

October 2021

Delusional Mitigation in Religious and Psychological Forms of Self-Cultivation: Buddhist and Clinical Insight on Delusional Symptomatology

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Introduction

The question and nature of human suffering will continue to be one of the most significant challenges humanity faces, and the means to alleviate human suffering continues to be a deserving aim of human activity. Human suffering is one of the most complex challenges we as a human species face in the forms of extreme hunger and poverty, domestic and inter-state conflict, famine, drought, health-care access, child mortality, racial, gender, and sexually-orientated forms of discrimination and prejudice that pose existential challenges to human happiness and flourishing. Central to the concerns of all the world's religions is the nature of human suffering in the world. Countless religious and spiritual traditions have proposed ways of overcoming this suffering since the beginning of human history. Religion poses a unique cognitive method of dealing with and effectively responding and interacting with the world in which we are located.

The project of psychology shares a similar aim with that of many of the world's religions: alleviating human suffering. Much of the science of psychology is directed towards the alleviation of human suffering, though the source and means of overcoming this suffering may differ between the approaches. The project of clinical psychology shares the goal of addressing human suffering, where suffering may be a feature of physical or mental illness that entails real human suffering to which psychological science seeks to alleviate and ultimately remove (Fleischman, 1999, pp. 3-32).

It is hypothesized that religion and psychology represent independent but compatible domains of addressing the problem of human suffering. Human beings have the radical ability to transform themselves and the world around them, and it is that religion and psychology enable radical human change in addressing the *real* presence of suffering in the world. The aim here is

to consider how religion and psychology enable individuals and societies to effectively perceive and interact within the world of events. Buddhism and psychology effectively train individuals to respond to events by cultivating states of clear human perspective that enable greater happiness and flourishing through modifying delusional perspectives that influence human suffering.

Buddhist Perspectives on Cultivation and Delusions

Fundamental to the Buddhas' teachings are to "avoid all evil, cultivate the good, purify your mind: this sums up the teaching of the Buddhas" (Easwaran, 2007, p. 170: Dhammapada, verse 183). The wide range of practices seen within Buddhism today still emphasizes cultivating what is ethically wholesome. The process of purifying one's mind enables an understanding of how human beings may change themselves through a process of intentional action (Harvey, 2000). Buddhism has a variety of teachings that function as a process of helping individuals develop a calmer, more integrated, and compassionate disposition that removes delusions that reduce the ability to see things as they truly are (Harvey, 2000, p. 3). Delusions are central within Buddhism; delusions cause attachment, creating suffering for individuals and those they interact with (Harvey, 2000, p. 3). Buddhism provides a guide that enables the transformation of human experiences away from the reality of suffering in the *dharma*: the nature of reality regarded as a universal truth taught by the Buddha, with the end of suffering gained through reaching a liberated state in *Nirvana* (Harvey, 2000, p. 3). Buddhism essentially consists of understanding, practicing, and realizing the reality of the dharma (Harvey, 2000, p. 3).

The Buddha teaches that greed, hatred, and delusion (*moha*) are states that contribute to suffering; and are harmful to the person when they arise (Harvey, 2000, pp. 9-10). When an individual is overwhelmed by negative cognitive states, they are more likely to commit harmful deeds and suffer due to the karmic results of their action (Harvey, 2000, p. 10). The Buddha

notes that the opposite of delusion, posed as a negative, in being non-delusional is beneficial, wholesome, and conducive to happiness, and therefore we should undertake to remove delusions as a means of producing happiness (Harvey, 2000, p. 10). The Buddha places a high value on states of mind, which are the antithesis of greed, hatred, and deluded unclarity or disorientation, as they are found to contribute to human happiness rather than human suffering (Harvey, 2000, p. 10). Delusions are suspended in the practitioner through the progressive development of human insight that facilitates greater understanding and introspection (Harvey, 2000, p. 10). Buddhists see the current context of life as a result of the karmic principle of actions, but Buddhism does not hold that individuals are to be presently blamed for their conditions since the actions of a past life are behind them; what is important is how they behave in the present and how others now treat them (Harvey, 2000, p. 16). Buddhist systems of belief and practice teach that human beings should not be judged and left to suffer, no matter the cause of such. Essential in the teachings of Buddhism is how individuals seek to address their conditions and how others treat them as capable of transformation.

The law of karma is seen as a natural and universal law inherent in the nature of things, and good and bad rebirths are not rewarding or punishing per se but are the natural result of certain kinds of actions (Harvey, 2000, pp. 16-17). Karma is viewed as the overall psychological impulse behind human emotion and action that influences their causes and affects karmic results (Harvey, 2000, p. 17). Deliberately mitigating negative affectivity is understood to derive good mental karma, where the mind is seen as continually generating good and bad karma (Harvey, 2000, p. 18). Buddhists hold that wrong views lead to wrong thought and that wrong speech and action come from misperceiving the nature of reality or being in discord with the fundamental nature of things: a delusion (Harvey, 2000, p. 18). Wrong actions or behavior results from

misperceiving reality; *delusions go against the grain of reality*, and they naturally lead to unpleasant results (Harvey, 2000, p. 18).

Dukkha is of primary concern within Buddhism; dukkha is commonly translated: as suffering, unhappiness, pain, dissatisfaction, discontentment, or strain (Harvey, 2000, p. 33). The aim of overcoming dukkha or suffering is both a personal and collective concern (Harvey, 2000, p. 33; De Silva, 2005, p. 107). Buddhists come to understand the role of suffering in human existence by seeing that they contribute to their suffering through a path of incorrect perceptions, cognitions, and behaviors (Harvey, 2000, p. 33). Through our knowledge of suffering, we gain the knowledge and care that others also experience similar qualities of suffering in existence. Individuals lack an understanding of impermanence, where the inherent nature of change and decay operates, and this lack of understanding concerning impermanence leads to suffering. Impermanence does not imply a fixed nature or self, which means humans are always capable of changing for the better and should be regarded accordingly, rather than dismissed as unworthy (Harvey, 2000, p. 34). Labeling someone as having a particular fixed nature often has a more harmful effect on them, whereas respecting them helps elicit change for the better, paralleling Carl Rogers' unconditional positive regard (Rogers, 1951). Rogers held that it is necessary within a clinical setting to support individuals despite what they have said or done in order to facilitate positive humanistic growth (Rogers, 1951, p. 64).

Buddhists perceive delusion or spiritual misorientation as *the veiling of truth from oneself* that obscures clear states of cognitive perception (Harvey, 2000, p. 47). Non-delusional states entail a clarity of the mind that enables insight into the nature of reality (Harvey, 2000, p. 47). Buddhists hold that the roots of unwholesome and harmful actions are interrelated, where greed and hatred manifest in delusional states (Harvey, 2000, p. 47). Buddhists highly value developing

or cultivating wisdom and knowledge to overcome deluded perspectives (Harvey, 2000, p. 47.) In Buddhism, human behavior is assessed in terms of its direct effects of causing suffering or happiness (Harvey, 2000, p. 47). Within the beliefs of Buddhist practitioners, a system of cultivation or development exists which helps individuals overcome negative states of greed, hatred, and delusion (Harvey, 2000, p. 51). Above all, the Buddhist perspective views prosocial behavior as part of a spiritual path that cultivates a more wholesome character by undermining ethical defilements through developing counteractive virtues (Harvey, 2000, p. 58). A process of gradual transformation is seen to culminate in a state of liberation (*Nirvana*) from all greed, hatred, *delusion*, and the subsequent suffering that follows. Liberation requires that people have not a fixed, unchangeable self but are capable of radical transformation brought about by analyzing the nature of the mind and behavior; this is the essential project of psychology. (Harvey, 2000, p. 58).

In conclusion, Buddhism aims to overcome greed/attachment, hatred, and delusion, which are seen as the roots of harmful actions, behaviors, and mental states that are the principal conditions of human suffering. The ultimate reality perceived within Buddhism is *Nirvana*, which entails the destruction of cognitive delusions and distortions. Delusions may be mitigated by avoiding intoxication and cultivating mental clarity that allows individuals to see things as they truly are through meditative development that cultivates insight (Harvey, 2000, p. 122).

Clinical Insight on Delusions

Delusional symptomatology is a characteristic and chronic feature of the schizophrenia spectrum and includes disorders such as schizophrenia, schizotypal personality disorder, schizoaffective disorder, and other psychotic disorders (Diagnostic and Statistical Manual of Mental Disorders, 2013, p. 87). Abnormalities define the spectrum of schizophrenia in one or

more of the following five domains: delusions, hallucinations, disorganized thinking, speech, and grossly disorganized or abnormal motor behavior (including catatonic states), and negative symptoms (i.e., those which take away affective or experiential states) (DSM-5, 2013, p. 87).

Delusions are highly personal ideas or belief systems, not endorsed by one's culture or subculture, that are maintained with conviction despite irrationality or evidence to the contrary (American Psychological Association Dictionary, 2020). Delusions may be transient and fragmentary; in delusional disorders, they are often highly systematized and elaborate (American Psychological Association Dictionary, 2020). Statistical data suggests that delusions are not primarily logical errors but are derived from emotional events (Kiran & Chaudhury, 2009, pp. 3-18; American Psychological Association Dictionary, 2020). Some research suggests that delusions may be the most significant symptom of schizophrenia (American Psychological Association Dictionary, 2020).

Delusions are fixed beliefs that are not amenable to change considering conflicting evidence (DSM-5, 2013, p. 87). Common types of delusions are delusional jealousy, delusions of control, delusions of reference, nihilistic delusions, and somatic delusions (American Psychological Association Dictionary, 2020). Persecutory delusions entail the belief that one will be harmed, harassed, and so forth by an individual, organization, or group in the pursuit of goals (DSM-5, 2013, p. 87). Referential delusions entail the belief that certain gestures, comments, environmental cues are directed at oneself, falsely believing they have personal meaning or significance (DSM-5, 2013, p. 87). Grandiose delusions entail individuals believing they have exceptional abilities, wealth, or fame (DSM-5, 2013, p. 87). Nihilistic delusions involve convictions that a major catastrophe will occur (DSM-5, 2013, p. 87). Somatic delusions are preoccupations regarding health and organ functioning (DSM-5, 2013, p. 87). Erotomaniac

delusions entail the false belief that another romantically desires them (DSM-5, 2013, p. 87). The DSM-5 does not address or specify religious delusions as a facet of the symptomatology of delusions and instead prefers to resist pathologizing religion. The Encyclopedia of Mental Disorders defines *religious delusions* as any delusion with religious or spiritual content, which may co-occur with other delusions (1998). It is necessary to note that beliefs considered normal for an individual's religious or cultural background are not delusions, regardless of their veracity (DSM-5, 2013).

Delusions may be bizarre and non-bizarre. Delusions are considered bizarre if they are implausible and are not understood, nor are common within same-culture peers and do not derive from ordinary life experiences (DSM-5, 2013, p. 87). Bizarre delusions are impossible; non-bizarre delusions are plausible, though they are not probable since they do not hold convincing evidence (DSM-5, 2013, p. 87). Delusions that express a loss of control over the mind or body are considered bizarre, including believing that one's thoughts have been removed and other thoughts not of personal origin have been inserted (DSM-5, 2013, p. 87). Another example of bizarre delusions entails believing that one's body is being manipulated by an outside force that entails delusions of control. The distinction between a delusion and a strongly held idea is sometimes difficult to differentiate and depends largely upon the level of conviction held with a particular belief despite strong and clear contradictory evidence of its validity (DSM-5, 2013, p. 87).

Psychological Forms of Delusion-mitigation through Cultivation

In referencing psychological forms of cultivation, we employ a comparative analysis of the respective lexical domains of religious and scientific knowledge to consider religious cultivation in terms of development, benefit, or improvement that essentially strongly covaries

with the construct of cultivation. The essential project of clinical psychology is aimed towards generating a healthy cognitive and behavioral composition of the person that enables the greatest level of functionality with a minimum amount of suffering. Psychology necessarily entails the cultivation or development of new cognitive states of human existence that transcend or mitigate the effect of major mental illnesses.

Self-cultivation is hypothetically constructed to define a process of cultivating the mind and body through a process of integration and communication. Self-cultivation is associated with attempts to go beyond normal states of being that enhance and continually develop an individual's capacities and potentials (Wang, Wang, and Wang, 2014, p. 351). Self-cultivation is conceived by Wang et al. (2014) as a psychological process that develops and improves one's mind and body into a more stable and organic whole (pp. 340-351). Self-cultivation is a developmental model that sees human beings as progressively becoming integrated into larger and larger circles of human concern (Wang et al., 2014, pp. 340-351). Self-cultivation entails the possibilities for growth towards an individual's potential (Wang et al., 2014).

There is a two-sided relation between nature and cultivation/improvement; culture relates to nature in a way that dialectically combines apparent contradictions between the nurturing of nature (Derksen, 2017, p. 202). Development as cultivation tends to shape and change nature, but the tools of cultivation are themselves derived from nature (Derksen, 2017, p. 202). Cultivation suggests spontaneous growth and its regulation through a natural process, while simultaneously, the practice of cultivation is a process that is intended through human regulation (Derksen, 2017, p. 202). The cultivated implies the uncultivated that comes before it; *cultivation transforms and shapes human nature, but only up to a point* (Derksen, 2017, p. 202). The concept of self-cultivation in psychology offers a perspective on human nature that entails transforming our

conditions through developmental practices (Derksen, 2017, p. 202). Self-cultivation is increasingly done with the help of experts, but it is not done by experts (Derksen, 2017, p. 202).

The pursuit of well-being broadly refers to states of optimal development, flourishing, happiness, life satisfaction, or otherwise leading a life worth living (Sovereign & Walker, 2020, p. 1-20). Happiness is a complex construct describing optimal function and experience; subjective well-being is described as the integration of several socio-affective constructs (Sovereign & Walker, 2020, p. 1-5). Subjective well-being constructs encompass an individual's emotional responses, cognitive satisfaction with their lives, and global judgments regarding their overall level of satisfaction (Sovereign & Walker, 2020, pp. 1-9). Sovereign and Walker (2020) note that the innate capacity for human learning, growth, and development are regarded as humanity's greatest potentials for continual development (pp. 1-20). Sovereign and Walker (2020) hypothesized that cognitive mechanisms might be fortified through self-development techniques that enhance subjective well-being (pp. 1-20). The human capacity to shape oneself according to one's own will has widely been held as the fundamental premise of most psychological and counseling techniques (Sovereign & Walker, 2020, pp. 1-9). This outlook is referred to as a growth mindset, one in which continually develops talents, skills, and abilities; and thereby increases the likelihood of attaining their ambitions (Sovereign & Walker, 2020, pp. 1-20).

Within a clinical application of psychology, the cultivation, development, or improvement of clinically significant levels of delusional symptomatology are endowed through a process of cognitive restructuring. Cognitive restructuring refers to a process of recognizing negative thoughts and changing them to be more realistic and rational (Craighead & Nemeroff, 2004, p. 148). Cognitive restructuring is designed to help patients identify and challenge their

patterns of thinking to see things in a more objective manner (Craighead & Nemeroff, 2004, p. 148). Cognitive restructuring seeks to replace negative patterns of thought and perception with alternative thoughts that are positive, calming, and insightful (Craighead & Nemeroff, 2004, p. 667). Cognitive restructuring entails identifying emotions, using emotions, understanding emotions, and managing emotions through self-regulation (Craighead & Nemeroff, 2004, p. 217). In the 1960s, psychologist Aaron Beck developed cognitive therapy based upon the principle that maladaptive behavior (ineffective, self-defeating behavior) is caused by irrational or deluded thinking patterns (Strickland, 2001, p. 134). Beck's theory is based upon the idea that instead of reacting to a situation's reality, individuals misperceive the situation and incorrectly respond to that context (Strickland, 2001, p. 134). Cognitive-based therapy seeks to change cognitive distortions by examining the rationality and validity of assumptions behind them; such is the process of cognitive restructuring (Strickland, 2001, p. 134; Craighead & Nemeroff, 2004, p. 148). One prominent therapy that employs this model is known as Cognitive-Behavioral Therapy (CBT).

Cognitive-Behavioral Therapy (CBT) involves exposing individuals to situations they apprehend until their anxiety subsides (i.e., in-vivo exposure) (Craighead & Nemeroff, 2004, p. 74). Second, CBT replaces anxious thoughts with a more balanced, realistic perspective, considering all possible factors rather than assuming the worst (Craighead & Nemeroff, 2004, p. 74). Third, CBT entails teaching individuals other relevant skills that help regulate their emotions (Craighead & Nemeroff, 2004, p. 74). CBT is a psychological treatment widely regarded as the treatment of choice for a wide range of mental disorders, including anxiety disorders, bulimia nervosa, and affective disorders (Craighead & Nemeroff, 2004, pp. 74, 148). Numerous studies have demonstrated that most patients treated with CBT benefit from treatment,

and such improvements are durable in reducing symptomatology (Craighead & Nemeroff, 2004, p. 148). Woolfolk argues that psychotherapy, a form of talk therapy, comprises an activity involved in the development, elucidation, and application of practical knowledge through the cultivation of character or the development of practical wisdom that may be applied to the world in which they operate (2015, p. 5).

In the clinical setting, patients strive for development and improvement through a therapeutic exercise of cultivating positive regard for themselves and others as a means of developing a differential state of experience (Waring, 2012, p. 25-35). In the therapeutic setting, individuals engage in structured activities to cultivate, develop, and improve their mode of being in the world. The goals of treatment can include positive states of mental health that transcend symptom relief, entailing a changing of an individual's emotional, cognitive, and behavioral dispositions in a way that increases the chances of achieving a satisfactory life (Waring, 2012, p. 25-35). The clinical application of psychology entails cultivating healthy psychological states through the development of practical wisdom by restructuring individuals' cognitive and behavioral patterns (Woolfolk, 2015).

Delusions are fixed and false beliefs that accompany major mental disorders (Alberini, Ye, & Johnson, 2013, pp. 81-87). Models constructed within translational neuroscience indicate that delusions override brain mechanisms that influence predictive learning, where prediction errors mismatch our expectancy in a given situation, and what is actually experienced is central to the basis of delusional formation (Alberini et al., 2014, 81-117). From the perspective of Alberini et al., delusions form due to aberrations of brain systems that underpin the successful anticipation of an adaptation to external and internal events (2013, 81-117). CBT therapy for psychosis has demonstrated efficacy for treating delusions and hallucinations (Freeman, 2011,

pp. 135-139). Reasoning biases, skewed views of self, and other factors based on adverse life experiences such as rumination, interpersonal sensitivity, catastrophic appraisals, and avoidance behaviors all show correlation with delusions (Freeman, 2011, pp. 135-139). Delusions entail distress for those experiencing them, and this distress contributes to human suffering, comparable to levels seen in generalized anxiety disorder (Freeman, 2011, pp. 135-139). Further, delusions can become exceedingly strong and override current environmental influences and social cues (Alberini et al., 2014, 81-117). Freeman (2011) found that by allowing individuals to discuss their experiences constructively in a psychoeducational setting, patients experienced a 25% reduction in their worries associated with persecutory delusions (pp. 135-139).

Psycho-Religious Eastern and Western Cultivation

Buddhism and Western psychology endow theoretical and methodological systems that facilitate well-being by cultivating mental balance through individuals intentionally and effectively addressing that which restricts human potential (Hwang & Chang, 2009, pp. 1010-1032). Traditional Buddhist literature does not generally discuss mental health as a topic distinct from teachings about the path to enlightenment (Hwang et al., 2009, pp. 1010-1032). However, Buddhist texts extensively explain how to train the mind in ways that alleviate suffering, which entails a psychological process of addressing the *causes* of human suffering (Hwang et al., 2009, pp. 1010-1032). All schools of Buddhist thought share a similar aim with Western psychology in the fundamental goal of reducing suffering (Hwang et al., 2009, pp. 1010-1032). The emphasis on human well-being in the absence of suffering transcends a stimulus-driven basis and instead depends upon the cultivation of a specific type of enduring beliefs and attitudes developed in one's psychological character (Hwang et al., 2009, pp. 1010-1032). This process of cultivating meaningful priorities, attitudes, perspectives, and

behaviors is prominent within positive psychology, and it is strongly emphasized in Buddhist practice (Hwang et al., 2009, pp. 1010-1032).

Western psychology and Buddhism both hold that happiness resulting from internally mediated mental training is more likely to be durable than externally derived happiness (Hwang et al., 2009, pp. 1010-1032). Current psychological research suggests a preliminary confirmation of Buddhist teachings, which hold that the degree of one's happiness is not fixed but instead can be consciously cultivated or developed (Hwang et al., 2009, pp. 1010-1032). In part, cognitive-based therapies sustain the Buddhist principle that all of existence is a creation of the mind, where people can gradually change their way of thinking, feeling, and acting *from psychological incongruity to homeostasis* that attains therapeutic goals (Hwang et al., 2009, pp. 1010-1032). It is noted that Buddhist meditation, in conjunction with psychotherapy, is effective in facilitating mood stabilization, reduced anxiety, reduced neurotic symptoms, and greater self-control (Hwang et al., 2009, pp. 1010-1032). Buddhist meditation helps one to be calm, relaxed, and peaceful and is effective for coping with negative emotions (Hwang et al., 2009, pp. 1010-1032).

Until recently, Western psychology primarily focused on diagnosing and treating mental disorders; now, scientific attention has shifted towards understanding and cultivating positive mental health (Hwang et al., 2009, pp. 1010-1032). In contrast, for the past 2,500 years, Buddhist teachings have systematically identified and diagnosed the symptoms of human suffering, determined their cause, and described cures for pathologies by providing a path to happiness and lasting contentment (Hwang et al., 2009, pp. 1010-1032). *Buddhism perhaps signifies one of the first forms of therapeutic counseling.* In many ways, the psychologist seems to play the role of the master in East Asian culture (Hwang et al., 2009, pp. 1010-1032). The psychologist

comprehends the individual's concerns and provides them with appropriate instruction on overcoming such concerns, where the individual cultivates themselves through the guidance of the psychologist.

However, it is necessary to note that the goal of cultivation within Buddhism is quite different from the conception within Western psychology (Hwang et al., 2009, pp. 1010-1032). Instead of using systematic methods of investigation for an individual's authentic self, the Buddhist model encourages the individual to cultivate an understanding of non-self (Hwang et al., 2009, pp. 1010-1032). The construct of self is a core concept in Western psychology; contrary to this, Buddhism is based on a non-self-cultivating process that aims to minimize or extinguish the self, leading to selflessness (Shiah, 2016, pp. 2-7). The non-self-approach involves executing the self-cultivating principles of giving up desires, displaying compassion, practicing meditation, and seeking to understand Buddhist wisdom, which directly concerns human suffering and the means of overcoming it (Shiah, 2016, pp. 2-10). Traditionally, Western psychology has sought to understand psychological functioning from an individualist perspective, emphasizing the need to satisfy, maintain, and strengthen the self (Shiah, 2016, pp. 1-2). The origin of the individualist view of self can be traced to early Christianity and marks an epistemological difference between the respective theoretical approaches of Western psychology and Buddhism (Shiah, 2016, p. 2). However, the ultimate aim of Western psychology and Buddhism is to overcome human suffering in pain and emotional disturbances caused by life's difficulties, challenges, and stressors (Shiah, 2016, pp. 2-8).

The Buddha's teachings aim to attain authentic and durable happiness by cultivating a transition from the self-state to the non-self-state (Dalai Lama, 1995; Shiah, 2016, pp. 2-10). Clinging to or being obsessed with delusions of self is a major cause of suffering as taught by the

Buddha; in contrast to the Western construct of the self, the goal of Buddhists is Nirvana, or a state of selflessness (Dalai Lama, 1995). Human cultivation leads to Nirvana, or the state of non-self, in a state of total liberation (Shiah, 2016, pp. 2-10). However, the concept of a totally liberated state in Buddhism is complex and transcends the magisterium of Western clinical psychology (Shiah, 2016, pp. 2-10). Nevertheless, the non-self-state includes psychological benefits, such as authentic and durable happiness, which are of central concern to the project of clinical psychology. Ultimately Buddhism holds that personal identity, and therefore concepts of self, are delusional and that the individual, as the self, turns out not to exist (Shiah, 2016, pp. 2-10). From the perspective of Buddhism, everyone who is not liberated is ‘delusional’ and is in some sense ‘mentally ill.’

Self-cultivation in Buddhism is associated with attempts to go beyond normal states of existence and by enhancing the development of a person’s capacities and potentials (Wang et al., 2014, pp. 340-342). *Self-cultivation* is a psychological process that develops one’s mind and body to reach beyond the normal or current state of being (Wang et al., 2014, pp. 340-342). Sustaining and fulfilling human development encompasses both separateness and belongingness. Any social or political system, such as individualism or collectivism that supports individuality or connection over the other is bound to interfere and distort human development (Wang et al., 2014, p. 340). Existential security is created through bonding, not separation (Wang et al., 2014, p. 342). Human development comes in the presence of a secure community that facilitates individual growth through prosocial and collective means (Wang et al., 2014, p. 342). Liberation from emotional disturbances leads to the reclaiming of existential and ontological security that is a human birthright or human right (Wang et al., 2014, p. 342). In Buddhism, to reclaim this

birthright means to be reconnected with the essence of humanity through awakening the *'heart-mind'* (Bai, Cohen, & Scott, 2013).

The Eastern idea of health extends beyond pathological reduction and instead encompasses existential and transpersonal concerns (Craighead & Nemeroff, 2004, p. 84). In the Eastern context, health is defined in terms of reducing unhealthy qualities, particularly regarding deluded perspectives, cultivation of healthy qualities, and maturation to transpersonal stages of development (Craighead & Nemeroff, 2004, p. 84). As all societies' emotional regulation processes have been influenced by their cultural philosophies and values, East Asian societies have been influenced by the values of forbearance, emotional self-control, and interpersonal harmony (Sanseeha et al., 2009; Wang, Wei, Koay, Lo, & Lee, 2019). Forbearance is a strategy used in East Asian cultures to regulate emotional processes through suppression, cognitive reframing, empathy, and self-cultivation (Wang et al., 2019, pp. 409-423). In the East Asian context, emotional regulation can involve several positive meanings and functions towards maintaining positive prosocial relations (Wang et al., 2019, pp. 409-423). A component of emotional cultivation in East Asian cultures is to regulate emotional affect by creating alternative thoughts and perceptions to understand how one's thoughts and actions will affect one's outcomes (Wang et al., 2019, pp. 409-423). Emotional cultivation in East Asian cultures strongly resembles the process seen in CBT. However, Buddhists' conceptions of self, or lack thereof, resembles Skinner's view that the mind does not exist (Skinner, 1974, pp. 113-131). Skinner holds that the mind, and the self, as conceived in consciousness, is an illusion, a hypothetical construct of cognitive psychology that does not exist (1974, pp. 113-131). Skinner's theory parallels the Buddhist belief that the self, as conceived in the mind, does not exist per se but rather is illusory in nature. However, Pio notes that Buddhists tend to view psychological

disorders as being primarily psychogenic or psychological in origin rather than somatic (physiological) in nature (1988, p. 127). This position of seeing disorder as psychological indicates a position towards cognitive-based approaches rather than a behavioral approach to psychology.

Buddhism suggests we apply the self-cultivating principle by following certain structured activities by applying compassion and obtaining new insight to overcome delusions of self and attain a non-self-state of authentic and durable happiness (Shiah, 2016, pp. 2-10). Eastern approaches to psychology emphasize that healthy mental states and qualities must be intentionally cultivated or developed to ensure psychological health and maturity entailing post-formal operational cognition and wisdom, post-conventional morality, transpersonal emotions, and meta-motives, such as altruism (Craighead & Nemeroff, 2004, p. 84). Post-formal operational cognition and knowledge denotes individuals who are more flexible, logical, willing to accept moral and intellectual complexities (Craighead & Nemeroff, 2004, p. 579). Post-conventional morality describes individuals who live by their own ethically formed principles expressed by moral actors who use a heuristic framework to make decisions based upon rights, values, duties, and ideals (Craighead & Nemeroff, 2004, p. 579).

Clinical Insight on Buddhism and Psychotic Symptomatology

This section will address the current clinical directions of research as they broadly relate to Buddhism, schizophrenia, psychotic delusions, and studies assessing Eastern-based cultivating practices. Raja, Azzoni, & Lubich (2000), investigated religious delusions through an observational study of 313 acute psychiatric inpatients admitted to emergency psychiatric care and compared patients with and without religious delusion (pp. 22–29). The authors note that little is known about the clinical features associated with religious delusions and how religious

delusions may differ across various diagnostic groups (Raja et al., 2000, pp. 22-29). Many patients were apprehended for displaying psychotic symptoms near St. Peter's Basilica in the Vatican City State (Raja et al., 2000, pp. 22-29). Of those assessed, 20.1% expressed religious delusions on the Assessment of Positive Symptoms, finding no significant variation between male and female patients in the rates of religious delusion (Raja et al., 2000, pp. 22-29). The investigators also found that religious delusions are not associated with self-directed harm (Raja et al., 2000, pp. 22-29). Raja et al. (2000) found that nearly 40% of those with religious delusions were diagnosed with schizophrenia and schizophreniform disorder, and another 12% were diagnosed with schizoaffective disorder (Raja et al., 2000, pp. 22-29). It is necessary to note that the DSM-5 defines delusions as fixed beliefs that are not amenable to change considering conflicting evidence (DSM-5, 2013, p. 87). However, in religious delusions, cases carrying religious themes, the question of the validity of beliefs is not relevant since the veracity of religious beliefs cannot be assessed (Raja et al., 2000, pp. 22-29).

Raja et al. (2000) found religious delusions to be common among patients with psychotic symptoms, attributing the high rate of occurrence to regional religious influences (Raja et al., 2000, pp. 22-29). Raja et al. found that religious delusions occurred at similar rates in all forms of psychosis (2000, pp. 22-29). Raja et al. (2002) found that individuals who presented religious delusions also exhibited comorbid psychopathologies and more severe positive psychotic symptoms compared to other patients and had more chronicity in their psychopathological symptomatology (pp. 22-29). Raja et al. (2002) found an association between religious delusion and more severe and chronic courses of psychopathology (Raja et al., 2000, pp. 22-29). Religious delusions exert an overt and covert influence on patients' thoughts, affect, and behavior (Raja et al., 2000, pp. 22-29).

Tateyama and colleagues (see Tateyama et al., 1993, pp. 151-185; 1998, pp. 59-68) compared the prevalence and contents of delusions of patients with schizophrenia in Japan to patients in Germany and Austria (Lysaker, Dimaggio, & Brune, 2014, p. 32). The number of patients with delusional symptomatology was equal in both samples. The number of patients with delusions about world-ending scenarios and the quantity of negative (paranoid ideas) and positive (grandiosity) delusions was the same (Lysaker et al., 2014, p. 32). However, the quality of these delusions differed; 20% of the German-speaking sample expressed religious delusions, only 6% of the Japanese samples expressed similar delusions (Lysaker et al., 2014, p. 32). In the German-speaking samples, delusional guilt was a common feature; it was rare in the Japanese sample (Lysaker et al., 2014, p. 32). Persecutory delusions were more common in the German-speaking sample than in the Japanese sample (Tateyama et al., 1998, pp. 59-68). One hypothesis into the source of these differences is that Asian religions, such as Buddhism, do not imply apocalyptic ideation or death as a penalty for or absolution from sin (Lysaker et al., 2014).

In contrast, ideas of shame, burdensomeness, and being viewed as worthless formed the most common context of delusions in Japanese patients (Lysaker et al., 2014, p. 33). Delusions in the Japanese sample included the feeling or perception that others spoke poorly about them (Tateyama et al., 1998, pp. 59-68). It is important to stress that East Asian countries are considered to be collectivist societies where one's individuality is less important than the interest of one's social group (Lysaker et al., 2014, p. 33). One's own needs and wishes might need to be neglected or suspended in favor of the social group's well-being; thus, individuals in collectivistic societies are more susceptible to social feelings of shame and worthlessness (Lysaker et al., 2014, p. 33). When considering Eastern and Western cultures, it is necessary to note that individualistic or collectivistic social models of organization influence an individual's

perspective of self. In the Eastern context, collectivists view themselves as dynamic entities, continually defined by their social context and relationships (Lysaker et al., 2014, p. 33). Individualistic societies perceive the individual self as a stable entity that is autonomous from other people and their environment (Lysaker et al., 2014, p. 33). Thus, differential concepts of self are epistemologically employed. Conceptions of the self are culturally determined, and these perspectives of the individual, in reference to the collective, differentiates views and representations of the self.

Schizophrenia is one of the most common types of severe and chronic mental illnesses, and it affects roughly 0.7% of the adult U.S. population at a given time (Sanseeha et al., 2009; DSM-5, 2013). Half of all of those who suffer from the disorder do not receive appropriate care, and roughly 90% of those with untreated schizophrenia live in developing countries (Sanseeha et al., 2009). Rates of psychopathology are generally similar around the world, while unique social and cultural influences in different population groups might impart differing perceptions of those pathologies (Sanseeha et al., 2009). Buddhism has been an integral part of Thai culture and influences how Thais view the world and express their beliefs (Sanseeha et al., 2009). The foundation of Buddhist morality is the law of cause and effect or the karmic principle that operates in the lifespan of individuals (Sanseeha et al., 2009). It is understood that malady results from wrong deeds done in the past, and *karma* emphasizes the cause and effect of deeds that will directly affect the person (Sanseeha et al., 2009).

Sanseeha and colleagues (2009) investigated the perspectives of Thais diagnosed with schizophrenia and the nature of individuals' views concerning their pathology. Sanseeha et al. (2009) selected 18 individuals diagnosed with schizophrenia, all of whom were practicing Buddhists (Sanseeha et al., 2009). In the study, all participants expressed a belief in the law of

karma (Sanseeha et al., 2009). Participants' responses indicated that they view the cause of their illness as stemming from supernatural powers, bad karma from the past, or biological factors (Sanseeha et al., 2009). Many participants and their relatives attributed the cause of their psychopathology to bad karma (Sanseeha et al., 2009). Attributing the cause of their psychopathology to bad karma indicates a strong underlying role that Buddhism and its cultural values and beliefs play in individuals' perceptions of the causes and nature of psychopathology (Sanseeha et al., 2009).

Buddhist Thai participants felt that they were discriminated against by society and were ashamed to be considered different, felt looked down upon because of their limitations, and felt isolated from society (Sanseeha et al., 2009). The findings of Sanseeha et al. (2009) echo the findings presented in Tateyama et al. (1993, pp. 151-158; 1998, pp. 59-68) that Asian-collectivistic societies express more significant worry with social perceptions in the context of delusional symptomatology than do individualistic cultures, paralleling the more significant social concern expressed within Buddhism. In Sanseeha's (2009) study, participants believed they were chronically ill and intentionally sought ways to mitigate their condition in realizing they had to manage their illness actively. Buddhist Thai practitioners did so by adjusting their self-care activities and social behaviors, encouraging themselves, seeking mental refuge, and following dharma or Buddhist morality to reduce the disorder's negative impact on their lives (Sanseeha et al., 2009). The participants used Buddhist teachings to provide direction or guidance for being happy by practicing mindfulness, positive concentration, meditation, and chanting to encourage one's mind to be at peace (Sanseeha et al., 2009).

Clinical Research on Buddhist-Derived Interventions

Over the past 30 years, a considerable number of mental health professionals have engaged in various forms of Buddhist psychotherapy such as compassion-based therapy, Buddhism-based grief therapy, and mindfulness-based techniques (Hwang et al., 2009, pp. 1010-1032; Shonin, Van Gordon, & Griffiths, 2014; Shiah, 2016, pp. 1-10). Mindful-based meditation techniques form the foundation of the Buddhist process of self-cultivation (Shiah, 2016, pp. 2-10). Many clinical researchers and theorists have attempted to integrate Buddhist practices into formalized psychotherapies, often focusing on meditation, and its effects on increasing emotional stability, positive affect, mindfulness, and improved attention (Shiah, 2016, pp. 2-10). It is of clinical and scholarly interest to investigate the causal relationship that is hypothesized between traditional Buddhist practices of self-cultivation that may serve the *function* of psychotherapy for individual practitioners and patients alike. For example, Zen Buddhism is used as a mode of psychotherapy in Japan (Shiah, 2016, pp. 2-10). Findings on Zen meditation's psychological effects include reduced anxiety, reduced neurotic symptoms, increased self-control, increased work efficiency, and an enhanced sense of compassion (Shiah, 2016, pp. 2-10). The use of meditation in conjunction with psychotherapy has been found to produce desirable effects in lessening negative self-reprisals, mood stabilization, and a reduced tendency for drug abuse (Shiah, 2016, pp. 2-10).

Buddhist-derived practices of mindfulness in the form of mindfulness-based cognitive therapy are supported by the American Psychiatric Association for the treatment of specific forms of depression (Shonin et al., 2014). The clinical utility of Buddhist-derived interventions spans a wide range of psychological disorders, including mood disorders, anxiety disorders, substance use disorders, personality disorders, and of concern; here, schizophrenia-spectrum disorders (Shonin et al., 2014). Buddhist-derived interventions effectively improve psychological

well-being, cognitive function, and emotion regulation capacity in subclinical and healthy adult populations, indicating possible benefits to a wide range of individuals (Shonin et al., 2014). The integration of Buddhist principles into clinical practice is likely due to the similarities between Buddhism and established clinical modes of treatment, such as CBT (Shonin et al., 2014). CBT and Buddhism both encourage individuals to challenge their perceptions of the world to enable greater human happiness and flourishing.

Convergent validity is a subtype of construct validity that measures the associations between the construct (i.e., cultivation) and other similar constructs (e.g., cognitive flexibility, cognitive reappraisal, and basic-psychological needs satisfaction) (Wang et al., 2019, pp. 409-423). As it is in every culture, East Asian emotional regulation is influenced by its particular cultural philosophies and values (Wang et al., 2019, pp. 409-423). The East Asian perspective on emotional regulation is defined by engaging in the practice of creating alternative thoughts to understanding how one's beliefs and actions will affect their outcome (Wang et al., 2019, pp. 409-423). Wang and colleagues (2019) sought to examine the relationship between emotional cultivation, cognitive flexibility, and cognitive reappraisal. Cognitive flexibility refers to the ability to perceive alternative explanations or generate alternative solutions (Wang et al., 2019, pp. 409-423). Cognitive reappraisal is the modification of the meaning of an event to influence the experience of emotion (Wang et al., 2019, pp. 409-423). Wang et al. (2019) sought to establish the convergent association between emotional cultivation and positive affect, emotional regulation, basic psychological needs satisfaction, gratitude, and cognitive flexibility (pp. 409-423). Wang et al. (2019) defined the construct of cognitive emotion regulation strategies as procedures that regulate emotion through self-control that generates alternative thoughts that consider the best for self and others (pp. 409-423).

Cultivating emotional strategies and understanding emotional connotations together accounted for an additional 9% of the variance explained in predicting cognitive flexibility, 2% of the variance explained by positive affect, and 21% of the variance in predicting emotional cultivating strategies was accounted for by the satisfaction of basic psychological needs (Wang et al., 2019, pp. 409-423). Cultivating emotional strategies and understanding emotional connotations significantly and uniquely predicted basic psychological needs satisfaction and gratitude (Wang et al., 2019, pp. 409-423). Understanding emotional connotations significantly and uniquely predicted cognitive flexibility (Wang et al., 2019, pp. 409-423). Emotional cultivation and cultivation emotional strategies had an intercorrelation of .93, indicating they are 93% more alike than they are different (Wang et al., 2019, pp. 409-423). Cultivating emotional strategies and understanding emotional connotations have an intercorrelation of .57, representing 32% of the variance of emotional cultivation (Wang et al., 2019, pp. 409-423).

Wang et al. (2019) findings indicate that cultivating emotional strategies and understanding emotional connotations explain 32% of the variables of emotional cultivation (2019, pp. 409-423). Emotional cultivation is strongly correlated with cognitive flexibility and reappraisal to the extent of .59 and .61, respectively (Wang et al., 2019, pp. 409-423). Emotional cultivation is also strongly correlated with basic psychological needs satisfaction to the extent of .66 and .31 for positive affectivity (Wang et al., 2019, pp. 409-423). The findings of Wang et al. (2019) indicate that cultivating techniques endow a psychological capacity to attain basic needs and a greater likelihood of experiencing positive psychological affect (pp. 409-423).

Conclusion

It is reasoned that Buddhist-based self-cultivating practices do represent an effectual therapeutic intervention that endows increased psychological well-being, cognitive function, and

emotion regulation capacities (Hwang et al., 2009, pp. 1010-1032; Sanseeha et al., 2009; Wang et al., 2014; Shonin et al., 2014; Wang et al., 2019). It is ascertained that Buddhist-derived clinical interventions that entail cultivating practices may be effective treatments for a variety of psychopathologies, including mood-spectrum disorders, substance-used disorders, and schizophrenia (Hwang et al., 2009, pp. 1010-1032; Sanseeha et al., 2009; Wang et al., 2014; Shonin et al., 2014; Shiah, 2016, pp. 2-10; Wang et al., 2019).

It becomes discernible that Buddhism and Western psychology share a desire to overcome human suffering as a core and shared goal, while significant epistemological differences exist between these two magisterial forms of knowledge and meaning. Buddhism does endow a psychological capacity to mitigate delusional perspectives, but it is not towards the same aims seen in Western psychology. Western psychology seeks the alleviation of individual suffering; it is concerned with the individual, Buddhism is wholly concerned with the impermanent nature of human dispositions, and as such, it opposes the Western focus on enduring personality states. While psychology is concerned with the present state of the individual, Buddhism is concerned with the future direction of that individual. Western clinical psychology seeks to alleviate symptomatology that entails human suffering in clinical populations, while Buddhism sees the entire world as intrinsically deluded. In Buddhism, not only do clinical populations experience significant levels of suffering, but all who are not liberated from delusions indeed suffer.

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