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The Emerging Role of Buddhism in Clinical Psychology: Toward Effective Integration

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Research into the clinical utility of Buddhist-derived interventions (BDIs) has increased greatly over the last decade. Although clinical interest has predominantly focused on mindfulness meditation, there also has been an increase in the scientific investigation of interventions that integrate other Buddhist principles such as compassion, loving kindness, and "non-self." However, due to the rapidity at which Buddhism has been assimilated into the mental health setting, issues relating to the misapplication of Buddhist terms and practices have sometimes arisen. Indeed, hitherto, there has been no unified system for the effective clinical operationalization of Buddhist principles. Therefore, this paper aims to establish robust foundations for the ongoing clinical implementation of Buddhist principles by providing: (i) succinct and accurate interpretations of Buddhist terms and principles that have become embedded into the clinical practice literature, (ii) an overview of current directions in the clinical operationalization of BDIs, and (iii) an assessment of BDI clinical integration issues. It is concluded that BDIs may be effective treatments for a variety of psychopathologies including mood-spectrum disorders, substance-use disorders, and schizophrenia. However, further research and clinical evaluation is required to strengthen the evidence-base for existent interventions and for establishing new treatment applications. More important, there is a need for greater dialogue between Buddhist teachers and mental health clinicians and researchers to safeguard the ethical values, efficacy, and credibility of BDIs.

Keywords: mindfulness, meditation, compassion, loving kindness, Buddhism

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> Wonderful, indeed, it is to tame the mind, so difficult to tame, ever swift, and seizing whatever it desires. A tamed mind brings happiness.
> —Buddha (as cited in Buddharakkhita, 1966, p. 15)

According to the Mental Health Foundation (MHF; 2010), one in four British adults practice meditation and 50% would be interested in learning to meditate as a means of coping with stress and improving their health. Furthermore, approximately 75% of general practitioners in the United Kingdom believe that meditation is beneficial for people with mental health problems (MHF, 2010). Comparatively lower figures are reported for America where over 20 million people (~ 6.5% of the population) practice meditation (Elias, 2009). The Buddhist-derived practice of mindfulness, in the form of mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), is now advocated by both the National Institute for Health and Care Excellence (2009) and the American Psychiatry Association (2010) for the treatment of specific forms of depression. Indeed in 2012, almost 500 scientific papers concerning mindfulness were published, which compares with just 50 papers concerning mindfulness published 10 years prior to this in 2002. Likewise, and in the last 5 years, other Buddhist principles such as compassion, loving kindness, and "non-self" have been integrated into a battery of purposefully developed psychopathology interventions (e.g., Gilbert, 2009; Johnson et al., 2011; Pace et al., 2012; Shonin, Van Gordon, & Griffiths, 2013b).

Interest into the clinical utility of Buddhist-derived interventions (BDIs) is growing. Potential treatment applications for BDIs span almost the entire spectrum of psychological disorders including, for example, mood disorders (Hofmann, Sawyer, Witt, & Oh, 2010), anxiety disorders (Vøllestad, Nielson, & Nielson, 2012), substance use disorders (Witkiewitz, Bowen, Douglas, & Hsu, 2013), personality disorders (Soler et al., 2012), and schizophrenia-spectrum disorders (Johnson et al., 2011). BDIs also effectuate improvements in psychological well-being, cognitive function, and emotion regulation capacity in subclinical and healthy adult populations (e.g., Chiesa, Calati, & Serretti, 2011; Desbordes et al., 2012; Eberth, & Sedlmeier, 2012; Van Gordon, Shonin, Sumich, Sundin, & Griffiths, 2013).

The assimilation of Buddhist practices by allied health disciplines is likely to have been influenced by factors such as: (i) increased rates of transnational migration resulting in greater cultural and ethnic diversity among service users (Kelly, 2008); (ii)

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the need to develop culturally syntonic treatments for Asian Americans and Asian Europeans (Hall, Hong, Zane, & Meyer, 2011); (iii) Buddhism's orientation as more of a philosophical and practice-based system relative to some religions in which a greater emphasis is placed on worship and dogma (Shonin, Van Gordon & Griffiths, 2013a); (iv) similarities between Buddhism and established therapeutic modes such as cognitive–behavior therapy (CBT) in terms of their construal of the relationship between thoughts, feelings, and behavior (Segall, 2003); (v) the need for novel interventions that can augment the effectiveness of psychopathology treatments in which relapse rates in modes such as CBT can be as high as 60 to 75% (e.g., Hodgins, Currie, el-Guebaly, & Diskin, 2007); (vi) the growth in research examining the effects of Buddhist meditation on brain neurophysiology (e.g., Cahn, Delorme, & Polich, 2010); (vii) the wider scientific dialogue concerned with the evidence-based applications of specific forms of spiritual practice for improved psychological health (Lindberg, 2005); (viii) the international recognition and acclaim of prominent Buddhist leaders such as Nobel Peace Prize Laureate Dalai Lama and Nobel Peace Prize Nominee Thich Nhat Hanh; (ix) increases in the number of seminal Buddhist works translated into English language (and improvements in the translation quality thereof); and (x) the recent (i.e., during the last 30–40 years) founding in the West of practice centers representative of the majority of the world's Buddhist traditions.

The manner in which Buddhism (when considered as a single entity) has been made available to the interested Westerner has been relatively unstructured. In conjunction with the rapidity at which Buddhist principles have been integrated into clinical interventions, it is therefore unsurprising that a degree of confusion has arisen within the clinical and psychological literature regarding the accurate meanings of Buddhist terms (Rosch, 2007). Dorjee (2010) provided an example of such confusion based on the term *insight*, which has been used within the psychological literature (e.g., Brown, Ryan, & Creswell, 2007) to refer to an increase in perceptual distance (e.g., from thoughts and feelings) that often follows mindfulness practice. However, within Buddhism, the term insight is generally used in the context of transcendent intuitive leaps of realization into the very nature of reality itself. A further example relates to the practice of "vipassana meditation," which is generally described in the health care literature as being synonymous with mindfulness meditation. Although there are some similarities between these two forms of meditation, according to traditional Buddhist perspectives (and as will be explicated later), they represent two distinct meditative modes (Van Gordon et al., 2013). In fact, even the term *mindfulness* takes on a different meaning in the Buddhist literature vis-à-vis its conceptualization by Western psychologists (Kang & Whittingham, 2010).

For techniques such as mindfulness, there have been various attempts to reconcile some of these terminological issues. Nevertheless, to date, there remains a lack of consensus among psychologists as to what defines the mindfulness construct (Chiesa, 2013). Furthermore, because scientific debate regarding the salutary health effects of Buddhist practice has predominantly focused on mindfulness meditation, terminological and operational issues relating to other clinically employed Buddhist principles have often been overlooked. Moreover, proposed schemas for interpreting or operationalizing Buddhist concepts invariably fail to consider the cooperating or mechanistic role of other Buddhist principles (Van Gordon et al., 2013). Indeed, hitherto, there currently is no unified and structured system for the effective interpretation, classification, and operationalization of Buddhist terms, principles, and practices within clinical settings.

Due to this, the purpose of the current paper is to propose such a system and establish robust foundations for the ongoing clinical implementation of Buddhist principles and practices. More specifically, this paper aims to provide: (i) succinct clinician-relevant interpretations of key Buddhist terms and principles that are truer and more closely aligned with their intended meaning (limited to those Buddhist terms that have become embedded or utilized within the clinical literature); (ii) an outline and discussion of current directions concerning the full-spectrum of Buddhist principles currently employed in clinical interventions (however, this paper is not intended as a systematic literature review—recent systematic reviews are highlighted where appropriate throughout the paper); and (iii) an assessment of issues that arise from the continued operationalization and roll-out of BDIs within clinical and psychological settings.

Contextual Background

Buddhism originated approximately 2,500 years ago and is based on the teachings of Siddartha Gautama (later becoming known as Shakyamuni Buddha) who taught throughout India. Although Buddhism takes on many different forms, one method of classification is to assign each particular tradition of Buddhism to one of three overriding vehicles (Sanskrit and Pali: *yanas*): (i) Theravada Buddhism[1] (sometimes subsumed under the title of Shravakayana—"the hearer vehicle"), (ii) Mahayana Buddhism ("the great vehicle"), and (iii) Vajrayana Buddhism ("the diamond vehicle"). Theravada Buddhism is the longest enduring school of Buddhism[2] and is prevalent throughout South East Asian countries such as Thailand, Sri Lanka, and Burma. Mahayana Buddhism is believed to have originated around the turn of the first century AD and is prevalent throughout East Asia (e.g., Japan, Taiwan, Korea, and Vietnam). Vajrayana Buddhism is generally considered to have originated in the seventh century and is associated with Himalayan plateau countries such as Tibet, Bhutan, Nepal, and Mongolia (and to a lesser extent Japan). All three vehicles are now practiced in the West.

The defining characteristics of each Buddhist vehicle might be concisely summarized as follows: (i) greater adherence in Thera-

[1] Although a number of prominent Buddhist scholars and teachers (e.g., the Dalai Lama) support the use of the term *Shravakayana* for referring to the first Buddhist *yana*, others view this as inadequate because Shravakayana appears to be terminology primarily employed by Mahayana/Vajrayana approaches. Likewise, Shravakyana does not by default encompass the mode of practice of the *pratyekabuddha* (Sanskrit; Pali: *paccekabuddha*)—a practice mode generally attributed to the first Buddhist yana. An alternative to Shravakayana is the term *Hinayana*. However, Hinayana is pejorative vernacular as it means lesser vehicle. Simply referring to the first vehicle as *Theravada* is equally problematic because the term Theravada refers to only one of the original 18 Buddhist schools. Thus, there is (a longstanding) debate within Buddhism regarding the most apt term for referring to the first Buddhist vehicle.

[2] Although Theravada is the longest surviving Buddhist tradition and is the modern day descendant of the historical Sthaviravada Buddhist school, it should be distinguished from presectarian Buddhism that survived for approximately 100 to 150 years after the death of the Buddha.

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vada Buddhism to the "original word" of the historical Buddha; (ii) greater emphasis in Mahayana Buddhism on compassionate activity and the "nondual" or "empty" nature of phenomena; and (iii) greater significance in Vajrayana Buddhism placed on "sacred outlook," the bond with the spiritual guide or "guru," and on more esoteric practices intended to effectuate a realization of the "nature of Mind." Notwithstanding these variances, the underlying Buddhist rudiments of wisdom, meditation, and ethical awareness reflect the root principles of each Buddhist vehicle. The three principles of wisdom, meditation, and ethical awareness are collectively known as "the three trainings" (Sanskrit: *trishiksha*; Pali: *tisso-sikkha*) and encompass the entire spectrum of Buddhist practices. Therefore, section headings of Wisdom, Meditation, and Ethical Awareness are used to conceptually stratify this paper (and each of these three sections are further divided into subsections—Meanings, Current Directions, and Clinical Integration Issues). The classification of Buddhist principles and derivative interventions according to categories of wisdom, meditation, and ethical awareness is also proposed as a system suitable for adoption by Western psychology as part of a unified operational approach.

Method of Interpretation and Didacticism

In our usage and descriptions of Buddhist terms, we have endeavored to impart some measure of their experiential meaning while adhering to widely accepted interpretations and didactic modes (the first two authors have been Buddhist monks for approximately 30 and 10 years respectively, and we all are research psychologists with a clinical focus to our research outlook). Although the views of teachers from a wide range of living Buddhist traditions are reflected, we have frequently favored interpretations as promulgated by the current Dalai Lama. Our reasons for so doing are because the Dalai Lama, although an obvious representative of the Tibetan Buddhist approach (and in particular the Gelug tradition of Tibetan Buddhism), is regarded by many living Buddhist traditions (some contemporary Chinese Buddhist traditions being notable exceptions) as somebody who embodies an authentic worldview of the Buddhist teachings. This fits well with our own view that although it is advisable for clinicians and researchers to be aware that there exist multifarious interpretations of Buddhist terms, it is probably more pragmatic and helpful if they (and perhaps Buddhist adherents more generally) adopt a unifying rather than divisive approach to the Buddhist teachings. Furthermore, the Dalai Lama (as with many Mahayana/Vajrayana Buddhist teachers) accepts the full authenticity of, and uses as a basis, the teachings of the earlier cycle of Buddhist transmission (e.g., the Theravada tradition). Interpretations by the Dalai Lama also were favored because he is frequently cited in the clinical and psychological literature and his teachings are readily accessible to a Western readership.

Consistent with our stated aims, explanations of Buddhist terms are restricted to only those that have become embedded or utilized within the clinical and psychological literature. The present paper is not intended to be an answer for all unresolved Buddhist debates regarding terminological propriety, nor a compendium providing "absolute" definitions of Buddhist terms (such a paper has never been written in the entire 2,500 history of Buddhism). Indeed, each tradition of Buddhism (and arguably each teacher within a given tradition) has their own experiential understanding of a given aspect of Buddhist practice. In fact, each individual term introduced in this paper could easily become the subject of several papers in their own right. Thus, although not without its limitations, the method employed for elucidating Buddhist terms and principles is deemed to be apt given the scope of the paper as well as its intended readership (i.e., researchers, academicians, and clinicians interested in the psychological and clinical applications of Buddhist practice).

Wisdom: Redefining Self and Reality

Meanings

Buddhist wisdom-related terms or concepts frequently referred to in the mental health literature include *wisdom*, *deluded*, *non-self*, *attachment*, *impermanence*, *interconnectedness*, *emptiness*, and *original nature*.

Wisdom. To appreciate some of the nuances of the Buddhist construal of wisdom (and of other aspects of Buddhist thought), Shonin et al. (2013a) recently proposed "ontological addiction" as a new category of addiction (i.e., in addition to substance addiction and behavioral addiction). *Ontological addiction* is defined as "the unwillingness to relinquish an erroneous and deep-routed belief in an inherently existing 'self' or 'I' as well as the 'impaired functionality' that arises from such a belief" (Shonin et al., 2013a, p. 64). The ontological addiction formulation is a means of operationalizing within Western clinical domains the Buddhist view that suffering, including the entire spectrum of distressing emotions and psychopathologic states, results from adhering to a false view of self and reality. Therefore, within Buddhism, wisdom refers to the gradual[3] development of insight that allows and facilitates an individual to undergo recovery from ontological addiction by reconstructing their view of self and reality. Thus, the Buddhist notion of wisdom differs from the Western psychological depiction in which wisdom is generally measured against parameters of knowledge, adaptive psychological functioning, and socioenvironmental mastery (Baltes & Staudinger, 2000).

Deluded. The term *deluded* (or delusional) is frequently used within Buddhism, yet it takes on a much broader meaning when compared to its use in clinical psychology. The concept of *mindlessness* provides a notable example for understanding this difference and for illuminating a key Buddhist premise. Mindlessness (as opposed to mindfulness) refers to a lack of present moment awareness whereby the mind is preoccupied with future (and therefore fantasized) conjectures or past (and therefore bygone) occurrences. In this regard, interesting similarities can be drawn between mindlessness and certain forms of hallucination. Insofar as hallucination refers to the perceiving of that which is not, we argue that mindlessness might be designated as a form of inverted hallucination, due to it being the nonperceiving of that which is. With the exception of individuals who have progressed along the spiritual stream, Buddhism assigns mindlessness as the default

[3] Although many Buddhist teachers advocate a gradual approach to the development of wisdom, other teachers (e.g., in certain Zen traditions) subscribe to an instant view of enlightenment. However, Trungpa (2006) contended that even where wisdom (or enlightenment) manifests instantly, such a breakthrough of realization simply reflects the coming to fruition of practice-born insights that had hitherto remained latent.

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disposition of the population en masse. Thus, the majority of individuals considered mentally healthy and psychosocially adaptive by Western conventions (e.g., as defined by the World Health Organization, 2013) would still be considered to be immersed in delusion according to Buddhist philosophy (Suzuki, 1983).

Non-self. There are numerous formulations of the self in Western psychology and many of these are constructed on the basis of their being a definite "I" entity (see Sedikides & Spencer, 2007). In such formulations, the self is often represented as being separate from the world around it such that the possibility of *self in other* and *other in self* is often overlooked (Sampson, 1999). Furthermore, even in the psychological study of human personality, social relationships, and cognitive and behavioral processes where a self is not explicitly posited, there is an implicit acceptance of an inherently existing "I" (Chan, 2008). Within Buddhism, the term *non-self* refers to the realization that the self or the I is absent of intrinsic existence (Dalai Lama, 2005). As explained in the *Shalistamba Sutra* (Reat, 1993), Buddhism asserts that the individual comprises five aggregates (form, feelings, perceptions, mental formations, and consciousness; Sanskrit: *skandhas;* Pali: *khandhas*) and that an inherently existing self may not be found within the aggregates whether in singular or in sum. For example, the form aggregate (e.g., the human body; Sanskrit and Pali: *rupa*), consists of (among other things) skin, bones, teeth, hair, organs, and tissue. Buddhist teachings assert that the body manifests only in dependence on its constituent parts and that the selfness of body may not be found.

Nonattachment. In many respects, the concept of non-self is intrinsically interwoven with the concept of nonattachment. The Dalai Lama (2001) asserted that attachment is an undesirable quality that leads to the reification of the ego-self. Afflictive mental states arise due to the imputed self incessantly craving after objects it deems to be attractive or harboring aversion toward objects deemed to be unattractive (Chah, 2011). Thus, we argue that the Buddhist notion of *attachment* could be defined as the overallocation of cognitive and emotional resources toward a particular object, construct, or idea to the extent that the object is assigned an attractive quality that is unrealistic and that exceeds its intrinsic worth. The Buddhist nonattachment construct is not discordant with the Western psychological construal of attachment that, in the context of certain relationships, is generally considered to exert a protective influence over psychopathology (Sahdra, Shaver, & Brown, 2010). The reason for this is because Buddhism does not assert that the relationship stakeholders of psychosocially and developmentally adaptive relationships (e.g., between caregiver and child) assign an attractive quality to those relationships that is *unrealistic and that exceeds their intrinsic worth*. An example of the Buddhist portrayal of attachment (i.e., as a maladaptive behavioral strategy) would be a relationship between husband and wife in which one or both parties' relationship behavior is controlling, possessive, and/or highly conditional.

Impermanence. Within Buddhism, *impermanence* refers to the fact that all phenomena are transient occurrences and are subject to decay and dissolution (Sogyal Rinpoche, 1998). Along with suffering and non-self, impermanence constitutes one of the three Buddhist seals[4] or marks of existence (for an introduction to basic Buddhist tenets and teachings, see Bodhi, 1994; Dalai Lama, 2005; Nhat Hanh, 1999a). The universal law of impermanence applies as much to psychological phenomena such as thoughts, feelings, and perceptions, as it does to material phenomena both animate (e.g., the birth, life, death of sentient beings) and inanimate. Cultivating an awareness of the certainty of death (and the uncertainty of the time of death) serves to heighten the practitioner's resolve for spiritual practice (Dalai Lama, 1995a).

Interconnectedness. The term *interconnectedness* is utilized in Buddhism to refer to the interbeing nature of all phenomena (Nhat Hanh, 1992). Each and every occurrence becomes a causal condition for the arising of all subsequent occurrences throughout space and time. For example, one person's out-breath forms part of the next person's in-breath, the decaying corpse provides sustenance for the blossoming tree, and so on. Thus, phenomena are empty of an independent self but are full of all things. Likewise, just as a wave is never separate from the ocean, the human consciousness, despite its relapse into a state of ignorance, can be considered inseparable from the realm of ultimate reality (Sanskrit: *dharmadhatu;* Pali: *dhammadhatu*; Rabjam, 2002).

Emptiness. *Emptiness* is closely related to the principle of non-self but takes on a greater level of profundity whereby all phenomena are deemed to be empty of intrinsic existence (including the concept of emptiness itself). According to the *Prajnaparamita-Hrdaya sutra* (more commonly known as the *Heart sutra*—a key Buddhist teaching on emptiness), "form does not differ from emptiness, emptiness does not differ from form" (Soeng, 1995, p, 1). The meaning of this phrase is profound and it implies that for the enlightened being, samsara (i.e., the mundane world of birth, suffering, death, and rebirth) and nirvana (i.e., the state of total liberation) are in fact one and the same thing. Indeed, a full realization of emptiness represents the quintessence of Buddhist practice and emptiness is intrinsically interrelated with each of the aforementioned wisdom constructs. For example, at a more subtle level, impermanence refers to the moment-by-moment transitory nature of existence (Dalai Lama, 2005). According to this view, phenomena are changing all of the time. Nothing remains static for even an instant. However, if phenomena are in a state of constant flux, then at what point can it be said that they actually exist to undergo change? Thus, the self-contradictory nature of impermanence can, in this manner, be used as a key for intuiting emptiness.

Nagarjuna (2nd-century AD) fathered the Buddhist Madhyamaka school of reasoning, which asserts a middle way between the diametrically opposed extremes of inherent existence and nihilism. However, rather than becoming attached to the concept of a middle way, Nagarjuna (1995) advocated complete freedom from the trappings of inflexible dualistic (e.g., self and other, good and bad, one or the other, etc.) conceptualizations. In other words, even the middle-way standpoint has to be relinquished because if the extremes of existence and nihilism are both belied, then the concept of a middle way is also rendered untenable. Thus, emptiness does not deny that phenomena appear but requires nonconceptualization to intuit the true and absolute manner in which such appearances abide (Huang Po, 1982).

Original nature. Terms such as the *original nature of Mind* occur throughout the Buddhist literature but particularly so in certain Vajrayana and Zen Buddhist contexts (Zen Buddhism is typically regarded as a Mahayana Buddhist vehicle but aspects of

[4] In certain Buddhist systems a fourth seal of nirvana is included.

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the more esoteric Zen approaches might actually be more consistent with Vajrayana practice). The word *Mind* is often capitalized in this context to denote the primordially enlightened Mind as opposed to the everyday mind with its various emotional and knowledge-based limitations. The phrase "nature of Mind" is used to express the view (or realization) that all phenomena are *Mind born* (Norbu & Clemente, 1999). This is a somewhat ineffable concept that is perhaps best illustrated via the analogy of a dream. Various psychosomatic sleep-state symptoms including anxious arousal, sudden screaming, and increased autonomic discharge (e.g., tachycardia, increased respiratory amplitude, perspiration) have been correlated with bad dreams and nightmare disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000; Zadra & Donderi, 2000). Therefore, although the entire dream experience is generally considered to be unreal and self-produced, it is nevertheless experienced as real at the time of dreaming. According to Buddhist exponents of this view, the mode of abiding of everyday waking reality exists in much the same manner (Dalai Lama, 2004; Urgyen, 2000). Although phenomena certainly appear, they are considered (or experienced) to be illusory, without substance, and are deemed to be none other than Mind's luminous spontaneous display (Dudjom, 2005). As stated by the Buddha: "One who looks upon the world as a bubble and a mirage, him the King of Death sees not" (as cited in Buddharakkhita, 1966, p. 67). *Wake-up* is therefore a term sometimes employed by Buddhist teachers (e.g., Norbu & Clemente, 1999) to refer to the process of recovering from ontological addiction and awaking from the deep sleep of primordial ignorance (Shonin et al., 2013a).

Current Directions

In contrast with treatment approaches based on the Buddhist practices of mindfulness or compassion, the clinical utilization of Buddhist wisdom techniques has progressed at a slower pace. Nevertheless, since 2010, several interventions have become operational that attempt to integrate Buddhist wisdom techniques as the central therapy component. An example is Buddhist group therapy (BGT), a 6-week program (weekly sessions of 2-hr duration) in which participants partake in mindfulness practice, diary keeping, sharing of personal stories, and tutoring in the Buddhist wisdom principles of suffering, impermanence, and selflessness (Rungreangkulkij, Wongtakee, & Thongyot, 2011). Diabetes patients ($n = 62$) of Buddhist background with depression who received BGT evinced significant reductions in anxiety over treatment-as-usual controls.

A further and more recent example is meditation awareness training (MAT) (Van Gordon et al., 2013). MAT is an 8-week, group-based secular intervention and employs a comprehensive approach to meditation whereby mindfulness practice is an integral part but does not form the exclusive focus of the program. MAT is grounded in the three Buddhist principles of wisdom, meditation, and ethical awareness, and includes practices designed to cultivate ethical awareness, patience, generosity, loving kindness, and compassion. The intervention also integrates concentrative and insight meditation techniques to encourage a gradual familiarization with concepts such as impermanence and emptiness. In a controlled pilot trial of MAT ($n = 25$), a subclinical sample of university students with issues of stress, anxiety, and depression demonstrated significant improvements over controls in psychological distress and dispositional mindfulness (Van Gordon et al., 2013). In a further recent study of MAT, participants (with issues of stress, anxiety, and depression) experienced a growth in personal agency and a greater willingness to relinquish rigid habitual behavioral patterns that they attributed to preliminary meditative-born insights into emptiness and impermanence (Shonin et al., 2013b).

In addition to the direct evaluation of interventions such as MAT and BGT, empirical support for the clinical utilization of Buddhist wisdom principles is derived from cross-sectional studies. An example is a cross-sectional study (comprising 511 adults and 382 students) by Sahdra et al. (2010) who found that nonattachment predicted greater levels of mindfulness, acceptance, nonreactivity, self-compassion, subjective well-being, and eudemonic well-being. They also demonstrated that the Buddhist nonattachment construct was negatively correlated with avoidance (of intimacy), dissociation, fatalistic outlook, and alexithymia (i.e., a deficiency in recognizing or describing feelings).

Further support for the clinical application of Buddhist wisdom practices comes from the tacit or explicit utilization of such practices within psychotherapeutic modalities more generally. For example, Segall (2003) identified the extent to which Buddhist principles are engrained within various cognitive–behavioral and experiential psychotherapies such as CBT and Gestalt therapy. It is also well-known that Albert Ellis's rational emotive behavior therapy (Elllis, 1994) is heavily influenced by the Buddhist view that attachment and self-grasping lie at the roots of suffering (Christopher, 2003). Furthermore, aspects of Zen Buddhist practice have been shown to support Smith's (1999) ABC (e.g., attentional, behavioral, cognitive) theory of relaxation via a mechanism of nonattachment to cognitive arousal that begets increases in mental quietude and relaxation (Gillani & Smith, 2001).

Indeed, according to Chan (2008), meditation on non-self could complement therapeutic techniques that work at the surface level of behavior and cognition via a mechanism of gradually uprooting egoistic core beliefs. Sills and Lown (2008) used terms such as *witness consciousness* to refer to the process of therapeutic reconnection and transformation that takes place as client and therapist begin to widen their view of self and work in an "open and empty ground state" (p. 80). Thus, an understanding of non-self can enhance therapeutic core conditions because "the more the therapist understands annata [non-self], the less likelihood that the therapy will be about the selfhood of the therapist" (Segall, 2003, p. 173).

The Buddhist principle of impermanence perhaps warrants additional discussion due to its potential utility for facilitating recovery from trauma and grief. Traditional Western models of grief are based on a phasic bereavement process and normally involve stages of (i) shock (ii) distress and denial, (iii) mourning, and (iv) recovery (e.g., Jacobs, 1993). However, a greater familiarization with the impermanent nature of life may exert a form of resilience effect. For example, Wada and Park (2009) suggested that increased acceptance and internalization of impermanence may help to soften the grieving process and facilitate earlier onset of the recovery and restorative phases. Likewise, Kumar (2005) posited that impermanence awareness can assist posttraumatic growth due

to a "radical acceptance" of the transitory and precious nature of human existence (p. 8).

Clinical Integration Issues

Although preliminary findings indicate clinical utility for Buddhist-derived wisdom practices, empirical evaluation of this area of Buddhist practice is at an early stage. Findings should therefore be considered in light of their limitations. For example, both the MAT and BGT quantitative studies (i.e., Van Gordon et al., 2013; Rungreangkulkij et al., 2011) were limited by (i) small sample sizes, (ii) between-groups baseline differences in medication status or levels of psychological distress, and (iii) the absence of an active control group. Furthermore, concepts such as non-self and emptiness are subtle, complex, and somewhat tangential to conventional Western thought. Rather than a data-driven or academic understanding, Buddhism emphasizes the need for regular and prolonged meditation practice so that the realization of such teachings can arise intuitively. Therefore, there are risks associated with concepts such as non-self (Michalon, 2001) that if misunderstood (or incorrectly taught), could easily accentuate any delusional schemas or give rise to defeatist, nihilistic, and/or psychosocially maladaptive beliefs. Additional caution is therefore recommended prior to considering such techniques as viable options for patients with cognitive impairment and/or reality-distortion complexes.

Meditation: Calming and Training the Mind

Meanings

Arguably, the two Buddhist terms related to meditation that are most widely applied in the clinical literature are *meditation* (including concentrative meditation and insight meditation) and mindfulness.

Meditation. Buddhist meditation involves a process of training and developing the mind, and most forms of Buddhist meditation integrate both concentrative (or serenity) and analytical (or insight) components (Dalai Lama, 2001).[5] Concentrative or "tranquil abiding" meditation (Sanskrit: *shamatha;* Pali: *samatha*) involves the calming of afflictive cognitive and emotional states whereas insight or analytical meditation (Sanskrit: *vipashyana;* Pali: *vipassana*) is the process of uprooting such afflictions (Rabjam, 2002). Therefore, to switch from samatha meditation to vipassana meditation, a subtle yet deliberate shift in meditative mode is required to penetrate the "truth" (i.e., the absolute mode of arising) of a particular object (such as the self) (Kongtrul, 1992). This depiction of samatha and vipassana meditation is not only consistent with the Tibetan and general Mahayana Buddhist view (e.g., Dalai Lama & Berzin, 1997; K'uan Yu, 1976), but also with the Theradava Buddhist perspective (e.g., Chah, 2011; Maha Boowa, 1997; Nyanatiloka, 1980).[6] Indeed, according to the Buddha's words as captured in the *Mahavacchagotta sutra* (Majhmima Nikaya sutra 73): "When these two things—serenity and insight—are developed further, they will lead to the penetration of many elements" (Bodhi, 2009, p. 600). Likewise, at various points in the Anguttara Nikaya (one of the five collections of sutras that collectively comprise the Sutra Pitaka—the basket or division of the Buddhist canon comprising the Buddhist sutras), direct reference is made to the "coupling or yoking of tranquillity and insight" (i.e., samatha-vipassana) in order to reach the stage where "all ignorance is abandoned" (Nyanatiloka, 1980, p. 194).

At the initial stages, samatha meditation typically involves the use of a reference point or object of placement to help anchor the mind (Ponlop, 2003). One-pointed concentration on objects such as the breath or a visualized object (normally of spiritual significance such as the Buddha), are typical examples of objects of placement. At more advanced stages, samatha meditation can be practiced with a much broader attentional aspect whereby present moment experience becomes the object of placement (Ponlop, 2003).

Mindfulness. As part of the practice of meditation, mindfulness is the process of ensuring that the mind remains concentrated on the object of placement. Mindfulness therefore involves an observance of emotional and cognitive processes (such as mental formations; Sanskrit: *samskara;* Pali: *sankhara*) that might otherwise result in a loss of concentration. Vigilance is a concept related to mindfulness and refers to the quality of awareness that oversees and regulates mindfulness. In other words, mindfulness ensures that the mind does not wander from the object of placement and vigilance observes that mindfulness is intact (Dalai Lama & Berzin, 1997). Buddhism emphasizes the importance of maintaining meditative awareness beyond formal meditation sessions. In fact, the more advanced meditator should essentially be aiming to practice "nonmeditation," in which no distinction is made between meditation and postmeditation periods (Dudjom, 2005). Therefore, mindfulness plays a vital role in the integration of meditative awareness into everyday life.

Among contemporary Buddhist scholars, there is a sensible level of agreement that the term mindfulness is an acceptable interpretation of both the Pali word *sati* and the Sanskrit word *smrti*. However, it is should be noted that there are different interpretations of both of these terms, and therefore depictions of the Sanskrit term *smrti* and the Pali term *sati* may not always be identical. For example, the Sanskrit root *sat* means truth or to exist, and so if it is accepted that the Pali term *sati* is a transformed borrowing from the Sanskrit *sat* (i.e., as opposed to being part of the Prakrit lexicon), then the Pali term *sati* might be construed as meaning the awareness of the existence of experienced phenomena

[5] Serenity and insight techniques are integral to the development of meditative awareness and are practiced by the vast majority of Buddhist traditions (including traditions from each of the three Buddhist vehicles). However, there are a number of exceptions to this generalization especially in certain Zen Buddhist traditions.

[6] As with many Buddhist practices, vipassana meditation is operationalized differently by different Buddhist traditions. Nevertheless, there is a strong degree of concordance between the three Buddhist vehicles that vipassana meditation involves the use of penetration analysis as a means generating meditative insight or wisdom. For example, in traditional Theravada vipassana practice, the practitioner learns to see the aggregate (or skandha nature) of all phenomena. Instead of seeing things as substances with an essential core, the meditator trains to see phenomena as composed of "skandha parts." All things granulate—no permanent core remains. When the practitioner can see the world through this granulating lens, then insight is said to have arisen. In Mahayana contexts, insight and therefore vipassana practice is depicted in a similar manner but relates more to realizing a nondual outlook—the disintegration of the self-other divide: "I am the child in Uganda, all skin and bones, my legs as thin as bamboo sticks, and I am the arms merchant, selling deadly weapons to Uganda" (Nhat Hanh, 1999b, p. 72).

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in a given moment. This would be distinct from certain interpretations of both *sati* and *smrti* that, from the Buddhist perspective, are less satisfactory due to depicting mindfulness as the faculty of remembering or recollecting (see review of mindfulness definitions by Gethin, 2011). However, given that both the Sanskrit root *smr* and the Pali *sati* can also denote intense thought (Har, 1999), mental activity (Rhys Davids, 1881), or intense cognition, then in the context of Buddhist meditative practice it seems acceptable to render both of these terms as meaning full retention of mind or full awareness of mind (and therefore mind objects) in the present moment (i.e., rather than the remembrance of past events). Slight variations in the meanings and interpretations of these terms are likely to be one reason (among others) why mindfulness is interpreted and operationalized differently by different Buddhist approaches (see, e.g., Kang & Whittingham, 2010; Rosch, 2007).

Despite the above mentioned variations in how Buddhism construes mindfulness, the notion of present moment awareness is regarded by all Buddhist traditions as a central component of mindfulness practice. This present moment awareness generally refers to a full awareness of processes relating to: (i) body, (ii) feelings, (iii) mind, and (iv) phenomena (collectively known as the four establishments of mindfulness; Pali: *satipatthana*; Sanskrit: *smṛtyupasthana;* Nyanaponika Thera, 1983). *Anapanasati* is a Pali word (Sanskrit: *anapanasmṛti*) that means mindfulness of breathing in and out and is a method of arousing the four establishments of mindfulness by using the breath to tie the mind to the present moment while awareness is directed, in turn, to each of the four abovementioned focus points (i.e., body, feelings, mind, and phenomena; see the *Anapanasati sutra;* Majjhima Nikaya sutra 118; Bodhi, 2009). Thus, mindfulness is essential for (i) maintaining meditative awareness, (ii) subduing discursive and ruminating thought processes (Nyanaponika Thera, 1983; Teasdale, Segal, & Williams, 1995), and (iii) cultivating a state of mind conducive to spiritual awakening (Sanskrit: *bodhipakṣa dharma;* Pali: *bodhipakkhiya dhamma*).

Current Directions

Mindfulness meditation has been shown to be efficacious for the treatment of health conditions ranging from depression, anxiety, bipolar disorder, sleep disorder, and substance-use disorders, to HIV, coronary heart disease, chronic pain, fibromyalgia, and cancer (for recent reviews, see Chiesa et al., 2011; Chiesa & Serretti, 2011; de Vibe, Bjørndal, Tipton, Hammerstrøm, & Kowalski, 2012; Eberth, & Sedlmeier, 2012; Fjorback, Arendt, Ørnbøl, Fink, & Walach, 2011; Hofmann et al., 2010; Klainin-Yobas, Cho, & Creedy, 2012; Shonin, Van Gordon, Slade, & Griffiths, 2013; Vøllestad et al., 2012). Discounting a small number of exceptions in which no reliable effect was reported (e.g., Toneatto & Nguyen, 2007), the strongest meta-analytical effect sizes (e.g., Hedges' $g >$ 0.85) are typically evinced for the treatment of mood and anxiety disorders (Hofmann et al., 2010; Vøllestad et al., 2012). However, effect sizes generally fall into the small to moderate range for the treatment of somatic illnesses (e.g., Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004; Ledesma & Kumano, 2009).

Group-based interventions using mindfulness meditation typically adhere to an 8-week secular format and comprise: (i) weekly sessions typically of 3-hr duration, (ii) guided mindfulness exercises, (iii) yoga exercises, (iv) a CD of guided meditations to facilitate daily self-practice, and (v) an all-day silent retreat component (Shonin, Van Gordin, Slade, et al., 2013). The two most established techniques are mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and MBCT (Segal et al., 2002). Variants of MBSR and MBCT include interventions such as mindfulness-based relapse prevention (Bowen et al., 2009) for the prevention of relapse following rehabilitation from substance use disorders, mindfulness-based childbirth and parenting for maternal well-being during (and post-) pregnancy (Duncan & Bardacke, 2010), and mindfulness-based eating awareness training for treating binge eating disorders (Kristeller & Wolever, 2010). Mindfulness is also integrated into a number of cognitive–behavioral one-to-one therapeutic modes such as dialectic behavior therapy (Linehan, 1993) and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999; for a review of the differences/commonalities between the various mindfulness-based interventions, see Chiesa & Malinowski, 2011).

Other forms of Buddhist-derived meditative interventions to be applied in clinical contexts include Vipassana meditation (VM), a technique devised by Satya Narayan Goenka[7] (for reviews, see Chiesa, 2010; Shonin, Van Gordon, Slade, et al., 2013). The VM program is generally conducted in silence as part of a standardized 10-day retreat and includes the use of prerecorded discourses on various Buddhist principles. Studies of VM have demonstrated a range of salutary effects—particularly for incarcerated samples. Examples of outcomes from VM studies in minimum and maximum security correctional settings include: (i) reductions in substance use, alcohol use, and alcohol-related negative consequences (Bowen et al., 2006); (ii) reductions in thought suppression (Bowen, Witkiewitz, Dillworth, & Marlatt, 2007); and (iii) improvements in levels of mindfulness, emotional intelligence, and mood disturbance (Perelman et al., 2012).

Clinical Integration Issues

Although there is a growing body of evidence that attests to the clinical utility of VM and mindfulness-based interventions (MBIs), a number of factors limit the overall validity of empirical findings. Examples of such factors are (i) an overreliance on self-report measures rather than clinical diagnostic interviews; (ii) poorly designed control interventions that do not account for nonspecific factors such as therapeutic alliance, psychoeducation, or physical exercise; (iii) fidelity of implementation not assessed (i.e., to control for deviations from the standard intervention format); (iv) absence of (or poorly implemented) intent-to-treat analysis; (v) variations in the experience and competence of program instructors; (vi) adherence to practice data not elicited; and (vii) heterogeneity between different MBIs in the usage of other Buddhist techniques such as loving-kindness meditation (Van Gordon et al., 2013).

There are also integration issues concerned with the availability of MBIs for service users. For example, only 20% of general practitioners in the United Kingdom report being able to access MBIs for their patients (MHF, 2010). Likewise, although they are based on aspects of Buddhist practice, MBIs do not necessarily

[7] Techniques such as transcendental meditation, kundalini yoga, sahaja yoga, and hatha yoga are not explicitly Buddhist based (i.e., they derive from Hinduism) and are therefore not discussed in the current paper.

represent culturally syntonic treatments for all Asian Americans and Asian Europeans, including those of Buddhist descent (Hall et al., 2011). For example, many lay Asian Buddhists do not practice meditation and may not even be familiar with Buddhist concepts such as emptiness and interconnectedness (see Hall et al., 2011). In fact, compared to the average dedicated Western lay Buddhist, it is probably accurate to say that the practice of the average lay Asian Buddhist is more orientated toward gaining merit (i.e., positive karma) and observing Buddhist ethics to be reborn in conditions (such as a Buddhist monk) that are more conducive to intensive spiritual practice.

Other integration issues relate to the credibility and competence of MBI program instructors. For example, although there are currently attempts to disseminate best-practice and assessment guidelines for MBI teachers (see Crane et al., 2012; Crane et al., 2013), as yet, there are no dedicated regulation and accreditation bodies to stipulate minimum competency levels for MBI instructors. Indeed as it stands, MBI instructors may have as little as 12 months' mindfulness practice and teaching experience following completion of a single 8-week course (MHF, 2010).

It is arguable that the most commonly reported integration issue relating to MBIs is that there remains a lack of consensus within psychology in terms of what defines the mindfulness construct (see Chiesa, 2013; Kang & Whittingham, 2010). Many of the issues in this debate relate to the extent to which Western psychological depictions of mindfulness are consistent with traditional Buddhist perspectives. Given that it is common for MBIs to proclaim a certain grounding in Buddhist practice, this may be potentially confusing (or even misleading) for service users because it is questionable whether mindfulness meditation, as used in MBIs, continues to resemble the faculty of right mindfulness as it is construed by the Buddhist teachings (Shonin et al., 2013b). Indeed, the term *mindfulness meditation* is actually not common to the Buddhist lexicon as in general the technique is simply referred to as mindfulness. Key examples of how Western psychological portrayals of mindfulness differ from the traditional Buddhist perspective are described in the following sections, and illustrative questions that may help to inform scientific debate regarding how best to define and integrate mindfulness within clinical contexts are outlined in Table 1.

1. *Context for practice:* Within Buddhism, mindfulness is practiced in conjunction with numerous other practices and perspectives and is just one aspect (the seventh aspect) of a key Buddhist tenet known as the Noble Eightfold Path. In particular, the successful establishment of mindfulness relies on a deep-seated understanding of the three root principles of wisdom, meditation, and ethical awareness—all of which interact to form a cohesive whole. Thus, concerns have arisen relating to whether MBIs lack foundational congruence and whether the spiritual essence and full potential treatment efficacy of mindfulness has remained intact in its clinically orientated and Westernized form (Howells, Tennant, Day, & Elmer, 2010; McWilliams, 2011; Rosch, 2007; Shonin et al., 2013c; Singh, Lancioni, Wahler, Winton, & Singh, 2008; Van Gordon et al., 2013). Thus, there is an urgent need for Western psychologists to determine and clarify whether, in addition to alleviating psychological and/or somatic distress, MBIs also are primarily intended (and provide the necessary infrastructure) to spiritually empower their participants.

2. *Nonjudgmental awareness:* According to Kabat-Zinn (1994), mindfulness is the process of "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (p. 4). Although there is agreement between Western psychological and (all of the) Buddhist perspectives that mindfulness is fundamentally concerned with becoming more aware of the present moment, the statement that mindfulness necessitates a nonjudgmental awareness requires closer examination. Insofar as the term *nonjudgmental* implies that the mindfulness practitioner should accept (i.e., and not try to reject or ignore) present-moment experiences,

Table 1
Questions Pertinent to the Effective Operationalization of Mindfulness in Clinical and Psychological Domains

Facet of mindfulness meditation	Illustrative question
Connectivity to other meditative components	• Is mindfulness (e.g., as utilized in programs such as MBSR and MBCT) considered to be a standalone practice or just one key faculty of meditation that cooperates with properties such as concentration and vigilance?
Attentional breadth	• Does use of the term *mindfulness meditation* (i.e., in Western psychological contexts) simply refer to the practice of everyday mindfulness (as practiced during day-to-day tasks) while adopting a seated meditation posture? • Alternatively, does seated mindfulness meditation involve greater concentration on a particular object of mind (e.g., the breath, feelings, or thoughts)? • If so, in what way does mindfulness meditation differ from referential forms of concentrative (*samatha*) meditation? • If seated mindfulness meditation practice does not involve such object-focused concentration, then in what way does it differ from nonreferential open-aspect forms of *samatha* meditation in which present moment experience is assumed as the focus of concentration?
Insight generation	• Do qualities of mindfulness meditation such as "a clear focus on aspects of active investigation of moment-to-moment experience" (Hofmann, Grossman, & Hinton, 2011, p. 1127) refer to a more analytical (and therefore insight-generating) component? • If so, is this an active form of analysis (consistent with the traditional Buddhist approach, see Chah, 2011; Dalai Lama & Berzin, 1997) that refers to a distinct shift toward a more penetrative meditative mode (i.e., by searching for the self, the mind, or the intrinsic existence of a particular object)? • Alternatively, does the Western clinical operationalization of mindfulness meditation feature a more passive form of analysis (as appears to be the case in Goenka's VM approach) in which (for example) insight simply refers to a better understanding of "the nature of thoughts and feelings as passing events in the mind" (Bishop et al., 2004, p. 234)?

Note. MBSR = mindfulness-based stress reduction; MBCT = mindfulness-based cognitive therapy; VM = Vipassana meditation.

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then it is likely that most Buddhist traditions would agree that this is an appropriate term. However, the term nonjudgmental could also imply that the mindfulness practitioner does not seek to discern which cognitive, emotional, and behavioral responses are conducive to the upholding of ethical commitments and to spiritual development in general. This would obviously be inconsistent with the Buddhist perspective. Thus, a more comprehensive elucidation by Western psychologists of the intended meaning of the term nonjudgmental is required to reconcile ambiguity concerning the use of this term.

3. *Insight generation:* In the clinical literature, the terms *vipassana meditation* and *insight meditation* are frequently used interchangeably with the term mindfulness meditation. Indeed, vipassana meditation is often referred to as a form of meditation in which awareness is directed in a nonreactive manner to the stream of internal thoughts, emotions, perceptions, and so forth, as they spontaneously arise in the present moment (e.g., Bowen et al., 2006; Chiesa, 2010; Sills & Lown, 2008). However, this depiction of vipassana meditation (and insight meditation) is inconsistent with the traditional (and already outlined) Theravada, Mahayana, and Vajrayana Buddhist perspectives. In these traditional contexts, vipassana meditation refers to the use of (various styles of) penetrative analysis to give rise to transcendent insight or wisdom (e.g., Bodhi, 2009 [e.g., see Majjhima Nikaya sutra 73]; Chah, 2011; Dalai Lama, 2001; K'uan Yu, 1976; Maha Boowa, 1997; Nyanatiloka, 1980; Rabjam, 2002). In fact the terms vipassana meditation and insight meditation, as used in the clinical literature, more accurately describe the practices of mindfulness or certain forms of open-aspect concentrative meditation (sometimes referred to as samatha without reference).

One possible source of this confusion are contemporary (i.e., 20th/21st century) and primarily Theravada-derived Buddhist insight meditation movements such as the one initiated by Satya Narayan Goenka (see previous subsection on Current Directions) in which vipassana meditation is depicted as being similar to mindfulness meditation. However, rather than a form of mindfulness practice (as implied by Goenka and certain Western psychologists), the classical Buddhist teachings explicate that vipassana (which actually means superior seeing) involves a different and more investigative meditative mode that can only be applied after first calming and placing the mind using samatha techniques (see previous section on the meanings of the terms meditation and mindfulness). This is certainly not to say that Goenka's and certain other contemporary styles belonging to the insight meditation movement are not authentic in their transmission of the Buddhadharma (because they undoubtedly are). However, it does mean that their use of certain Buddhist terms is not always consistent with the traditional construal. Furthermore, although mindfulness meditation certainly leads to the generation of insight in the sense that it facilities for example, a better understanding of "the nature of thoughts and feelings as passing events in the mind" (Bishop et al., 2004, p. 234); mindfulness meditation is not insight meditation as per the traditional Buddhist understanding. Thus, for the purposes of avoiding (further) inconsistency, terminological inaccuracy, and confusion in the clinical psychology literature, it is our view that any contemporary system that differs from the interpretation of samatha and vipassana meditation as depicted in the classical Buddhist (Theravada, Mahayana, and Vajrayana) literature, should not be adopted by Western clinicians and researchers.

Although there is an urgent need for greater clarity relating to several aspects of the Western psychological mindfulness formulation, rather than academicians striving to devise and disseminate an all-encompassing model and definition of mindfulness, one insightful means of reconciling aspects of the mindfulness definition debate might be to just accept that "the definition of mindfulness will vary depending on whether one is interested in mindfulness from a social psychological, clinical, or spiritual context, or from the perspective of a researcher, clinician, or a practitioner, and their various combinations" (Singh, Lancioni, Wahler, Winton, & Singh, 2008, p. 661). Likewise, it is improbable that an absolute definition of mindfulness will ever be formulated because as a spiritual phenomenon, certain dimensions of the mindfulness construct will always be somewhat ineffable and only fully understood by those individuals who can tap into them on the experiential rather than empirical or academic plane.

Ethical Awareness: Constructive Thoughts and Behaviors

Meanings

Terms frequently employed in the clinical literature that can be subsumed under the heading of ethical awareness include *ethical discipline* (also referred to as ethical awareness) as well as more conduct-related terms such as *generosity*, *patience*, *loving kindness*, and *compassion*.

Ethical discipline. Ethical discipline lies at the roots of Buddhist practice and serves to ensure that spiritual progress does not fall prey to spiritual materialism (Trungpa, 2002) or become derailed by mundane aspirations. Tsong-kha-pa (2004) defined ethical discipline as "an attitude of abstention that turns your mind away from harming others and from sources of such harm" (p. 143). Without ethical awareness in terms of which actions (of body, speech, and mind) to adopt and which to reject, then constant craving for sensory or emotional gratification prevents meditative quiescence from arising (Dalai Lama, 2001). Various systems (or combined systems) of precepts are used as supports for observing ethical discipline (e.g., the Pratimoksha vows of Theravada Buddhism, the Bodhisattva vows of Mahayana Buddhism, the Samaya vows of Vajrayana Buddhism).

Precepts are not imposed as a series of rigid rules. Rather, they serve to synchronize spiritual practice with the law of the effects of actions (karmic law). The Buddha advocated a middle way between the behavioral extremes of overindulgence and total abstinence (Nanamoli Bhikkhu, 1979). However, rather than the avoidance of certain experiences or situations, the most essential point is that actions should be governed by a complete freedom from attachment or aversion. For example, in the *Mahasakuludayi sutra*, the Buddha explained that he sometimes ate "choice rice and many sauces and curries," lived "in gabled mansions," and acquainted with "kings and king's ministers," yet such activities did not affect his virtue or wisdom (Bodhi, 2009, pp. 633–634). Thus, for the highly experienced practitioner who is free from attachment, ethical awareness transcends any concept of right or wrong (Rabjam, 2002; Trungpa, 2003).

Generosity. Rather than Western psychology's construction of generosity (or altruism) as concern for the welfare of others

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(Batson, 2011), Buddhism conceptualizes generosity more as a dedication and unconditional giving of one's entire being (e.g., presence, time, meditative insight) and resources (including spiritual teachings) for the benefit of others (Dalai Lama, 1995b). Most important, this begins with altruism and kindness toward oneself.

Patience. Patience is born from generosity and nourishes the practitioner with fortitude to endure the challenges of spiritual practice as well as the wrongs inflicted by others. Santideva (1997), an eighth century Indian Buddhist saint stated that "the mind does not find peace, nor does it enjoy pleasure and joy, nor does it find sleep or fortitude when the thorn of hatred dwells in the heart" (p. 60). According to the Buddhist view, patience leads to contentedness and a state of open acceptance to the present moment and is therefore a key attribute of mindfulness. The Buddhist idea of perfected patience is a state beyond all hope and fear and beyond any desire to modify the present moment.

Loving kindness and compassion. Loving kindness refers to the wish for all beings to have happiness and its causes; while compassion refers to the wish for all beings to be free from suffering and its causes (Bodhi, 1994). Within the Tibetan *lojong* (mind training) modality, a meditation technique known as *tonglen* or *giving and taking* involves straddling the visualization practices of taking others' suffering and giving one's own happiness astride the in-breath and out-breath, respectively. In this manner, giving could be regarded as the meditative actualization of loving kindness and taking as compassion.

The Buddhist construal of loving kindness and compassion does not involve any sense of pity and is perhaps best elucidated within the framework of the Four Immeasurable Attitudes (Sanskrit: *catvari brahmaviharahs;* Pali: *cattari brahmaviharas*) of (i) joy, (ii) loving kindness, (iii) compassion, and (iv) equanimity. Joy (as one of the four immeasurable attitudes) emphasizes the Buddhist view that loving kindness and compassion can only be forged from a mind that is already pacified and well-soaked in meditative bliss. Equanimity stresses the need for unconditionality and impartiality in the cultivation of loving kindness and compassion that are extended in equal and unlimited measure to all sentient beings irrespective of whether they be friend or foe (for an in-depth elucidation of the Four Immeasurable Attitudes see the "Vissuddhi Magga" [an important Buddhist treatise on the "Path of Purification"]; Nanamoli Bhikkhu, 1979). Each of these conduct-related practices (e.g., generosity, patience, loving kindness, compassion) should be conducted free from any dualistic view. For example, when compassion is suffused with emptiness, and therefore stems from a realization that there is no self (and hence no giver) and no other (and hence no receiver), then, according to Buddhist teachings, acts of great compassion (Sanskrit and Pali: *maha karuna*) can arise spontaneously (Khyentse, 2007; Trungpa, 2003).

Current Directions

In the last 10 years, compassion meditation (CM) and loving-kindness meditation (LKM) have been the subject of increasing clinical interest (for reviews, see Hofmann, Grossman, & Hinton, 2011). This is consistent with the growth of publications relating to CM and LKM in mainstream Western meditative culture (e.g., Chodron, 1996). Accordingly, a number of novel interventions have been formulated with the intention of operationalizing CM and LKM as palatable techniques for Western service users. Of notable interest is an intervention known as cognitively based compassion therapy (CBCT; Pace et al., 2009). CBCT is a group-based, 6-week (or similar) long secularized intervention based on the Tibetan Buddhist mind training technique. Participants attend weekly or twice-weekly classes ranging from 50 min to 2 hr duration and receive instruction on meditative practices intended to cultivate self-compassion and compassion.

Outcomes from recent studies of CBCT include (i) reductions in innate immune and distress responses to psychosocial stress in healthy adults (Pace et al., 2009), (ii) reductions in salivary concentrations of C-reactive protein (an inflammatory biomarker for psychopathology) in adolescents with high rates of early life adversity (Pace et al., 2012), (iii) reductions in levels of depression for adolescents at-risk for psychopathology (Reddy et al., 2013), (iv) improvements in empathic arousal in healthy adults (Mascaro, Rilling, Negi, & Raison, 2013), and (v) increased emotion regulation capacity as evinced by increases in right amygdala responses to an image-based emotion eliciting task (Desbordes et al., 2012).

A further technique incorporating compassion practices is compassion-focused therapy (CFT; Gilbert, 2009). CFT is a one-to-one therapeutic mode in which clients/patients typically attend 1-hr sessions over a 12-week period. CFT integrates a technique the author terms compassionate mind training in which a client's shameful and self-disparaging tendencies are displaced by therapist-led compassionate regard. Outcomes from several small pilot studies suggest that CFT may help to (i) reduce anxiety and depression in patients with chronic mood disorders, and (ii) reduce hostile auditory hallucinations in patients diagnosed with paranoid schizophrenia (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008).

Recent studies also have returned promising findings for the clinical utilization of LKM. Participants of LKM interventions are typically instructed to direct feelings of love and kindness first toward themselves, then toward a neutral person (e.g., the postman), toward a person who was a source of difficulty (e.g., a disrespectful former boss), and finally toward all living beings (Carson et al., 2005). Similar to CM interventions, LKM interventions are normally group based and of a secular nature. Participants attend weekly sessions (1- to 2-hr duration) over a 6- to 8-week course and receive a CD of guided meditations to facilitate daily self-practice.

Outcomes of recent LKM intervention studies include (i) reductions in pain intensity and psychological distress in patients with chronic lower back pain (Carson et al., 2005), (ii) improvements in asociality, blunted affect, self-motivation, interpersonal relationships, and relaxation capacity in patients diagnosed with a schizophrenia-spectrum disorder (Johnson et al., 2009), and (iii) improvements in anhedonia, intensity of positive emotions, consummatory pleasure, environmental mastery, self-acceptance, and satisfaction with life in outpatients with a schizophrenia disorder (Johnson et al., 2011).

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Clinical Integration Issues

It appears that CM and LKM interventions represent promising novel treatments for a broad spectrum of psychological disorders. Nevertheless, findings from CM and LKM intervention studies should be considered with caution due to being limited by factors such as (i) small sample sizes (sample sizes in the above mentioned studies ranged from three to 93 participants), (ii) differences between intervention and control groups in baseline characteristics, (iii) fidelity of implementation not controlled for, (iv) poorly designed control conditions, and (v) high attrition rates.

Caution is also recommended in the delivery of CM and LKM techniques to avoid adverse treatment effects. For example, some care providers (e.g., nurses) have been identified as at-risk for compassion fatigue, a form of secondary traumatic stress incurred during the provision of care to patients with illnesses of a distressing nature (or who have experienced a traumatic event; Yoder, 2010). For this reason, prior to embracing the suffering of others (and acting unconditionally to alleviate that suffering), Buddhist practitioners are first taught to cultivate emotional stability within themselves and to become fully aware of the nature of their own suffering (Khyentse, 2007). Consistent with this approach, higher levels of self-compassion (Thompson & Waltz, 2008) and mindfulness (Follette, Palm, & Pearson, 2006) have both been shown to reduce maladaptive posttraumatic avoidance strategies. Thus, there are certain risks associated with the practices of compassion and loving kindness yet it appears that these can be mitigated via the prior development of self-compassion and mindful awareness. In a similar vein, future clinical and scientific enquiry could explore whether the Buddhist practices of joy and equanimity (i.e., the other two of the four Brahmaviharas) can augment the effectiveness of LKM and CM interventions, or whether these practices have clinical utility in their own right.

Considering the complications involved in defining mindfulness, it is probable that attempts to define CM and LKM will meet with similar operational challenges. Indeed, in addition to the degree of construct overlap that exists between CM and LKM, there is also an element of overlap between both of these meditative techniques and mindfulness meditation. For example, Johnson et al. (2009) described LKM as a technique that "involves quiet contemplation, often with eyes closed or in a nonfocused state and an initial attending to the present moment" (p. 503) in which participants are instructed to "nonjudgementally redirect their attention to the feeling of loving kindness when attention wandered" (p. 504). Based on such descriptions, it is difficult to discern where mindfulness practice ends and LKM (or CM) practice begins. Thus, an operational challenge for CM and LKM interventions is the need to establish clear and accurate workable definitions as well as a thorough depiction of the unique attributes of these techniques relative to other forms of meditation.

Conclusions

There is growing evidence for the salutary effects of BDIs in the treatment of psychopathology. Although clinical interest has predominantly focused on mindfulness meditation, recent years have seen an increase of investigation into other Buddhist techniques. Nevertheless, much remains to be done in terms of strengthening the evidence base for BDIs and for exploring currently untapped ground. For example, Ekman, Davidson, Ricard, and Wallace (2005) emphasized the pivotal role that Buddhist principles can play in informing the direction of emotion-based research. Likewise, although there is some research examining the role of patience as a predictor of adaptive psychosocial functioning (e.g., Curry, Price, & Price, 2008), exploring the Buddhist dimensions of such qualities (e.g., nonreactivity, contentedness, desirelessness, etc.) may lead to greater application within the clinical setting.

According to the Buddhist teachings, sustained ethically informed and insight-driven effort over a prolonged period of time are prerequisites for *sukha* (a Sanskrit and Pali term interpreted by Ekman et al., 2005, as meaning enduring psychological well-being[8]). Therefore, a certain degree of realism is required in terms of what treatment outcomes can be expected from BDIs of 8-week (or similar) duration. Indeed, treatment plans are likely to benefit by factoring in regular meditation booster sessions as well as progressively more advanced meditation or mindfulness training. Likewise, instructors of BDIs may wish to consider the merits of receiving prolonged training in meditation so as to be able to impart an embodied authentic transmission of the subtler aspects of meditation practice (Shonin et al., 2013c). Of vital importance in this respect is that clinicians who utilize Buddhist techniques in client–patient contexts understand that the Buddhist approach to spiritual transmission is one that encourages the individual to investigate and experience the potency of the Buddhist teachings for themselves, and to awaken and then rely on the teacher within. This is consistent with the Buddha's dying words as recorded in the Mahaparinivana sutra (Digha Nikaya sutra 16):

> Therefore, Ananda, you should live as islands unto yourselves, being your own refuge, with no one else as your refuge. (Buddha as cited in Walshe, 1995, p. 245).

Integration issues are an inevitable consequence of the migration of Buddhist practices from Eastern to Western cultures, and from spiritual to clinical domains. Indeed, Buddhist practice traditionally takes place in the context of spiritual development whereby enlightenment, a state of total liberation and omniscience, is the ultimate goal. Therefore, one obvious concern that Buddhist teachers are likely to have regarding the ongoing integration of Buddhist practices into clinical psychology is that rather than being employed for the purposes of eliciting favorable treatment outcomes for patients with psychological disorders, the Buddhist teachings could actually be used to help patients achieve much more of their full human potential.

Evidently, there is a degree of confusion within the clinical and psychological literature relating to the appropriate usage of certain Buddhist terms and practices. Due to this, there is a need for greater dialogue between experienced Buddhist teachers and psychopathology clinicians and researchers to establish robust operational foundations for BDIs. There is also a need for greater disciplinary dialogue so that clinicians and researchers adopt a unified and structured approach toward the clinical implementation of Buddhist practices. Such dialogues will not only be para-

[8] Other interpretations of "sukha" typically depict it as a blissful state—particularly in association with Theravada jhana practice.

mount in safeguarding the ethical values, efficacy, and credibility of BDIs, but will also help to preserve the authenticity of the Buddhist teachings in general.

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