionate approach in the treatment of mental instability. This awakening not only saved the life of Patacara, who was considered an outcast by the society but also enabled her to help numerous other people who were in grief and were unable to understand the essence of living.

Buddhist teachings and mental health: the current trends

Buddhism has proved its relevance in all walks of life and in all ages, time and again. Buddha's teachings can be considered a course of therapy and Buddhist meditation techniques have been abundantly utilized in modern-day psychotherapy for several mental and other chronic illnesses (Cullen, 2011). In recent time, psychotherapy has experienced a shift in its approach. A third wave of cognitive behavioral approach has been implemented for the treatment of a broad range of psychopathologies (Shonin et. al., 2013).

Many Buddhist principles and doctrines like compassion, kindness and selflessness have been used as a therapeutic tool (Gilbert, 2009; Johnson et al., 2011; Pace et al., 2012; Shonin, Van Gordon, & Griffiths, 2013b). The Buddhist derived interventions or the BDIs have created a stir in the therapeutic regime for various mental disorders. Many psychological disorders like anxiety disorders (Vøllestad, Nielson, & Nielson, 2012), mood disorders (Hofmann, Sawyer, Witt, & Oh, 2010) and personality disorders (Soler et al., 2012) have shown positive treatment response for BDIs. These interventions have proved their relevance and utility not only as therapy for disorders but are also useful for enhancing positive traits and qualities like empathy, grit and wellbeing in an otherwise healthy population (Chiesa, Calati, & Serretti, 2011; Desbordes et al., 2012; Eberth, & Sedlmeier, 2012; Van Gordon et. al. 2013).

One of the most widely used concepts of Buddhism is that of mindfulness. The Buddhist-derived practice of mindfulness, in the form of mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), is advocated by both the National Institute for Health and Care Excellence (2009) and the American Psychiatry Association (2010) for the treatment of specific forms of depression. Mindfulness has its roots in Buddhism and is most often defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003). Mindfulness is the skill to non-judgmentally observe emotions, sensations, or cognitions. Two forms of psychotherapy developed on the underpinning of mindfulness are- mindfulness based stress reduction (MBSR) and mindfulness based cognitive therapy (MBCT). Mindfulness based stress reduction is a procedure that has been employed among patients with a wide variety of chronic clinical ailments, as well among groups of relatively healthy individuals who have hoped to improve their abilities to cope with the normal but often significant stresses of daily life (Grossman et. al., 2004). The therapy has shown substantial benefits for individuals suffering from chronic pain, fibromyalgia, cancer, anxiety disorders, depression and the stresses of contexts as diverse as medical school and prison life (Grossman et. al., 2004). MBSR consists of multiple forms of mindfulness practice, including formal and informal meditation practice, as well as hatha yoga (Kabat-Zinn, 1990). The practice of MBSR focused attention on one,s breathing, step by step focused attention on one's body scan-based attention, shifting attention across

sensory modalities, non-judgmental experience of moment-to-moment, walking meditation, and eating meditation. The informal practice of MBSR entails brief pauses involving volitionally shifting attention to present moment awareness. Together, this package of mindfulness practices aims to enhance the ability to observe the immediate content of experience, specifically, the transient nature of thoughts, emotion, memories, mental images, and physical sensation (Goldin et al. 2010). MBSR has been shown to diminish the habitual tendency to emotionally react to and ruminate about transitory thoughts and physical sensations (Ramel et. al., 2004; Teasdale et al., 2000), enhance behavioral self-regulation (Lykins & Baer, 2009) and even amplify immune functioning (Davidson et al., 2003).

MBCT is based on MBSR and also integrates cognitive approach and instructions. It was developed as relapse prevention for people with recurrent depression. MBCT integrates aspects of cognitive–behavioral therapy for depression (Beck, Rush, Shaw, & Emery, 1979) into the mindfulness-based stress reduction (MBSR) program developed by Kabat-Zinn (1990). The observation regarding the effectiveness of MBCT is that it has been found to reduce the risk of depression relapse by approximately half (Teasdale et al., 2000; Ma and Teasdale, 2004). It has also been shown effective for people dealing with anxiety, stress, irritability, and exhaustion (Hofman et al., 2010; Khoury et al., 2013). The principle of MBCT revolves around teaching and training the patients who are currently in remission from recurrent major depression to become more aware of, and to relate differently to, their thoughts, feelings, and bodily sensations. MBCT enables the individual with skills that allow him/ her to view the dysfunctional cognitions in a disengaged manner and to break depression related ruminative thought patterns. This works as a protective factor to reduce the risk of relapse and recurrence of depression.

In addition to mindfulness, another construct from Buddhist philosophy that is being incorporated into therapy and treatment is compassion toward self and others (Germer, 2009; Gilbert, 2009; Neff, 2011). Dalai Lama (1995) has defined compassion as “sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it.” According to Neff (2015), self-compassion involves meeting ourselves with warmth and understanding when we suffer rather than ignoring our pain or criticizing ourselves.

CONCLUSION

According to Dhammapada, Buddhism advocates the concept of "Ārojaparamā labhā that is, “health is the greatest achievement”. Not only physical health, Buddha has also been vocal about his take on mental health and he has tried to break the then prevalent myths associated with mental disorders. He was of the opinion that mental ailments are the result of one’s misconstrued reality.

In the current trends of Psychology and psychotherapy, Buddhist concepts and principles enjoy a dominant position. They form the basis of a number of therapeutic streams. The notion of mindfulness is one such conceptual gem. Mindfulness has been expanded and carved into full-fledged forms of psychotherapy which have proved their utility in the treatment of innumerable diseases and disorders. Thus, Buddhist philosophy continues to enrich our knowledge of health and sickness and also provides remedies that are beyond temporal boundaries.

REFERENCES

Aich TK (2013). Buddha philosophy and Western psychology. *Indian J Psychiatry.*55: S165–70.

American Psychiatric Association. (2010). American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder (3rd ed.). Arlington, VA: American Psychiatric.

Beck A. T., Rush A. J., Shaw B. F., & Emery G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Chiesa, A., Calati, R., & Serretti, A. (2011). Does mindfulness training improve cognitive abilities? A systematic review of neuropsychological findings. Clinical Psychology Review, 31, 449 – 464. doi: 10.1016/j.cpr .2010.11.003.

Cullen M. Mindfulness-based interventions: An emerging phenomenon. Mindfulness 2011; 2:186-93.

Dalai Lama (1995). The Power of Compassion. Delhi: Harper Collins.

Davidson RJ, Kabat-Zinn J, Schumacher J, Rosenkranz M, Muller D, Santorelli SF, Sheridan JF (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine.*65:564–570.

Desbordes, G., Negi, L. T., Pace, T. W. W., Wallace, B. A., Raison, C. L., & Schwartz, E. L. (2012). Effects of mindful-attention and compassion meditation training on amygdala response to emotional stimuli in an ordinary, non-meditative state. Frontiers in Human Neuroscience, 6(292), 1–15. doi:10.3389/fnhum.2012.00292.

Eberth, J., & Sedlmeier, P. (2012). The effects of mindfulness meditation: A meta-analysis. Mindfulness, 3, 174 –189. doi:10.1007/s12671-012- 0101-x.

Germer, C. K. (2009). The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions. New York, NY: Guilford Press.

Gilbert, P. (2009). The Compassionate Mind: A New Approach to Life's Challenges. Oakland, CA: New Harbinger.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. Clinical Psychology & Psychotherapy, 13, 353–379. doi:10.1002/cpp.507.

Goldin, P. R., & Gross, J. J. (2010). Effects of mindfulness-based stress reduction (MBSR) on emotion regulation in social anxiety disorder. *Emotion (Washington, D.C.)*, *10*(1), 83–91. https://doi.org/10.1037/a0018441.

Grossman, P., Niemann, L., Schmidt, S., and Walach, H. (2004). Mindfulness Based stress reduction and health benefits. A meta-analysis. J. Psychosomat. Res. 57, 35–43. doi: 10.1016/S0022-3999(03)00573-7.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A metaanalytic review. Journal of Consulting and Clinical Psychology, 78, 169 –183. doi:10.1037/a0018555.

Johnson, D. P., Penn, D. L., Fredrickson, B. L., Kring, A. M., Meyer, P. S., Catalino, L. I., & Brantley, M. (2011). A pilot study of loving-kindness meditation for the negative symptoms of schizophrenia. Schizophrenia Research, 129, 137–140. doi:10.1016/j.schres .2011.02.015.

Kabat-Zinn J. *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness.* Dell Publishing; New York: 1990.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present and future. Clin. Psychol. 10, 144–156. doi: 10.1093/clipsy.bpg016.

Kalra S, Priya G, Grewal E, Aye TT, Waraich BK, SweLatt T, (2018). Lessons for the health-care practitioner from Buddhism. *Indian J Endocr Metab 22*:812-7.

Lykins ELB, Baer RA (2009). Psychological functioning in a sample of long-term practitioners of mindfulness meditation. *Journal of Cognitive Psychotherapy.*23:226–241.

National Institute for Health and Care Excellence. (2009). Depression: Management of depression in primary and secondary care. London, England.

Neff, K. D. (2011). Self-Compassion. New York, NY: William Morrow.

Neff, K. D. (2015). Self-Compassion: The Proven Power of Being Kind to Yourself. New York, NY: William Morrow.

Pace, T., Negi, L., Dodson-Lavelle, B., Ozawa-de Silva, B., Reddy, S., Cole, S., . . . Raison, C. L. (2012). Engagement with cognitively-based compassion training is associated with reduced salivary C-reactive protein from before to after training in foster care program adolescents. Psycho neuroendocrinology, 6(Suppl. 1), S43.

Ramel W, Goldin PR, Carmona PE, McQuaid JR (2004). The effects of mindfulness meditation on cognitive processes and affect in patients with past depression. *Cognitive Therapy and Research.* 28:433–455

Segal, Z. V., Williams, J. M., & Teasdale, J. D. (2002). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York, NY: Guilford Press. doi: 10.1037/e533222009-006

Shonin E., Van Gordon W., Griffiths M.D. (2014). The Emerging Role of Buddhism in Clinical Psychology: Toward Effective Integration. *Psychology of Religion and Spirituality 6*(2), 123–137. DOI: 10.1037/a0035859.

Shonin, E., Van Gordon, W., & Griffiths M. D. (2013b). Meditation awareness training (MAT) for improved psychological wellbeing: A qualitative examination of participant experiences. Journal of Religion and Health, doi:10.1007/s10943-013-9679-0.

Shonin, E.S., Van Gordon, W., Slade, K. & Griffiths, M.D. (2013). Mindfulness and other Buddhist-derived interventions in correctional settings: A systematic review. *Aggression and Violent Behavior, 18*, 365-372.

Soler, J., Valdepérez, A., Feliu-soler, A. Pascual, J., Portella, M., & Martín-blanco, A., Perez, V. (2012). Effects of the dialectical behavioral therapy-mindfulness module on attention in patients with borderline personality disorder. Behaviour Research and Therapy, 50, 150 –157. doi: 10.1016/j.brat.2011.12.002.

Teasdale JT, Segal ZV, Williams JMG, Ridgeway VA, Soulsby JM, Lau MA (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology.*68:615–623.

Van Gordon, W., Shonin, E., Sumich, A., Sundin, E., & Griffiths, M. D. (2013). Meditation awareness training (MAT) for psychological wellbeing in a sub-clinical sample of university students: A controlled pilot study. Mindfulness. Advance online publication. doi:10.1007/s12671- 012– 0191-5.

Vøllestad, J., Nielsen, M. B., & Nielsen, G. H. (2012). Mindfulness and acceptance-based interventions for anxiety disorders: A systematic review and meta-analysis. British Journal of Clinical Psychology, 51, 239 –260. doi:10.1111/j.2044-8260.2011.02024.x.

Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Srivastava, P. & Srivastava, M. (2024). The Buddhist Perspective of Mental Health: Destigmatization and Relevance in Psychotherapy. *International Journal of Indian Psychology*, *12*(1), 1628-1634. DIP:18.01.150.20241201, DOI:10.25215/1201.150