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Abstract and Keywords

This chapter surveys an interface of growing interest to clinicians and patients, from four points of view. First, it explores the growing dialogue between Buddhism and modern psychology, tracing it to a surprising complementarity in ideas and methods. Second, it shines light on the distinctiveness between Buddhist and modern psychology, exploring the religious and ethical aspects of Buddhism neglected by many proponents of dialogue. Third, it reviews key areas of potential conflict, where clinicians may helpfully challenge Buddhist patients to reconsider their understanding and practice of Buddhism. Fourth, it surveys key areas of potential contribution, where mental health researchers, clinicians, and patients may benefit from studying Buddhist theories or applying Buddhist methods.

Keywords: Buddhism, modern psychology, conflict, Buddhist patients, Buddhist methods

Including Ethics in the Dialogue Between Buddhism and Modern Psychology

Among the many religious traditions practiced in the world today, none has more actively engaged in dialogue with contemporary psychiatry, neuropsychology, and psychotherapy than Buddhism.[1] Nonetheless, since the majority of that dialogue has centered on meditation practices, little has been written on the interface between the ethics of contemporary psychology and the traditional ethics of Buddhism. I hope this chapter will shine some light on this neglected area, and help clinicians better understand and manage the complexity of this promising convergence.

One remarkable feature of the dialogue between Buddhism and contemporary psychology has been the rise of new modalities that integrate Buddhist meditation practices such as mindfulness into medicine and psychotherapy. Integrative methods such as mindfulness-based stress-reduction (MBSR), mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), and dialectical behavior therapy (DBT) have gained traction given the growing evidence that mindfulness enhances the efficacy of conventional relaxation techniques and psychotherapy.[2] But such modalities tend to extract meditation techniques from the philosophical-ethical matrix in which they are traditionally practiced, sidestepping the thorny issues raised when Buddhist culture and modern scientific psychology come together.

While the growing integration of mindfulness may raise tough questions, answering these turns out to be easier than one might expect. I suggest two reasons why this is so. First, Buddhist psychology assumes forms of inquiry, practice, and ethics closer to those of modern science than other religious traditions. Second, Buddhist practice assumes therapeutic aims and educational methods closer to those of psychotherapy than other religious traditions. This relative affinity for science and psychology explains why Asian Buddhist traditions in our global age have actively engaged with these disciplines, in ways that help bridge the gulf dividing modern science from the religious traditions of contemplation and ethics we know in the West (Dalai Lama 2006; Wallace 2009).

Of course, Buddhist medicine, psychology, and psychiatry still belong to an ancient religious tradition, with systems of philosophy, contemplation, and ethics that have deep family resemblances to those of Hinduism, Christianity, Judaism, and

Islam (Loizzo 2006, 2009a). While modern practitioners of mindfulness may minimize these resemblances, there are many Western converts to Buddhism and many more Asian Buddhists who embrace them in traditional ways. In this chapter, I have tried to span the spectrum of Buddhist practitioners, and address the key ethical issues their beliefs and practices pose for integrative research and clinical practice.

To cover this range, I will address the interface of Buddhist ethics with contemporary psychiatry under four headings. First, I explore the surprising complementarity of ancient Buddhist and modern Western psychology. Second, I address the cultural and historical differences that make these traditions unavoidably distinct. Third, I expose some of the key areas of conflict that face researchers who study Buddhist methods and clinicians who treat Buddhist patients. Finally, I survey some of the most promising areas of contribution, where Buddhist psychology, meditation, and ethics may offer contemporary psychology, psychiatry, and psychotherapy valuable alternative theories and methods.

The Four-Dimensional Interface of Buddhist and Modern Psychology

The Complementarity of Buddhism and Scientific Psychology

A rough contemporary of Socrates and Hippocrates, Shakyamuni Buddha—the Awakened Sage of the Shakya clan—is known to us as a religious figure, but he is known to his heirs as a "supreme philosopher," "enlightened teacher," and "consummate healer" (Thurman 1986; Loizzo 2007, pp. 37–42). Seen as an awakened human rather than an inspired prophet or incarnate God, tradition has it that he is best celebrated for his discovery that suffering and happiness are caused not by nature or God, but by our own habits of intention, expression, and action. One formula some call "the Buddhist creed" runs: "Every experience comes from causes, and he who discovered that taught those causes, that we can control them, and even the way. Hail that Great Sage" (Loizzo 2012, p. 15). Historically, Siddhartha Gautama was a North Indian prince who was so moved by his subjects' suffering that he set out to find ways to break the cycle of fear-based action and reaction that drives humans towards illness, aging, and death. After six years of study, reflection, and meditation, he became Shakyamuni, the historical Buddha, when he realized he could break that cycle by cutting its root causes: obsessive misperception, addictive craving, and compulsive habits (Strong 2007).

All Buddhist thought and practice, including Buddhist ethics, assume Buddha's framework of contemplative self-analysis and self-healing, his Four Noble Truths: (1) suffering; (2) origin; (3) cessation; and (4) path (Bodhi 2006; Loizzo 2012, chapter 1). (1) Body and mind driven by stress and trauma stay in a reactive mode, prone to preventable physical, mental, and existential suffering. (2) Such suffering originates as a natural part of the life cycle, from evolutionary causes such as stress and developmental conditions such as trauma. (3) Suffering can be alleviated and eventually ceased, given our natural potential for learning and transformation. (4) The path to the cessation of suffering is one of lifelong learning and change, based on the core disciplines of wisdom, meditation, and ethics. Adopted by Indian medicine as a diagnosis, etiology, prognosis, and treatment for behavioral disorders, this model is seen as framing all Buddhist learning as a liberative path from compulsion to freedom, a learning path from delusion to wisdom, and a healing path from self-destructiveness to self-mastery (Zysk 1991; Wujtasik 1998). Traditionally, the Buddha or Buddhist teacher is to be engaged as a doctor, the teaching is to be considered as medicine, and the practice it prescribes is to be followed as a treatment for the human condition (Birnbaum 2003; Loizzo, Blackhall, and Rapgyay 2009).

Linked with this focus on health and well-being, another area of overlap is that the methods of inquiry Buddha advised anticipated the empirical method of evidence-based inquiry developed in the European Enlightenment and modern science. Like modern scientists, Shakyamuni and his heirs advised relying on reason and evidence as the gold standards for valid knowledge. They also challenged divine revelation and scripture, relegating the authority of tradition and experts to secondary sources of hypothetical knowledge, acceptable only to guide further study when reason and evidence prove inconclusive (Loizzo 2009a, Dunne, 2004). Like Socrates, the Buddha advised critical thinking, "Take my words as a goldsmith buys gold … only after thorough examination, not out of faith" (Thurman 1986, p. 190). Yet he also cautioned against extreme skepticism, on the empirical grounds that those who suffer owe it to themselves to accept the most reasonable and promising solutions provisionally so they can try them.

Though it seems surprising, this synergy with the scientific spirit of the Greek and European Enlightenments helps explain why many today see areas of overlap between modern Western psychology and ancient Buddhist psychology. Three areas of overlap between Freud's "new science" and Buddhist thought offer examples. (1) Both Shakyamuni and Freud based their approach to the mind on the premise that mental acts have causal efficacy, with determinate impacts on

mind/body development. (2) Both assumed a generally evolutionary approach to the life of the mind, and viewed development as an interaction between inherited instincts and social learning, nature and nurture. (3) Both adopted a healing method of corrective social learning that combines a liberative self-analysis with a social-emotional art of reparenting (Loizzo 2012, pp. 13–26).

Given these resemblances, it should not surprise us that Buddhism and modern psychology, especially psychotherapy, are unusually compatible in the realm of ethics. Like the ethics of Greek philosophy and modern psychiatry, Buddhist ethics are naturalistic, therapeutic, and, broadly speaking, evolutionary. Virtue and vice are traditionally understood as referring to healthy versus unhealthy actions, defined by their developmental result in experiences that are pleasant or painful, happy or unhappy (Pruden 1991, vol. 2, pp. 404–407). While the list of 10 negative and positive forms of action reads like the Ten Commandments,[3] Buddhist principles of ethical action are explained naturalistically as impersonal facts of life.

The link between an action or *karma* and its developmental effect is no more or less than the natural causality at work in the mind, a causality that is both analogous and congruous with the biological link between a seed and its fruit, a fertilized egg and an adult body (Keown 1995). Acts of anger lead to injury. Acts of tolerance lead to peace. Often confused with the concept of rebirth, it is said that Shakyamuni meant the theory of *karma* to explain how each individual is a free and responsible agent of her own development. He taught *karma* as an ethical middle way to help people avoid two extremes: the theistic extreme that our fate is determined by God; and the materialist extreme that our fate is a random accident of nature (Loizzo 2007). This ethical middle way is based on a causal middle way that explains how both continuity and change are possible in mental life (Potter 1972). The critical theory of selflessness—that beings lack any mind, self, or soul that is unitary, fixed, or independent—explains how change is possible, while the positive theory of *karma*—that the effects of intentional action are conserved through development—explains how an individual maintains a living continuity through change (Loizzo 2012, chapter 3).

Despite clichés about Asian culture being collectivist, Buddhist ethics is based on the ultimate value of individual freedom and responsibility (Dalai Lama 2001; Dalai Lama and Norman 2013). Once the way to personal freedom and happiness is clear, the next horizon of Buddhist ethics is to pursue our enlightened self-interest and the common good by developing our innate capacity for love, compassion, and altruism. This ethos involves the cultivation of self-transcendent qualities like generosity, justice, tolerance, enterprise, meditation, and wisdom.[4] The third horizon, beyond personal freedom and great compassion, is to integrate the passion and genius of our unconscious mind to transform our life and world for the best.[5] This ethos involves the cultivation of heroic altruism, galvanized by 14 primary and eight secondary vows (Tsong Khapa and Sparam 2005). These horizons of Buddhist ethics—known in Tibetan Buddhism as the Individual, Universal, and Integral Vehicles—are emphasized in the Theravāda traditions of South Asia, the Mahāyāna traditions of East Asia, and the Vajrayāna traditions of Central Asia, respectively (Strong 2007). They may be correlated with three great ethical orientations that emerged in the Abrahamic religions: the ethics of vice and virtue in the Old Testament; the ethics of love and compassion in the New Testament; and the ethics of ecstatic communion in mystical forms of Christianity, Judaism, and Islam. According to the Tibetan tradition, it is optimal to practice all three forms of ethics synergistically (Dudjom Rinpoche 1996; Loizzo 2012, chapter 9).

Like psychotherapy, Buddhist ethics assumes that each individual mind has a natural potential for freedom and causal efficacy, even though that potential is normally blocked by misperception, stress emotions, and reactive habits. It assumes that the work of self-healing and change depends on a secure bond between teacher and student, like the healing alliance of relational psychotherapy. Within that bond, the student is responsible for analyzing her mind and changing her outlook, motivation, and behavior, in light of insights and methods the teacher suggests. The teacher is responsible to help the student overcome emotional resistances and mental blocks to self-analysis and change by offering insights with unconditionally loving acceptance, along with meditative techniques and lifestyle changes that support learning and transformation. This mutual contract—forged by "taking refuge" in the Buddha's example, teaching, and community—is the main gateway to membership in all Buddhist traditions (Loizzo 2012, p. 121). In some, the teacher is added as a fourth "refuge," a living Buddha, role-model or mentor, fostering an intimate confidential bond that resembles the transference relationship of dynamic psychotherapy (Loizzo 2012, p. 365).

Although the teacher–student bond in Buddhist psychology has the broad aim of reducing everyday suffering, it is applied by Buddhist medicine and psychiatry to the special case of treating physical and mental disease (Loizzo and Blackhall 1998; Loizzo, Blackhall, and Rapgyay 2009; Clifford 2006). In such cases, the healing contract is the same, except that patients may be unable to engage in self-healing, so doctors must offer conventional treatments—changes in activity or

diet, medication, surgery—to help restore their patient's self-efficacy. Supporting the ultimate value of personal agency, one of the ethical guidelines in Buddhist medicine and psychiatry is that the doctor must take care to use the least intrusive remedy possible, and to do whatever possible to engage and empower the patient's own natural capacity for self-healing.

The Distinctiveness of Traditional Buddhist and Modern Scientific Psychology

Given the surprising overlap between Buddhist and modern psychology, one can see why so many clinicians and patients today see them as complementary. In fact, the points of convergence are so remarkable that it is easy enough for proponents of dialogue unfamiliar with traditional Buddhism to lose sight of the vast cultural and historical differences between them. So any thorough survey of the interface between the ethics of Buddhism and modern psychiatry must address these areas of contrast, as well as the areas of complementarity.

The most obvious place to begin is that, despite its openness to science and its focus on psychological healing, Buddhism is every bit as much a religious tradition as it is a therapeutic philosophy or scientific psychology. However Buddhists understand Shakyamuni Buddha, he is certainly one of the world's great religious figures, and is revered as such by hundreds of millions of practitioners in countries all around Asia. Though seen as fully human, legend has it that he was the incarnation of a divine altruist named Svataketu, who lived in a heaven called Tushita and chose to be reborn on earth to relieve the suffering of the human condition. Some scholars believe that the myth of Buddha's heavenly origin and human birth inspired the myth of Christ's immaculate conception.[6] While Buddha critiqued Indian myths of divine creation, he did not reject Indian theism entirely, but chose to revise it in a humanistic light. Though some portray him as an Enlightenment philosopher sage, Shakyamuni, like Socrates and Jesus, was more concerned with ethicizing and democratizing religion than with rejecting it (Obeyesekere 2002).

Further confounding easy comparisons is the unique way the Buddha claimed authority. Taking his reform of religion further than Jesus or Socrates, he declined to present himself as an incarnate God or as a prophet inspired or chosen by gods. Instead, he based his teaching on the egalitarian claim that he could help his students precisely because he was human too, and could address them as a wounded healer, a sleeper who had awakened (Franco 1997). This therapeutic claim sheds light on his choice to base his spiritual teaching and community on causal explanation and reproducible methods.

Despite its affinity with science, Buddhist thought and practice are more like those of modern psychotherapy than conventional science. Like psychotherapy but unlike conventional science, Buddhist psychology gathers its data by shared introspection, analyzes them through dialogue, and shows the validity of its insights and methods by replicating the Buddha's own self-healing from teacher to student, generation to generation. Like psychotherapy but unlike conventional psychiatry, Buddhist psychology and medicine assume a wounded healer model that equalizes the doctor–patient relationship, and favors a more open, educational, and empowering role for doctors in supporting patients' active self-healing and healthy life change (Clifford 2006; Loizzo, Blackhall, and Rapgyay 2009, Loizzo 2012).

Another point of contrast can be found in the approach to the mind/body connection. While modern science embraced materialism, reducing self and mind to brain, and most religions embrace idealism, reducing self and mind to eternal soul, Buddhist science is committed to a middle way. It assumes that mind and body evolve, grow, and work only through interdependence and interaction, without either one being reducible to the other (Loizzo 2011, 2014). For Buddhists, this distinction has profound ethical implications. They warn that mental agency is undermined by materialist views that reduce mind to an emergent property or accident of matter (Varela, Thompson, and Rosch 1996; Wallace 2006). This leads to areas of dissonance between the two traditions. An interactive model supports therapeutic optimism about the mind's capacity to change itself and the body, while a reductive model would tend to favor bottom-up treatments like medication over top-down treatments like meditation or psychotherapy. This dissonance is less pronounced in the encounter of Buddhism and psychotherapy, since Freud stopped short of reducing mind to brain, and insisted that mental acts have determinate effects on body and mind.

Even in the realm of psychological insight, the divergent models of mind/body causality in Buddhist and modern psychology lead to conflicting bioethical prescriptions (Keown 1995). Leaning more towards materialism, Freud and his heirs tend towards a permissive, ventilatory view of emotions, teaching patients to air their hurt, resentment, and anger. Given its top-down interactionism, Buddhism advises a middle way between suppression and ventilation, akin to the top-down learning model of cognitive therapy. Once emotions are accepted without guilt or shame, students must distinguish

between reactive emotions that reinforce stress and trauma, and positive emotions that promote healing and change. With these two kinds of impulses distinguished, self-healing involves the ethical choice to let go of the unhealthy habits and cultivate healing alternatives. Given its bioethics of freedom and responsibility, Buddhist students are urged not to stop at simply understanding hurt and trauma. They are encouraged to unlearn and transform reactive habits that result from childhood or adult wounds, since these habits reinforce prior trauma, adding self-inflicted insult to traumatic injury.

Another difference with modern psychotherapy has to do with the contrast between genetic interpretation and intergenerational analysis. Buddhist psychology sees early development in surprisingly familiar terms, as driven by instinctive desire for the opposite gender parent and instinctive aggression for the same gender parent (Pruden 1991, vol. 2, pp. 394–396). But as Buddhist ethics urges students to take responsibility for reactive habits, it expands the scope of self-analysis beyond early interactions with parents, framing childhood suffering in light of intergenerational patterns and evolutionary instincts bigger than any particular parent-child dyad or triangle (Loizzo 2011, 2014). This larger frame challenges any victim narratives that blame parents globally for this life's suffering, narratives that ultimately disempower their makers by reinforcing distorted self-images based on worst-case childhood feelings of helplessness and powerlessness (Loizzo 2012, pp. 107–111).

The pivot in Buddhist self-analysis comes from the *karmic* view that each individual is the intergenerational agent of her own incarnation and development, effectively *choosing* her parents and early environment rather than *vice versa*. Though this could be read as blaming the victim, traditionally it is seen as the natural extension of honoring the freedom and power of the individual mind. In modern terms, this amounts to the strong constructivist view that each mind is ultimately responsible for its development, since its activity drives the way it engages, interprets, and responds to interactions in childhood and adulthood.

This second difference with modern psychotherapy derives from two distinctive features of the Buddhist multi-life view of evolution and development. I use the word "evolution" here broadly to mean any view that traces the origin of life to a series of natural transformations of prior life, rather than to the design of a creator or spontaneous generation. The two distinctive features of the Buddhist view of life are: 1) that evolution mainly reflects the inheritance of characteristics acquired over prior generations through repeated habit, akin to the Lamarkian view enjoying a resurgence in current epigenetics; and 2) that the transmission of learned habits across generations in the course of development involves a multi-life continuity of general character types as well as individual variations of agency.[7]

Traditionally, this view assumes as a bioethical corollary the metaphysics of reincarnation. Like the theory of "transmigration" assumed in ancient Greece and Rome, *karma* theory offers a middle way between the creationist view advanced by the Catholic Church and the modern science of natural selection (Obeyesekere 2002). It also bears some resemblance to modern psychological models of intergenerational transmission of character traits assumed by Freud and family therapists like Nagy (Loizzo 2011). Since traditional models of *karmic* inheritance assume a parallel track of physical inheritance through the egg and sperm, this theory may be best understood as focusing on the learned, psychological inheritance that shapes development through imprinting and modeling in childhood and adulthood. Whereas the creative aspect of *karma* theory helps explain transformation, this conservative aspect explains why character change involves stopping an intergenerational force of nature, and requires a radical self-analysis that goes to the shifting bedrock of identity and development.

The final area of difference separating Buddhism from modern psychology lies in their institutional and methodological foundations. While modern psychology developed within the institutional environment of modern medicine, Buddhist psychology evolved within the environment of an ancient monastic community and liberative education (Joshi 1964; Dutt 2008). Of course, since the modern scientific academy grew out of a fusion between the Greek academy and the medieval monastery, there are some links between the traditions. But Buddhism combined an ancient curriculum of science and medicine with a monastic learning community from the start, and never divorced them. So Buddhist psychology is more educational than medical, and relies more on traditional group instruction and communal living than on individual tutoring and mentoring (Loizzo 2012, pp. 23–25). An interesting hybrid of these traditions is found in DBT, where individual psychotherapy is set within a learning process that includes group instruction in mindfulness meditation and behavioral life skills (Linehan 1993). The example of DBT not only suggests the potential benefits of the Buddhist contemplative learning model and methods, but also shows how very different the context and practice of Buddhist psychology are from those of conventional psychotherapy.

Potential Ethical Conflicts between Buddhism and Modern Psychology

Given the distinctive origins, principles, and practices of Buddhist psychology and modern psychiatry, we would expect there to be areas where their encounter may yield ethical conflicts. Over the years in which I have worked with both recent Western converts and traditional Asian Buddhists, I've found areas where modern psychology raises ethical challenges for Buddhist culture and practice, as well as areas where Buddhism raises ethical challenges for modern psychology. I will address the former in this section, and the latter in the following section, "Potential Contributions of Buddhist Theory and Practice to Modern Psychiatry".

Since Buddhist psychology, meditation, and ethics have been preserved as embedded in a range of traditional cultures, Western converts and Asian Buddhists often feel a need to maintain those traditions, and suspect changes that may adapt Buddhist teaching and practice to modern life. Here, as with other religions, clinicians may help Buddhist practitioners reassess any attachment to traditional forms of doctrine or ritual that could impede healing insight and change. A brief case vignette may illustrate this conflict:

> A single mother came to me having trouble separating from her college-age daughter. Herself the daughter of a narcissistic, holocaust survivor mom and a misogynistic military dad, my patient belonged to a conservative Buddhist community and practiced visualizing a female Buddha that seemed to reinforce her idealization of her mom and devaluation of herself. I encouraged her to join a more progressive community, where she was taught to visualize *herself* as a strong female Buddha and also a fierce male Buddha. I believe this change in practice helped her challenge her poor self-image, and find the strength to separate from her daughter and build her first healthy relationship with a man.

In such cases, the more clinicians understand the critical thinking and healing ethos that are essential to Buddhism in all its forms, the more effective we may be in helping our Buddhist patients realize those essentials and enjoy their benefits.

One area of Buddhist teaching that is easily misunderstood is the basic theory of selflessness. Western converts and even some Asian Buddhists interpret his theory to mean that they should transcend or even eliminate "ego" entirely, rather than simply renounce self-limiting identity patterns that maintain unhealthy habits or resist healthy change. As in other traditions, such misunderstandings can lead to unhealthy self-denial, self-negation, guilt, shame, or remorse, so reinforcing regression, anxiety, and depression rather than healing them. Here too, clinicians may helpfully challenge such literal views, ideally with some understanding of the genuine intention behind the Buddha's nuanced views of self—as a relative process of learning and development—and guilt—as a signal emotion that may foster positive self-correction.

Another key area of misunderstanding is the complex theory of *karma* or active development. Recent converts and traditional Buddhists may interpret his theory for a mind-over-matter idealism or stoic moralism, and use it to deny the importance of early development and physical or emotional vulnerabilities. This can rationalize a self-defeating perfectionism, leading people to try to "burn off" negative emotions or reactive habits through meditative or ritual practices of "purification," when in fact they may need more self-acceptance, social-emotional support such as psychotherapy, lifestyle changes such as recovery, or even biological treatments such as medication. A brief case vignette may illustrate this conflict:

> A Middle Eastern convert to Buddhism came to me complaining of intimacy problems he traced to an emotionally abusive relationship with his narcissistic father. In fact, his chronic dysthymia did reflect childhood verbal abuse at the hands of his dad, and was now impairing his ability to be emotionally accessible and responsive to the women he was dating. Maintaining his depression was a self-punitive tendency to blame himself for his father's rages, and he often attributed his trouble with women to the "negative *karma*" caused by his anger at his dad. He had formed a strong tie with a Tibetan Buddhist teacher, but transferred his father-complex onto the Tibetan man, and refused antidepressants on the assumption that the teacher would insist he "burn off" his anger and shame through meditation alone. When I pressed him to ask, the teacher surprised him by admitting that he himself had been helped by antidepressants after he had fled Tibet. Within a year on SSRIs, he began a healthier relationship with his current wife.

A still more vexing though related conflict may arise in the case of traditional appeals to "past life actions" to close loopholes in the moral explanation of adverse events such as medical illnesses, psychosocial trauma, accidents, or natural disasters. Such appeals not only stretch the application of *karma* theory beyond its critical scope—i.e. to explain the active nature of development—but more importantly risk blaming the victim and closing patients off to appropriate social and medical remedies (Loizzo 2014). Here again, clinicians may helpfully challenge such misuses of *karma* theory, ideally with some understanding of its traditional use to affirm individual freedom and empower self-efficacy in the realm of

personal healing, growth, and change.

The case of the Middle Eastern man raises another area of potential conflict: psychopharmacology. Since Buddhist medicine and psychology assume the primacy of mind and behavior as a determinant of health and illness, both place the highest value on guarding patient agency and empowering self-efficacy as much as possible. So this tradition challenges modern reductive models and invasive methods such as a first-line reliance on pharmacology, advising instead that we try the least invasive remedies first, and always complement somatic treatments with intensive instruction and ongoing support for self-healing strategies such as cognitive education, meditation, and lifestyle change (Clifford 2006; Loizzo, Blackhall, and Rapgyay 2009). This conflict challenges clinicians and patients to weigh up the pros and cons of medication carefully in light of all the alternatives. I will return to this challenge and offer a case vignette in the next section, "Potential Contributions of Buddhist Theory and Practice to Modern Psychiatry."

The next area of potential conflict lies in the common tendency to overlook the limits of meditation alone in fostering self-analysis and self-transformation. This is most likely among recent converts to Buddhism, who tend to see meditation as a quick fix or active ingredient easily extracted from the complex philosophical-ethical matrix of Buddhist learning. Such converts should be made aware of the traditional warning that meditation alone cannot bring lasting healing and change, but must be combined with profound psychological insight and ethical transformation in order to be of full benefit. Obviously, this is an area where clinicians may helpfully emphasize the healing value of psychological insight, and healthy emotional-behavioral change, ideally with some awareness of the resonance of these values with traditional Buddhist psychology (Loizzo 2012, pp. 61–62).

A complex area of potential conflict lies at the interface between modern psychology and traditional Buddhist religious communities. Since these communities—whether in Asia or the West—preserve roles and relationships that evolved over centuries in traditional cultures, their members may find them socially limiting, and may have difficulty adapting to the realities of contemporary life. On the simplest level, the social style of these communities may conflict with the increasing pressure their members face for assertiveness at work and expressiveness at home. More complex is the tension between Buddhist communities that revolve around male-dominated monastic orders and contemporary society, with its growing movement towards gender equality and gender-neutral roles. The most serious potential conflict here lies in the abuse of power in such communities, including the extreme ethical violations such as the sexual abuse of students (Welwood 2002). Of course, clinicians may helpfully challenge such limits, tensions, and violations when they occur, ideally with some understanding of the progressive intent of Buddhist communities to foster an empowering environment of unconditional safety, individual freedom, social mobility, and racial, cultural, and gender equality. Of note, from the Buddha's day to the present, sexual impropriety, along with murder, stealing, and fraudulent claims, is one of the four ethical infractions requiring automatic expulsion from any Buddhist monastic order (Robinson, Johnson, and Bikkhu 2004).

The final area of potential conflict is one that Buddhism shares with other religious traditions: the risk of being used to deny psychological problems and rationalize ethical flaws, also known as spiritual bypassing (Welwood 2002). Although it may seem that Buddhism should be immune from such misuse, given its rich and effective analytic psychology, alas any human system of thought and practice can be misused or abused. Of course, the checks and balances of the Buddhist teaching tradition—the teacher–student bond, the process of group confession and dialogue, and cross-training in analytic, meditative, and ethical disciplines—are meant to make contemplative learning and self-analysis as potent a cure for human delusion, denial, and self-deception as possible. Nonetheless, in practice most Buddhists—especially lay practitioners in Asia and the West—don't get the benefit of this system. In Asia, a classical Buddhist education has traditionally been reserved for monks and nuns, leaving lay Buddhists to rely mainly on ritual-devotional practices (Swearer 2010). Given the paucity of monastic centers of learning in the West, Western converts rarely get access to classical Buddhist education, and so rely mainly on meditation and diluted versions of Buddhist philosophy and ethics (McMahon 2008). Even those converts who do have access to rigorous education may have areas of bypassing helpfully challenged by clinicians, and may well benefit from non-Buddhist interventions like psychotherapy or recovery for addictions.

Potential Contributions of Buddhist Theory and Practice to Modern Psychiatry

Even the briefest survey of Buddhist and psychiatric ethics would be incomplete without addressing the areas where the Buddhist tradition can contribute to modern psychology and psychotherapy. The first of these needs no introduction: the use of a wide range of meditation and yoga techniques to facilitate self-analysis and self-healing, as alternatives to psychopharmacology as well as psychotherapeutic tools such as free association, relaxation, guided imagery, eye-

movement desensitization reprocessing (EMDR), or somatic experiencing (Van der Kolk and Levine 2011; Kaparo 2012). While studies comparing the efficacy of meditation with medication or conventional psychotherapy are few, there are more every year, and enough pilot data to make some general observations.

Although this is not the place to review the research, we have strong evidence that meditative techniques can reduce the need for psychotropics and analgesics, and that mindfulness can enhance the effectiveness of cognitive therapy in treating anxiety, depression, and personality disorders (Khoury et al. 2013; Loizzo, Charlson, and Peterson 2009; Williams et al. 2007; Loizzo 2000). With the number of studies rising each year, the literature suggests that meditation and yoga may be useful in the whole range of mental conditions, from dysthymia to schizophrenia (Loizzo et al. 2010; Loizzo 2000, 2009b). Since there seem to be good grounds for clinicians to accept such practices, this trend raises some key issues relevant to psychiatric ethics.

As I mentioned above, this tradition challenges modern reductive models and invasive methods such as a first-line reliance on pharmacology, advising that we try the least invasive remedies first, and always complement somatic treatments with intensive instruction and ongoing support for self-healing strategies (Clifford 2006; Loizzo, Blackhall, and Rapgyay 2009). Even with psychotherapy, the Buddhist approach would place more emphasis on empowering the patient to be an active participant in healing, typically prescribing a whole regimen of self-care including rigorous group instruction, painstaking self-analysis, routine meditation practice, and commitments to healthy motivation and action (Loizzo, Charlson, and Peterson 2009). While the art of prescribing and maintaining the right self-care imposes demands on both clinicians and patients, the Buddhist tradition considers these ethically necessary and practically indispensable to ensure that the teamwork of doctor and patient has an optimal outcome.

This tradition also poses a public health challenge for psychiatry, in that it offers teachable methods of self-care and self-healing that could appreciably reduce the time and cost of conventional healing, while expanding the scope and impact of community mental health. Given the evidence that meditation and psychotherapy employ similar neural mechanisms—reducing traumatic stress reactivity and enhancing neural plasticity and learning—the existence of methods shown to promote profound emotional and visceral self-regulation opens horizons of healing long considered inaccessible to psychotherapy (Loizzo 2000, 2013). The profound mind–brain effects of techniques such as compassion training, role-modeling imagery, narrative self-transformation, and deep abdominal breathing challenge psychotherapy to push its limits, and reconsider the unconventional methods of self-psychology, Jungian analysis, narrative therapy, bioenergetics, and Lacanian analysis (Loizzo 2012, pp. 490–493).

The second main area of potential contribution that challenges modern psychiatry derives from the first. Given that Buddhist psychology and medicine adopt an approach of assisted self-healing, they advise a more egalitarian, pedagogic relationship between doctor and patient. As a result, the ethos of Buddhist psychology and medicine challenges modern psychology, psychiatry, and medicine to explore a doctor–patient relationship more akin to the contractual model of therapeutic alliance developed in humanistic psychology (Loizzo 2012, pp. 131–132).

The third area of potential contribution stems less from the meditative tools of Buddhist psychology than from the basic philosophical-ethical insights that guide self-analysis and self-healing in the Buddhist tradition. As I mentioned above, the basic assumption that the mind and nervous system evolve, develop, and work in two-way mutual dependence and interaction rather than through strict bottom-up or top-down causation clears a middle way for psychology that promotes therapeutic optimism, while acknowledging the psychophysical nature of conditioned and instinctive resistances to change. The healing alliance in Buddhist practice encourages both parties realistically, by emphasizing the fundamental plasticity of mind and brain, while recognizing the need for cognitive learning, meditation, and lifestyle change to overcome resistances and free the mind's full potential for transformation and optimal health. The balance of optimism and realism implied by this model of active development challenges modern psychology and psychotherapy to find its own middle way, and to stretch its horizons beyond disease management to positive psychology and transformational healing (Loizzo 2012, 2009b).

Two additional areas of potential contribution related to Buddhist theory represent two sides of the coin of its distinctive evolutionary psychology. The first is the contribution of a rigorously intergenerational view of human suffering, healing, and transformation, growing out of the *karmic* theory of active development. The second is the contribution of a radical optimism about personality development and character change, based on the analytic psychology of the basic theory of selflessness.

According to Buddhist science, consciousness and the mind are just as embedded within a multi-life evolutionary stream

of causality as are the body and physical heredity. Given its interactionist stance on the evolution of mind and body, Buddhist psychology assumes that personal identity, character, and agency are as much part of an intergenerational process of development as is the unfolding of a particular body from the genetic seeds of a specific egg and sperm. In an unlikely twist on Freud's view of identity, this tradition traces identity to the convergence of two parallel streams of heredity interacting from conception through childhood. In this view, a *karmic* stream of psychological identity and habit patterns engages with a genetic stream of biological identity and instinctive patterns, within the Oedipal triangle of a developing mind's desire for the opposite sex parent, competition with the same sex parent, and reification of a new hybrid self-construct. As Freud believed that a child's ego was a "reincarnation of former ego structures" transmitted across generations *via* the parents' unconscious (Freud 1960, p. 38), the Buddhist view is that identity is formed based on the substrate of the natural recycling and recombination of ancestral patterns in the course of development (Loizzo 2011, 2014).

The main challenge this poses for contemporary psychotherapy is to widen the focus of genetic analysis to include the wide-angle lens of intergenerational patterns. Ethically, this approach involves a "big picture" perspective on parents as part of a multi-life flow of human development, fostering a more adult sense of identification with prior generations. The aim here is not to deny childhood experience, but to challenge the myopic, black-and-white view of self, other, and life that is inevitable for a developing mind. This progressive view also fosters a greater sense of the child's agency and potential, encouraging the growth of empathy for and forgiveness of parental flaws. This view is further tempered by the assumption that the child's hunger to learn and grow is the main engine of development, placing some degree of responsibility on the individual for actively appropriating some aspects of parental identity and behavior while rejecting others (Loizzo 2012, pp. 107–111). Overall, this challenge overlaps with the long view of development taken in humanistic and positive psychology, as well as the intergenerational outlook of family systems approaches. Ethically, it resonates with Wittgenstein's critique that psychoanalysis may privilege a rhetoric of victimization, and risk reinforcing rather than healing the traumatic distortions of self, other, and relationship which plague the childhood mind (Bouveresse 1996).

The second area of theoretical contribution relates to the radical analytic framework of selflessness. While technically this theory does not negate the reality of the empirical person, it does conclusively rule out the possibility of any self, soul, personality, or agent that is permanent over time, independent of its constituent parts, or identifiable without reference to social context, cultural conventions, or linguistic expressions. In short, this theory offers a view of self and a model of personality even more critical than postmodern concepts of them as neuro-psychologically developed and psychosocially constructed. The main challenge this poses to modern psychotherapy is that it insists that any and all aspects that make up identity, personality, and character can be changed, given a deep enough analysis and powerful enough methods of transformation. While similar in some ways to the challenge of learning theory, the interactionist model of development in Buddhism assumes like psychoanalysis that older habits of character have deep roots in unconscious patterns of perception, emotion, and response, and are also anchored in energetic, chemical, and molecular patterns etched into the nervous system (Loizzo 2011, 2012, pp. 529–536). More like the positive neuropsychology of today than familiar cognitive or dynamic models, the theory of selflessness challenges any preconceived limits to self-transformation, and offers a radically optimistic ethos of change that urges that clinicians must make available the insights and tools patients need to transform suffering into happiness (Loizzo 2013). A case vignette illustrates this contribution:

> A writer and single mother came to me for help with her frustrating relationships with men. As a girl, she had unconsciously identified with her father, an immigrant of humble origins who acted as caretaker to her emotionally immature mother, a narcissistic painter. This identity pattern had structured her failed, caretaking relationships with narcissistic men. As we exposed and dismantled this self-object pattern over a brief two-year therapy, for the first time in her life, at 60, she was able to meet and marry a mature, caring man.

The last set of potential contributions relate to the precepts of traditional Buddhist ethics. The first of these pertains to the psychobiology of craving, and its link to habits and lifestyles of obsession, addiction, and compulsion. In Buddhist psychology, as in modern research, the variety of compulsive behaviors—from the reactivity of extreme stress and trauma to the cravings and urges of everyday life—are driven by the same cycle of mind/body conditioning that reinforces addictions. So Buddhist psychology takes the dynamics of craving and compulsion—even of the garden variety—very seriously as a block to any process of relaxation, healing, positive learning, and healthy change (Loizzo 2012, pp. 128–135).

The ethics of Buddhist psychology assumes that a path to healing cannot be well-grounded or sustained in the presence of addictive habits or a compulsive lifestyle; and it sees the work of renouncing craving and compulsions as a prerequisite

for real healing and change. This renunciative stance challenges the permissive stance of modern psychology and psychotherapy, aligning instead with the science of addiction and the modern ethos of recovery. This helps explain the ethical problem of weakness of will, since the powerful biology of addiction can maintain unhealthy habits in the face of even the most rational insight or the best intentions. The traditional case that even minor addictions can block progress makes sense given that the biology of addiction reinforces not only specific addictive behaviors but also, along with them, all the human suffering and unhealthy defenses that drive and support the addiction (Loizzo 2012, pp. 107–114). A case vignette illustrates this contribution:

> A news producer came to me looking for alternatives. He had been told by his therapist of 20 years that only medication could help his depression further, but was reluctant. In tracing his dysthymia to a masochistic enmeshment with his dad, we uncovered a covert addiction to homosexual pornography and masturbation, focusing on sexualized father figures. Once he was able to stop his addictive behavior using 12-step recovery, we were able through psychotherapy to dismantle his identification with his traumatic role as his father's homoerotic fantasy object. This work eventually resolved his depression, and transformed his masochistic relationship with his wife and children.

As in modern self-help or addiction treatment, the remedy for weakness of will is unlimited, unconditional social support, a tone of radical acceptance, and a contemplative pedagogy of guided self-reflection, meditation, and ethical living. The most basic guidelines of ethical practice include avoiding antisocial actions—violence, negative speech, inappropriate sexuality—as well as renouncing intoxicants that impair the higher faculties needed to avoid such actions (Loizzo 2012, pp. 129–132). Another precept of ethical living for all sheds further light on the key role communication and social cohesion play in healing.

As I mentioned above, negative speech doesn't just refer to lying or deceptive speech, but also to speech that is socially harmful, such as abusive speech, divisive speech, and idle gossip. Taken together, the indispensable role of a healing group process in personal change and the vital importance of honest, kind, conciliatory, and meaningful speech pose two major challenges to modern psychology and psychotherapy. Specifically, they challenge the individual paradigm of modern theory and practice, insisting that healing group process add a missing ingredient that is vital to deep psychological insight and change. And they challenge the ventilation paradigm of modern dynamic therapy, insisting that indulging negative habits of speech and the moods underlying them reinforces the reactive mindset that feeds the repetition of trauma, adding self-inflicted insult to developmental injury (Loizzo 2012, pp. 124–126). With the modern psychology of recovery and learning, Buddhist psychology challenges us to look seriously at paradigms such as the evidence-based model of DBT, which does more with less by combining intensive group learning with cognitive and emotional skills training.

The two remaining areas of contribution follow from the social ethos of Buddhist psychology. Given its mission to offer asylum, education, and health care to people regardless of gender, race, or class, Buddhism developed cost-effective methods of communal instruction in contemplative healing. Like the modern paradigm of DBT derived from it, this tradition employs a multi-modal approach to mental health, integrating group education and social support with individual mentoring, meditation, and ethical life skills. It challenges modern psychiatry to explore such hybrid methods to help bridge the gap between the gold standard of long-term psychotherapy and the vast, unmet mental health needs of the public at large (Loizzo 2012, p. 25). This is especially true given the *de facto* alternative: primary reliance on psychotropics prescribed by internists with minimal training, to the exclusion of full psychiatric assessment and treatment, or even partial access to mental health education and skills training.

The final area of contribution stems from the ethical value Buddhism places on healing group cohesion. The medical model of Buddhist learning assumes that Buddhist teachings must be taken as so many remedies for the wide diversity of human forms of suffering. This plus the ethical precept that healing speech must be caring and inclusive lead this tradition to approach the diversity of psychological theory and practice more as a medical pharmacopeia than as a matter of exclusive orthodoxy. The ethical guideline that all teachers and students must work to reconcile the various teachings prescribed as remedies to different people by Shakyamuni and his heirs has led to a "big tent" approach to the theories and methods of Buddhist psychology rather than a competitive or schismatic "either-or" approach.

Over time, this inclusive emphasis gave rise to a comprehensive framework called the gradual path, integrating the whole range of Buddhist teaching and practice along a spectrum aligned with different stages of healing and human development. Preserved in its most expanded form in Tibet, this framework begins with medical and psychiatric

approaches, and then moves on to individual psychological healing, and social-emotional healing, to culminate in the highest reaches of human creativity and integration. This integrative approach challenges modern psychology and psychotherapy to be more inclusive, and to embrace the whole variety of therapies as multiple tools that may help people with diverse learning styles struggling with distinct forms of suffering at different stages of their healing and development (Loizzo 2000; Loizzo, Charlson, and Peterson 2009). This challenge resonates with recent studies on the efficacy of various mental health interventions, which have shown that medication and psychotherapy are equally effective, and that differences in technique are not a major variable in the efficacy of psychotherapy, while empathic relationship is (Wampold 2001; Norcross 2002).

Buddhism, Compassion, and the Healer's Art

I hope this survey has shed some light on the complex ethical interface of Buddhism with modern psychiatry, psychology, and psychotherapy. Buddhism is unique among the world's religions in its active engagement with science, and its affinity for scientific approaches to life, mind, and healing. I believe this affinity in part is what led world historian Arnold Toynbee to predict that the encounter of the Abrahamic West with Buddhist civilization will be the most positive transformative event of our age (Toynbee 1957). It also helps explain the recent trend towards a convergence of Buddhist insights and methods with current neuropsychology and psychotherapy. That growing trend has made my work in this chapter more timely and complex than it otherwise might have been.

The unusual contours of the ethical encounter of Buddhist teaching with modern psychology reflect its traditional healing aims, and its long history of finding a middle way between science and spirituality (Dalai Lama 2006). I have tried to flesh out these contours by looking at that middle way from both sides of the modern Enlightenment dichotomy of science versus religion. In surveying the complementarity of Buddhism with modern psychology, I hope to have clarified why many clinicians and patients are embracing it as a psychology, while glossing over its religious dimension. In surveying the distinctiveness of these two healing traditions, I hope to have put in perspective some of the ethical contrasts that may arise when clinicians work with traditional Asian Buddhists or recent Western converts, contrasts like those that arise when modern psychology meets practitioners of any other religion.

The chapter's final two sections have focused more pointedly on areas of potential ethical conflict and contribution that emerge when Buddhist thought and practice intersect with modern psychology and psychiatry. In the first, "Including Ethics in the Dialogue Between Buddhism and Modern Psychology," I tried to orient clinicians to some of the sensitive areas where they may need to challenge their Buddhist patients to reexamine the way they hold their religious outlook or practice. And in the second, "The Four-Dimensional Interface of Buddhist and Modern Psychology," I tried to alert clinicians and researchers to the less obvious areas where this ancient Asian contemplative tradition may productively challenge the received consensus or common practice of current psychiatry.

Overall, in the many years I have spent working at the interface of these two traditions, three key points of ethical relevance stand out. First, because of its rare integration of science and spirituality, Buddhism may act as a catalyst to promote greater dialogue between neuroscience, psychology, and religion (Loizzo 2013). To the extent that it does, that is a welcome role which goes beyond a specifically Buddhist perspective on psychiatric ethics (Dalai Lama and Norman 2013). Ideally, such a dialogue will prompt philosophical, ethical, and aesthetic debate within psychiatry, psychology, and psychotherapy, opening the field to spirituality in general and enriching its capacity to foster health, growth, and change.

Second, because of its self-healing aims and educational methods, Buddhism may be a valuable complement to the reductive model and pharmacological methods that have become more prevalent in modern psychiatry and psychology. This is especially true I believe when it comes to the three cardinal values Buddhist medicine shares with other spiritual healing traditions: relying on the least invasive, most self-healing methods possible; trying anything, whatever works; and basing all healing on a foundation of mature empathy and compassion. In the many years in which I have tried as a clinician to integrate Buddhist methods of self-analysis, meditation, and healing community into my work, I believe they have given my patients and me a much bigger tool chest with which to engage problems that resisted all the conventional tools.

Finally, more important than any fresh insights or tools is the ethos of radical openness and unwavering compassion behind them all. When all my modern knowhow falls short, this humble ethos has helped free me to admit my limitations, and to work creatively with my patients, trying anything and everything that might unlock their natural capacity for change. Though it seems anachronistic, I believe the most vital ingredient of Buddhist ethics is the empirical spirit of Shakyamuni

himself, whose compassion to help humanity and openness to learn from all obstacles made him the Hippocrates of scientific psychology, as well as Asia's Socrates and Christ. In the end, like our psychotherapy, his tradition sees the ultimate measure of ethics as the tireless, methodical improvement of our humanity, one heart and mind at a time. In the words of the Buddhist Aristotle, Dignaga, "I honor the teacher who realized bliss, the protector who sought the happiness of all, personifying the method" (Loizzo 2012, p. 71).

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Notes:

(1) Examples of this dialogue include the work of Germer et al. (2012, 2013), Davidson (2013), Epstein (2004, 2013), Welwood (2002), Molino (1998), Rubin (1996), and Saffran (1995).

(2) For an example of this integration, see Williams et al. (2007). For a recent review, see Khoury et al. (2013).

(3) The 10 modes of negative action are: (1) killing; (2) stealing; (3) inappropriate sexuality; (4) false speech; (5) divisive speech; (6) abusive speech; (7) idle speech; (8) craving; (9) aversion; (10) mistaken views. They are complemented by 10 modes of positive action. See Loizzo (2012, pp. 115–116).

(4) The classical Mahāyāna transcendences become 10 with the addition of empathic art; inspiration; heroism; and intuitive wisdom. These overlap with a list from the Theravāda tradition. And they are complemented by a set of 18 primary and 46 secondary vows. See Loizzo (2012, chapter 6), and Dalai Lama and Vreeland (2002). For a popular presentation of this ethic of compassion, see Dalai Lama and Cutler (2009).

(5) The heroic ethos of Vajrayāna Buddhism involves upholding 14 primary and eight secondary vows. See Loizzo (2012, chapter 9) and Berzin (2011).

(6) Such observations go back to Rhys Davids in 1878 and Müller in 1882. See Bentley (1992).

(7) Like the Greek theory of transmigration, the Buddhist theory of evolution explains the obvious diversity of human and animal life and the mythological diversity of beings in hellish, ghostly, and heavenly realms in one and the same way, tracing it to the effects different habits of mind and action have on evolution and development. It also distinguishes the former fully materially embodied forms from the latter mentally constituted forms. See Pruden (1991, vol. 2, pp. 371–377).

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