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ORIGINAL PAPER

Contributions and Challenges to Clinical Practice from Buddhist Psychology

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Abstract Psychotherapy is considered to belong to a branch of medicine, and adheres to many conventions of the medical model. As psychotherapists continue to embrace mindfulness (a foundational practice derived from Buddhist psychology), the way we understand suffering and what is to be done about it may be informed by the insights gained in mindfulness practice. Some of these insights depart in degree and in type from the assumptions underlying the medical model, as well as from prevalent ideas of suffering, treatment, and most challenging, the idea of the self who is assumed to be at the center of suffering. By examining a number of influences of mindfulness on clinical practice, the author suggests subtle and potentially radical influences on the way we think of the healing process. It is hypothesized that the Buddhist model may offer a transtheoretical and transcultural model of suffering and its treatment.

Keywords Mindfulness · Buddhism · Psychotherapy · Medical model · Meditation

Techniques and principles of Buddhist psychology have found their way into the practice of psychotherapy, as evidenced by the explosion of peer-reviewed published research articles, from 1 in 1984 to over 2,200 by 2013, and the embrace of the topic in the current volume of Clinical Social Work Journal. The most compatible of these techniques is the practice of mindfulness, or the cultivation of the capacity for direct, open, non-reactive, and close attention. Integrating mindfulness in clinical settings has already gained acceptance by clinicians for its capacity to alleviate psychological distress (Hill and Updegraff 2012; Hofmann et al. 2010; Keng et al. 2011).

For many clinicians and patients, first exposure to mindfulness is through healthcare as a means to reduce stress, and not through an interest in Buddhist thought. For these individuals, the use of mindfulness for its medical and therapeutic benefit becomes the lens through which mindfulness is understood. Of those who initially practice mindfulness for relief from symptoms such as depression and anxiety, some may develop insights into the nature of suffering that go beyond symptom reduction, yet these insights are not adequately described in familiar clinical terms. One's exposure to mindfulness practice, begun in a clinical context and carried into something larger, may inform—and perhaps transform—our understanding of how suffering can be alleviated.

The purpose of this paper is to point beyond current clinical applications (which are amply described elsewhere) to suggest ways in which psychotherapy's flirtation with mindfulness may challenge and illuminate assumptions about what we are, why we suffer, and what is to be done about it, including reflections on the nature of the medical model as it applies to the treatment of mental suffering.

How We Understand Suffering

Suffering, both mental and physical, does not occur in a vacuum; no sooner does it arise than we seek to explain and

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make sense of it, and this sense becomes an integral part of the experience of suffering itself. Even one's experience of somatic disease is heavily colored by non-disease factors that surround it (Kleinman 1980). And of course, the explanation of the cause of one's suffering determines what is *to be done*. For instance, if we hold that delusions are a consequence of possession (once a commonly held explanation), then exorcism is a natural response. Or, if we hold the formerly common belief that severe mental symptoms are caused by sin or moral weakness (Kroll and Bachrach 1984), then it makes sense to punish or banish the sinner. Any account of suffering, however irrational or antiquated, may be superior to no explanation at all, by helping to bind the anxiety of uncertainty. So, in the face of suffering whose origins are unclear, we all become theorists of that suffering.

Theories of suffering may be informal or formal. Informal theories may be folk beliefs shared within a culture (for example, see Fadiman's excellent (1997) volume, "The spirit catches you and you fall down"), or those we invent from our own hypothesizing. In the latter instance, an individual suffering from undiagnosed depression may attribute his or her distress to being worthless, unlovable, somehow undeserving of happiness due to guilt over some real or imagined transgression. Psychotherapy often entails reframing a patient's harsh or limiting explanations with a formal diagnosis which is more conducive to treatment.

Formal theories are those found in scientific and clinical literature. Though the etiology of many specific disorders remains unknown, there is a large body of formal theory in professional journals regarding causes and treatment. In our clinical training we are immersed in theories that guide our clinical practice. Implicit in the medical model is the notion that suffering is most often a symptom of an underlying condition. In mental health as in medicine, one identifies symptoms, and from them, infers the existence of the underlying condition, which becomes the focus of treatment. The assumption is that when the underlying condition is resolved, symptoms abate. Steeped in this medical model, psychotherapy often mimics this effort to isolate, analyze, and excise the problem, much as we might with any somatic disorder. When the condition is chronic or intractable, treatment focuses on symptom management.

We now take for granted that mental health is nested within medicine, though this can be traced in part to historical happenstance; had Freud been a philosopher, a novelist, or a rabbi, we might wonder if psychoanalysis would have had a very different shape. Regarding mental health as a subset of medicine has significant consequences, as the practice of psychotherapy must conform, however imperfectly, to the conventions of medicine, such as diagnoses, procedure codes, medical records, treatment plans, third party reimbursement, professional licensing, malpractice insurance, continuing education, and so on. Like fish unaware of water, we take these elements for granted.

Implications of Medicalization of Psychological Suffering

The benefits of coming to regard human unhappiness as medical (including its extreme expression in major mental illness) are evident, and reflect genuine progress over the days before the Moral Treatment movement of the 18th century. By categorizing mental suffering as analogous to other forms of physical illness, medicine abandoned explanations that were metaphysical, theological, or moral in nature. And if early medically-informed treatment was only slightly less harmful than in the pre-enlightenment, its *intent* was to diagnose and alleviate suffering. Notions of moral weakness or evil were replaced by the search for causes in natural law, and the wish to cure—or at least treat—mental suffering; fear and superstition were replaced by understanding and compassion. Viewing mental distress as a medical phenomenon means that mental suffering can, in principle, be examined empirically, leading to more effective treatment.

In principle, a condition given a medical diagnosis may be perceived as less stigmatizing than a lay interpretation of one's own suffering or another's conduct. This step alone helps to remove some of the isolation and alienation that often accompanies mental suffering. Consequently, individuals who suffer in silence may seek help, and of these, many find relief, or at least company.

For all the benefits of medicalizing mental suffering, there are a number of underappreciated and less fortunate consequences. The promise of destigmatization, by seeing mental illness as a medical condition, has not been kept; even onetime "scientific" terms (such as *moron, imbecile, lunatic,* and *idiocy)* become epithets. Though the basis of scientific medicine is empiricism, to date, only a few forms of treatment have been subjected to randomized controlled studies, and many accepted treatments may be no more effective than placebo alone (for example, Dunn et al. 1996; Kirsch 2010). Treatment may fail, and consequently, some patients may be left more despairing by the end of a course of therapy, adding the burden of guilt to their original chief complaint.

Evidence of the medicalization of suffering can be seen in the proliferation of psychiatric diagnoses in the diagnostic and statistical manual from 112 in 1952 to approximately 250 in DSM-5. The earlier edition contained a greater proportion of conditions meriting hospitalization—conditions that look most like bona fide diseases and, from our current perspective, putatively biological in origin. The later additions to the manual have been less disease-like, and though still in need of treatment (e.g., "gambling disorder"), are less persuasively biologically based. While DSM-5 has raised the bar for a

disorder to earn inclusion in a number of diagnostic categories, it remains populated by what might be described as unwanted behaviors and feelings. One need only consider the rise in prevalence of ADHD for boys, conduct disorders, and social shyness, or unhappiness with one's gender as a medical diagnosis. Arguments have been made for the inclusion of particularly virulent forms of racism as a mental illness (Poussaint 2002), and for inclusion of codes for "Religious or Spiritual Problem." (Admittedly, such categories in the DSM do not necessarily denote pathology, but merely acknowledge the presentation of spiritual or existential issues in a clinical setting.) The point is: More of ordinary human unhappiness has come to be regarded as evidence of a disorder.

But not all human suffering is profitably cast in the light of a disorder. Religious traditions (expressed, for example, in the Buddha's First Noble Truth) are often explicit that suffering is a condition of being human and therefore, to some degree, inescapable. Medicalization may give a false impression that *any* suffering is evidence that "something is wrong with me," and is therefore potentially treatable. Consequently, people turn to mental health professionals for problems that might formerly have been simply endured or understood in a religious context. Unfortunately, a failure to overcome one's distress in treatment may reinforce a sense of personal weakness and inadequacy. By placing all our misery at the feet of psychotherapy or psychopharmacology, thereby implying it is a disorder, a precious opportunity *to encounter the truth of life's difficulty* may be lost. For example, I am aware of two individuals (personal communication) who entered psychoanalysis with, among other concerns, a fear of death. In both cases their fear was interpreted as an expression of castration anxiety. Each felt a degree of relief from giving their fear a clinical account, but that account begs the question what about death?

With the notion that suffering equals disorder, clinicians eager to be helpful may oversell their skills, or fail to distinguish a treatable condition from human encounters with mortality, uncertainty, mystery, paradox, and inevitable loss. Our well-intended effort to address such distress has its own potential side effects. Psychotherapy, when conducted carelessly, can engender an untherapeutic dependence on the clinician, foster rumination, and leave a patient more financially stressed due to out of pocket costs. In an area with as few standards as psychotherapy, the degree of bad care remains unknown.

The Buddhist Formulation of Suffering

The Buddha purportedly said, "I teach only suffering and the end of suffering" (Majjhima Nikaya 22 2010). Despite the growth of Buddhism as a world religion, it originated as something arguably more akin to psychotherapy, concerned with freedom from suffering (not sin) that was understood to have psychological and behavioral causes. In this respect, mindfulness practice is arguably secular. Its application does not require taking on any particular belief system, and given its focus, nor is there any necessary contradiction with a patient or therapist's own religious sensibilities.

In many respects, the Buddhist formulation of suffering appears similar to the medical model. For example, the foundational teachings of the Four Noble Truths (the truth of suffering, the cause of suffering, the potential for alleviation of suffering, and the eightfold Noble Path) align neatly with the formulation of symptoms, diagnosis, prognosis, and treatment plan. Even the Buddha likened his teachings to that of a physician (Anguttara Nikaya 10:108, n.d.). The root causes of suffering—greed, hatred and delusion—are often described as poisons or toxins. Despite their apparent compatibility, however, these two traditions depart in many ways, and it is in these differences that we can see the potential for Buddhism to influence the medical model as it is applied to mental suffering.

Buddhist psychology distinguishes between *pain* and *suffering*. The former is inescapable, as humans are vulnerable to loss, sickness, physical pain and death. Suffering arises any time we are separated from what is loved, or compelled to be in the presence with what is unloved (including physical or mental pain, bad moods, physical discomfort, disturbing memories, irritating people, fear, anxiety, or any unpleasant state). The suffering that is addressed by mindfulness is regarded as the product of our *relationship* to experience, and not raw experience itself, and is therefore fundamentally workable. Ordinarily, our relationship to experience is colored by our opinionatedness. That is, we frequently judge our experience through the lens of our preferences, trying to escape what is unpleasant and maximize what is pleasant. This is precisely what Freud described as the "pleasure principle" (1913). There is no escaping the constant ebb and flow of pleasant and unpleasant experience. The problem arises due to our well-practiced habits intended to control experience and shape it to conform to our preferences. This is a form of resistance to experience, or "grasping" in Buddhist terminology. This process can be overt and fully conscious, or very subtle and largely outside of awareness. But in every moment of suffering, whether mild or extreme, there is the presence of the desire for it to be *different*. From this formulation, our efforts to relieve suffering by gaining what we want, holding on to what is pleasant, or insulating ourselves from what we dislike, is at best short-lived, restless, and endless.

Treatment, in this model, occurs via insight into this process of resistance to experience, gained through direct mindful observation. As one sees how efforts to resolve

suffering (by resisting what is unpleasant) only add to it, we gradually learn to drop agendas for each moment and accept things as they are, irrespective of our preferences. In this framework, clinician and client abandon even the intent to "fix" anything. The notion of dropping the impulse to change differentiates this approach from the medical model. In addition, through mindfulness we learn to perceive thoughts as just thoughts, to distinguish them from the actuality of things. This grants further freedom from the entrapment of viewing everything from well-rehearsed, frequently limited, narratives. Far from the idea of change that underlies most forms of psychotherapy, we learn to accept experience without the overlay of our stories, contentiousness and preferences. Our struggles begin to abate. Some implications of this formulation are described below.

How Might Mindfulness and Buddhist Psychology Inform Our Understanding of Suffering and the Nature of Treatment?

The following catalog of current and future influences is by no means comprehensive. Additionally, many of these elements are not exclusive to mindfulness or Buddhist practice, and some can already be found in some degree within psychotherapy. Some of these (like the use of mindfulness for stress reduction) are easily appropriated by conventional psychotherapy practice, others less so. They are laid out roughly in the order of accessibility by our own idiom, ending with dimensions of Buddhist practice that are most challenging, and pose an invitation to reconsider how suffering is alleviated.

Introspection

Both psychotherapy and Buddhist practice place the locus largely within the person, and the causes and cures of suffering are found through systematic introspection. Through this process, individuals develop an expanded capacity for objective observation that may be unusual in ordinary daily awareness. Buddhist meditation is not unique in its use of introspection, though its methods (for example, attentional training) enable a level of uncommonly close direct observation by setting aside the limits of language (the currency of dyadic psychotherapy). In this sense, Buddhist meditation is even more radically *internal* than interpersonal psychotherapy.

The popularity of mindfulness for both the therapist and patient has helped restore an interest in mind. While the mind has always been of central concern in psychoanalytic psychology, it has lost favor with the rise of more behavioral, protocol-driven, and empirically validated treatments that focus on what can be defined and measured. Often scorned as a legitimate topic of empirical assessment (and therefore susceptible to bad science), subjective experience is becoming an object of interest by researchers who seek to examine phenomena from both first and third person perspectives (e.g., Britton et al. 2011; Wallace 2007). Buddhist psychology has never made the sharp distinction between mind, body, and spirit that are found in Western thought. By looking at how changes *in* the mind influence changes *to* the brain, we see a glimmer of hope of bridging the mind–body dualism that has kept disciplines isolated from one another.

The Expanded Role of "Practice"

There is nothing new in the observation that practice reinforces learning, though Buddhist meditation explicitly extends this to capacities not conventionally considered promising candidates for cultivation. Qualities explicitly identified in the Buddhist tradition that can be grown, often without limit, include concentration, mindful attention, curiosity (in particular, in our own mental states), non-judgmental acceptance, generosity, compassion and loving kindness, joy, and tranquility. The efficacy of the practice of these mental qualities is being supported by neuroscientific studies that establish neurological correlates of many of these states (e.g., Decety and Michalska 2010). It also implies that we consider what we practice in psychotherapy, in prolonged sessions of contemplation of our own sorrows; when does protracted psychotherapy become a rehearsal and reinforcement of problems, rather than their solution?

A number of brain structures, known collectively as the 'default mode network', are active during rest, day dreaming, and unfocused attention, during which time we are often engaged in thinking about ourselves (Northoff et al. 2006). Conversely, there is evidence that mindfulness meditation is associated with decreased activity in these structures (Ott et al. 2010). Lazar et al. (2005) found changes to the thickness of selected areas of the cortex after only 8 weeks of MBSR training. These findings strongly suggest that what we do with our minds has consequences for brain function and structure. The implication is that what we do with our minds, even when we are not explicitly engaged in purposeful activity, is becoming strengthened; are we practicing grievance, injuries, fear, or regret? Rehearsing limited or unrealistic views of ourselves? Knowing the potential power of practice, we are invited to choose alternate qualities to be strengthened. Indeed, this observation invites us to take expanded responsibility for our habits of mind. The Buddhist tradition recognizes the capacity for the purposeful selection of such mental qualities, and it contains practices deliberately

intended to cultivate such desired qualities (Olendzki 2013).

The concept of practice provides a practical alternative to often repetitious and ineffective search for causes of distress during psychotherapy. For example, even if one comes to understand why a particular social encounter predictably triggers rage, such insight is rarely sufficient to overcome well-established mental habit. As an alternative, when one sees a recurrent pattern as reinforcing such habits, the task becomes one of working skillfully with the bare experience of anger through mindful awareness in present-moment experience *as a way to practice an alternative inner response*. Through mindful attention to anger (that is, neither analyzing, repudiating, or clinging to the experience in favor of direct embodied investigation), one can develop skills to simply observe anger, without rehearsing the slight, thereby allowing it to be known fully, to arise and pass. Formulating the issue of anger as one of practice offers a skillful pathway less susceptible to shame.

> A well meaning 40 year old scientist with supervisory responsibilities periodically exploded at subordinates in ways that left him feeling ashamed and regarded with caution by his co-workers. He felt his anger was a personal flaw, evidence of moral failure and weakness. I offered an alternative account of anger as an *event,* something that is strengthened through the brain's neuroplasticity by repetition, and could be replaced with *restraint*, through practice. As a scientist he understood. He was relieved on two counts: his anger, though deeply troubling to him, could be seen without the moral overlay that led to excessive shame, and it could now be viewed as *workable* through practice, in a way that had failed to yield through analysis or self-chastisement.

By viewing our dispositions as something available to training, we gradually help let go of fixed ideas of ourselves. Paraphrasing Freud, we might say, "Where there were traits, there will be states."

Intersubjectivity

Suffering frequently causes individuals to feel isolated and alone. But when known through mindfulness, suffering gradually reveals our fundamental likeness to others, leading to the overcoming of alienation. As we come to know ourselves, we simultaneously come to understand the universality of suffering, and of the shared aspiration to be happy (Neff 2003). This natural affinity is strengthened when both therapist and patient are engaged in the same process of mindful introspection. While dimensions of intersubjectivity are already well explored in psychology and psychoanalysis (e.g., Kohut 1971; Stolorow and Atwood 1992), it is given a different underpinning in Buddhism through the ideas of *impermanence* and *non-self* (*anicca* and *anatta,* respectively, in Pali, the language in which early Buddhist teachings were first written). Whereas western psychology is tasked with understanding how communication and intimacy are possible across the interpersonal gulf, Buddhist psychology asserts that we are originally deeply interdependent, and therefore it is our apparent separateness that requires explanation. Intersubjectivity, then, is already a natural condition revealed by wisdom. With this growing perception, clinical work takes on a new immediacy as our innate intimacy becomes our default condition, simply by virtue of being human.

Compassion

The explicit purpose of Buddhist meditation is the cultivation of wisdom and compassion, so it is natural that interest in mindfulness should reopen the door to the role of compassion, not just as a means to effective treatment relationships, but as an end in itself, as an expression of our deepest understanding. If empathy is the capacity to imagine another's experience, compassion deepens this to the resonance in our own hearts with the suffering with another, accompanied by the wish to help (Germer 2009). The importance of compassion's close relative, empathy, is well established in psychotherapy (Bohart et al. 2002; Elliott et al. 2011). It has even been claimed that the common factor of empathy *is* the most active factor in effective treatment (Duncan and Miller 2000), though the movement toward "empirically validated treatment" led to greater attention to specific measurable interventions. Compassion, when directed toward oneself, is more associated with well-being than the popular construct, self-esteem (Neff 2012). Again, when approached through Buddhist practice, it has broader significance. It suggests the possibility of self-acceptance even in the absence of self-improvement—that is, one can heal independent of being 'fixed'. Among Buddhist practitioners, compassion is radical, challenging us to extend it—without limit or discrimination—to all beings. This is articulated in the challenging Boddhisattva's vow to dedicate oneself to the wellbeing of all beings as a precondition for one's own liberation, inviting us to weigh other's happiness as equal in importance to our own. Compassion is regarded not merely as a developmental accomplishment available to those who have learned the capacity for reciprocity and empathy, but as a natural expression of our innate nature, to be revealed as much as cultivated. Here, too, a concept already familiar to psychotherapy is being reinvigorated and broadened by contact with Buddhist practice. It suggests that compassionate *action* in service to others is both a vehicle to personal happiness as well as its consequence.

In the face of suffering, we commonly add self-criticism and shame to an already intolerable experience, adding further insult to the original injury. But extending compassion to ourselves is not dependent on being *deserving,* and can be practiced simply because we are suffering. In this respect, we (and our clients) are never without some response to suffering, even when solutions to problems cannot be found.

> Covering for another clinician, I saw Karen, a 55 year old woman in crisis. Forced to retire from her teaching career due to the overwhelming symptoms of PTSD from severe early abuse, she was largely reclusive. When a neighbor refused her requests to keep his dog out of her yard, she retaliated by smearing the neighbor's door with dog feces from her yard. Frightened by her anger and what she had done, she came to the clinic for an emergency appointment. I asked if there was someone toward whom she felt warmly, and suggested she consider doing something for this person, and to return the next day for a follow-up appointment. On her return she told me she brought ice cream to an elderly shut-in neighbor. This act broke the spell of anger and fear that had possessed her. She asked, "How did you know?"

Construction of Experience

Both the western and Buddhist traditions recognize how we construct our own experience, conditioned by multiple causes such as personal history, culture, language, genetics and disposition, situation, and so on. Because meditation examines conditioning on a more microscopic level, it extends this insight into the moment-to-moment construction of identity and a separate self. And, because much of this inquiry is non-verbal and rests on concentrated attention to the mind, it further illuminates the constructed nature of our own concepts, offering an additional avenue of freedom from excessive conviction in our own limiting views. In this respect, mindfulness illuminates the real-time process of conditioning itself, rather than just 'my' conditioning of early development. As clinicians engage in sustained meditation practice, even cherished clinical theories come to be illuminated as ideas, more or less useful, but not to be mistaken for the thing they describe. Even as we have our clinical knowledge close at hand, clinging less tightly to beloved models of treatment supports W.R. Bion's admonition (1967) to approach patients without memory or desire.

Understanding how we construct much of our own experience has many consequences for psychotherapy. We become far less prone to see clients through the veil of our theories, and in this, deepen our appreciation of their absolute individuality. We see our clients freshly, and understand that they will teach us what we need to know to be of help. We also come to understand the degree to which most of our suffering is self-inflicted, illuminating new avenues to help our clients begin to perceive this as well.

Ethical Conduct

Long exiled to the periphery of psychotherapy as a byproduct of the superego, morality and ethical conduct are squarely at the center of the Buddhist approach to overcoming suffering. Because Buddhist thought considers the harmful consequence of unethical conduct as a matter of natural (not divine) law, it considers our conduct an essential element to well being. Fortified by mindfulness practice, Buddhist psychology invites us to examine whether mental contentment is possible as long as we are engaged in harmful activity. This places ethics as a cause—not only a product—of agitation and unhappiness. The role of ethics is extended further by considering that *all* acts, including those of thought, speech, and action, have consequences for our well-being. In this respect it regards the *motivation* of all such acts as critical in determining whether they lead to more or less suffering. While such a formulation is not necessarily alien to clinical work, psychotherapy has yet to fully embrace it as a critical element in the treatment process.

Psychotherapists are taught to set aside judgment, and a non-critical attitude is an essential ingredient for a safe therapeutic relationship. For some, this becomes an obstacle to confronting a client who is engaged in harming or unethical behavior (which might be of any scale, such as an extramarital affair, reading another's email, pocketing mistakenly returned change, gossiping), lest such confrontation be mistaken for judgment. But if we see (supported by mindfulness practice) the distress caused by harmful behavior in our own experience, we are challenged to find a way to bring this observation into the therapeutic equation. In therapy, it can be very instructive to suggest that a client deliberately suspend harming activity, or further, to do something positive for others, in the spirit of an experiment asking, "Let's try it just to see if it feels different." An example can be seen in the case of Karen, above.

> Jay compulsively bought CDs, which he concealed from his wife. He lived in fear of being discovered, and in shame once he was. Yet, his behavior persisted. In addition to exploring the reasons for his conduct, I suggested he suspend this activity for 3 months, in the spirit of an experiment, to see how it felt. He later reported that the freedom of not having to hide something about himself felt better than the momentary pleasure of buying the CDs.

When Jay found the relief of not lying exceeded the pleasure of his buying behavior, he realized that what he thought he had been doing for himself was actually a form of self-harm, as it caused him suffering. Learning to abandon deceit was actually a form of self-care that could be explored and expanded.

The Nature of Suffering and Its Amelioration

The Buddhist formulation of the genesis of suffering departs more sharply from psychotherapy's underlying medical model. While both traditions share common notions of the causes of suffering (e.g., unrealistic beliefs and distortions of reality), Buddhist psychology poses the more radical idea that grasping (*tanha,* in Pali) underlies *all* suffering. In this context, grasping is the nearly reflexive tendency to respond to much of experience with the desire to rid oneself of the unpleasant, to maximize the pleasant, and to control experience to make it more palatable. Grasping can be overt, or subtle enough to occur outside of awareness. Mindfulness meditation reveals it as nearly incessant, and is the process beneath all suffering, including extreme distress and the subtle sense of unsatisfactoriness present even in the absence of identifiable stressors.

Conversely, letting go of grasping leads to the overcoming of suffering. The implication of this is that much of what we customarily consider the essential work of psychotherapy—improving self-esteem, identity, adjustment, resolving conflicts, and so on—may be beneficial, but are not ultimately essential for liberation from suffering. That is, we need not be free of personal problems or conflicts, or engage in self-improvement at all in order to diminish psychological distress. This conception of freedom from suffering goes beyond adjustment or the removal of symptoms, suggesting a happiness that is not dependent on changing the conditions we formerly identified as obstacles to peace. This represents a radical departure from the medical model of psychotherapy.

Though acceptance is finding its way into psychotherapy through ACT, DBT, and other instances of the "third wave" (Hayes 2011) of behavioral therapy, the idea of grasping as an underlying mechanism of all suffering has not yet found its way into the vernacular of psychotherapy. This view of the source of suffering is contrary to the ethos of consumerism which promotes the gratification of needs as the path to satisfaction, and to the common conception that therapy is a means to identify one's needs and learn how to get them met.

The Buddha's First Noble Truth, which simply asserts that there is no immunity from suffering, offers a potential corrective to the Western sense of entitlement to happiness. By recognizing suffering as ubiquitous, it questions the assumption of suffering as evidence of a disorder or something to be 'fixed,' welcoming a consideration of suffering from a broader existential and spiritual perspective. Can we simply meet that which cannot be fixed, with an attitude of open acceptance? If psychotherapy has promised too much, this simple acknowledgment of suffering helps to balance unrealistic expectations for a "cure," and, as described above, potentially lessening the isolating effects of mental suffering. It also points the way to deeper insight into how suffering is self-created through our *relationship* to experience. Growth in acceptance may be experienced as learning to 'let things be.' With continued practice, we find ourselves surprised when we find we are not upset by something that formerly caused a predictable reaction in us. We gradually discover we don't relate to the world as a reflection of our needs, but take things as they are.

> A middle-aged woman's lifelong passion is music. She finally lands a job related to supporting a symphony orchestra. Predictably, it is underfunded, and she must do much of the office work herself. While filing, she is silently complaining; "This is beneath me; I shouldn't have to do this menial work," and so on. In a moment, she notices what she is doing, both filing *and* complaining, and in the next moment begins to laugh, and to drop the complaining. She discovers that filing is not inherently menial or unpleasant, but is made so by her rejection of the experience. She continued to file without further complaint.

The Nature of the Self

The understanding of the nature of the person is where these traditions most radically depart, and where principles of Buddhist psychology will most challenge our theories, both formal and informal. In the Buddhist formulation, the experience of self is dependent on conditions, arising when they support it, abating when they do not. In this sense, the self is only another phenomenon in the flux of events, neither driving them, nor being the recipient of experience, nor in any way separate from them. It is an event with no intrinsic enduring reality. This is the doctrine of 'not self' (*anatta,* in Pali).

This formulation is highly contrary to the Western tendency to reify a separate and enduring self. As anthropologist Lee put it (1959, p. 132), "The self is most nearly identified with consciousness and reason and will; and in our culture, reason and will power and consciousness—particularly self-consciousness—spell mastery and control. So here, too, we find the implication that the self is in control of the other." Shweder and Bourne (2002, p. 129) described the Western sense as "A kind of sacred

personalized self is developed and the individual *qua* individual is seen as inviolate, a supreme value in and of itself. The 'self' becomes an object of interest *per se."* This view underlies much of our common sense understanding, a kind of folk understanding that is embedded in psychotherapy.

Common sense notions aside, the Western tradition contains ample accounts of the self as constructed, in social anthropology, (Leenhardt 1947; Mead 1932), philosophy (Hume 1748), and psychoanalytic psychology (Hartmann 1958). More recently, neuroscience (Gillihan and Farah 2005) has pointedly failed to identify any single structure responsible for the sense of "I", but regards it as a high level illusion of interacting neurological subsystems. Not surprisingly, this scientific view is less enamored with the self's vaunted qualities, seeing it as "… a social construct, rarely unique, and never fully autonomous, of no special value or dignity (Novak 1970)."

This intellectual strand, however, has not fully informed the commonsense view of self as understood by psychotherapists or their patients. Over the history of civilization, anthropocentrism and geocentrism have gradually lost their privileged positions, pushed aside by Aristarchus, Giordano Bruno, Galileo, Isaac Newton, Charles Darwin, and Sigmund Freud, among others. However, we remain stubbornly egocentric, supported by ontogeny (born as "infantile narcissists"), our simple boundedness by skin, our genetic uniqueness (to the point of rejecting germs or transplanted organs), and the instinctive urge for our own survival. Animals share this last trait, though without the narcissism that comes from the ability to live symbolically, to take oneself as an object. While maturity is marked by a movement away from self-centeredness toward generosity, reciprocity, and social responsibility, this movement is always within the assumption of an enduring and separate self, and must therefore remain incomplete, a compromise between the needs of oneself and others.

We might understand the Buddhist formulation of the self to be the next step in this ongoing psychological Copernican revolution. The radical notion of not-self is offered as empirically verifiable, not mere theory. Direct insight into the illusory nature of the self leads to a radical reorganization of personality as one comes to perceive the self as insubstantial and empty of an enduring separate existence. In the face of such an insight (which can be gradual or sudden), the need for constant support for our identity & self-esteem, defensiveness, aggression, and greed are gradually diminished or abandoned when they are revealed as the source of our distress rather than the basis of the safety and satisfaction we seek. Subjectively, growing in the understanding of our genuine interdependence gives rise to a sense of affinity and compassion with all other beings. There is less contentiousness with much of experience, because we discover just how much is "not about *me."* We take things—potentially, *all* things—less personally.

While there is a radical dimension to the realization of not-self, it is not so remote from our ordinary experience. For instance, when we are absorbed in a book or a challenging game of tennis, the experience of self—of the one to whom experience is happening, the one who is doing, the one who possesses, and so on—is absent, and so, in these moments, is conflict. Self arises in the face of our contentiousness with experience (that is, grasping), and we commit the perceptual error of imagining that the self was an enduring observer of experience.

In mindfulness practice, we may have moments of alert awareness, minus the sense that it is happening to "me," the homunculus at the center of all experience. We can also observe the process of the self in the moment of its arising. Gradually, this changes our perception of the self from a preoccupying "thing" demanding our protection, to an impersonal event. From such a perspective, life becomes far less complicated.

This contribution of mindfulness is arguably the least compatible with the assumptions about one's selfhood underlying psychotherapy, and suggests a different developmental trajectory from that which underlies theories of abnormal psychology. However, as more psychotherapists and their patients undertake committed meditation practices, the privileged position of the self may gradually be challenged as well as the edifice of clinical theory built around it as it seeks to accommodate these phenomena. One potential influence on the practice of psychotherapy is the disenchantment with the restless effort to 'become,' to support one's sense of specialness, of acquisitiveness, to seek safety in permanence. In its place, psychotherapy may make more space for our inevitable inconsistency, for our imperfection and foibles. A therapist who understands that well-being does not depend on the need to gain or eliminate anything may be better positioned to offer the same possibility to clients in the form of radical acceptance. Or, if a psychotherapist has had a deep insight into the empty and transitory nature of one's own self-construct, would he or she feel differently about putting the establishment of a cohesive sense of self, or establishing a greater sense of identity, at the center of treatment?

Discussion

Where the objects of investigation are easily observed (for example, the spleen), there is little controversy over *what* is being investigated. Because the constructs of psychotherapy are largely intangible, there is tremendous room for inventiveness in theorizing about the mind, personality,

normal development, pathology and treatment often to the frustration of scientists. But where there was formerly isolation between psychoanalysts, behavioral psychologists and neuroscientists, we have recently begun to witness increased collaboration among clinical researchers across diverse fields, and we are beginning to benefit from cross-fertilization between them. Tenets of Buddhist psychology, once considered outside the domain of scientific psychology, are being examined empirically.

This movement has already expanded the palate of concepts and techniques available to the practicing clinician, a trend likely to continue with ongoing exposure. It may yet lead to embracing different visions of human potential, the cause of suffering, increased incorporation of a two millennia-old form of self help, and a broader questioning of what we think we are, all in the service of overcoming suffering among our patients and ourselves.

We are captive to the concepts that we inherited from our training and our culture. If we assume that our nature is bound by instinctual urges (as was asserted in early Freudian psychoanalytic theory), then adaptation is at best a compromise between those urges and the constraints of society. Mental conflict, then, is traceable to the injuries incurred in the difficult developmental process of becoming socialized. If we believe that much mental distress comes from parental failure to fully see and affirm a child's separateness and uniqueness, or from holding learned unrealistic ideas, or from internalizing harsh object introjects, or from a bad batch of neurochemical transmitters, it will inform our approach to treatment.

The Buddhist formulation, and its associated practice of mindfulness meditation, offers its own unique formulation. But it goes beyond providing yet another arrow in our therapeutic quiver in two ways. First, it identifies a mechanism that underlies every moment of suffering, regardless of differing circumstances. In this, it offers the possibility of being truly transtheoretical and transcultural, with potential benefit to therapists of different clinical orientations. Second, by helping illuminate the consequences of clinging to particular views we are granted a degree of freedom from rigid adherence to *any* position, including fixed views of illness and cure, of others, and of ourselves. In this, it offers a perspective on well-being that goes beyond the medical analog of symptom reduction or adaptation by offering a glimpse of happiness less bound by conditions. It invites us to consider a state of well-being that is broader than the absence of symptoms, a revisioned view of our own potential and human nature itself.

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