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Buddhism and Psychiatry

Moving Beyond Mindfulness in Mental Health Care

Brendan Kelly

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This book is dedicated to Regina, Eoin, and Isabel.

Content Advisory

This book discusses issues such as depression, suicide, self-harm, mental illness, and related matters in direct terms, in order to demystify, delineate, and understand them better. For this reason, certain readers might find certain sections distressing. Appropriate caution is advised. If you are distressed by any of the themes or discussions in this book, please seek psychological support from a qualified mental health professional as soon as possible. Thank you.

Disclaimer

This book is intended as general discussion only and does not in any way represent medical, psychiatric, or legal advice for individual persons. Readers are advised to attend their own doctors, mental healthcare professionals, or legal advisors for advice and guidance appropriate to their particular needs. This book does not in any way replace the advice and guidance that your own doctor, mental healthcare professional, or legal advisor can give you. If you are concerned about any of the issues raised in this book, be sure to consult your doctor or other mental healthcare professional. For legal advice, consult a legal practitioner.

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A Note on Language

Throughout this book, original language and terminology from the past and from various reports and publications have been maintained, except where explicitly indicated otherwise. This reflects an attempt to optimise fidelity to historical material and diverse sources. It does not reflect an endorsement of the broader use of such terminology in contemporary settings.

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About the Author

Brendan Kelly is Professor of Psychiatry at Trinity College Dublin, Consultant Psychiatrist at Tallaght University Hospital, Dublin, and visiting Full Professor at the School of Medicine at University College Dublin.

In addition to his medical degree (MB BCh BAO), he holds master's degrees in Epidemiology (MSc), Healthcare Management (MA), Buddhist Studies (MA), Mindfulness-Based Interventions (MSc), and an MA (jure officii) from Trinity College Dublin; doctorates in Medicine (MD), History (PhD), Governance (DGov), and Law (PhD), and a higher doctorate in History (DLitt).

Professor Kelly has authored and co-authored over 350 publications in peer-reviewed journals, over 750 non-peer-reviewed publications, 27 book chapters and book contributions, and 21 books (including 14 as sole author).

Professor Kelly's recent books include *The Modern Psychiatrist's Guide to Contemporary Practice: Discussion, Dissent, and Debate in Mental Health Care* (Routledge, 2025), *Asylum: Inside Grangegorman* (Royal Irish Academy, 2023), and *Resilience: Lessons from Sir William Wilde on Life After Covid* (Wordwell, 2023). In 2024, he co-edited, with Professor Mary Donnelly, the first edition of the *Routledge Handbook of Mental Health Law.*

In 2018, Professor Kelly became Editor-in-Chief of the *International Journal of Law and Psychiatry.* In 2020, he was elected as Dun's Librarian

at the Royal College of Physicians of Ireland. Professor Kelly is a Fellow of the Royal College of Psychiatrists, Royal College of Physicians of Ireland, and Trinity College Dublin. In 2024, he was elected to membership of the Royal Irish Academy.

Professor Kelly appears frequently in newspapers and on radio, discussing topics relating to mental illness, mental health, and mindfulness.

CHAPTER 1

Introduction: Buddhism and Psychiatry

Abstract Buddhism and psychiatry constitute a field of growing interest owing to the emergence of mindfulness from Buddhist tradition and the valuable but sometimes unnuanced incorporation of mindfulness-based techniques into contemporary mental healthcare. Buddhist thought also has other links with psychiatry and mental health, separate to the current embrace of mindfulness. These other links are intrinsically valuable, and hold added relevance in an era of mindfulness. These associations and thematic resonances are explored throughout this book in order to bring these connections back to light and further contextualise the recent enthusiasm for mindfulness-based interventions. This book is aimed at readers who are interested in Buddhism, psychiatry, mental health, mindfulness, and meditation. This introduction to the volume discusses the recent emergence of mindfulness in many countries around the world, notes the existence of other links between Buddhist thought, mental healthcare, and psychiatry, and provides an overview of the structure of the book. This book argues that identifying and understanding these links and echoes between Buddhism and psychiatry can help to identify themes of common interest, articulate certain therapeutic approaches with added clarity, and enrich our understandings of both Buddhism and psychiatry.

Keywords Buddhism • Psychiatry • Mental health • Mental healthcare • Psychotherapy • Mindfulness • Equanimity • Meditation • Spirituality • Religion

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Buddhism and Psychiatry

Buddhism and psychiatry constitute a field of growing interest for a number of reasons. These include, most notably, the emergence of mindfulness from Buddhist tradition and the valuable but sometimes unnuanced incorporation of mindfulness-based techniques into contemporary mental healthcare. Buddhist thought also has other links with psychiatry and mental health, however, separate to the current embrace of mindfulness. These other links are intrinsically valuable and have added relevance in an era of mindfulness. These associations and thematic resonances are explored in this book in order to bring these connections back to light and further contextualise the recent enthusiasm for mindfulness-based interventions.

This book is aimed at readers who are interested in Buddhism, psychiatry, mental health, mindfulness, and meditation. This introduction to the volume reflects on the recent emergence of mindfulness in many countries around the world, notes the presence of other links between Buddhist thought, mental healthcare, and psychiatry, and provides an overview of the structure of the book. Overall, this book argues that identifying and understanding links and echoes between Buddhism and psychiatry can help to identify themes of common interest, articulate certain therapeutic approaches with added clarity, and enrich our broader understandings of both Buddhism and psychiatry.

As with all publications, this book comes from a particular perspective. I am a medical doctor and practising psychiatrist with formal qualifications in Buddhist studies and mindfulness-based interventions. I have written elsewhere on themes relating to Buddhism, mental healthcare, and psychiatry (see, e.g., Kelly 2008, 2011, 2016, 2022, 2023a). As a trained mindfulness teacher, I have deep respect and affinity for mindfulness-based practices and find them helpful for a range of conditions when they are used appropriately. I also have an enduring personal interest in Buddhism and have written a book about meditating each day for a year (Kelly 2019).

In light of this background, allied with developments in mental healthcare over recent decades, it appears wise to start any consideration of Buddhism and psychiatry by addressing the elephant in the room: mindfulness.

The Rise and Rise of Mindfulness

Mindfulness is everywhere. This is not a Zen Buddhist koan, but a fact. Over recent decades, 'mindfulness' has permeated healthcare, education, workplaces, and popular culture in many countries which did not previously have strong Buddhist traditions. Some days, it is difficult to avoid discussions about mindfulness on the airwaves, resist invitations to sign up to meditation courses online, and navigate ubiquitous advice to 'live in the moment'.

In essence, mindfulness means paying attention to the present moment, as simply and directly as possible (Kabat-Zinn 2013). It means maintaining a careful awareness of thoughts, emotions, and actions, but not judging them (Kelly 2023b). It involves staying focussed on the 'now' as much as possible and, when the mind wanders, re-directing it back to the present moment with gentleness and persistence. Mindfulness is both simple and difficult at the same time.

In the sphere of health and wellbeing, mindfulness techniques have been integrated into secular programmes aimed at reducing stress, enhancing mental health, and even improving productivity in workplaces. Apps, workshops, and books on mindfulness have proliferated, offering accessible tools for managing life's challenges and a great deal more. In short, mindfulness is everywhere and is often presented as the solution to everything.

This remarkable enthusiasm is partly a response to growing awareness of mental health problems, partly a result of the pressures of fast-paced lifestyles, and partly the consequence of relentless commercialisation of an ancient Buddhist practice which finds echoes in other contemplative, spiritual, and religious traditions. It is also based, in part, on the intrinsic value of mindfulness-based techniques, which have a distinguished and justified place in Buddhist thought and practice.

The risks of unnuanced enthusiasm for mindfulness include misinterpretation of the nature and scope of the practice, excessive expectations, dilution of the essence of particular techniques, and complete detachment from its spiritual origins. Too often, mindfulness is presented as a simple solution to complex problems, implicitly placing excessive responsibility on the individual rather than their circumstances. Mindfulness can also be misrepresented in such a way as to seem to advise acceptance of unfairness or injustice. The opposite is true: mindfulness helps us to see reality as it is and take ethical action as a consequence of that clear-sightedness.

As a spiritual practice, mindfulness is extraordinarily powerful and psychologically useful, but it is not for everyone. It is not the solution to every personal problem. It is not a panacea for every social ill.

Mindfulness cannot take the place of wise action in our lives and communities. True mindfulness does not pretend that it can. In our imperfect world, we cannot live mindfully in the present moment, and truly see reality as it is, without feeling a need to engage with that reality and make the world a better place. That is what mindfulness prompts us to do: to see reality as it is, and to live our lives based on that direct experience.

Mindfulness is not passive; it is active. It means tuning in, not dropping out. Mindfulness does not mean blind acceptance. It means noticing reality as it is, with our eyes wide open and all of our senses fully alert. Mindfulness means engaging with the world as it exists in this moment, not as we imagine it to be. Mindfulness means facing up to reality, possibly for the first time, and basing our actions on that reality.

In the end, and possibly paradoxically, mindfulness means standing up, not sitting down. It's time.

Moving Beyond Mindfulness

This book grew from the recognition that, notwithstanding the dominance of mindfulness in recent decades, and its great value, there are other links between Buddhist thought, mental healthcare, and psychiatry. These other echoes and resonances merit attention and thought, and are explored in this book, along with appropriate recognition of the role of mindfulness-based therapies.

The overall relationship between religion and psychiatry is complex and, at times, uneasy (Verhagen 2010). Inevitably, this tension is reflected at various points throughout this book. As Deane (2014) points out, however, the rise of mindfulness has focused renewed attention on the relationship between Buddhism and psychiatry, notwithstanding the more general tensions between religion and psychiatry, as well as their potential synergies:

> Buddhist-derived 'mindfulness' practices are currently enjoying popularity amongst both the lay population and health professionals in the West, especially in the treatment of psychiatric conditions such as depression. This popularity leads to questions regarding how people in diverse Buddhist

> communities might conceptualise psychiatric illness and healing. (Deane 2014; p. 444)

Elucidating these conceptualisations is a complex, multi-layered task, not least because Buddhism is a vast spiritual and religious tradition with a wide diversity of teachings, practices, and schools (Lopez 2015). Nevertheless, exploring these themes and associations is a task which holds deep promise.

To begin, there are long-standing links between certain elements of Buddhist thought on the one hand and specific psychological therapies on the other. These include well-described interactions between Zen Buddhism and psychoanalysis (Fromm et al. 1960) and dialectical behaviour therapy (Palmer 2002), among other approaches (Watson 1998). Arguably, the study of meditative and contemplative insights and relevant religious traditions can act as a bridge between religious experiences and scientific psychology (Rosch 2002). It can also assist with the operationalisation of psychological theories in the form of psychotherapies.

The present book, however, concerns the relationship between Buddhism and psychiatry more broadly, rather than focussing solely on psychotherapy. This book defines psychiatry as the branch of medicine that is concerned with the treatment and study of mental illness, so it encompasses not only psychological therapies but also other forms of treatment (e.g., medication) and social interventions (Kelly 2025). In practice, these treatments and therapies are often delivered as part of multi-disciplinary mental health teams.

What, then, are the links between Buddhism and psychiatry more broadly, beyond mindfulness and Buddhist-inspired psychotherapies?

There is a growing literature on this theme, a significant proportion of which focuses on Tibetan Buddhism (see, e.g., Clifford 1984, 2001; Plakun 2008; Deane 2014, 2018). This book seeks to explore these and other associations and thematic resonances between Buddhism and psychiatry in order to bring these connections back to light, contextualise the recent enthusiasm for mindfulness, and hopefully enrich our broader understandings of Buddhism and psychiatry.

The next chapter, Chap. 2, starts this task by focusing on 'Mental Disorder in Buddhism and Psychiatry'. Chapter 3 moves on to explore 'Treatment of Mental Disorders in Buddhism and Psychiatry', while Chap. 4 looks at 'Moving Beyond Mindfulness'. Chapter 5 concentrates on 'Equanimity in Buddhism and Psychiatry', arguing that equanimity is a

quality that can be usefully cultivated and accorded greater importance in mental healthcare, rooted in both medical tradition and Buddhist thought. Finally, Chap. 6 presents relevant 'Conclusions', including suggested directions for future research and advice about mindfulness, equanimity, and similar practices in psychiatry and other settings.

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CHAPTER 2

Mental Disorder in Buddhism and Psychiatry

Abstract This chapter is devoted to the idea of 'Mental Disorder'. It commences with a discussion of Buddhist ideas about *dukkha* or unsatisfactoriness, and the varying extents to which this concept relates to the fundamental nature of reality, human unhappiness, the ups and downs of everyday life, reactions to prevailing social orders, and states of mind which we now consider to be 'mental health conditions', 'mental illnesses', or 'mental disorder'. This chapter also explores 'mental disorder' in international classification systems in psychiatry, including the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (Text Revision) (DSM-5-TR)* and the World Health Organization's *ICD-11: International Classification of Diseases (Eleventh Revision) (ICD-11)*, as well as general approaches to diagnosis in clinical practice. The chapter concludes by examining the relevance of these concepts and various Buddhist ideas (e.g., *dukkha*, impermanence, dependent arising, non-self) to responses to suffering and the diagnosis of mental health conditions today. Throughout the chapter, there is an emphasis on different systems of interpreting and patterning human suffering, the commonalities across Buddhist and other traditions, and the ways in which these perspectives offer different opportunities for understanding.

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Keywords Mental disorder • Mental illness • Unhappiness • Suffering • Diagnosis • Mental health • Psychiatry • Buddhism • *Dukkha* • Psychotherapy

Suffering, Diagnosing, Understanding

As sentient beings, all humans suffer. Sometimes that suffering is readily apparent in our day-to-day lives, especially during periods of particular challenge, hardship, or distress. At other times, there can be a quiet hum of discomfort or dissatisfaction, almost in the background. Usually, these feelings of quiet unhappiness are mixed with moments of joy, hope, and positivity in a rapidly changing concatenation of emotions, thoughts, and behaviours. In essence, we live in states of mixed emotions, with dissatisfaction forming a habitual part of that kaleidoscope of feelings.

This chapter is devoted to these and similar ideas about the human condition and, in particular, differences and commonalities across Buddhism and psychiatry in relation to suffering. Particular attention is devoted to conditions that psychiatry terms 'mental illnesses' or 'mental disorders'.

The chapter commences with a discussion of Buddhist ideas about *dukkha* or unsatisfactoriness, and the varying extents to which this relates to a range of other, connected concepts including the fundamental nature of reality, human unhappiness, the ups and downs of everyday life, reactions to prevailing social orders, and states of mind which we now consider to be 'mental health conditions', 'mental illnesses', or 'mental disorders'. These relationships are complex but important if we are to locate individual suffering in its broader, relational context.

The second part of the chapter explores current ideas about 'mental disorder' in international classification systems in psychiatry, including the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (Text Revision) (DSM-5-TR)* (American Psychiatric Association 2022) and the World Health Organization's *ICD-11: International Classification of Diseases (Eleventh Revision) (ICD-11)* (World Health Organization 2019). This part of the chapter also looks at general approaches to diagnosis in clinical practice, which are usually considerably less rigid than a surface reading of *DSM* or *ICD* would suggest. Diagnosis is a very human process, aimed at understanding

conditions rather than categorising people, alleviating pain rather than simply labelling it.

The chapter concludes by examining the relevance of these concepts and various Buddhist ideas to responses to suffering and the diagnosis of mental health conditions today. Throughout the chapter, there is an emphasis on different systems of interpreting and patterning human suffering, the commonalities across Buddhist and other traditions, and the ways in which diverse perspectives offer new opportunities for understanding. The idea of 'mental disorder' is explored in some depth, suggesting that 'disorder' is different to 'dysfunction' and 'distress', even though 'disorder', 'dysfunction', and 'distress' can overlap and inter-relate in various ways within each person.

Dukkha or Unsatisfactoriness

When considering the relationships between Buddhism and psychiatry, it is important to note that Buddhist teaching is at once a philosophy, a psychology, and an ethics (Bodhi 1999). In other words, Buddhism provides a specific system or set of beliefs about reality (philosophy), a theory of the human mind and human behaviour (psychology), and a set of recommendations for appropriate, skilful conduct (ethics). This differs from the purpose of psychiatry, which is the branch of medicine concerned with the study of mental illness and its treatment through psychological therapies, other forms of treatment (e.g., medication), and social interventions (Kelly 2025). Nevertheless, both Buddhism and psychiatry are centrally concerned with the nature and alleviation of suffering, and so they merit comparison and consideration in this context.

The most immediately relevant aspects of Buddhist teaching are the 'four truths' and the 'eightfold path', both of which are key to Buddhist psychology (Kelly 2008). The 'four truths' are concerned with human suffering (*dukkha*) and how to overcome it:

(a) *Dukkha*: Often translated as 'suffering', *dukkha* can also mean 'pain', 'unease', or 'unsatisfactoriness'. In essence, *dukkha* describes the unsatisfactory nature of much of human experience and behaviour, and highlights a need to identify the root cause of *dukkha* and overcome it. Life is inherently characterised by dissatisfaction. This includes physical pain, emotional distress, existential unease, and other forms of dissatisfaction. Even enjoyable experiences are tran-

sient and cannot provide lasting fulfilment. Recognising this truth encourages us to confront the reality of imperfection rather than avoiding it.

(b) *The cause of dukkha*: In Buddhism, *dukkha* is seen as the result of craving (also termed 'attachment' or 'grasping'), hatred, and delusion. These experiences are commonly implicit in our responses to sensory phenomena. Craving finds its roots in ignorance about the nature of reality, leading to desires for sensory pleasures, existence, and non-existence. Clinging to impermanent things and passing experiences generates a cycle of suffering and dissatisfaction. This truth constitutes much of the basis for Buddhism's focus on cognition, cognitive training, and the practice of meditation, including mindfulness.

(c) *The cessation of suffering*: By facing *dukkha* and overcoming craving, aversion, and delusion, we can achieve the cessation of suffering. This is the ultimate aim of Buddhist practice and is known as *nibbana* or *nirvana*, a condition of profound peace and freedom from the cycles of birth, death, and rebirth (*samsara*). *Nirvana* is attained by eradicating ignorance and realising the true nature of reality.

(d) *How to overcome dukkha*: The fourth truth concerns the way we can overcome dissatisfaction or suffering and attain *nirvana*. This truth refers to the 'eightfold path', based on the three key principles of wisdom, moral virtue, and meditation (Harvey 1990).

The Buddhist 'eightfold path' is a practical framework for thought and behaviour which emphasises ethical conduct, mental discipline, and wisdom. It encompasses every aspect of life. The elements of the path are right view, right intention, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration:

1. *Right view (samma ditthi)*: This involves understanding the 'four truths' and seeing life as it truly is. It means recognising the impermanent, unsatisfactory, and interdependent nature of all phenomena.
2. *Right intention (samma sankappo)*: This means cultivating intentions of renunciation, goodwill, and harmlessness. It involves relinquishing desires, fostering compassion, and avoiding ill-will or harmful thoughts.

3. *Right speech (samma vaca)*: This means speaking truthfully, kindly, and constructively. Avoiding lies, gossip, divisive speech, and harsh language promotes harmony and understanding.
4. *Right action (samma kammanto)*: This means acting ethically and responsibly by refraining from stealing, harming living beings, or engaging in sexual misconduct. It involves living with integrity and compassion towards all sentient beings, including ourselves.
5. *Right livelihood (samma ajivo)*: This means choosing a profession or way of living that does not violate ethical principles or harm others. It involves avoiding jobs that exploit or cause suffering to humans or animals.
6. *Right effort (samma vayamo)*: This means making an effort to cultivate wholesome states of mind and abandon or avoid unwholesome ones. It involves preventing negativity insofar as possible and fostering qualities such as kindness and mindfulness.
7. *Right mindfulness (samma sati)*: This means developing awareness of the present moment in the body and awareness of current feelings, thoughts, and phenomena. This practice helps with controlling one's reactions and seeing the true nature of reality.
8. *Right concentration (samma samadhi)*: This means practising meditation to develop focus and improve mental clarity. It involves cultivating states of equanimity and calm, leading to insight in due course.

As with the 'four truths', Buddhist teachings present various more detailed accounts of the 'eightfold path', involving, for example, the division of 'right mindfulness' into contemplation of body, feeling, mind, and *dharma* (which means the truth about how things really are) (Gethin 1998). In practice, the 'eightfold path' is not a linear sequence but an integrated approach where all aspects are interdependent. It provides a holistic guide for living ethically, thinking wisely, and developing mental clarity, ultimately leading to liberation from *dukkha*.

In this way, the 'eightfold path' is a cornerstone of Buddhist practice and is relevant to everyone who seeks to live a more balanced, meaningful life. This point is essential: Buddhist teachings about *dukkha* and its resolution are seen as being relevant to *everyone*, not just people who identify as having symptoms of mental illness or psychological problems. Achieving this more realistic understanding of the human condition is a key feature of Buddhist thought (Keown 2001) which is said to hold value for *all* people, not just those who are especially troubled.

This is a significant difference between Buddhism and psychiatry: Buddhism is concerned with the alleviation of suffering in every sentient being, while psychiatry is primarily concerned with the alleviation of suffering in people who have particular psychological problems or mental illnesses, rather than experiencing the dissatisfactions of day-to-day existence. While preventive psychiatry and public health psychiatry are growing areas, they are primarily concerned with preventing mental illness, rather than improving the psychological quality of daily life or facilitating insight into the nature of reality as it truly is.

In this way, Buddhism focuses more on the nature and quality of routine existence, the fundamental dissatisfactions of mundane reality, common levels of human unhappiness, and the ups and downs of daily life, rather than focusing primarily on times of extreme distress or diagnosed 'mental disorder', as psychiatry does.

An awareness of this difference can be useful for mental health professionals in practice, as can a familiarity with the concepts and language of Buddhism and other spiritual and religious traditions. Singh writes that 'just knowing the term *dukkha* can be valuable to a clinician treating a patient from one of these Indian religions':

> The word can also be used while assessing mood. One does not need linguistic fluency in an Indian language; the word can be used within an English sentence: 'are you feeling *dukkha*?' It works not just with patients with limited English, but also second-generation or English-fluent patients of Indian origin, and they respond very differently to this as opposed to 'are you depressed?', since *dukkha* has cultural meaning well over and above a simple translation of depression. (Singh 2022; p. 293)

'Mental Disorder' in Psychiatry

Against the background of this difference of purpose between Buddhism and psychiatry, it is useful to consider what psychiatry means by 'mental disorder', before exploring in more detail the relationships between these two conceptual approaches to suffering and its alleviation.

The formal classification and diagnosis of mental disorders are in continual states of incremental change. In recent decades, this has led to the development and revision of comprehensive diagnostic manuals such as the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (Text Revision) (DSM-5-TR)* (American

Psychiatric Association 2022) and the World Health Organization's *ICD-11: International Classification of Diseases (Eleventh Revision) (ICD-11)* (World Health Organization 2019). While both of these documents aim to standardise mental health diagnoses across clinical settings insofar as possible, their definitions of mental disorder differ subtly yet critically in terms of their focus, applicability, and conceptual underpinnings.

DSM-5-TR defines a mental disorder as a syndrome that is characterised by clinically significant disturbance in a person's cognition, emotional regulation, or behaviour, which reflects dysfunction in the psychological, biological, or developmental processes which underlie mental function (American Psychiatric Association 2022; p. 14). Like *ICD-11*, *DSM-5-TR* emphasises that such disturbances usually cause significant distress or disability in social, occupational, or other important areas of functioning. It explicitly excludes behaviours that are socially deviant or conflicts between an individual and society unless they result from a dysfunction within the individual.

For example, *DSM-5-TR* defines panic disorder as the presence of recurrent, unexpected panic attacks, characterised by an abrupt surge of intense fear or discomfort that peaks within minutes. These attacks must include at least four symptoms such as palpitations, sweating, trembling, shortness of breath, feelings of choking, chest pain, nausea, dizziness, chills, paraesthesia, derealisation or depersonalisation, fear of losing control, or fear of dying. To meet the diagnostic criteria, at least one of the attacks must be followed by a month or more of persistent concern or worry about further panic attacks or their consequences (e.g., having a heart attack, losing control), or a significant maladaptive change in behaviour connected with the attacks, such as avoiding situations that might trigger them. The disturbance cannot be attributed to the physiological effects of substances, medical conditions, or other mental disorders (e.g., social anxiety disorder, post-traumatic stress disorder). *DSM-5-TR* also emphasises the debilitating nature of panic disorder which often interferes with daily functioning and can lead to avoidance behaviours.

DSM-5-TR's emphasis on mental disorders as *syndromes* reflects the fact that the conditions it describes are mostly based on symptoms, rather than biological tests. Nevertheless, *DSM-5-TR*'s systematic approach aims to provide reliable, research-based diagnostic criteria that facilitate consistent diagnoses across clinicians and support empirical research into mental health treatments. Its structured approach, with detailed symptom lists

and diagnostic criteria, enhances diagnostic precision and is widely used in mental health research. Another strength of *DSM-5-TR* is its integration of dimensional assessment measures alongside traditional categorical diagnoses. On this basis, clinicians can also usefully assess symptom severity and impact on daily functioning.

There are inevitable limitations to the use of symptom-based categorisation for mental health conditions in systems such as *DSM-5-TR*. Mental disorders cannot be fully understood through symptoms alone, as social, cultural, and psychological factors play important roles. Reductionist approaches have been criticised for potentially leading to the medicalisation of normal human experiences, such as grief or anxiety in response to life stressors. Additionally, misuse of *DSM-5-TR*'s symptom-focused diagnostic criteria can result in rigid, one-size-fits-all diagnosing that does not adequately capture the complexity of an individual's mental state, especially their strengths. *DSM-5-TR* explicitly warns against this kind of tick-box approach to diagnosis, noting that its guidelines must be informed by clinical judgement.

Similar arguments pertain to *ICD-11*, which defines mental, behavioural or neurodevelopmental disorders as syndromes which are characterised by clinically significant disturbances in a person's cognition, emotional regulation, or behaviour which reflect dysfunction in psychological, biological, or developmental processes underlying mental and behavioural function (World Health Organization 2019). *ICD-11* emphasises that these disturbances are generally associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of human functioning. Any distress and dysfunction must not simply be responses to common life events such as bereavement unless they exceed normal cultural and contextual expectations.

The primary strength of *ICD-11* is its global and culturally inclusive scope. The World Health Organization developed it for use in all member states, and it aims to provide diagnostic guidelines that are applicable across diverse healthcare systems and sociocultural contexts. To this end, it integrates considerations of cross-cultural variations in symptom presentation and emphasises functional impairment as a key consideration. *ICD-11*, if used correctly, offers clinicians a flexible, person-centred approach, which is crucial in settings where cultural perceptions of mental health differ.

ICD-11 adopts a dimensional perspective on many mental disorders, acknowledging that mental health exists on a continuum from wellness to

illness rather than solely as discrete categories. This approach is reflected in its inclusion of diagnostic qualifiers like severity levels and specifiers for different presentations, which enhance its clinical utility by allowing more tailored diagnoses and treatments.

Despite these strengths, it can be argued that *ICD-11*'s broad, flexible criteria can lead to diagnostic subjectivity. The absence of strict symptom thresholds may cause inconsistency in how different clinicians interpret diagnostic guidelines, especially in regions with varying levels of access to mental health training and expertise. Additionally, *ICD-11*'s focus on global applicability arguably compromises the depth and specificity of diagnosis needed for research purposes and may hinder efforts to develop standardised treatment protocols (albeit that standardisation has its own demerits and is not a panacea for anything).

Overall, while both *DSM-5-TR* and *ICD-11* share fundamental similarities in their definitions of mental disorder, their differences reflect divergent conceptual and practical approaches to mental health diagnosis. One of the most notable distinctions is their intended use and scope. *DSM-5-TR* reads as more research-focused and tailored to the North American healthcare system, while *ICD-11* appears more designed for use in global public health contexts and emphasises accessibility and cultural flexibility.

ICD-11's focus on cultural sensitivity and functional impairment is particularly valuable in diverse settings. For some people, emotional distress may manifest as physical symptoms, such as somatic complaints, rather than as cognitive or emotional disturbances. *ICD-11*'s flexible diagnostic criteria arguably allow clinicians greater scope to account for such variations without necessarily diagnosing a mental disorder in cases where symptoms align with culturally accepted expressions of distress. Ultimately, a great deal depends on how these diagnostic aids are used in clinical practice and if they are used at all.

The incorporation of dimensional approaches to categorisation is welcome and aligns with contemporary research suggesting that mental health symptoms exist along a spectrum. Boundaries between disorders are often fluid. An over-reliance on discrete diagnostic categories reflects a more traditional, disease-based model of mental health, which can limit its applicability in complex cases involving comorbidities or overlapping symptoms.

Despite their differences and positive aspects, both *DSM-5-TR* and *ICD-11* present significant potential for overdiagnosis and inappropriate

medicalisation if they are not used with caution, wisdom, and compassion. For example, both manuals include disorders such as mild depressive episodes and generalised anxiety disorder, which create risk for the pathologisation of normal human experiences of sadness and worry. Moreover, the implicit focus on symptom reduction as a treatment goal in both systems may neglect broader psychosocial factors that contribute to mental health and well-being, and which decisively shape landscapes of suffering, treatment, and recovery.

For clinicians, understanding the various merits and demerits of *DSM-5-TR* and *ICD-11* is useful for effective diagnosis and treatment planning. In research-intensive or specialised psychiatric settings, *DSM-5-TR*'s structured diagnostic criteria might be preferred for their apparent precision and consistency. In contrast, in international and cross-cultural contexts, *ICD-11*'s flexible and arguably more culturally sensitive criteria might be more appropriate for capturing the full range of mental health presentations.

For researchers, *DSM-5-TR*'s structured criteria provide a more standardised foundation for clinical trials and empirical studies, facilitating comparability across studies. However, *ICD-11*'s emphasis on functional impairment and cultural sensitivity opens new avenues for research into how mental health conditions manifest across different sociocultural contexts.

Overall, *DSM-5-TR* and *ICD-11* represent two of the most influential systems for defining and diagnosing mental disorders, each reflecting both similar and distinct conceptual and practical approaches. Despite their merits, both manuals face shared challenges in balancing the need for diagnostic reliability with the complexity of mental health. Ultimately, a comprehensive understanding of both diagnostic systems, alongside a person-centred approach, is essential for promoting accurate diagnosis and effective treatment in diverse clinical contexts. At all times, it is essential that clinicians and researchers remain vigilant about the limitations of overly rigid diagnostic frameworks, particularly when addressing the nuanced interplay of biological, psychological, and social factors in mental health and ill-health.

Finally, diagnosis is important for clinical and legal accountability in psychiatry, and for research, but no diagnosis is ever perfect. One size does not fit all. Flexible use of diagnostic systems can bring significant clarity to complex issues, improve the evidence-base for treatment, and help to build a more holistic, inclusive understanding of mental health. In the

end, however, diagnosis using *DSM-5-TR, ICD-11*, or any other system is a very human process that should be aimed at understanding rather than categorising. Diagnostic discussions should be open and flexible, seeking to co-create a shared language for therapy, aimed at alleviating suffering.

Diagnosis is a powerful tool. It should be used with compassion and care, if it is used at all.

Diagnosis, Impermanence, Non-self

Notwithstanding their various merits and advantages, *DSM-5-TR* and *ICD-11* clearly present risks of excessive labelling, over-rigid diagnosis, medicalising normal experiences, and stigmatising people who are simply (if deeply) struggling with problems of living. While there are warnings against such misuse, there remains considerable scope for improvement in how these tools are used in practice. Can Buddhist teachings help us with this task? Can concepts rooted in Buddhist thought add wisdom, moderation, compassion, and—ultimately—meaning to descriptions of mental disorders, and how they are used?

Perhaps the first insight from Buddhist thought concerns the basic threshold for diagnosing mental disorder, given the ubiquity of *dukkha* or unsatisfactoriness in life (as discussed above). *Dukkha* is everywhere, so a certain amount of dissatisfaction and unhappiness is inevitable. This suggests that diagnosing a mental disorder is not always appropriate when dissatisfaction and unhappiness are the only problems that a person describes. That is not to say that dissatisfaction and unhappiness are not significant (they are) or that they cannot be features of mental disorder (they can), but it suggests that, given their ubiquity, the existence of dissatisfaction and unhappiness should not necessarily prompt diagnosis; often, other, non-medical responses are more appropriate.

Even when dissatisfaction and unhappiness are more severe or are accompanied by other symptoms, and a diagnosis is made, the teaching of *dukkha* can still be helpful. This is reflected in the emphasis that certain psychological therapies, such as dialectical behaviour therapy, place on the idea of 'distress tolerance' (Palmer 2002). Distress tolerance means learning how to navigate a certain level of distress in a healthy way, rather than using maladaptive behaviours such as alcohol, drug misuse, or other forms of self-harm. In other words, *dukkha* will not be completely eliminated in the short term, so learning how to minimise and tolerate it can prevent people from being paralysed by even low levels of frustration,

dissatisfaction, and distress. That is not to say that we should accept and tolerate high levels of distress, which need to be addressed at root, but rather that distress tolerance skills can help many people to get by on a day-to-day basis and so enable them to make bigger, positive changes.

The Buddhist idea of impermanence is also helpful in relation to psychiatric diagnosis. This teaching refers to the idea that all phenomena are impermanent and will inevitably change (*anicca*). This perspective can be usefully applied to the clusters of symptoms described in psychiatric classification systems, such as the symptoms outlined above for panic disorder in *DSM-5-TR*. Rather than viewing these clusters as fixed entities that define a person's identity or inevitable prognosis, they can be interpreted as transient configurations arising from complex interplays of biological, psychological, and environmental factors. For example, anxiety or depressive symptoms may ebb and flow, influenced by changing life circumstances, inner psychological states, biological shifts, and any number of other factors. This flexible understanding of the features of distress encourages clinicians to avoid rigidly applying diagnostic labels and instead adopt a dynamic perspective that accommodates the evolving nature of mental health and ill-health.

This approach is further underpinned by the Buddhist teaching of dependent arising (*paṭicca-samuppāda*), which is a foundational principle that explains the interdependent and conditional nature of existence. This teaching states that all phenomena arise, persist, and cease due to specific causes and conditions. Nothing exists independently or permanently; everything is contingent on a complex web of interconnected factors, and everything constantly evolves. This idea can be usefully applied to psychiatric diagnoses which are changeable, relational, and subject to revision over time (Kelly 2016). Everyone is different, and so is their mental state. You cannot diagnose the same disorder twice.

This is further linked to the Buddhist idea of non-self (*anattā*). This teaching does not assert that the 'self' does not exist, but rather that there is no fixed, independent, or permanent 'self' underlying existence. Instead, what we perceive as the 'self' is a collection of constantly changing physical and mental processes. This teaching challenges the perception of a unified, enduring identity and emphasises that the 'self' arises dependently owing to surrounding conditions.

This teaching also blurs the boundary between 'self' and 'other', consistent with growing knowledge about the social nature of human neurological and psychological function. Our brains are exquisitely attuned to

the minds and behaviours of other people in our families and social groups. We respond to each other continually in extraordinary, subtle, powerful ways. No single person is an island. In reality, no single person is even a single person. We merge with each other all the time: emotionally, psychologically, and behaviourally.

Overall, Buddhism teaches that these ideas of impermanence, dependent arising, and non-self can foster detachment from ego-driven desires, reduce *dukkha*, and encourage compassion, mindfulness, and insight into the impermanent and interconnected nature of existence. Understanding these Buddhist concepts can facilitate a more nuanced and flexible engagement with psychiatric classification systems, especially in clinical practice (Kelly 2016). In other words, what we perceive as fixed entities (e.g., the 'self', a diagnosis) are, in reality, transient phenomena arising from specific causes and conditions. This approach strongly supports seeing any 'diagnosis' as a term of significant but limited use that is applied to clusters of symptoms which are always subject to change and amelioration.

Similarly, the 'self' that experiences these symptoms, although clearly in existence to a certain degree, is not as concrete, unchanging, boundaried, or permanent as it appears. Change is not only possible, but inevitable. This perspective challenges the tendency to equate mental disorders with fixed personal attributes. For instance, someone diagnosed with bipolar disorder may be seen not as 'bipolar', but as a person temporarily experiencing a set of symptoms which are shaped and re-shaped by internal and external factors. Recognising the impermanence of both the 'self' and its suffering (*dukkha*) emphasises the possibility of positive change, fosters greater compassion, and reduces the stigma that is wrongly associated with mental illness. All will change.

Compassion, Cognitive Flexibility, Mindfulness

Buddhist teachings place immense emphasis on compassion (*karuṇā*) which can serve as an important critical lens for engaging with *DSM-5-TR* and *ICD-11*. A compassionate approach involves seeing beyond the diagnostic label to understand the unique lived experience of the individual. It also requires a recognition that classification systems, while useful, are inherently limited and cannot fully capture the depth of human suffering. Compassionate engagement with these systems discourages reductive thinking, encouraging clinicians to consider the broader context of a person's life, including cultural, social, and spiritual dimensions.

The teaching of non-self further underpins the value and importance of compassion. If the 'self' is not separate from the broader network of existence, the suffering and pain experienced by others is not fundamentally different from one's own. *Dukkha* is universal. This interconnected view reinforces the ethical imperative to approach psychiatric diagnosis and treatment with deep compassion and sensitivity. It also underpins the core values of medical and psychiatric treatment: solidarity, care, and the alleviation of suffering. If there is no fixed self, the boundaries between 'self' and 'other' dissolve, and the well-being of the patient is indistinguishable from the ethical duty of the clinician. This fosters a deeper, more altruistic approach to care.

Cognitive flexibility is another useful construct in this context. Engaging with psychiatric classification systems clearly necessitates considerable cognitive flexibility from the outset. *DSM-5-TR* and *ICD-11* should not be treated as rigid rulebooks but as evolving tools which are subject to continuous revision and reinterpretation. If they are used, they need to be applied in this light, i.e., flexibly, and in the context of each individual person. Mindful awareness of the impermanence of these systems allows clinicians to use them skilfully without becoming overly attached to their constructs, which will inevitably change over time as further revisions appear.

DSM-5-TR and *ICD-11* do not reflect immutable truths, but provisional constructs shaped by specific historical, cultural, and scientific contexts. As such, they should be used with humility and a recognition of their limitations, as well as our own. Changes in diagnostic criteria over time reflect shifts in societal values, scientific understanding, and clinical priorities. The evolving definitions of a wide range of disorders illustrate how these systems adapt to new insights and changing social norms.

The value of cognitive flexibility is further supported by insights from Buddhist psychology which emphasise the complexity and fluidity of mental states, viewing them as dynamic processes rather than static entities. By adopting this perspective, clinicians can better appreciate the intricate interplay of factors contributing to mental health conditions and avoid oversimplification. For instance, a diagnosis of panic disorder might involve recognising the interplay of genetic predispositions, environmental stressors, biological inputs, and cognitive patterns as they pertain to a person's changing mental state over time. Mindful awareness of how these interdependencies evolve can lead to a more holistic, individualised, and responsive approach to diagnosis and treatment.

Overall, incorporating Buddhist teachings into diagnostic practice does not necessitate abandoning existing classification systems but rather reinterpreting them through a more compassionate, flexible, and dynamic lens. This integration could take several practical forms:

- *Training and Education*: Clinicians could benefit from training in mindfulness and other approaches to mental health which find some of their roots in Buddhist thought and which will be of particular relevance to certain practitioners and certain patients. This might involve learning to recognise the impermanence of symptoms when making a diagnosis, the interdependence of mental phenomena, the importance of compassion in care, and being aware of the spiritual dimension of suffering in some people, if they find that helpful.
- *Individualised Care Plans*: Treatment approaches could be more tailored to reflect the unique and ever-changing nature of each individual's experience. Rather than necessarily adhering to diagnostic criteria in day-to-day practice, clinicians could adopt a more exploratory and collaborative approach, continually re-considering established diagnoses as treatment progresses. No single diagnosis will necessarily pertain forever.
- *Personal Reflection*: Clinicians could engage in regular personal reflection about the process of diagnosis, among other matters, informed by both medical ethical principles and the ideas of non-self and interconnectedness, to ensure that their diagnostic and other practices remain person-centred and as flexible as is feasible.
- *Cultural Sensitivity*: A Buddhist-informed approach emphasises the importance of cultural context during the diagnostic process. This aligns with contemporary calls for greater cultural competence in psychiatry, ensuring that diagnostic criteria are applied in ways that respect diverse worldviews and different life experiences.
- *Research and Innovation*: Further research could explore the intersections of Buddhist philosophy and psychiatric practice, as well as other spiritual and religious traditions. This could potentially lead to innovative models of diagnosis and understanding that integrate mindfulness, compassion, and enhanced cognitive flexibility, among other ideas.

Buddhist Thought and Diagnosis in Psychiatry

DSM-5-TR and *ICD-11* are powerful tools as general guides to diagnosis in psychiatry, but they are not without their flaws. By integrating insights from Buddhist teachings, clinicians and researchers can adopt a more flexible, compassionate, and context-sensitive approach to psychiatric classification. This perspective emphasises the impermanence of symptoms and diagnoses, the interconnectedness of all beings, and the ethical imperative to approach mental healthcare with humility and compassion. In doing so, it invites a reimagining of psychiatric practice that honours the complexity and fluidity of human experience. In this and other ways, the teachings of Buddhism can serve as a resource for mental health for many people (Westermeyer 1973).

Other traditions of medical practice, such as Tibetan medicine, have different classification paradigms for experiences and symptoms which *DSM-5-TR* and *ICD-11* would regard as features of various mental disorders (e.g., panic attacks) (Samuel 2019). Like *DSM-5-TR* and *ICD-11,* these other systems need to be used with flexibility and compassion, if they are to be used. Regardless of the degree to which a person's experiences align with particular diagnostic categories within any given classification system, the *person* always comes first. Each individual is unique; every diagnostic entity is imperfect, and everything changes all the time. The process of diagnosis, if it is undertaken at all, should reflect these truths.

That being said, different systems of describing, interpreting, and patterning human suffering offer diverse perspectives and new opportunities for sharing and understanding. Samuel (2019) demonstrates this point vividly in a paper about 'unbalanced flows in the subtle body: Tibetan understandings of psychiatric illness and how to deal with it':

> [T]he Tibetan model of psychiatric disorders differs from the Western model in that its goal is not simply the curing of the disorder, so that the patient can return to 'normal' life, but an active state of health which implies positive social engagement with the welfare of others […] The point is to become a better person, and if the disease is cured, this is in a way a side-effect. Put otherwise, like any of the sufferings of *saṃsāric* life, psychiatric illness offers an opportunity for transcendence. (Samuel 2019; p. 790)

When they are used wisely, definitions of specific mental disorders in *DSM-5-TR, ICD-11,* and other classification systems can reflect both

differences and commonalities across various traditions, including Buddhism. This, in turn, can lead us to re-conceptualise the experiences that many call 'mental disorders' in new, challenging, and hopefully transformative ways, as Samuel demonstrates.

The intention and tone of diagnostic assessments are pivotal in shaping the benefits or otherwise of the diagnostic process. While the idea of 'mental disorder' in *DSM-5-TR* and *ICD-11* differs from terms such as 'dysfunction' and 'distress', these terms also overlap and inter-relate in various ways and should be adapted to the needs of each person. There is, in the end, a commonality in these experiences of suffering which underlines many Buddhist teachings, including ideas of non-self and consequent cosmopolitan solidarity (Ward 2013). By recognising this, we can use the diagnostic process to not only link to an evidence-base to support rational treatment, but also foster a therapeutic alliance that enhances understanding and benefits all.

We suffer together and so we heal together. Change is constant and inevitable. Skilful diagnosis can and should reflect these truths.

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CHAPTER 3

Treatment of Mental Disorders in Buddhism and Psychiatry

Abstract There are parallels and differences between approaches to psychological distress in Buddhism and psychiatry. Buddhist temples were historically centres of medical learning and practice, and psychiatry emerged in the nineteenth century as a result of similar impulses to alleviate distress. In recent decades, there is particular emphasis on mindfulness in cognitive behaviour therapy (CBT), mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), and acceptance and commitment therapy (ACT). As evidence for these therapies grows, important critiques emerge, highlighting the extent to which 'mindfulness' has been co-opted by corporate and neoliberal interests to promote individual self-improvement while allegedly ignoring broader systemic injustices. This perspective has merit, but mostly relates to misapplications of mindfulness, rather than its correct use. True mindfulness lets us see the world as it really is and provides powerful impetus for change. This chapter argues that wise use of psychiatric medications (e.g., antidepressants, antipsychotics) shares Buddhism's focus on the alleviation of suffering and works in cooperation with meditation, rather than against it. Similar considerations apply to mental health legislation which permits admission and treatment without consent in severe mental disorder. Applying the lens of Buddhist approaches to law is a rewarding way to explore this challenging topic.

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Keywords Mental disorder • Mental illness • Suffering • Mental health • Psychiatry • Buddhism • *Dukkha* • Psychotherapy • Cognitive therapy • Mindfulness

Treatment in Psychiatry and Buddhist Thought

This chapter focuses on the treatment of mental disorders in psychiatry and analogous ideas about psychological suffering in Buddhist thought. The chapter starts with an historical perspective, examining the emergence of psychiatry as a field within medicine and traditions of mental or psychological healing in Buddhist history, noting, for example, that Buddhist temples were historically centres of medical learning and practice in many countries.

The chapter continues with a discussion of mindfulness both in Buddhism and in the context of recent psychotherapeutic applications, such as mindfulness-based stress reduction (MBSR) for stress, mindfulness-based cognitive therapy (MBCT) for depression, acceptance and commitment therapy (ACT), and other developments along similar lines, often in countries without strong traditions of Buddhism. The chapter explores some of the challenges raised by the confluence of 'Western' psychotherapy and Buddhist teachings, including key critiques of mindfulness as it is currently conceptualised, as well as responses to some of these issues.

This chapter argues that wise, evidence-based use of psychiatric medications (e.g., antidepressants, antipsychotics) shares Buddhism's focus on the alleviation of suffering and works in cooperation with meditation, rather than against it. Finally, this chapter brings a Buddhist perspective to bear on one of the most controversial issues in contemporary psychiatry: legislation which permits admission and treatment without consent and substitute decision-making in certain circumstances, owing to severe mental disorder. This discussion argues that applying the lens of Buddhism is a neglected but rewarding way to explore this challenging topic in psychiatry.

Psychiatry: The Historical Perspective

Conditions which are now regarded as mental disorders feature in human history, ancient mythologies, and religious traditions for as long as there are records. In many countries, disturbances to thinking, emotions, and behaviour were commonly attributed to spiritual factors, supernatural

phenomena, or the operation of other unseen forces (Scull 2015). A change occurred in medical texts written in the tradition of Hippocrates (c.460–c.370 BCE), a Greek physician, when his followers described 'hysteria' as a mental illness in women that was linked to the womb rather than attributable to the gods or the mysterious forces of fate (Kelly 2022). Hippocrates and his followers developed the idea that disease resulted from an imbalance in the four 'humours': black bile, yellow bile, phlegm, and blood. They placed particular emphasis on the role of the brain in creating emotions, knowledge, perceptions, and our responses to the world.

Over the following centuries, the management of what is now called 'mental illness' was increasingly medicalised, resulting in the widespread emergence of mental hospitals, or asylums, in the eighteenth and nineteenth centuries. Prior to this, religious orders often provided a certain amount of care to a select few. For example, the Priory of St Mary of Bethlehem in London housed insane men in the 1400s and later developed into Bethlem ('Bedlam'), one of the oldest psychiatry hospitals in Europe (Shorter 1997). Despite similar, isolated provision by monasteries and convents elsewhere, people with mental illnesses were most commonly neglected, confined in prisons, or left in the care of families who were not resourced to care for them humanely.

As a result of this situation, large networks of public asylums were established across much of the world during the eighteenth and nineteenth centuries, inspired by the Enlightenment's emphasis on reason and humanitarian reforms. However, these institutions were soon overcrowded and often became places of confinement rather than care. One of the earliest reforms of this situation came from Philippe Pinel in France, who advocated for 'moral treatment' at Bicêtre and La Salpêtrière in Paris, emphasising kindness and structured routines. In England, William Tuke founded the York Retreat (1796), pioneering compassionate care. These were, however, relatively isolated developments within a much larger system of institutions that appeared to grow unstoppably in response to social determinants rather than demonstrated medical or psychiatric need.

During the nineteenth century, asylums continued to expand in many countries as industrialisation, urbanisation, and other social shifts gathered pace. Governments institutionalised care based on the idea that large asylums could provide therapeutic environments for many, despite mounting evidence that poor conditions developed as the institutions struggled with rising patient numbers. In the twentieth century, new psychiatric

treatments, including electroconvulsive therapy and lobotomies, were introduced, alongside psychoanalysis, in an effort to alleviate distress and discharge patients from asylums. Many of these approaches were later abandoned owing to lack of efficacy or harm caused (Kelly 2022).

Eventually, deinstitutionalisation commenced in earnest in the mid-twentieth century, fuelled by new psychiatric medications (e.g., chlorpromazine) and changing attitudes. This led to the closure of many asylums in favour of community-based care. By the late twentieth century, mental hospitals had largely been replaced by outpatient services, although some institutions remain in operation in certain parts of the world.

Over this period, ideas about mental disorders also changed. Mental illness was increasingly seen as being largely similar to physical illnesses, owing not least to the benefits of certain medications, such as antipsychotics and antidepressants. These treatments remain imperfect, and often have side-effects, but they are generally just as effective as treatments in other areas of medicine, and sometimes more so (Leucht et al. 2012). The absence of an identifiable biological basis for most mental illnesses, whose diagnoses are chiefly based on symptoms, does not undermine empirical evidence of the benefits of treatment, but does point to the need for more research (Kelly 2025).

Buddhist Healing Practices and Traditions

In parallel with the emergence of psychiatry, Buddhist traditions of mental or psychological healing continued to evolve over time but remained centrally focused on the nature of suffering (*dukkha*), the importance of compassion (*karuṇā*), and the 'eightfold path' to the alleviation of suffering (see Chap. 2: 'Mental Disorder in Buddhism and Psychiatry'). In Buddhism, these concepts are seen as relevant to not only the routine unhappiness of everyday life, but also the challenges presented by more extreme states of sadness and distress which accord with current conceptualisations of mental disorders in international classification systems. For the most part, these more severe conditions are seen as quantitatively rather than qualitatively different to the mundane dissatisfactions of human life, so general Buddhist ideas still apply, albeit with some modifications owing to the severity of the person's mental state.

The *Pali* canon of early Buddhist literature demonstrates some of these ideas and provides a clear exposition of Buddha's approach to states of mental distress. The story of *Patacara* is a good example. *Patacara* was

born into a wealthy family in ancient India but eloped with a man of lower status (Somasundaram and Murthy 2018). They lived happily, although they also endured hardship. When *Patacara* became pregnant, she set out to return to her parents' house. On the journey, she gave birth and went back to her new home. Later, while pregnant again, she attempted the journey once more. A storm broke out, and *Patacara* gave birth in the wilderness. Tragically, her husband died from a snakebite and, soon after, both of *Patacara*'s children died.

Devastated, *Patacara* eventually reached home, only to learn that her parents and brother had died tragically. Overwhelmed by grief, *Patacara* wandered the streets in despair, yelling and naked. People threw stones at her. In this profoundly distressed and alienated state, *Patacara* encountered the Buddha, who comforted her and taught her about the impermanence of life, the impermanence of suffering, and the path to its alleviation. Healed and inspired by these teachings, *Patacara* became a nun and, through diligent practice, became renowned for her wisdom and mastery of the *Vinaya* (monastic discipline).

Buddha's emphasis on compassion and impermanence in this story is consistent with Buddhism's generally humane approach to mental illness. It demonstrates early destigmatisation of mental illness and the idea that extreme states of mental distress are amenable to treatment and amelioration, no matter how disturbing the symptoms might be. Suffering can always end, if we find the right path.

In many countries, such as Japan, Buddhist temples duly became historical centres of medical learning and practice (Shinfuku 2019). In the eleventh century, for example, the *Iwakura Daiun* temple in Kyoto was renowned for caring for people with mental illness after a princess was healed by drinking water from its well. This is consistent with other, non-Buddhist traditions of water from wells curing mental illness at locations such as *Gleann na nGealt* ('Well of the Mad') in Ireland (Kelly 2016). In Kyoto, people with mental illness gathered around the temple and were housed by neighbouring villagers, consistent with similar (non-Buddhist) provisions at Geel in Belgium. A psychiatric hospital was later built at the location in Kyoto, as healing traditions were medicalised over time.

As with many other spiritual and psychological traditions, Buddhist ideas about mental illness were not replaced by medicalisation, but persisted alongside it and interacted with evolving clinical paradigms in various ways. This is a long-standing feature of the history of psychiatry: folkloric, traditional, and spiritual concepts and practices tend not to

disappear as hospitals and medications proliferate, but are integrated into blended paradigms. This is typified by the geographical continuity between many religious sites, such as the Priory of St Mary of Bethlehem in London and *Iwakura Daiun* temple in Kyoto, and later psychiatric hospitals and treatment centres at these locations.

In terms of specific treatments, various forms of psychotherapy are explicitly rooted in Buddhist traditions and have continued to develop over time (Kelly 2008a). These approaches include Naikan therapy, which essentially involves a programme of structured self-reflection (Murase and Johnson 1974), and Morita therapy, based on the acceptance of certain feelings and realities and positive engagement with the world (Brazier 2003). These and other, similar psychological approaches use Buddhist ideas, often drawn from Zen tradition, to inform psychotherapeutic engagement and address conditions such as anxiety and depression in various different ways.

Zen Buddhism has also interacted considerably with other established schools of psychotherapy, most notably psychoanalysis in the United States during the 1950s and 1960s (Fromm et al. 1960). This remarkable encounter was part of a broader cultural shift towards Eastern spirituality and alternative therapies at that time. Various influential cultural figures explored Zen's emphasis on direct experience, present-moment awareness, and non-duality. This resonated deeply with many psychoanalysts who were increasingly exploring non-Western approaches to the mind. Freudian psychoanalysis was in decline as the dominant form of psychotherapy in the mid to late twentieth century, so other avenues were attractive to therapists in search of novel approaches. Buddhism—especially Zen Buddhism—had a rich trove of concepts to offer.

Other schools of Buddhism provide different forms of understanding and treatment rooted in their own histories and traditions. While these all tend to embrace certain unifying Buddhist ideas (e.g., compassion, impermanence, dependent arising), there are also differences across traditions and between regions. In Tibetan Buddhism, for example, tantric deities can be invoked for healing purposes, depending on the nature of the presenting problem (Clifford 1984). In this school of thought, the root cause of mental illness is seen as living a life that is contrary to a person's spiritual inclinations, insights, and inherent disposition. As a result, all three varieties of Tibetan medicine are engaged in treatment: dharmic, tantric, and somatic. This is somewhat different to other schools of Buddhism, such as

Zen, but is consistent with broader Tibetan medical tradition and with overarching Buddhist ideas which transcend the many schools and subdivisions within Buddhist practice.

Arrival and Place of Mindfulness in Contemporary Therapies

Notwithstanding the myriad links between psychiatry, psychotherapy, and specific aspects of diverse Buddhist traditions, mindfulness is now the dominant Buddhist concept in mental healthcare in many countries, even those without strong Buddhist traditions. This is an interesting and generally positive development, although a certain degree of nuance is sometimes lost when the term 'mindfulness' is used in a non-mindful way. Sometimes, excessive enthusiasm for 'mindfulness' erodes understanding and leads to misapplications of the practice as originally conceived. A certain amount of adaptation is inevitable, and a degree of flexibility is built into the practice, but the original essence of mindfulness merits respect and preservation, even as applications multiply. Like all other concepts, 'mindfulness' is not infinitely elastic.

As discussed in Chap. 1 ('Introduction: Buddhism and Psychiatry'), mindfulness means paying attention to the present moment, as simply and directly as possible (Kabat-Zinn 2013). It involves maintaining a careful awareness of thoughts, emotions, and actions, but not judging them (Kelly 2023). It means staying focussed on the 'now' as much as possible and, when the mind wanders, re-directing it back to the present moment with gentleness and persistence. The *Satipaṭṭhāna Sutta*, one of the most important discourses in the *Pāli* Canon of Theravada Buddhism, explores mindfulness in some detail.[1] Four 'foundations' of mindfulness are described by the Buddha:

- Mindfulness of body (*kāyā*)
- Mindfulness of feelings (*vedanā*)
- Mindfulness of mind/heart (*cittā*)
- Mindfulness of qualities (*dhammā*)

[1] https://www.accesstoinsight.org/tipitaka/mn/mn.010.than.html (accessed 22 February 2025).

Each of these foundations of mindfulness can be seen as having various constituent elements. For example, mindfulness of the body can include mindfulness of breathing, mindfulness of postures, mindfulness of activities, and mindfulness of physical characteristics (Goldstein 2013). Various methods and techniques are used to cultivate each of these aspects or dimensions of mindfulness, all centred on developing awareness of the present moment and cultivating a mindful relationship with reality.

Mindfulness now forms part of a range of psychological therapies for a variety of conditions. These applications include, most notably, mindfulness-based stress reduction (MBSR) for stress (Kabat-Zinn 2013), mindfulness-based cognitive therapy (MBCT) for depression (Segal et al. 2018), and various other developments along similar lines (Williams and Penman 2023). Many of these approaches also find significant roots in cognitive behaviour therapy (CBT) and related techniques. They therefore represent a merging of mindfulness with established models of CBT or, perhaps, a re-emphasising of mindfulness within the evolving architectures of these paradigms.

In general terms, CBT is a structured, goal-oriented therapy that focuses on identifying and changing negative thought patterns and behaviours. CBT is commonly used for conditions such as mild and moderate depression, eating disorders, and a range of anxiety-related problems (e.g., social phobia, obsessive compulsive disorder) (Kelly 2025). Against this background, MBCT is a structured integration of CBT with mindfulness, which has proven helpful for preventing relapse in some individuals with recurrent depression (Segal et al. 2018). MBCT incorporates mindfulness meditation and CBT techniques to help people recognise early signs of negative thinking patterns and disengage from automatic, habitual reactions that can lead to distress.

MBCT is now an evidence-based approach to preventing relapse in depression. In 2021, one 'systematic review and network meta-analysis' of MBCT provided clear support for its effectiveness compared to treatment as usual (TAU) in this population:

> [W]e found that MBCT is more effective than TAU in the long-term in preventing relapse of depression and has statistically significant advantages over TAU and placebo for time to relapse of depression […] Subgroup meta-analysis by number of previous episodes of depression showed very similar results. Use of booster sessions may result in improved outcomes, and its use, timings, frequency and attendance should be clearly reported. (McCartney et al. 2021; p. 19)

Mindfulness and Other Forms of Psychological Therapy

In practice, many therapists now integrate mindfulness techniques, such as meditation and mindful breathing, into various CBT interventions to enhance treatment outcomes for anxiety, depression, and stress-related disorders. This combination allows individuals to cultivate a more balanced relationship with their thoughts and emotions, leading to greater resilience and well-being. In this way, mindfulness and CBT are integrated and synergistic, each enhancing the other's effectiveness in promoting mental health and addressing specific issues and conditions (Kelly 2008b).

Mindfulness is also a feature of dialectical behaviour therapy (DBT), a psychotherapy that is commonly used in conditions such as emotionally unstable personality disorder. DBT is somewhat similar to CBT and also involves group sessions, building skills such as mindfulness, and developing coping strategies other than self-harm for managing emotional instability. In DBT, mindfulness is one of the four core modules, along with distress tolerance, emotion regulation, and interpersonal effectiveness. The mindfulness module equips individuals with skills to observe their thoughts, emotions, and sensations without judgment, fostering a heightened awareness of the present moment. Such awareness enables people to recognise and distance themselves from automatic, often maladaptive reactions, thereby enhancing emotional regulation and reducing impulsive behaviours.

The integration of mindfulness into DBT serves several therapeutic functions. First, it aids in the acceptance of reality as it is, which is essential for reducing the emotional suffering associated with resistance to current experiences. Second, mindfulness practices help people to identify and understand their emotional responses, creating a space between stimulus and reaction. This space allows for more deliberate and constructive choices in behaviour, rather than reflexive and unhelpful actions such as self-harm.

DBT can be a challenging therapy, but it can also be highly effective for reducing self-harm in certain conditions, including (but not limited to) emotionally unstable personality disorder. Mindfulness is a central element of this approach, providing tools to cultivate present-moment awareness and acceptance. This practice improves emotional regulation, reduces impulsivity, and enhances overall psychological well-being. Ongoing research continues to explore the nuanced ways in which mindfulness

within DBT facilitates therapeutic change and positive outcomes, but its place within the DBT paradigm is already clearly established.

Acceptance and Commitment Therapy (ACT) is another form of psychotherapy that integrates mindfulness and behavioural change strategies to enhance psychological flexibility (Hayes et al. 2006). ACT focuses on the ability to adapt to life's challenges while staying true to one's values. Rather than eliminating negative thoughts and emotions, ACT encourages individuals to accept them as part of the human experience and commit to meaningful actions. This therapy is based on six core processes:

- *Acceptance*: allowing difficult emotions and experiences to exist without resistance.
- *Cognitive defusion*: learning to see thoughts as mere mental events rather than absolute truths.
- *Being present (mindfulness)*: cultivating non-judgmental awareness of thoughts, feelings, and surroundings.
- *Self-as-context*: understanding that one's identity is more than transient thoughts or emotions.
- *Values*: clarifying what truly matters in life to guide decisions and actions.
- *Committed action*: taking meaningful steps towards a fulfilling life, even in the presence of discomfort.

Mindfulness plays an essential role in ACT by fostering awareness and detachment from unhelpful thought patterns. ACT is used for anxiety, depression, chronic pain, and stress, by shifting focus from avoiding discomfort to living a values-driven life. The therapy promotes resilience and well-being by balancing acceptance with purposeful action.

Overall, mindfulness has found a clear role in many modern psychotherapies and, arguably, has always been present to a certain degree in approaches such as CBT. This relationship has sometimes been implicit rather than explicit, but psychotherapeutic approaches to mental wellbeing have always incorporated elements that are resonant of mindfulness and other Buddhist techniques. In other words, there is a degree of commonality in how we approach the suffering mind that is evident across cultures, between spiritual traditions, and over time. Mindfulness, in one form or other, has always been part of that.

Perspectives and Critiques of Mindfulness

The confluence of Buddhist ideas such as mindfulness with 'Western' psychotherapies has the potential to offer many benefits, including more culturally appropriate mental healthcare for certain populations (De Silva 2006; Chandradasa and Kuruppuarachchi 2019). The arrival of a certain version of mindfulness in countries without strong Buddhist traditions has also led to complexities, confusions, and misunderstandings of mindfulness. These developments merit consideration and reflection, along with the critiques they have prompted.

Divino (2024) raises key issues in a valuable paper exploring 'the historical transformation of mindfulness, through a process of transculturation and commodification, into a biopolitical tool':

> The development of mindfulness has been influenced by the sociocultural context of neoliberal and capitalist societies, resulting in a model that fosters self-regulation and emphasizes social control […] Despite garnering significant attention within the scientific community for its documented efficacy in addressing mental health concerns, inquiries persist regarding the authenticity of mindfulness in its contemporary, secular guise and its alignment with traditional Buddhist contemplative practices. (Divino 2024; pp. 125, 140)

One of the key issues is the extent to which the modern mindfulness movement has been co-opted by corporate and neoliberal interests to promote individual self-improvement while ignoring broader systemic injustices (Purser 2019; Forbes 2019). The argument is that certain contemporary versions of mindfulness, stripped of their Buddhist ethical roots, have become tools for productivity and stress management rather than paths to genuine liberation. 'Mindfulness' has been commodified into a market-friendly product, detached from its radical potential to challenge oppressive social structures. Corporations, governments, and even the military use mindfulness to encourage employees and citizens to accept stress and adversity rather than addressing the root causes of inequality, overwork, and exploitation.

This powerful critique of the modern mindfulness movement has merit, but it mostly relates to common misapplications of mindfulness, rather than its correct use. It is true that certain iterations of the current mainstream form of mindfulness reinforce neoliberal ideologies of disproportionate personal responsibility while ignoring collective action and social

change, but it is also true that mindful, reflective application of mindfulness does the exact opposite. True mindfulness lets us see the world as it really is—and anyone who sees reality in this mindful way will inevitably want to change the world for the better, through powerful, peaceful means. Mindfulness is pacifist, not passive.

Against the background of the over-selling of mindfulness in recent decades and a certain drift in meaning, we need a renewed integration of mindfulness with social and political consciousness. This means a return to the ethical and transformative roots of mindfulness, rather than the diluted, consumer-friendly version that is sometimes seen on car bumper stickers and in poorly informed smartphone apps. It means re-focusing on justice within mindfulness, including confronting and addressing issues of race in the contemporary mindfulness movement (Karelse 2023). It means re-discovering the vital energy of mindfulness for positive transformation of society. Mindfulness means opting in, not opting out (Kelly 2023).

Medication or Meditation?

So far, this chapter has considered the therapeutic impact of Buddhism on psychiatry chiefly through the relationship between mindfulness and various models of psychotherapy. However, psychotherapy is just one of the treatment modalities in contemporary psychiatry, and mindfulness is just one of the ways in which Buddhism interacts with psychotherapy. The relationship between Buddhism and psychoanalysis was already mentioned (above). There are also other ways in which Buddhist thought and practice intersect with psychotherapy, depending on the modalities used (see, for example: Epstein 2007).

In terms of psychiatry more broadly, it is useful to consider psychiatry's relationship with Buddhism in the context of contemporary psychiatry's overall approach to understanding and treating mental illness. This approach is rooted in a 'bio-psycho-social' model which acknowledges biological, psychological, and social dimensions to health, illness, and healthcare (Engel 1977). The bio-psycho-social model of psychiatry acknowledges that mental health conditions arise from a complex interplay of genetics, brain chemistry, and physical health (biological); thoughts, emotions, stressors, and coping mechanisms (psychological), and relationships, culture, and socioeconomic conditions (social). This model moves beyond purely medical, purely psychological, or purely social explanations of mental illness and its treatment (Kelly 2025). This framework

emphasises that effective treatment often requires a combination of medication, psychotherapy, and social support. By considering multiple influences, the bio-psycho-social model promotes personalised care, addressing both individual vulnerabilities and external stressors to improve mental well-being.

How does Buddhism interact with these other dimensions of psychiatry? The next chapter will look specifically at relationships between Buddhism and psychotherapy apart from the substantial contributions of mindfulness to this field (Chap. 4: 'Moving Beyond Mindfulness in Psychiatry'). In terms of other aspects of psychiatry, the previous chapter already examined potential roles for Buddhist thought in diagnosis, exploring the relevance of various Buddhist ideas (e.g., *dukkha*, impermanence, dependent arising, non-self) to responses to suffering and diagnosis of mental health conditions for some people (Chap. 2: 'Mental Disorder in Buddhism and Psychiatry'). That chapter argued that by integrating insights from Buddhist teachings when this is appropriate, clinicians and researchers can adopt a more flexible, compassionate, and context-sensitive approach to psychiatric classification.

The remainder of the current chapter is devoted to two additional areas in which Buddhist thought can interact further with psychiatry and offer valuable perspectives on thought and practice: the use of psychiatric medication for the treatment of mental disorders, and the use of mental health legislation for treatment without consent in certain severe conditions. First: medication or meditation?

The use of psychiatric medication for mental illness presents an interesting philosophical and ethical question when examined through the lens of Buddhist psychology. Buddhism emphasises the alleviation of *dukkha* (suffering) through insight, ethical living, and meditation. This might suggest that Buddhist psychological approaches prioritise internal transformation over external interventions such as medication. However, Buddhism is deeply pragmatic and profoundly compassionate. The principle of *upaya* (skilful means) allows for the use of whatever methods are beneficial in reducing suffering. If psychiatric medication helps to alleviate pain and stabilise a situation, allowing the person to engage more effectively in mindfulness, ethical practice, and self-awareness, it is entirely consistent with Buddhist teachings. The principle of *ahimsa*, which relates to non-harm, also supports the use of medication when it alleviates distress, deepens awareness of reality, and enhances well-being.

Similar to contemporary bio-psycho-social psychiatry, Buddhist psychology encourages a holistic view of mental suffering. It sees distress not merely as a biochemical imbalance but as intertwined with one's perceptions, attachments, and *karmic* patterns. While medication can ease symptoms and potentiate healing, it is not enough on its own. True liberation from suffering, according to Buddhism, comes from meditation, self-inquiry, and the development of wisdom. Therefore, medication might be seen as an aid rather than a complete solution. This is also the case in contemporary psychiatry, which recognises psychological and social dimensions to distress, as well as biological factors addressed by medication.

In this way, psychiatric treatments and Buddhist psychology are not in opposition to each other and can work best together. This is the 'Middle Path' of which Buddhism speaks, eschewing excessive asceticism or avoidable suffering if it can be alleviated (Epstein 1993). There is, in theory, a potential risk that psychiatric medication might affect a person's search for truth or meaning stemming from their experiences of conditions such as depression (Bhat 2006, 2007). It is important to bear this possibility in mind, but also to counterbalance it against the likelihood that relieving disabling symptoms will enhance, rather than impede, engagement with reality and progress towards enlightenment (Green 2007).

In the end, the evidence supporting psychiatric medications such as antidepressants and antipsychotics is as strong as the evidence for treatments in other areas of medicine, and often stronger (Leucht et al. 2012; Kelly 2025). When it is used skilfully and ethically, psychiatric medication can provide relief that enables deeper engagement with psychological therapies and healing practices aimed at long-term transformation. A balanced approach, integrating medication, when necessary, with psychotherapies, mindfulness, ethical conduct, and wisdom, aligns with the Buddhist idea of reducing suffering in a compassionate and skilful manner.

Mental Health Legislation and Buddhist Values

Issues relating to psychiatric treatment become more complex when treatment is administered under legislation which permits admission and treatment without consent and substitute decision-making in certain circumstances, generally owing to severe mental disorder (Donnelly and Kelly 2024). Such legislation is a long-standing feature of the history of psychiatry in many countries. It can apply for periods of time to the minority of people with mental illness who lack decision-making capacity,

present a risk to themselves or others, and/or are in conditions of severe distress, which can be alleviated by treatment. While admission and treatment without consent are usually strictly supervised, governed by law, and aimed at alleviating suffering, can they ever really be consistent with the principles of Buddhism?

The first point to note is that Buddhist approaches to the relevant therapeutic and legal considerations in this situation are—like all Buddhist thought—rooted in the familiar concepts of compassion (*karuṇā*), non-harming (*ahimsa*), and the alleviation of suffering (*dukkha*). These values suggest that actions with the intention and effect of relieving distress are skilful undertakings, consistent with core Buddhist values. At the same time, Buddhist traditions emphasise moral responsibility and the *karmic* consequences of past actions. These principles create an intricate framework for evaluating the justification of involuntary psychiatric treatment for people with severe mental illness. These principles do not provide a simple, blanket answer as to whether treatment without consent is always, ever, or never consistent with Buddhist values. However, they constitute a framework for examining broader issues and, perhaps more pragmatically, for consideration in individual cases.

The second point of relevance here concerns the position of law in Buddhist traditions. The field of Buddhism and law is vast and diverse, covering a wide variety of historical periods, geographical areas, and cultural contexts (French and Nathan 2014). That being said, Buddhist monastic law (*Vinaya*) provides insights into the way that (what we now term) mental illness was seen and managed within Buddhist communities and offers some broader guidance.

The *Vinaya Pitaka* contains rules regarding monks and nuns who experience severe mental distress. According to these regulations, individuals showing signs of significant mental instability could be excused from responsibility for certain actions and from strict adherence to monastic discipline in certain circumstances.[2] They could be provided with understanding rather than expulsion from the community. This demonstrates a recognition that severe mental suffering requires accommodation rather than punitive measures. The emphasis was on support, kindness,

[2] https://www.accesstoinsight.org/tipitaka/vin/sv/bhikkhu-pati.html#as ('Adhikaraṇa-Samatha: Rules for settling disputes', Section 3); https://www.wisdomlib.org/buddhism/book/vinaya-3-the-cullavagga/d/doc370226.html; https://www.wisdomlib.org/buddhism/book/vinaya-2-the-mahavagga/d/doc370097.html (all accessed 25 February 2025).

and the provision of conditions conducive to healing, including a calm environment, meditation, and ethical guidance. The matter of overriding the apparent wishes of an individual who is seriously mentally ill is not addressed explicitly, but the severity of such conditions and the need for care are clearly recognised.

Modern psychiatry, shaped in part by mental health legislation, permits involuntary treatment in cases where individuals with severe mental illness pose a risk to themselves or others, lack understanding of their condition, and would benefit from treatment which cannot be otherwise provided (Kelly 2025). This approach is justified by legal and ethical principles emphasising public safety, beneficence, and the protection of individuals who lack decision-making capacity. However, from a Buddhist perspective, involuntary treatment raises concerns regarding autonomy, non-harming, and the ethics of coercion. These concerns are very similar to the issues which inform legal debates about these matters in virtually all jurisdictions around the world.

Buddhist thought generally upholds the principle of non-coercion, valuing self-awareness and voluntary transformation as essential to ethical and spiritual development. The idea of imposing treatment against someone's apparent wishes, even for the person's well-being, rests uneasily with the Buddhist emphasis on inner wisdom and self-directed change. However, the principle of *upaya* (skilful means) suggests that interventions aimed at alleviating suffering can be justified if they are carried out with genuine compassion and minimal harm. In addition, such interventions need to be weighed against the risks of inaction, which would include prolonged, avoidable mental distress and sustained, avoidable risk to self or others—neither of which would be considered skilful in Buddhist thought or defensible from a legal perspective.

A Buddhist-informed approach to involuntary treatment would emphasise minimising coercion, ensuring compassionate care, and seeking to restore the individual's autonomy as soon as possible, which are also the aims of well-formulated mental health legislation. A Buddhist approach would also advocate for holistic care, integrating psychiatric treatment with psychological therapies (including mindfulness-based therapies where appropriate), community support, and ethical considerations that respect the dignity of the person.

Overall, while Buddhism prioritises non-harming, it also acknowledges the need for compassionate intervention when appropriate. A legal approach that is consistent with Buddhist values would seek to balance the

necessity of involuntary treatment with the principles of non-harming and ethical care, ensuring that any intervention genuinely serves to alleviate suffering rather than merely control behaviour. Examining mental health legislation from this perspective serves to re-emphasise the importance of these values and is a neglected but rewarding way to explore this challenging topic in psychiatry.

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CHAPTER 4

Moving Beyond Mindfulness in Psychiatry

Abstract This chapter explores the relationships between Buddhism and psychiatry beyond 'mindfulness'. There is sometimes a tendency to take mindfulness out of its cultural context and apply it to virtually everything, despite the fact that the effects of contemplative practices vary considerably between people and across contexts. Conceptual differences also arise, pertaining to concepts such as 'self', 'non-self', and 'self-esteem'. Addressing these complexities in psychiatry and psychotherapy can yield benefits, provided they are approached with sensitivity and humility. Moving beyond mindfulness also means exploring and making available the rich trove of ideas and frameworks outlined in the *Abhidharma*, a collection of psychological works from the traditional Buddhist canon. In addition, it is useful to explore specific Buddhist traditions (such as Tibetan Buddhism) and the application of Buddhist ideas to particular issues in mental health (such as stress, self-harm, and suicide). Combining insights from Buddhism and psychiatry can help to optimise mental wellbeing, promote psychological healing, and deepen wisdom. Quite apart from mindfulness, Buddhism and psychiatry have a surprising amount in common, although they also differ in substantial, interesting ways. In the end, the relationship between Buddhism and psychiatry is a rich, rewarding one—and it is not all about mindfulness.

Keywords Mental disorder • Suicide • Self-harm • Stress • Mental health • Psychiatry • Buddhism • Psychotherapy • Mindfulness

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Buddhism, Psychotherapy, Psychiatry

This chapter focuses on 'Moving Beyond Mindfulness in Psychiatry' and explores certain links between Buddhist thought and elements of mental healthcare other than mindfulness. The chapter acknowledges a contemporary tendency to take mindfulness out of its cultural context despite the fact that the effects of contemplative practices vary considerably between people and across different settings. This recognition highlights the complexity of decontextualised meditative activities. This is followed by an exploration of areas of significant difference between Buddhism and psychiatry, including the concepts of 'self-esteem' and 'self', as well as ways to navigate these perspectives with thought, humility, and care.

The chapter then shifts focus to specific tenets of Buddhist psychology in the *Abhidharma*, which is a collection of psychological works from the traditional Buddhist canon. These ideas include Buddhist expositions of consciousness (including active cognitive processes and passive states) and 'dependent arising' (especially in the context of psychiatry). Attention is devoted to Tibetan Buddhist traditions pertaining to the identification and management of states which appear similar to 'mental disorders'; the potential role of the 'five precepts' of Buddhism (refraining from killing, stealing, sexual misconduct, incorrect speech (e.g., telling lies), and using intoxicants) in managing stress; and Buddhist approaches to self-harm and suicide.

Throughout the chapter, there is an emphasis on combining insights from Buddhism and psychiatry in order to optimise mental wellbeing, promote psychological healing, and deepen wisdom. Quite apart from mindfulness, Buddhism and psychiatry have a surprising amount in common, although they also differ in substantial, interesting ways. In the end, each tradition has a considerable amount to learn from the other—and it is not all about mindfulness.

Mindfulness Beyond 'Mindfulness'

Recent decades have seen a remarkable upsurge of interest in mindfulness. The various merits and demerits of this development were discussed in the previous chapter (Chap. 3: 'Treatment of Mental Disorders in Buddhism and Psychiatry'). While the popularity of mindfulness is positive overall, there is little doubt that certain versions of 'mindfulness' are over-sold,

simplified beyond what is reasonable, and consequently misunderstood. This is a pity.

Many, although not all, of these problems stem from removing techniques such as mindfulness from their social and cultural contexts, resulting in potential changes to the nature and effects of the practices (Kirmayer 2015). In other words, mindfulness in cultures without strong Buddhist traditions is likely to differ from mindfulness in more Buddhist contexts in terms of understanding, practice, and impact. If there is little knowledge of the origins of mindfulness and Buddhist understandings of the world, then the effects of mindfulness and other meditative practices are likely to vary.

In 2017, Lindahl and colleagues published an especially useful 'mixed-methods study of meditation-related challenges in Western Buddhists' (Lindahl et al. 2017). This study 'did not directly investigate meditation-related difficulties in mindfulness-based interventions' (p. 26), but used 'qualitative interviews with Western Buddhist meditation practitioners and experts in Theravāda, Zen, and Tibetan traditions' (p. 1) to develop 'a taxonomy of meditation-related experiences, with a special effort to capture under-reported experiences characterized as challenging, difficult, distressing, or impairing, and which may need specific kinds of support':

> Thematic content analysis yielded 59 categories of experiences across 7 domains, including cognitive, perceptual, affective, somatic, conative, sense of self, and social […] The valence and level of impact ranged from very positive to very negative, with the associated level of distress and functional impairment ranging from minimal and transient to severe and lasting. This range of experiences and impacts suggests that very few of the experiences were universally appraised as adverse. Instead, the valence and impact of any category of experience was dependent on a complex interaction with other influencing factors (Lindahl et al. 2017; pp. 24–25).

Socio-cultural context is likely to have a significant influence on an individual's appraisal of their experiences while meditating and afterwards:

> While one of the central aims of the [Varieties of Contemplative Experience] study is to understand the influence of meditation techniques on resultant experience, querying phenomenology within the broader context of influencing factors—some of which are sociocultural in nature—enhances our understanding of the impact of cultural contexts and conceptual frameworks on meditation experiences, as well as on how such experiences are appraised

> […] it may be the case that *some* of the 'adverse' responses to meditation experiences can be attributed to a lack of fit between practitioner goals and expectations and the normative frameworks of self-transformation found within the tradition. Thus, Western Buddhist practitioners not only have to navigate multiple interpretative frameworks, but also different opinions about which frameworks have authority. (Lindahl et al. 2017; p. 25)

Context therefore shapes experience when meditating, meaning that contemplative techniques are likely to have different consequences across various socio-cultural settings. In addition, several of the key concepts which inform Buddhist approaches differ significantly from analogous concepts in other settings.

For example, Buddhism teaches that the 'self' is not as firm, concrete, or unchanging as we imagine it to be. Instead, Buddhism presents the doctrine of 'non-self' (*anattā*), asserting that what we consider the 'self' arises owing to various causes and conditions, and is best seen as a fluid process rather than a fixed identity. While this approach might be regarded as conflicting with psychotherapies which often intensify the notion of selfhood, the Buddhist approach articulates a diffuse sense of self that is looser and more flexible (Meadows 2003). This idea can be therapeutic and liberating by demonstrating the possibility of positive, powerful change.

The Buddhist concept of 'non-self' nevertheless presents a profound challenge to the notion of 'self-esteem', which is a feature of much Western psychological thought (Michalon 2001). This challenge arises because the idea of self-esteem inherently assumes that a fixed 'self' can and should possess a certain degree of worthiness—an evaluative idea that can, paradoxically, lead to significant suffering. An approach based on self-acceptance is more likely to benefit many, combined with an awareness of the transience of the 'self'.

The principle of 'non-self' also introduces important considerations in the practice of psychoanalysis (Oh 2022), and the relationship between Buddhism and this particular field of psychotherapy is filled with potential (Kostner 2018). Addressing all of these opportunities and complexities across psychotherapy and psychiatry can yield substantial benefits, provided they are approached with careful thought, sensitivity, and humility (Osborne and Bhugra 2003). One size does not fit all.

Moving Deeper into Buddhism: The *Abhidharma*

Key tenets of Buddhist psychology are explored in the *Abhidharma*, a collection of psychological works from the traditional Buddhist canon (Bodhi 2000). In *Abhidharma* Buddhism, consciousness (*vijñāna*) is seen as a dynamic flow of discrete moments rather than a permanent self. Consciousness operates through both active cognitive processes and passive states. Like everything, consciousness arises conditionally owing to surrounding causes and conditions, and is subject to constant change (dependent arising).

By understanding consciousness as conditioned and impermanent, Buddhist practitioners can weaken attachment and make progress towards liberation (*nirvāṇa*). This paradigm emphasises insight into the conditioned nature of mind as a pathway to the end of suffering. To better appreciate the relationship between Buddhist psychology and Western psychotherapy and psychiatry, it is useful to explore the concepts of active cognitive processes, passive states, and dependent arising, as they are outlined in the *Abhidharma* and elsewhere in the Buddhist canon.

In Buddhism, the interplay between active cognitive processes and passive states is fundamental to understanding the nature of mind and attaining enlightenment. Active cognitive processes (*saṅkhāra*) are the mental formations that arise through deliberate thought, perception, and intention. These processes encompass our active engagement with the world, including planning, decision-making, and interpreting experiences. They form part of the 'five aggregates' (*khandhas*) that constitute human existence: form, sensation, perception, mental formations, and consciousness.

Saṅkhāra emphasises the role of volition (*cetanā*), which is the intentional mental force driving actions (*karma*). This active engagement can either perpetuate the cycle of suffering (*saṃsāra*) through attachment and aversion or, when developed through mindfulness and ethical conduct, lead towards liberation (*nirvāṇa*). Various meditation practices cultivate awareness of these cognitive processes, allowing practitioners to observe them and eventually transcend the habitual patterns that bind them.

By way of contrast, passive states in Buddhism relate to *passaddhi* (tranquillity) and *upekkhā* (equanimity). These states can emerge when the mind is free from agitation, craving, and aversion. Passive states are not inertia but reflect openness and receptivity, so that the mind rests naturally without grasping or rejecting phenomena. Achieving these states often

requires *samatha* meditation, which focuses on stillness and concentration.

In Buddhism, the dynamic relationship between active cognitive processes and passive states is an essential element of the path to enlightenment. While active processes can help to develop wisdom (*paññā*) by ascertaining the nature of reality, passive states cultivate the calm that is required to see things as they truly are. Growing familiarity with both aspects of the mind's activity allows practitioners to navigate life with clarity, compassion, and, hopefully, growing freedom from suffering.

These ideas about active cognitive processes and passive states are complemented by the concept of 'dependent arising', which lies at the heart of Buddhist thought. In essence, dependent arising (*pratītyasamutpāda*) describes the interconnected, inter-dependent nature of all phenomena. It explains how things come into existence, persist, and cease to be, not independently but owing to specific causes and conditions that surround them. Key to this doctrine is the idea that nothing exists in isolation; everything arises in dependence with other factors.

The resultant cycle of birth, death, and rebirth is termed *saṃsāra*. It represents the continuous suffering and impermanence experienced by sentient beings owing to attachment, desire, and delusion. In this cycle, actions (*karma*) influence future existences, trapping beings in a perpetual loop of dissatisfaction. Liberation from *saṃsāra* is achieved by attaining enlightenment (*nirvāṇa*), which requires understanding the 'four truths' of Buddhism and following the 'eightfold path' (see Chap. 2: 'Mental Disorder in Buddhism and Psychiatry'). By overcoming ignorance and desire, one can break free from *saṃsāra*, ending the cycle of rebirth and attaining lasting peace and liberation.

In the *Abhidharma*, breaking this cycle begins with eliminating ignorance. This means developing insight into the nature of *anicca* (impermanence), *dukkha* (suffering), and *anattā* (non-self). By understanding how conditions create experience, we can weaken craving and clinging, leading to liberation (*nirvāṇa*). Thus, dependent arising not only explains the origin and persistence of suffering and dissatisfaction, but also points the way to freedom from them.

These concepts and ideas in the *Abhidharma* can relate to psychotherapy and psychiatry in various different ways. The distinction between active cognitive processes and passive states is instinctually reasonable to many people and can inform psychotherapy by valuing both modes of being and re-negotiating the balance between them. The concept of

dependent arising indicates that suffering, like everything, is dependent on surrounding causes and conditions. All of these can and will change in time. This opens up real possibilities for healing, renewal, and growth.

In more specific terms, Strassman and Galanter published a paper in 1980 titled 'the *Abhidharma*: a cross-cultural model for the psychiatric application of meditation' (Strassman and Galanter 1980). These authors discussed the similarities and interchangeability of drug-induced 'highs' and states of consciousness in meditation outlined in the *Abhidharma*. They mooted the idea of exchanging one state of consciousness for another as a more rational approach to therapy in such cases. They also noted that the *Abhidharma*'s paradigm might be useful in elucidating the psychology of the 'expansion' of consciousness, and that dissections of cognitive, emotional, and perceptual experiences in Buddhist tradition could assist in exploring unconscious processes. The authors noted the cultural and religious underpinnings of the *Abhidharma* and consequent complexities in application, but they also pointed to emerging evidence that meditation appeared to help with certain conditions (e.g., headache).

Interest in using meditation to address various medical and psychiatric conditions has surged in recent decades, particularly with the rise of mindfulness-based interventions. However, much of this interest has shifted away from the detailed and systematic approach of the *Abhidharma*, focusing instead on highly selected aspects of Buddhist psychology rather than its complete framework. While this shift is understandable and pragmatic, it's extent is unfortunate. In narrowing the focus to this degree, a significant amount of valuable knowledge is set aside. As a result, practitioners miss out on the full depth of the *Abhidharma*, including its many sub-paradigms that could resonate with certain individuals and help to re-structure their thinking in positive, creative ways.

For example, the *Abhidharma* outlines 'four planes of consciousness' which some people might find helpful as they reflect on their habitual thought patterns, especially if they practise mindfulness or meditation:

1. Sense-sphere consciousness, which is generally linked with sensory desires
2. Fine-material-sphere consciousness, which is attained through meditation focussed on material phenomena (e.g., the breath)
3. Immaterial-sphere consciousness, which is attained through meditation focussed on non-material phenomena (e.g., infinity)

4. Supra-mundane consciousness, which supersedes other levels and is linked with the cessation of suffering or *nirvāṇa* (Kelly 2023)

These and other frameworks in the *Abhidharma* are often detailed, intricate, and exquisite. For that reason, various of them would likely resonate with certain people who find themselves in states of distress or who seek to re-structure their thinking or re-frame their psychological approach to life. In other words, the simplification of complex Buddhist thought into certain versions of 'mindfulness' has its merits, but it also has drawbacks and misses a great deal of the richness in Buddhist tradition.

Tibetan Buddhist Practices and Healing Traditions

Various schools of Buddhism offer different kinds of cultural richness, spiritual resources, and therapeutic potential in mental healthcare. Tibetan psychiatric tradition, for example, has tended to regard possession by evil spirits as a major cause of mental illness (Clifford 1984). Treatments included yogic and tantric practices ('magic') and the application and practice of religion (*dharma*). Throughout these therapeutic endeavours, there was particular emphasis on the Buddhist values of compassion and dedication to the wellbeing of others.

These ideas coexisted with a keen awareness of relationships between emotions and physiology, rooted in broader traditions of Tibetan medicine and, especially, the three 'humours'. The three 'humours' refer to the fundamental principles that sustain life and balance within the body. They are:

- Wind or air (*rLung*), which represents movement and energy flow, governing respiration, circulation, and neurological functions. Wind or air is linked with mental activities, mobility, and nervous system regulation.
- Bile (*mKhris-pa*), which symbolises heat and metabolic processes, managing digestion, liver functions, and body temperature. Bile is related to emotions like anger and decision-making abilities.
- Phlegm (*bad-kan*), which represents cohesion and stability, overseeing bodily fluids, immunity, and mental calmness. Phlegm is linked with traits such as attachment and lethargy.

Balancing the three humours is essential for health, according to Tibetan medicine. Imbalance produces illness. Wind (*rLung*) is the humour that is generally associated with problems of the mind or mental illness. Wind also controls the other two humours and mixes with them, indicating that Tibetan tradition recognised a psychological element in all illnesses, even physical conditions.

According to this paradigm, and drawing on Buddhist thought more broadly, there were five specific causes of 'insanity' in Tibetan medicine: *karma* (e.g., having brought suffering to someone in a past life), grief-worry (and similar psychological factors), physical (humoural) imbalances, poison (organic toxins), and 'evil spirits' or 'demons' (Clifford 1984). Treatments varied according to the cause of the disorder.

Treatments for humoural imbalances were proper food, a therapeutic environment, and human relationships. Other interventions included deep breathing, acupuncture, and moxibustion, which involves burning dried medicinal herbs on or near specific points of the body to balance the three humours. Herbal medicine could also be used to provide further relief from symptoms. As a result, the pharmacology of Tibetan medical psychiatry is extensive, including asafoetida, nutmeg, and clove.

In Tibetan traditions, 'evil spirits' or 'demons' are understood as symbols, often reflecting forces and emotions which are usually beyond conscious control. These can include unconscious tendencies (such as laziness) and attachment to wealth, emotional extremes, or spiritual pride. The Buddhist teachings of non-self (*anattā*) and dependent arising (*pratītyasamutpāda*) are relevant to treatment. Like the 'self', 'evil spirits' or 'demons' are devoid of concrete, lasting reality. They exist owing to external causes and conditions and are in states of constant change. Realising this truth is the pathway to healing.

In practice today, Tibetan communities often adopt a pluralistic approach in which narratives of mental illness commonly include religious dimensions (Deane 2018). This involves integrating traditional Buddhist approaches with contemporary psychiatric methods in a holistic manner. As we have discussed, Tibetan Buddhism has traditionally viewed mental illness through the lens of spiritual imbalance, often attributed to disrupted energies, *karma*, or afflictive emotions like anger and attachment. The resultant practices included meditation, mantras, and rituals aimed at restoring harmony and balance. The role of Tibetan lamas and monks in providing guidance and performing rituals remains significant in addressing both spiritual and psychological distress.

Increasingly, contemporary psychiatric approaches complement, but do not replace, this wisdom and these interventions. Tibetan practitioners frequently acknowledge the value of psychiatric medications and therapies, especially for severe mental health conditions. Clinics and hospitals in Tibetan regions often integrate psychotropic medications with traditional Tibetan medicine, which uses herbs and holistic treatments. Additionally, mindfulness and compassion-based therapies, rooted in Buddhist practice, are now recognised by both Tibetan healers and psychiatrists for their efficacy in treating anxiety, depression, and trauma.

This integration of traditional Buddhist practices and contemporary psychiatric methods reflects a pragmatic approach among Tibetan Buddhists, aimed at providing comprehensive mental healthcare. By embracing both spiritual and medical perspectives, they offer a balanced perspective that addresses the well-being of body, mind, and spirit.

Similarly, contemporary psychiatry increasingly incorporates Buddhist concepts into new and evolving clinical paradigms to address a range of mental health challenges. Beyond mindfulness-based therapies, various other forms of psychotherapy draw on Buddhist principles. For example, Morita therapy (Spencer 1964; Jia et al. 2018) and Naikan therapy (Reynolds 1977; Ozawa-de Silva 2015; Shen et al. 2024) are influenced by Buddhist thought, as are approaches that integrate Buddhist ideas with other psychotherapeutic traditions (Epstein 1995). These developments are likely to expand and evolve further in the coming years.

In addition to these clinical applications, Buddhist teachings and writings offer alternative ways to understand and alleviate suffering outside the conventional frameworks of mental illness, psychotherapy, and spirituality. These approaches often emphasise Buddhist ethical principles rather than explicitly psychotherapeutic ones. For instance, certain Buddhist paradigms offer useful approaches to managing stress and can provide valuable insights into cultivating fortitude. One example and possible application is considered next.

Stress and the 'Five Precepts' of Buddhism

Buddhism offers a comprehensive approach to managing stress and psychological symptoms through various of its psychological, philosophical, *and* ethical teachings. One of the many frameworks presented in the Buddhist canon is known as the 'five precepts' (*pañca-sila*). These precepts involve refraining from (1) killing, (2) stealing, (3) sexual

misconduct, (4) incorrect speech (e.g., telling lies), and (5) using intoxicants.[1] While these precepts primarily constitute ethical guidelines, their practical application can influence mental well-being by promoting mindfulness, self-discipline, and harmony—and addressing stress.

The first precept emphasises refraining from killing and extends beyond physical acts of harm to include the cultivation of compassion towards all sentient beings. This principle encourages people to adopt an attitude of empathy and kindness, which can counteract feelings of aggression and anger, both of which are key contributors to stress. By practising compassion meditation, individuals can reduce hostility and enhance positive emotions. Moreover, a decision to consciously avoid harming other beings generates a sense of integrity and self-acceptance, which can alleviate internal conflicts and reduce anxiety.

The second precept advises against stealing, which includes both material and non-material theft, such as time and intellectual property. Adhering to this precept promotes integrity and trustworthiness in relationships and reduces interpersonal conflicts, which are a significant source of stress. In addition, living honestly helps to prevent the guilt and cognitive dissonance which stem from unethical actions. Guilt can exacerbate symptoms of anxiety and depression, making this precept especially relevant for people dealing with these problems. By practising generosity and fair conduct, individuals can replace feelings of insecurity and scarcity with a sense of gratitude and abundance, which can buffer stress and enhance life satisfaction.

The third precept involves avoiding sexual misconduct, which includes any actions that result in harm or exploitation in relationships. This precept promotes mindfulness and self-control regarding one's actions and desires. Conducting ethical relationships reduces the stress associated with duplicity, betrayal, guilt, and relational instability. By contrast, impulsive and unethical behaviours can lead to anxiety, guilt, and complications in relationships. Mindful awareness of one's actions and intentions in relationships promotes healthier attachments and emotional intelligence, which can protect against depression and stress. Moreover, maintaining boundaries and respecting the autonomy of other people contribute to a supportive, stable social environment, which is essential for mental well-being.

[1] https://www.accesstoinsight.org/ptf/dhamma/sila/pancasila.html (accessed 12 March 2025).

The fourth precept encourages honesty and truthfulness, especially avoiding lies which are motivated by harmful intentions. Communicating honestly and living authentically prevent the cognitive dissonance that arises when our actions contradict our values. Cognitive dissonance is an acknowledged source of psychological distress, contributing to guilt, stress, and anxiety. Moreover, honest communication enhances clarity and trust in relationships, which can prevent conflict and misunderstandings, which are common stressors in day-to-day life. Practices such as mindful speech, which prioritises kind, truthful, and purposeful communication, can improve interpersonal dynamics and diminish the emotional burden of evasion, half-truths, or deceit.

The fifth precept advises against using intoxicants that cloud the mind, including drugs and alcohol. This precept articulates the importance of maintaining mindfulness and mental clarity, which are vital for managing psychological symptoms and stress. Intoxicants can impair judgment and intensify anxiety and depression. Moreover, reliance on substances as coping mechanisms hinders the development of healthier stress management strategies, such as physical exercise, mindfulness meditation, and reflective practices. Mindfulness practices, which accord with this precept, can help to enhance emotional regulation, reduce stress, and prevent relapse in people with substance use problems. By avoiding intoxicants, we can cultivate a focused mind that is better able to respond to stress with fortitude and equanimity (see Chap. 5: 'Equanimity in Buddhism and Psychiatry').

For some people, the ethical framework provided by the 'five precepts' can complement contemporary psychotherapeutic approaches, such as cognitive behaviour therapy (CBT) and acceptance and commitment therapy (ACT). The focus on truthfulness, for example, accords with CBT's focus on challenging cognitive distortions, and the practice of compassion is consistent with the acceptance component in ACT. In addition, the five precepts' focus on mindfulness and self-discipline can increase the efficacy of these therapies by encouraging individuals to develop healthier coping mechanisms and habits of ethical living, which are foundational for long-term well-being.

In these ways, the 'five precepts' of Buddhism can offer some people a useful, holistic approach to managing stress and psychological symptoms by prioritising ethical conduct, self-discipline, and mindfulness. By integrating these principles into day-to-day life, we can develop a stable and compassionate mind that is better able to navigate life's challenges with resilience and ease. As modern psychology increasingly acknowledges the

benefits of mindfulness and ethical living, the relevance of these teachings becomes ever more apparent in the creation of mental well-being.

In 2022, Wongpakaran and colleagues published a study of the 'moderating role of observing the five precepts of Buddhism on neuroticism, perceived stress, and depressive symptoms' (Wongpakaran et al. 2022). They found that 'observing the Five Precepts offers evidence that it buffers the effect of perceived stress on depression. People with high levels of observing the Five Precepts are less likely to develop depressive symptoms' (p. 1). They recommended that observing the 'five precepts' 'should be promoted even among the general population and those who have yet to experience stress':

> However, although Five Precepts can be viewed as healthy behaviors to be fostered for oneself and others, some, especially non-Buddhists, may find it uncomfortable when considering it as culture or religion related. Therefore, mental health professionals may adopt a careful approach emphasizing 'behaviors' rather than religious matters, the same way mindfulness meditation is recognized. Such an approach may make it more acceptable and open to practice and further research. (Wongpakaran et al. 2022; p. 11)

Incorporating the 'five precepts' into therapeutic processes does not mean adopting Buddhism as a religion but rather recognising the general psychological benefits of mindfulness, self-awareness, and ethical living. Psychotherapists can encourage certain clients to reflect on these principles in a secular manner, using them as tools for addressing stress and fostering healthy relationships, rather than as religious beliefs.

Self-Harm and Prevention of Suicide

The purpose of this chapter is to explore the relationships between Buddhism and psychiatry beyond considerations of 'mindfulness'. The chapter started by noting that the effects of contemplative practices vary considerably between people and across contexts, and conceptual differences also arise, often pertaining to concepts such as 'self', 'non-self', and 'self-esteem'. Addressing these complexities can yield substantial benefits, provided they are approached with sensitivity and humility. Moving beyond mindfulness also means exploring and making available the rich trove of concepts and frameworks outlined in the *Abhidharma*, as discussed above. In addition, it is useful to explore specific Buddhist

traditions, such as Tibetan Buddhism, and the application of Buddhist approaches to particular issues in mental health, such as stress.

The remainder of this chapter provides an overview of approaches to self-harm and suicide from Buddhist and psychiatric perspectives. There are commonalities and differences between Buddhism and psychiatry in relation to these matters, which merit discussion and exploration.

The over-arching point of commonality across Buddhism and psychiatry in relation to self-harm and suicide is that both traditions value human life deeply. The prevention of self-harm and suicide is one of the key features of psychiatry, as evidenced by psychiatry's focus on treating mental illness (at individual level) and programmes for the prevention of self-harm and suicide (at population level) (Kelly 2025). Buddhism also places profound value on life, seeing it as a rare and precious opportunity for spiritual growth and liberation. Central to this perspective is the principle of *ahimsa* (non-harm), which emphasises respect and compassion for all sentient beings. The first precept, which prohibits killing, further reflects this deep respect for life. In Buddhism, life is seen as a vehicle for cultivating ethical conduct, mindfulness, and wisdom, thus facilitating the journey to enlightenment. By celebrating the interconnectedness of all beings, Buddhism encourages actions that enhance and preserve life, fostering an ethical and compassionate approach to living harmoniously with others.

Notwithstanding the value that both psychiatry and Buddhism place on preserving life and preventing suicide, it is notable that both Western and Buddhist traditions demonstrate occasional, conditional acceptance of some forms of self-harm. For example, certain Western traditions acknowledge that, under specific circumstances, self-harm and even suicide can be seen as an act of altruism or a noble sacrifice (e.g., Saint Maximilian Kolbe who volunteered to die in the place of another man in the German death camp of Auschwitz in 1941). Western religious traditions, such as Christianity, have a lengthy history of regarding martyrdom as a form of sanctified self-harm, with martyrs sometimes regarded as saints.

In the Buddhist canon, suicide by enlightened individuals has sometimes been seen as blameless in certain circumstances, such as in the story of *Vālkali*, a spiritually advanced follower of Buddha who was ill and died by suicide but nevertheless attained *nirvāṇa* (Lamotte 1987; Sharma 1987). Self-immolation by monks from various schools of Buddhism has sometimes been seen as a way to attain awakening (Benn 2007) or as a protest against discrimination or oppression (Biggs 2005; Woser 2016). Self-burning is seen as a way to appeal to the moral consciousness of the

oppressor and the world in general, drawing attention to injustice without inflicting harm on other people. In Western history, self-immolation has been used to draw attention to political injustices, such as the self-immolation of Jan Palach in Czechoslovakia in 1969 to protest against Soviet oppression. While often interpreted through a pathological or psychological lens, such acts also resonate with a moral dimension similar to Buddhist interpretations of certain self-sacrifices.

Notwithstanding these areas of similarity across Buddhism and psychiatry, there are also differences in how self-harm is understood and interpreted. In Buddhism, views about the decision to engage in self-harm or suicide are often contextual, hinging on the motivations behind the act or its spiritual consequences. For instance, self-harm or suicide to apparently facilitate spiritual advancement features in the history of Buddhism, as further evidenced in the story of the monk *Godhika* whose spiritual progress was limited by illness, leading to spiritual frustration which prompted him to cut his throat. Despite Buddhism's overarching reverence for life, Buddha later stated that *Godhika* had attained *nirvāṇa*.[2] Western interpretations, significantly shaped by Christian theology and secular law, have tended to routinely frame self-harm as intrinsically sinful or pathological. The focus is often on individual suffering or individual mental ill-health. Many countries regard aiding and abetting suicide as a crime.

There is clear tension between spiritual and pathological interpretations of self-harm and suicide. The Buddhist perspective integrates concepts such as *dukkha* (suffering), *anattā* (non-self), and *ahimsa* (non-harm), viewing self-harm through a lens that emphasises both the deep value of life and its impermanence. The Buddhist teaching of rebirth also suggests that death does not represent escape from *saṃsāra*—the cycle of death and rebirth to which life in the material world is tied, according to Buddhism. In this paradigm, a suicidal impulse can be seen as craving for non-existence (Udomratn 2010). These ideas are relevant to conceptual approaches to suicide prevention in some settings, along with the fifth precept of Buddhism, which advises against the use of intoxicants such as drugs and alcohol—both of which are associated with suicidal behaviour (Disayavanish and Disayavanish 2007).

Western and psychiatric frameworks tend to interpret self-harm as a sign of individual psychological distress, which is often deeply relevant and

[2] For a discussion of this and other stories such as that of *Channa*, another monk, see: Pio 1988; Kelly 2011.

profoundly helpful in individual cases, but sometimes ignores spiritual dimensions, altruistic explanations, and socio-economic factors. This narrow focus can limit the understanding of the complexities of these acts and therefore hamper the provision of care and support, as well as prevention.

Exploring the similarities and differences in Buddhist approaches to self-harm and suicide and Western and psychiatric approaches shows that there are different ways to think about these behaviours and to interpret them. Understanding the cultural and spiritual contexts of self-harm can lead to more empathetic treatments and forms of support. Therapists who appreciate how spiritual and religious factors might relate to self-harm in some people can provide more nuanced care. This might involve acknowledging the potential or perceived altruism in certain acts of self-harm and factoring this into the conversation.

At the level of healthcare systems, policies addressing self-harm and suicide can benefit from incorporating a deeper understanding of cultural and spiritual contexts when this is appropriate. The potential for improved therapeutic practices, culturally sensitive policy development, and enriched empathy for people who self-harm, underlines the value of comparative analyses across spiritual, psychological, and cultural traditions. This can support a more integrated approach to understanding self-harm and suicide—one that respects the true complexities of these experiences and behaviours.

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CHAPTER 5

Equanimity in Buddhism and Psychiatry

Abstract Equanimity is an important concept in the relationship between Buddhist tradition and contemporary mental healthcare. In both practices, equanimity matters deeply, so it represents a useful point of interaction between Buddhism and psychiatry. In the history of medicine, equanimity has been emphasised by such figures as Irish asylum doctor James Duncan (1812–1895) and Canadian physician Sir William Osler (1849–1919). Recent decades have seen a remarkable growth in literature linking various aspects of Buddhism with psychiatric care, as well as cross-cultural conceptualisations of equanimity and emotional equilibrium. Links with Buddhist thought include the 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition, which are loving-kindness (*mettā*), compassion (*karuṇā*), empathetic joy (*muditā*), and equanimity (*upekkhā*). This chapter discusses the resonances between Buddhism and psychiatry in this context, along with the limits of equanimity and the need for other values to complement it. The chapter concludes by presenting evidence of the benefits of cultivating equanimity in the general population and among health professionals, along with practical ways to deepen equanimity, especially in psychiatry but also more broadly. These approaches focus on five key themes: (a) emotional awareness; (b) mindfulness; (c) reflective practices; (d) self-compassion and self-care; (e) anchoring in professional purpose.

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Equanimity in Buddhist Thought and Medical Practice

This chapter focuses on an important but relatively neglected concept in the relationship between Buddhist tradition and contemporary mental healthcare: 'Equanimity'. This chapter argues that the concept of equanimity represents a useful point of interaction between the two practices and merits careful consideration and engagement. In short, equanimity matters deeply in both Buddhism and psychiatry. It rewards close attention and conscious thought.

The chapter starts by exploring conceptualisations of equanimity in the histories of psychiatry and medicine, with particular reference to the work of Irish asylum doctor James Duncan (1812–1895) and Canadian physician Sir William Osler (1849–1919), both of whom emphasised equanimity in clinical care. More recent literature explores links between psychiatric nursing and Zen Buddhism, as well as cross-cultural conceptualisations of equanimity and emotional equilibrium. Links with Buddhist thought include the 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition, which are loving-kindness (*mettā*), compassion (*karuṇā*), empathetic joy (*muditā*), and equanimity (*upekkhā*). These are explored in some detail and linked with equivalent values in the histories of psychiatry and medicine.

This chapter then discusses the limits of equanimity and explores the need for other values to complement equanimity in clinical practice. The chapter concludes by presenting evidence of the benefits of cultivating equanimity in the general population and among health professionals, along with practical ways to deepen equanimity, especially in psychiatry but also more broadly. These approaches focus on five key themes: (a) emotional awareness; (b) mindfulness; (c) reflective practices; (d) self-compassion and self-care; (e) anchoring in professional purpose.

Equanimity in Medicine and Mental Healthcare

Equanimity has featured episodically but repeatedly in the histories of psychiatry and medicine, most notably through the writings of prominent physicians and educators. In Ireland, asylum doctor James Duncan (1812–1895) placed particular emphasis on cultivating an aura of calmness and imperturbability in the interests of minimising suffering:

> Can anything be imagined more calculated to guard against the inroad of disease than such a state of calm contentedness? It is the impetuosity of our feelings that most generally gives rise to derangement. The ebb as well as the flow of the tide of passion is full of danger. Where these do not occur, or where they are kept within proper bounds, there is little ground for apprehension. The equanimity of temper that is produced by a well-regulated mind is really of the greatest use; and no means ought to be spared in the education of young persons to secure for them this inestimable blessing. (Duncan 1853; pp. 156–7)

Duncan duly brought this value into his medical and psychiatric practice, prioritising the 'inestimable blessing' of 'equanimity of temper' and 'a well-regulated mind'.

Celebrated Canadian physician and educator Sir William Osler (1849–1919) also emphasised equanimity (Sokol 2007). In *Aequanimitas*, Osler argued that, 'in the physician or surgeon no quality takes rank with imperturbability', which 'means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgement in moments of grave peril' (Osler 1906; pp. 3–4). In Osler's view, equanimity did *not* imply detachment, because 'a clear knowledge of our relation to our fellow-creatures and to the work of life is also indispensable' (p. 6). Neither did equanimity mean any lack of engagement, empathy, or compassion. In fact, these values lie at the heart of clinical care. Judicious equanimity is required to maintain and deepen them.

Recent decades have seen a growth in literature linking various aspects of Buddhism with psychiatric care including, for example, links between Zen Buddhism and psychiatric nursing (Barker 1996). There have also been extremely useful explorations of 'tranquility' across cultures:

> From time immemorial, human beings have longed and strived for tranquility. Testimonies of this are widespread in sacred, philosophical, and medical texts, literature, and art. Throughout history and across cultures,

> contemplative, philosophical, spiritual, religious, and mystical traditions have developed their own practices to reach certain experiences of tranquility […] In many Eastern traditions and practices (e.g., the six Brahmanic or orthodox schools such as Yoga, the non-orthodox or Shramanic schools of Indian philosophy such as Buddhism, Chinese traditions such as Daoism, etc.), tranquility has been a key focus for several thousand years. (Christoffersen et al. 2022; pp. 1, 2)

There are many cross-cultural conceptualisations of 'emotional equilibrium or equanimity' which merit reflection and comparison. Specific 'examples of historical concepts of emotional tranquilities' include '*apatheia* of the stoics, *ataraxia* of the stoics, skeptics, and epicureans, *metriopatheia* by Aristotle, Crantor, and Augustine, *vairagya* and *pratyahara* in Yoga, and *passaddhi* and *upekkha* in Buddhism' (Christoffersen et al. 2022; p. 3).

Passaddhi, which is often translated as 'calmness' or 'tranquillity', refers to the quieting and soothing of body and mind. *Passaddhi* arises when agitation of the mind settles. It is cultivated through ethical living, mindfulness, and meditative practice. It is a form of tranquillity that is not dull, lifeless, or detached. It is characterised by clarity, awareness, and equanimity. In Buddhism, *passaddhi* is seen as a medicine for anxiety and restlessness. It encourages an untroubled, composed approach to life's challenges, helping us to respond with wisdom and awareness, rather than reactivity. *Upekkhā* or 'equanimity' is considered further in the next section of this chapter, as one of the 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition.

It is important to emphasise that these ideas about tranquillity, calmness, and equanimity do not equate with simple disconnection from emotions or events. As Christoffersen and colleagues point out, 'experiences of tranquility seem also to share, again in varying degrees, a two-sided *structural* feature of detachment and absorption':

> Detachment has been a key concept in several schools of thought in East and West, reflected in concepts such as *vairagya* in Yoga and *Abgeschiedenheit* in the works of Meister Eckhart. Etymologically, 'to detach' (from old French, *destachier*; *des* 'apart' and *attachier* 'attach or connect') means 'to untie' or 'to disconnect.' Detachment comes in different degrees, ranging from a limited kind that concerns only one domain (e.g., the disconnection from passions in *apatheia*) to an unlimited kind in which everything

> eventually is obliterated from consciousness (e.g., in *asamprajnata samadhi*). (Christoffersen et al. 2022; p. 6)

In addition, however, 'the detachment that characterizes tranquil experiences seems simultaneously to imply some degree of absorption into another kind of awareness' (Christoffersen et al. 2022; p. 7). Writing in the context of psychiatry, Uebel notes that genuine equanimity involves the vibrancy and awareness of a mind that is awakened (Uebel 2024). This is a key point for equanimity in clinical care: equanimity in this setting does not mean stepping away, but stepping towards, with awareness, steadiness, and calm.

In medicine, then, equanimity embraces Duncan's 'equanimity of temper' and 'well-regulated mind' (Duncan 1853; p. 157), Osler's 'coolness and presence of mind under all circumstances' (Osler 1906; p. 4), the *passaddhi* or calmness of Buddhism, and a quality of engagement, awakeness, and absorption to ensure we remain connected with our tasks and with those around us. A curious balance of detachment and engagement is needed, tempered with kindness, consideration, and ethical conduct to maintain a steady focus on what truly matters.

The 'Four Immeasurables' of Buddhist Thought

The link between equanimity in medicine and in Buddhist thought is underpinned by the 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition. These are four universal and boundless qualities of heart and mind that practitioners of Buddhism are encouraged to cultivate. These qualities or values are regarded as the basis of a compassionate, ethical, and awakened life, seeking to dissolve barriers between ourselves and others. Practising the Four Immeasurables helps to deepen an attitude of unconditional goodwill towards all beings without limit, without discrimination, and without judgement.

The Four Immeasurables are loving-kindness (*mettā*), compassion (*karuṇā*), empathetic joy (*muditā*), and equanimity (*upekkhā*) (Wallace 2010; Feldman 2017). It is useful to consider each of these qualities in turn, and to explore their relationships with the practice of medicine in general and psychiatry in particular.

Loving-kindness or benevolence (*mettā*) is the first of the Four Immeasurables. It refers to an all-encompassing and unconditional love that is free from attachment, expectation, or self-interest. *Mettā* is the

heartfelt wish for the well-being and happiness of all beings, regardless of their relationship to us and regardless of other factors which commonly cloud our judgement. *Mettā* is a warm, open-hearted friendliness that is extended equally to ourselves, loved ones, strangers, and even people whom we find difficult. *Mettā* is not possessive or dependent on how other people treat us. Rather, it seeks to dissolve barriers of fear, judgment, or resentment, and encourage kindness in thought, word, and deed.

In medicine, deepening *mettā* means developing therapeutic relationships that are honest, open, and unaffected by prejudice or personal judgement. In this way, *mettā* reflects the interconnectedness of all life, fostering a sense of universal belonging that lies at the heart of good clinical care. *Mettā* supports connecting with others, helping with their problems, supporting them in their suffering, behaving ethically, and cultivating compassion, equanimity, and sympathetic joy. All of these values lie at the heart of good medicine and good psychiatric care.

Compassion or *karuṇā* is the second of the Four Immeasurables. Buddhism sees *karuṇā* as the natural response of the heart when confronted with suffering. *Karuṇā* is the genuine desire to alleviate hardship and pain, rooted in deep sensitivity to the fragility and vulnerability of life. *Karuṇā* arises from understanding that suffering is universal. Nobody is exempt from disappointment, loss, illness, or death. Genuine compassion acknowledges these shared human experiences and approaches other people with care, empathy, and the intention to help.

In medicine, compassion means actively developing kindness, patience, and an attitude of service to others. It encourages wise and skilful action when faced with difficulty and challenge. *Karuṇā* extends to all beings, consistent with the boundless nature of the awakened heart. In this way, it reflects the missions of medicine and psychiatry to alleviate suffering with kindness, knowledge, and compassion. In clinical care, compassion is the feeling of being motivated to act in the presence of suffering. For clinicians who are expected to be compassionate in their everyday life or work, compassion requires sustained courage and a continued willingness to engage with suffering, rather than avoiding it (Behan and Kelly 2025). This can prove challenging, but it is profoundly worthwhile and is essential in medicine.

Empathetic joy or altruistic joy (*muditā*) is the third of the Four Immeasurables. *Muditā* refers to the capacity to take delight in the success, happiness, and well-being of other people without jealousy, envy, or comparison. *Muditā* arises from a heart which is free from possessiveness

and selfishness, and which is able to celebrate joy, beauty, and accomplishment wherever they are seen. Developing this quality means nurturing a sense of abundance, and understanding that joy is not a finite resource. *Muditā* is sometimes considered the most challenging of the Four Immeasurables, because it requires an open heart that does not cling to status or ego.

In medicine and psychiatry, *muditā* supports a profound and often underappreciated emotional and ethical perspective. Healthcare professionals are trained to alleviate suffering, but the ability to truly rejoice in a patient's resilience, recovery, or even small improvements can transform clinical care. It can shift the practitioner's focus from a deficit-based paradigm to a deeper appreciation of human strength and dignity. In psychiatry, where progress can be non-linear and gradual, *muditā* nurtures hope and patience. It helps clinicians to celebrate early steps in recovery, growing ability to reconnect with others, and return of self-agency.

Cultivating *muditā* can also serve as an antidote to emotional exhaustion and professional burnout. Instead of being overwhelmed by suffering, the healthcare professional becomes emotionally nourished by witnessing resilience and recovery. *Muditā* connects clinical work with human flourishing—not only healing specific conditions, but sustaining a generous, joyous, and liberated way of living and connecting with others.

Equanimity or serene impartiality (*upekkhā*) is the fourth of the Four Immeasurables and is often considered to be their crowning quality. *Upekkhā* is a state of inner balance, emotional steadiness, and mental clarity that remains relatively undisturbed by surrounding events. *Upekkhā* is not indifference or cold detachment. It is active, wise acceptance of the uncontrollable and impermanent nature of life. It allows us to engage with the world joyfully and compassionately, without being overwhelmed by aversion, attachment, or other unskilful responses to passing circumstances and events.

In medicine, *upekkhā* provides the spaciousness to respond to challenges with clarity and calm rather than impulsive reaction. When combined with loving-kindness, compassion, and sympathetic joy, *upekkhā* enhances clinical relationships and provides valuable grounding in difficult circumstances. Most of all, *upekkhā* demonstrates a commitment to calm abiding, regardless of diagnosis, prognosis, or untoward medical events. In this way, *upekkhā* allows healthcare workers to care deeply without being destabilised by the inevitable setbacks, suffering, or losses we encounter in our work.

In psychiatry, where human vulnerability and emotional complexity are ever-present, *upekkhā* nurtures clear-sighted engagement with people in states of advanced distress. It helps clinicians to avoid over-identifying with patients, developing rescuing tendencies, or withdrawing emotionally. *Upekkhā* allows healthcare professionals to hold space for distress without judging, while also attending to professional boundaries and sustaining personal stability. This stance supports ethical decision-making, reduces the risk of compassion fatigue, and consolidates long-term commitment to care.

Limits of Equanimity in Thought and Practice

The idea of equanimity (*upekkhā*) in clinical care acknowledges that suffering and healing unfold owing to many causes, some of which are beyond the clinician's control, and some of which can be managed by the healthcare team. As a result of this balanced approach, equanimity helps to build a foundation for resilient, wise, sustainable care. It balances reasonable care with reasonable expectation. It reflects both the imperative to act to alleviate suffering and the need for acceptance and solidarity in the face of setbacks. In short, equanimity promotes a sense of calm abiding in difficult, changing circumstances.

However, while equanimity is undoubtedly valuable, it has significant limitations on its own. There are situations where too much emotional detachment can be unhelpful, or even harmful, especially if it is not accompanied by appropriate engagement with care. The key limits of equanimity in medicine relate to emotional authenticity, interpersonal relationships, avoidance of engagement, and ethical concerns owing to excessive or inappropriate equanimity. We will consider each of these in turn.

One of the primary critiques of equanimity relates to emotional authenticity. In seeking to remain composed at all times, healthcare professionals can suppress natural emotional responses—such as grief or joy—which are important for human connection and psychological wellbeing. For instance, expressing anger in the face of injustice or sharing sadness at the death of a patient can be both necessary and appropriate. A state of unwavering equanimity can dilute the richness of emotional life, leading to disengagement or numbness. This is especially relevant in clinical settings, where equanimity may be mistaken for avoidance of difficult feelings rather than healthy management of them.

Another limitation of equanimity centres on interpersonal relationships. Human connection is built not only on calm and stability, but also on spontaneity, empathy, and engagement. A person who remains perpetually tranquil or continually calm might be perceived as disengaged or distant. At emotionally charged moments, people often seek appropriate emotional resonance, rather than detachment from others. Excessive equanimity can fail to realise these opportunities for therapeutic support and thus diminish relationships in the clinical setting. Appropriate equanimity enhances relationships at such times, but rigid emotional stances do not.

In addition to these concerns about emotional authenticity and interpersonal engagement, some people can inadvertently misuse equanimity as a way to avoid confrontation, conflict, or accountability. They can hide behind a veneer of calmness instead of addressing underlying issues. This, along with all excessive equanimity, has the further demerit of not being sustainable in the longer term. At times of intense stress or trauma, even the most trained, self-regulated mind can struggle to stay balanced. Unwavering commitment to the ideal of equanimity can be an unrealistic standard in these situations. Such a position can erode trust, rather than build it. It can also lead to an inappropriate sense of personal failure. Equanimity is often very helpful, but it is not always the answer.

Finally, excessive equanimity can be ethically problematic in certain contexts. In a world filled with inequality, suffering, and negative outcomes, there are times when emotion, responsiveness, and active engagement are morally necessary. Political activists and human rights defenders often act precisely because they permit themselves to feel deeply disturbed. In this context, equanimity can reflect moral disengagement, especially if it leads us away from collective responsibility.

Christoffersen and colleagues discuss the importance of an 'ethical life' in their exploration of 'Eastern and Western perspectives' on 'tranquillity':

> Finally, our description of tranquility would be incomplete if we failed to mention that to reach most of the described tranquil experiences, it is, across traditions such as stoicism or yoga, Buddhism or Christianity, considered a prerequisite to live an ethical-spiritual life in accordance with the culturally or spiritually defined virtues and rules; or, as bluntly stated in the Book of Isaiah, 'there is no peace for the wicked' (48:22). Although living an ethical

> life usually is considered a prerequisite for experiencing tranquility, ethical living is not itself a tranquil experience. (Christoffersen et al. 2022; p. 7)

In medicine and psychiatry, equanimity is a powerful tool for clarity and resilience, but it must be accompanied by ethical engagement, emotional honesty, and relational sensitivity. Other values which are essential in mental healthcare include a sense of justice, self-awareness, and a sense of beauty (Kelly and Feeney 2006), along with knowledge, moderation, and leadership skills (Kalra et al. 2017).

Like all virtues, equanimity is most effective when used in balance—not as a shield from the intensity of clinical work, but as a steady anchor within it. Recognising the limits of equanimity allows equanimity to serve as a companion to the other three of the Four Immeasurables of Buddhist thought: loving-kindness (*mettā*), compassion (*karuṇā*), and empathetic joy (*muditā*). When combined with equanimity and knowledge, these qualities form the core of effective, humane clinical care (Kalra et al. 2018).

Benefits of Equanimity

So far in this chapter, we have considered the idea that equanimity is an important but relatively neglected concept in the relationship between Buddhist tradition and contemporary mental healthcare. In the history of medicine, equanimity has been emphasised by various prominent figures, such as Duncan and Osler. Recent decades have seen a notable expansion in literature about Buddhism and psychiatry. The 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition are a point of particular continuity with medicine: loving-kindness (*mettā*), compassion (*karuṇā*), empathetic joy (*muditā*), and equanimity (*upekkhā*).

This chapter concludes by exploring evidence of the benefits of cultivating equanimity, both in the general population and among health professionals. Does a focus on equanimity actually help? If so, how? This chapter also considers practical ways to deepen equanimity and convey an appropriate level of equanimity in psychiatry and mental healthcare.

Equanimity is an important outcome in research about meditation and contemplative practices in order to understand how these activities can improve wellbeing (Desbordes et al. 2015). In 2021, Wongpakaran and colleagues researched the 'role of equanimity on the mediation model of neuroticism, perceived stress and depressive symptoms' among '644 general participants' in their study:

> The present study investigated the extent to which neuroticism, perceived stress and equanimity influenced depressive symptoms […] high levels of equanimity were associated with decreased depressive symptoms […] As hypothesized, equanimity not only serves as a mediator for perceived stress or neuroticism and depression, but also as a moderator for those relationships. In other words, equanimity has a mediating effect on neuroticism and perceived stress, and has a buffering effect on depressive symptoms related to neuroticism and perceived stress. (Wongpakaran et al. 2021; p. 9)

The following year, Francis and colleagues published 'a randomized controlled trial' of 'group mindfulness-integrated cognitive behavior therapy (MiCBT)' and noted the centrality of equanimity in this therapeutic intervention:

> In MiCBT, interoceptive awareness and equanimity are achieved through a process of systematic exposure to body sensations using a sequence of body scanning exercises to practice and cultivate equanimity toward body sensations. Since habitual reactivity is a common factor shared by numerous mental health conditions (Vøllestad et al. 2011), treatments which address these underlying processes are likely to have transdiagnostic effects. (Francis et al. 2022; p. 2)

This research group duly found that MiCBT reduced levels of depression, anxiety, and stress, and improved flourishing significantly more than treatment as usual. In a remarkably valuable analysis of their results, they confirm equanimity as a key 'change variable' in this intervention:

> Results of parallel mediation models suggested that equanimity was the most important change variable for symptom reduction and interpersonal skills did not show a significant mediation effect for flourishing when compared to awareness (decentring) and equanimity. That equanimity was the most important change variable is consistent with the theoretical framework provided by the co-emergence model of reinforcement (Cayoun and Shires 2020). Specifically, the acquisition of equanimity is facilitated by scanning the body systematically in detail without reacting to perceived body sensations. (Francis et al. 2022; p. 11)

Research among healthcare professionals also accords significant weight to equanimity. In 2023, Brun and colleagues published 'a qualitative study' of 'mindfulness and compassion training for health professionals'

(Brun et al. 2023). This group found that 'the training had an overall positive impact' on healthcare professionals' 'ability to feel compassion toward their patients and themselves, helped them develop kindness toward themselves and their patients, and enhanced their attention to their patient's needs and theirs' (Brun et al. 2023; p. 1). In addition, 'participants were better able to accept the difficult work experiences or those their patients experienced, with more perceived equanimity and less reactivity'.

So, in light of the value of equanimity (while also mindful of its limitations), and given the evidence supporting equanimity for wellbeing among healthcare workers, what can we do to cultivate greater equanimity? What steps can mental healthcare professionals and other people take to improve our levels of equanimity, and accord it an appropriate role in our lives?

Cultivating Equanimity in Mental Healthcare and Elsewhere

In order to cultivate greater equanimity in psychiatry, it is important to recognise that healthcare settings are often intrinsically deeply demanding, regardless of our levels of equanimity. Clinical situations are frequently characterised by unpredictability, urgency, and emotional intensity. These appear to be unavoidable qualities of the field in which healthcare professionals have chosen to work. These circumstances are not the result of our doing, but we still need to deal with them and operate within them.

As Duncan and Osler understood, the ability to remain balanced, calm, and composed in such settings is both therapeutic and challenging. As the Four Immeasurables of Buddhism confirm more generally, equanimity—along with loving-kindness, compassion, and empathetic joy—is an essential requirement for wellbeing and authentic connection with other people. When we care, we cure.

So, against this background, how can we use this knowledge to cultivate greater equanimity in healthcare in general and psychiatry in particular? What steps can we take in practice?

The following suggestions focus on mental healthcare professionals but can be applied more generally. They centre on five key themes: (a) emotional awareness; (b) mindfulness; (c) reflective practices; (d) self-compassion and self-care; (e) anchoring in professional purpose. These ideas are informed by both Buddhist thought and the growing literature

that supports the value of mindfulness and self-awareness, provided these are practised with an appreciation of their benefits and due cognisance of their limitations.

(a) *Emotional Awareness*

First, for the cultivation of equanimity, it is useful to deepen our self-awareness, including awareness of emotions in our day-to-day lives. In psychiatry, this means actively noticing the often-intense feelings that arise in the complex circumstances of mental healthcare, and viewing these feelings with as much equanimity as feasible. This is not always easy, but it is a deeply useful habit to develop.

Equanimity does not mean suppressing our emotions or denying them, but, rather, being aware of our feelings without getting overwhelmed by them. Conscious emotional literacy helps: e.g., acknowledging and naming each feeling as it arises. This simple cognitive practice can help us to respond to situations with awareness, rather than reacting in the moment. Often, the emotions that arise at a specific instant will either diminish when they are brought into awareness or dissipate when they are named (e.g., a flash of excessive anger owing to a minor impediment in our day). Emotional literacy recognises the power of these brief emotions, and manages them better.

(b) *Mindfulness*

A commitment to mindfulness practice can support emotional awareness and other aspects of equanimity. We explored mindfulness in some depth earlier in this book, noting its nature and many benefits, but also its limitations (see Chap. 3: 'Treatment of Mental Disorders in Buddhism and Psychiatry'). Mindfulness is not the answer to everything, but it is a reliably useful skill or habit of mind, especially in healthcare.

In terms of specific benefits, mindfulness trains our attention to stay in the present moment as much as possible. It means observing sensations, emotions, and thoughts that arise without getting excessively involved with them. Regular mindfulness practice, even for 15 minutes each day, can enhance emotional regulation, reduce reactivity, and cultivate a calmer, more resilient state of mind. For some people, this means sitting and focusing on the breath, but there are many other opportunities for mindfulness. These include mindfulness of movement (e.g., while walking to work) or deepen-

ing our moment-to-moment awareness during routine activities (e.g., cooking or eating).

It is important for health professionals to note that mindfulness does not mean internalising responsibility for impossible circumstances, accepting unreasonable working conditions, or ignoring injustice when we see it. Mindfulness means noticing what is present in the moment, simply and directly. A great deal of what we experience in each moment are feelings rather than facts. While feelings are important, they are not always based on reality. Being mindful of this, we come to recognise feelings as feelings, not as facts. This allows excessive or unfounded emotions to abate. That leaves us with the facts in each situation, and our feelings about those facts. This approach results in greater equanimity and a clearer vision of what we need to do next; e.g., help people in distress, prevent suffering when we can, or take political action against injustice (Kelly 2023).

In essence, mindfulness means looking reality in the eyes, rather than hiding from it. It means getting engaged, not enraged. It means standing up, not sitting down.

(c) *Reflective Practices*

Developing from the theme of mindfulness, it is useful for healthcare workers and other people who seek deeper equanimity to engage in reflective practices such as supervision, peer discussion, or journaling. This means designating time to look back on personal reactions, difficult encounters, positive outcomes, and potential lessons learned. It is important to approach this activity in a safe, supportive space that allows genuine openness to new thoughts and fresh perspectives. In Buddhism, this mindset is known as 'beginner's mind'. This approach is characterised by curiosity and openness, rather than assumptions or pre-judgments. This mindset can reduce frustration, allow more thoughtful reflection, and deepen equanimity, provided there is a supportive context for this to occur.

Peer support is an especially important element of reflective practice in psychiatry. Much mental healthcare is delivered by multi-disciplinary teams which offer valuable opportunities for learning from other team members with different clinical backgrounds. Regular discussions with trusted colleagues about the emotional complexities of working in psychiatry can be grounding and enlightening for all. Supervision structures, peer support groups, and informal debriefings after particular events help to

normalise emotional reactions and reassure professionals that they are not alone (Foley and Kelly 2007).

Approaching these activities with a Buddhist 'beginner's mind' reduces defensiveness and reactivity, and helps us to learn with equanimity. This kind of supervision and peer-support also acknowledges the common humanity that lies at the heart of both good psychiatric practice and Buddhist thought. This is further reflected by the Four Immeasurables in the forms of loving-kindness, compassion, and empathetic joy, along with equanimity. We are never alone.

Reflective practices also help us to develop the equanimity to accept what we cannot control in healthcare, which accounts for a great deal of what we encounter each day. These uncontrollable factors often include landscapes of injustice that generate so much suffering in the first place, the outcomes of certain conditions with poor prognosis, and the limited resources available in many systems of health and social care. The support and understanding of peers can help to manage these daily frustrations and unburden individuals who feel excessive responsibility for outcomes which are largely beyond their control.

This, in turn, deepens equanimity by helping us to distinguish between what we can change today and what we must accept for now. Thus, we can focus our energies wisely: providing patient care with the resources available to us today and—in parallel—seeking systemic change for health justice in the longer term.

In this way, cultivating equanimity does not mean being passive. Quite the opposite: equanimity means calm abiding, steadiness, and resolute commitment to our goals.

(d) *Self-compassion and Self-care*

Self-care is a key element of equanimity and cultivating a settled mind. This means paying attention to nutrition, physical exercise, and sleep patterns, especially for shift workers. These basic biological considerations are foundational to emotional stability, mental clarity, and greater equanimity. Simple, direct actions like stepping outside for fresh air or taking 'breaks to breathe' at work can help to restore balance and recalibrate emotions throughout the day. It is also useful to consciously ground our minds in the earth, possibly using a short mindfulness practice for equanimity (Bays 2022; p. 196).

Taking a broader perspective, setting healthy boundaries is an act of profound self-care in a field such as psychiatry, where the needs of patients and families can feel infinite. Healthcare

professionals are naturally empathetic, often having entered their field for that very reason. However, over-identifying with patients' suffering can contribute to compassion fatigue and emotional exhaustion. Combining compassion with clear professional boundaries reduces work-related stress, helps to maintain internal steadiness, and enhances equanimity.

Buddhism teaches that the boundaries between self and others are not as firm or as clear as we imagine them to be (see Chap. 4: 'Moving Beyond Mindfulness in Psychiatry'). Instead, Buddhism articulates the idea of 'non-self' (*anattā*), suggesting that what we consider the 'self' arises owing to various causes and conditions, and is best seen as a fluid process rather than a fixed identity. From this perspective, compassion for ourselves forms a seamless part of compassion for other people, who also suffer and seek to be happy in the same ways that we do.

Practising self-care and self-compassion, and acknowledging one's limits, diminishes stress, supports emotional balance, enhances connections with other people, and fosters equanimity. As part of this process, cultivating compassion towards ourselves and our colleagues nurtures a more supportive, equanimous work environment for all.

(e) *Anchoring in Professional Purpose*

Finally, and in addition to focusing on emotional awareness, mindfulness, reflective practices, and self-care, healthcare workers can enhance equanimity by anchoring ourselves in professional purpose. In healthcare, as in Buddhism, the intention is to alleviate suffering. Equanimity is easier to build and sustain when we remain connected to this deeper purpose in our work. Reflecting on our desire to help others, our personal values, and the meaning behind routine tasks provides perspective when the challenges of clinical care feel overwhelming.

In all work roles, professional purpose is a valuable reminder that equanimity does not mean indifference or emotional detachment. It means maintaining clarity and balance amidst the inevitable challenges of healthcare and psychiatry, as well as during positive, rewarding times. Equanimity means fostering compassion, resilience, and calm presence.

Most importantly, equanimity results in better care for our patients, so it benefits both them and us. This matters deeply because, in the end, there is no 'them'. There is only 'us'.

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CHAPTER 6

Conclusions: Buddhism, Psychiatry, Mindfulness

Abstract There are valuable links, echoes, and resonances between Buddhism and psychiatry, including (but not limited to) mindfulness. Many of these shared insights can help with understanding, therapy, and alleviation of suffering. 'Equanimity' is a point of particular continuity between traditions and could usefully be accorded greater importance across mental healthcare. Several aspects of the relationship between Buddhism and psychiatry would benefit from further research: the neurobiology and physiology of meditation; Buddhist concepts of 'non-self' and 'emptiness' as they relate to Western psychotherapy; the challenges that much Buddhist thought presents to how we see ourselves as individuals (rather than being essentially continuous with other people); the symbiotic relations between psychiatry and a broader range of spiritual, religious, and philosophical traditions, not just Buddhism. As with all Buddhist advice, these thoughts are presented with humility and the intention of alleviating suffering. The invitation is not to change the world, but to try to consciously practise mindfulness, equanimity, or similar techniques each day, even for a few minutes. If we focus on the present moment for a little longer, with a little less distraction, and a little more equanimity, we connect better, heal more, and find the earth we seek within ourselves.

B. Kelly, *Buddhism and Psychiatry*,
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Buddhism, Psychiatry, Mental Healthcare

This book started by noting that Buddhism and psychiatry constitute a field of growing interest owing to the emergence of mindfulness from Buddhist tradition and the valuable but sometimes unnuanced incorporation of mindfulness-based techniques into contemporary mental healthcare. The book sought to explore this and other links between Buddhism and psychiatry, with particular emphasis on continuities, echoes, and resonances that provide additional insights into understanding, therapy, and the alleviation of suffering. I hope it has been helpful.

Chapter 1 provided an 'Introduction' to Buddhism, mindfulness, and mental healthcare, and was followed by Chap. 2, which focused on 'Mental Disorder in Buddhism and Psychiatry'. Chapter 3 examined 'Treatment of Mental Disorders in Buddhism and Psychiatry', and Chap. 4 explored 'Moving Beyond Mindfulness in Psychiatry'. Chapter 5 concentrated on 'Equanimity in Buddhism and Psychiatry', arguing that equanimity is a quality that can be usefully cultivated and accorded greater importance across mental healthcare, rooted in both Buddhist thought and medical tradition. In short, equanimity matters.

Overall, this book argues that identifying and understanding the associations, links, and resonances between Buddhism and psychiatry can help to identify themes of common interest, articulate certain therapeutic approaches with added clarity, and enrich our understandings of both Buddhism and psychiatry. These are two especially rich areas of human thought and practice. Together, they offer expansive opportunities for connecting better, healing more, and understanding deeply. Those are the intentions behind this book.

Future Research in Buddhism and Psychiatry

In light of increased interest in the relationship between Buddhism and psychiatry, the recent growth of literature on specific themes within this field (especially mindfulness), and the various arguments presented in this book, future thought and research in this field could usefully focus on several key areas.

First, the relationship between contemplative practices and neurobiology is now an area of established interest (e.g., Lopez 2008; Kelly 2008), with growing evidence of the impact of mindfulness on the brain. In 2023, one meta-analysis of studies reported fascinating 'evidence for structural brain changes following mindfulness interventions':

> These interventions, both traditional and mind-body formats, have the ability to affect neural plasticity in the brain regions associated with pain modulation and sustained attention. During the mindfulness intervention, the repeated practice of engaging one's attention and awareness to the self repeatedly activates these regions of the brain. Over time, neural plasticity could lead to an increase in the volume of these regions. This further cements the long-term benefits and neuropsychological basis of mindfulness-based interventions. (Siew and Yu 2023; p. 8)

These are important, promising findings, especially in the field of neuroscience, which remains at a relatively early developmental stage in many ways (Marinoff 2011; Kelly 2022), including in relation to the neurobiology of religious practice and spiritual experience (Rim et al. 2019). As a result, this is an area that would benefit from further examination in the future, with particular emphasis on the neurobiological correlates of meditation and the broader physiology of mindfulness and contemplative practices, which affect not just the brain, but the body as a whole (see Chap. 3: 'Treatment of Mental Disorders in Buddhism and Psychiatry').

Second, future research could usefully focus more on the Buddhist concept of 'non-self', which can seem to rest uneasily with Western psychotherapeutic concepts such as 'self' (Oh 2022), 'self-esteem' (Michalon 2001), and 'ego' (Osborne and Bhugra 2003) (see Chap. 4: 'Moving Beyond Mindfulness in Psychiatry'). Similarly, Buddhist ideas about 'emptiness' can appear inconsistent with certain aspects of cognitive therapy (Meadows 2003). Nevertheless, deeper exploration of these apparent contradictions is not only interesting in itself but can also lead to useful therapeutic insights for certain psychological approaches, especially in depression and anxiety disorders.

Third, much psychotherapy and psychiatric care focuses on symptoms in specific individuals and their personal adjustments to their social situations (Samuel 2015). Buddhist ideas about self and 'non-self', on the other hand, present much deeper, fundamental challenges to how we conceptualise our existence, how we see our place in society, and how we

understand our continuity with other people and the world around us (Ward 2021) (see: Chap. 2: 'Mental Disorder in Buddhism and Psychiatry'). Exploring these apparent contradictions and discontinuities between psychotherapeutic and psychiatric practice on the one hand and Buddhism on the other can help us to navigate these complexities and enrich our therapeutic endeavours.

Finally, stepping beyond Buddhism, it is worth noting that appropriate interactions between psychiatry and all religious and spiritual traditions (including but not limited to Buddhism) offer substantial opportunities for enhanced understanding, treatment, and recovery from states of distress and unwellness (Bhugra 1996; Lucchetti et al. 2021). Incorporating such considerations is not appropriate for everyone, but is helpful for, and appreciated by, many. There can also be more specific benefits such as the reduction of stigma that is still wrongly associated with mental disorder and its treatment (Somasundaram and Murthy 2018).

The idea of equanimity offers particular opportunities (see Chap. 5: 'Equanimity in Buddhism and Psychiatry'). Equanimity is important in many spiritual, religious, and philosophical schools of thought, and merits particular attention as a point of continuity and connection across traditions:

> In Greek and Roman philosophy, tranquility was considered central to happiness (*eudaimonia*) by skeptics (e.g., Pyrrho of Elis and Sextus Empiricus), epicureans (e.g., Epicurus and Lucretius), and stoics (e.g., Chrysippus, Seneca, Epictetus, and Marcus Aurelius). Tranquility was the core experiential aspect of notions such as *ataraxia*, *apatheia*, and *euthymia*, which were important notions in these philosophical schools. These notions all describe a calm state of mind in which one is not disturbed or overwhelmed by strong emotions or passions, impulses or wishes. (Christoffersen et al. 2022; p. 2)

These are all areas which would benefit from further research and exploration in the future: the neurobiology and physiology of meditation; Buddhist concepts of 'non-self' and 'emptiness' as they relate to Western psychotherapy; the challenges that much Buddhist thought presents to how we see ourselves as individuals in the world (rather than seeing ourselves as being more continuous with other people); continued exploration of symbiotic relations between psychiatry and a range of spiritual, religious, and philosophical traditions, not just Buddhism.

Buddhism, Equanimity, Mindfulness

The relationships between religion and medicine, psychiatry, and psychology have been long-standing sources of fascination and fruitful reflection (see, e.g., Rivers 1924; Jung 1978; Peteet et al. 2021). Over recent decades, this interest is especially apparent in relation to Buddhism and mental healthcare. Enhanced focus on the research directions outlined above will likely ensure that this remains the case into the future, with particular focus on refining and deepening mindfulness-based interventions in clinical care.

Finally, Buddhism teaches that we live in the present moment, not least because the present moment is the only moment that we have. Life is a succession of present moments.

In this context, Chap. 5 ('Equanimity in Buddhism and Psychiatry') examined the 'Four Immeasurables' or *brahmavihārā* of Buddhist tradition, which are loving-kindness (*mettā*), compassion (*karuṇā*), empathetic joy (*muditā*), and equanimity (*upekkhā*) (Wallace 2010; Feldman 2017). This chapter suggested several practical ways to deepen equanimity, especially in psychiatry but also more broadly. These approaches focus on five key themes: (a) emotional awareness; (b) mindfulness; (c) reflective practices; (d) self-compassion and self-care; (e) anchoring in professional purpose.

As with all Buddhist advice, these conclusions and recommendations are presented with humility and the intention of alleviating suffering. The invitation is not to seek to change the world in the first instance. That will come in time (see Chap. 5: 'Equanimity in Buddhism and Psychiatry'). The initial invitation is to try to consciously practise mindfulness, equanimity, or similar techniques each day, even for a few minutes. Some days will work out well. Some days won't. Most will be somewhere in the middle. Equanimity, in particular, helps enormously.

We should not seek to become Buddhas (Kilroy 2025). But if we focus on the present moment for a little longer, with a little less distraction, and a little more equanimity, we will connect better with other people, heal more, and find the earth we seek within ourselves, within each other, and within the world around us.

Everything we need is right here, right now. It always was and always will be. There will never be a better place to start and never a better time. We only have here, and we only have now. In the end, that is more than enough.

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