A Historiography and Critical Analysis of the Role of Theravada Buddhism in Cognitive Behavioral Therapy

Anna-Sophia Mehta*

This article discusses the historical context of Theravada Buddhism, the original intentions Buddhism embodies, and the practices it employs. Further analysis into modern implementations of Buddhism by mental health practitioners is discussed, and further developments in the field of mindfulness-based, Buddhism-inspired therapies which may re-calibrate the end goals of therapy (shifting end goals from overall happiness and the elimination of emotional discomfort to general well-being and contentment with one's life despite ups and downs) are evaluated with the goal of future exploration and experimentation in mind.

This article utilizes a review of literature published by the American Psychological Association, as well as various international psychological associations including the Scandinavian Psychological Association within a period ranging from the past twenty years (between 2001 and 2021), using the key words Theravada Buddhism, mindfulness, Obsessive-Compulsive Disorder (OCD), anxiety, Cognitive Behavioral Therapy (CBT), asceticism, and ritualistic behavior. The information presented is divided into three subsections–a detailed history of Buddhism and its methods, the more modern applications of traditional Buddhist ideology, and the more diverse applications and differentiations of Buddhist concepts.

In structuring the article, laying the foundations for further inquiry, the author constructed a timeline evaluating the origins and intentions behind Bud-

*Senior Student, Fulton Science Academy.

Contact: amehta1@fultonscienceacademy.org

dhism; in addition, researchers implored into when Buddhism was applied to psychology as well as what key features of Buddhism were utilized in this application. The effectiveness of modern applications of Buddhism in therapies, such as Mindfulness-Based Behavioral Therapy (MBCT), is also discussed, as well as the relation of mindfulness-based therapies to preexisting interventions such as CBT in order to prompt discussion regarding aspects of Buddhism beyond mindfulness and how they may be applied to these preexisting interventions to treat obsessive-compulsive and anxiety disorders. This article proposes a distinction between meditative mindfulnessm passive acceptance and equanimity, a more active and less demure variant of acceptance (referred to as radical, or defiant, acceptance, in spite of adversary or conflicting events that threaten one's mental and emotional stability).

1 Buddhism and its Methods

This section is intended to provide insight into the historical foundations of Buddhism, detailing the origins of practices such as asceticism and the denial of material pleasure and how these traditions have woven their way (both figuratively and literally) into modern Buddhism and modern implementations of Buddhism (e.g. in MBCT).

The rise of Buddhism in India in the 6th Century BC marked the end of the Brahmanic period's dominance. With this ceased the worship of the Yaksas, the Gandharvas, the Vriksas, the Devatas, and the Nagas—Brahmanic celestial beings [1, p. 54]. The fabled prince Siddhārtha (Siddhattha), also known as Gautama (Gotama), whom we now know as the Buddha today, was the son of Suddhodana, chieftan of a Sākya clan. Suddhodana "did all possible arrangements for Siddhārtha's enjoyments in order to retain his affections and prevent him from undertaking a vow of solitariness and poverty;"[1, p. 54]. Siddhārtha lived a life of luxury. Through a series of tribulations, Siddhārtha came to the realization that the impermanence of all worldly things and a fixation on materialistic items and luxury would lead to dissatisfaction and an unfulfilling life. He then set off to meditate in the forest, aiming to attain immortality.

On his journey, Siddhārtha came across the hermitage of Rudraka Rāmaputra, a famous philosopher. He pursued the eighth stage of meditation, called sāmapatti– a complete passiveness of the senses. Siddhārtha realized that this was not the path he needed to follow to achieve enlightenment, as it did not lead to disen-

chantment, or nibanna ('quenching' of the activities of the worldly mind and its related suffering.) Siddhārtha came across Uruvilva-Senāpatigrāma while meeting the Pancavaggiyas–the five mendicants, practicing rigorous asceticism; he realized that this, too, was not the path he needed to follow to achieve enlightenment. Sitting down under the Bodhi tree, Siddhārtha sought to achieve final liberation by vowing to stay under the tree, letting his skin, nerves, and bones waste away, and letting his life-blood dry up until he achieved such. In his meditation, Siddhārtha "acquired the knowledge of his former states of existence ... the nature of all beings through his divine eyes ... [and] the knowledge which uprooted the mental impurities consisting of greed, anger, and *delusion*,"[1, p. 54]. Siddhārtha realized that ignorance was the root cause of all worldly sufferings and, at dawn of his long night, he attained the highest level of knowledge; he was the Buddha, the fully Enlightened one.

The practice of Theravada Buddhism is based on extinguishing ignorance–practitioners seek to "outwit, outlast, and eventually uproot the mind's unskillful tendencies,"[2, p. 1-9]. Buddhists practice generosity (*dana*) to prune their craving; they practice virtue (*sila*) and goodwill (*metta*) to protect themselves from straying off-course, inhibiting themselves from turning to anger. The purpose of the ten recollections of Buddhism is to alleviate one's self-doubt, cultivate self-respect, and overcome lethargy and complacency, retaining oneself from falling into pursuits of unbridled lust. Through the journey of awakening, Buddhists aim to recognize that their future well-being is not something predestined by fate or random chance, but a responsibility which "rests squarely on one's own shoulders." Thus, the resolve to uproot the mind's unskillful tendencies arises–and the aim to live a morally upright life, choosing one's action with care, grows [2, p. 1-9].

Observing these practices briefly in context of Obsessive-Compulsive and Anxiety disorders causes a contention to arise in that the fixation on the need to 'correct' one's flaws may lead to the exacerbation of the inherent sense of guilt which many individuals with obsessive-compulsive or anxiety disorders may face. On the contrary, though, establishing fixed, grounding rituals to 'cleanse' oneself of the feeling of impurity and allowing an afflicted individual to find grounding in logical affirmations of their 'goodness' may strengthen one's resolve [3]. Differentiation arises between the habitually ritualistic nature of OCD and the intentionally ritualistic nature of Buddhism. Rituals in OCD are rooted in anxiety; they propose themselves as "perfectly calibrated pain medication," as solutions to the frantic disarray of one's life–rituals on behalf

of Buddhism not only attempt to ground the individual, but they find success in that they attempt to unify the individual as well, "restor[ing] a sense of coherence and continuity." Additionally, "some rituals are designed to help us 'keep ourselves together'" [3].

A common misconception is that Buddhism demands for complete surrender of worldly pleasure, including the most basic necessities such as food, leading to complete deprivation of the senses; if one observes Siddhārtha's path to enlightenment, however, a key detail of his journey is the rejection of self-deprivation of food. He sought to find a midway between luxury and austerity, taking food–much to the disgust of his fellow ascetics[1].

2 Buddhism in Clinical Psychology

In more recent years, Buddhism has not only been popularized as a religious practice, but as a model for the practices of mindfulness, humility, and self-reflection regardless of one's beliefs in (but with no disrespect to) the notion of 'Buddha'.

The intersection of Buddhism and clinical psychology was largely fostered by Jon Kabat-Zinn of the Massachusetts Institute of Technology, founder of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School[4]. Kabat-Zinn developed the Stress Reduction and Relaxation Program by adapting Buddhist teachings on mindfulness following his studies in meditation under Thích Nhat Hanh (a Vietnamese monk known as the 'Father of Mindfulness') and Seungsahn (one of the first Korean Zen Masters). Kabat-Zinn restructured his Stress Reduction and Relaxation Program into an eight-week course entitled Mindfulness-Based Stress Reduction (MBSR), establishing a foundation for Buddhism's application to clinical psychology and in treating stress, pain, and illness[5, p. 35].

Mindfulness-Based Stress Reduction (MBSR) was developed as an intervention that facilitates self-regulation in order to reduce stress and manage emotions. Its primary focus is on employing various meditation techniques that reinforce the development of mindfulness. Participants are educated on gaining a higher level of awareness of their thoughts and feelings with the goal of changing their relationship to them. Throughout the course, participants meditate in order to recognize their thoughts and feelings as mental events that ebb

and flow as opposed to perceiving them as an intrinsic aspect or facet of their identity and therefore as an accurate reflection of reality. MBSR is a largely skill-based and psychoeducational therapy–that is, participants are informed on the psychological and physiological components of stress and emotions in order to dispel stigma, and they are educated on how to approach stressful or highly-emotional situations utilizing meditative skills. Similarly to Cognitive-Behavioral Therapy, which employs 'homework' and facilitates the recognition of thought processes and encourages awareness of behavior and active thinking to dissuade individuals from falling into negative and habitual thought loops, MBSR assigns 'homework' to participants, encouraging them both formally and informally to bring mindfulness to their thoughts, emotions, and behaviors, addressing them with mindfulness meditation exercises.

MBSR has been demonstrated by two studies in nonclinical samples to potentially be effective in mitigating stress, anxiety, and dysphoria in the general population. The results were impressive, with 65 percent and 35 percent reductions in total mood disturbance and stress symptoms, respectively, although it is not possible to eliminate social desirability effects that may have altered patients' self-reported mood and stress changes. A 2010 pilot study by Jacob Piet of the Institute of Psychology of Aarhus University in Denmark further investigated the application of a Buddhist mindfulness-based model in intersection with clinical psychology, specifically Cognitive-Behavioral Therapy. The aim of Piet's investigation was to pilot test Mindfulness-Based Cognitive Therapy (MBCT), a blended approach incorporating mindfulness, defined as non-judgmental awareness of present moment experiences, with Cognitive-Behavioral Therapy, in combination with Cognitive-Behavioral Therapy (abbreviated to GCBT–general Cognitive-Behavioral Therapy in Piet's study) for young adults with social phobia (SP) exhibiting symptoms of stress, anxiety, and depression. Participants of the study were treated with GCBT (which combined elements from Heimberg's and Clark and Wells' GCBT and individual cognitive therapy for SP, entailing (a) psycho-education on SP and CBT, (b) analysis of patients' individualized case-formulations based on the Clark and Wells model, (c) cognitive restructuring, and (d) exposure to feared social situations). Treatment also included MBCT (carried out "according to a manual by Segal *et al.* developed for the treatment of chronic depression," employing mindfulness meditation techniques and 30-40 minutes of daily homework practicing mindfulness)[6, p. 403–410].

Participants in Piet's study were generally satisfied with treatments; on a 1-5

scale, the mean score was 3.67 for participants treated with MBCT and 3.73 for patricipants treated with GCBT. Piet *et al.* found that MBCT produced "significant pre-post improvements," although participants were generally highly satisfied both with MBCT and GCBT while, in comparison to GCBT, mindfulness may not have been as efficacious, it proved advantageous in its lower cost, ease of implementation, as well as acceptability as it was a general stress reduction focused course as opposed to GCBT, which presents itself more clearly as treatment for a psychiatric disorder. Piet *et al.* ultimately concluded that "a better strategy for combining the two methods [MBCT and GCBT] would consist [of] assimilative intergration of methods from MBCT into [G]CBT, or vice versa"[6, p. 403–410].

3 Buddhism Beyond Mindfulness: Future Directions

A majority of pre-existing integrative therapies combine meditative aspects of Buddhism such as the body scan, gentle mindful yoga exercises, sitting meditation [6, p. 403]. Contrastingly, the utilization of proactive and grounding rituals integrative into one's day-to-day life, utilizable even in more dire contexts (such as a situation in which an individual with an obsessive-compulsive or anxiety disorder may be experiencing heightened states of stress) is emphasized less. This article seeks to lay the groundwork for future exploration into a more assertive form of self-reflection based on the Buddhist principle of acknowledging one's role and responsibility in their mental well-being and virtue, endorsing the pursuit of grounding through the objective evaluation of one's context–equanimity.

Desbordes *et al.* define mindfulness as "the quality of mind that one recollects continuously without forgetfulness or distraction while maintaining attention on a particular mental object,"[7, p. 356-372] although the operational definition of mindfulness still varies in the psychological field. Conversely, equanimity is evaluated as observing without interference in neutrality, neither intensifying nor dampening mental states, instead claiming a state of mind "that cannot be swayed by biases and preferences," [7, p. 356-372] establishing mental equilibrium and a sense of calm and serenity regardless of positively or negatively provocative stimuli.

Equanimity, in the context of Buddhism, can be categorized as a stable

mental state; a neutrality towards all experiences of objects regardless of their pleasant- or unpleasantness[6, p. 403]. Preexisting meditative techniques integrated into modern therapies largely entail the practice of mindfulness, though this operational definition of mindfulness does not necessarily align with the original Buddhist interpretation. A variety of mindfulness techniques have already been adopted in clinical psychology (see Piet *et al.*, for example)–but how can equanimity, an almost *less*-demure differentiation of mindfulness, lead to more assertive pursuits of mental clarity? How can the emerging field of contemplative science benefit from this distinction?

Understanding the implications of equanimity will allow for a more precise implementation of mindfulness in modern therapies. Additionally, facilitating the development of a newer approach enables practitioners to define its results more operationally. At the time of MBCT's development, surveys were largely implemented to evaluate its success. When synthesizing equanimity with the broad definition of mindfulness, a more quantitative and objective perspective can be attained instead of constricting the evaluation of a revised therapeutic practice to a self-report questionnaire.

Regardless of the implementation of, or differentiation between equanimity and mindfulness, it is hoped that identifying this difference and generally detailing the context of mindfulness-based therapies brings light to improving one's overall well-being as a goal of therapy instead of maximizing pleasure or 'temporary' emotional states such as happiness. It may prove more efficacious, even, if therapeutic or mental health practitioners employ immaterial satisfaction, equanimity, and the strengthening of skills supporting contentment as a benchmark or metric of success over evaluating the consistency of one's happiness.

4 Acknowledgments

The author would like to thank Dr. Ramin Ahmadoghlu for useful discussions and suggestions, and for his generous mentorship and support. Thank you to the editors and teachers at Fulton Science Academy for their contributions to Scripta, and to the editorial team and the student researchers of Scripta. *Conflict of Interest*: None declared.

References

[1] K. L. Hazra. *History of Theravada Buddhism in South-East Asia*. Mushiram Manoharial Publishers Pvt. Ltd., 54 Rani Jhansi Road, New Delhi, 110055, 1982.

[2] J. T. Bullitt. What is theravada buddhism? *Insight Edition*, pages 1–9, 2005.

[3] M. Bieber. Learning to fall apart: how buddhist ritual helped me ride out the storm of ocd. *Aeon*, 2013.

[4] B. Boyce. Jon kabat-zinn: The man who perscribes the medicine of the moment. *Shambhala Sun*, 2005.

[5] J. Wilson. Mindful america: The mutual transformation of buddhist meditation and american culture. *Oxford University Press*, page 35, 2014.

[6] J. Piet, E. Hougaard, M. S. Hecksher, and N. K. Rosenberg. A randomized pilot study of mindfulness-based cognitive therapy and group cognitive-behavioral therapy for young adults with social phobia. *Scandinavian Journal of Psychology*, 51:403–410, 2010.

[7] G. Desbordes, T. Gard, E. A. Hoge, B. K. Holzel, C. Kerr, S. W. Lazar, A. Olendzki, and D. R. Vago. Moving beyond mindfulness: Defining equanimity as an outcome measure in meditation and contemplative research. *Mindfulness*, 6:356–372, 2014.