d requires the use of complementary therapies
e involves assessment of a person's level of mental health as well as of symptoms of his/her disorder.

4. Mental health:
   a depends on good physical health
   b can be assumed in the absence of symptoms
   c involves a sense of personal integrity and contentment
   d implies continuing progress through life towards emotional resilience and personal maturity
   e implies contentment and equanimity.

5. Patients' mental well-being is enhanced:
   a when they are treated with dignity and respect
   b if professional carers pay due attention to their own spiritual needs
   c when patients are able to spend time with staff who seem sympathetic and unhurried
   d when they have the opportunity, environment and resources for quiet reflection and for purposeful activities
   e when they are regularly persuaded to attend religious services.

**MCQ answers**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| a F | a F | a F | a F | a T |
| b T | b F | b T | b F | b T |
| c F | c T | c T | c T | c T |
| d T | d F | d F | d T | d T |
| e T | e F | e T | e T | e F |

# Commentary

David Brazier

Culliford (2002, this issue) has given us a valuable tour of what is involved in an appraisal of a patient's spirituality and its relevance to the assessment of mental state and prognosis. My task here is to provide some commentary from the perspective of a Buddhist. What immediately confronts me, therefore, is whether the teachings and practices of Buddhism do, in fact, find a place upon the map here set out. This is not a straightforward question, and this alone illustrates the fact that this is a subject within which one has to be willing to encompass, or at least allow for, differences of basic paradigm. However, what strikes me particularly is the fact that the Buddhist paradigm actually may be less at odds with the medical model than many might imagine.

Culliford writes that 'spirituality does not fit easily with our understanding of science'. However, science, whether in its general or specifically medical form, does not strike one as being uncomfortably related to Buddhism. In fact, the Buddha is often referred to as a kind of doctor and there is some evidence that his immediate followers did, in many cases, practice medicine and probably did so with methods and approaches that, for their time, would not be considered unscientific. Of course, 'spiritual care and psychiatric treatment go together'. What is required is for psychiatric staff to realise that they are already engaged in spiritual work whether they recognise it or not, although having said this, certain caveats need to be made about the use of the term spiritual.

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Although there certainly are other-worldly Buddhists, it is difficult to escape the conclusion that the founder of this system was a man who respected empirical evidence and was primarily intent on relieving human suffering here in this world. It is the fact that Buddhism offers little overt clash with science that has given it an appeal to Western investigators. It has also made Buddhism a fertile source of techniques, some of which are now in use in Western hospitals, for reducing anxiety, preparing patients for traumatic procedures, improving healing and so on. These techniques draw on the Buddhist mind-training traditions and are researchable (e.g. Kasamatsu & Hirai, 1966; Schwartz, 1975).

Buddhists may hold a variety of metaphysical beliefs, but belief does not really provide the core of their religious perspective and experience. This has a great deal more to do with practices, and these practices, diverse as they may be, are concerned with advancing an individual along a spectrum from ignorance to enlightenment. Now, ignorance, as used here, is not a universe apart from the Western concept of mental dysfunction, and enlightenment could be, and has been, described as radiant mental health (Trungpa, 1992). In fact, if psychiatric practitioners coming to Buddhism make some allowances for differences of terminology, they may find themselves in more familiar territory than they expected.

The focus that Culliford places on skills (Box 7) is therefore to be welcomed from a Buddhist perspective. The fact that his list of 11 authors offering help in this respect (Box 8) contains at least seven who have been substantially influenced by Buddhism, shows how Buddhist-based methods have already established themselves in the psychological world.

Having said this much, it none the less remains an open question whether Buddhism can really be considered a spirituality, given that the Buddha rejected the notion of the soul or spirit. Buddhists are generally willing to accept this appellation for practical reasons, just as they accept being classified as a religion for bureaucratic purposes, but the term Buddhism is a Western coinage and all three terms do a certain violence to the Buddhist concept of a path of enlightenment. This is not irrelevant. Many Western scholars who would not identify themselves with religion or spirituality would, none the less, be happy to consider themselves part of a path of enlightenment, and historians have even been known to use religion and enlightenment as contrary terms. The psychiatric task is to bring the patient closer to enlightenment, even if this is at the level of realising that he is not actually a Martian, that the television is not communicating to her individually, that his obsessions or worries are unrealistic, or that loss and disaster are part and parcel of the reality of life. All these psychological tasks are an integral part of moving toward enlightenment, which is nothing less than an encounter with the world in its fully radiant realness.

Buddhism is a set of practices conducive to individual and collective enlightenment. Scientific investigation is a subset of such activity, provided that it is conducted within a suitably ethical framework. The clash between Buddhism and science, in so far as it exists at all, is therefore quite different from that between science and theism. Buddhism's objections are simply that many elements of medical science are unethical owing, *inter alia*, to the Western attitude that non-human life is expendable, for instance. There is no serious clash on metaphysics, nor on the desirability of empirical verification. Buddhism is concerned with body, speech and mind and therefore can be seen as a complete science of human well-being, within which medicine has always had an honourable place. Tibet, which was one of the bastions of Buddhism until the Chinese invasion in the 1950s, was traditionally known as the land of medicine. We should not, therefore, conceptualise Buddhism as dealing with one dimension of life and medicine with another, but rather see medicine as one of a number of practical arts that have a proper place within the Buddhist scheme, and psychological medicine as having a great deal to learn from the investigations that Buddhists have conducted into the nature, habits and functioning of the mind over 2 millennia.

Finally, Culliford develops a distinction between cure and healing. The Buddhist view is that all phenomena depend on conditions and that when conditions change, their dependent phenomena perforce change with them. Diagnosis is therefore not alien to the Buddhist tradition, but the range of conditions that a Buddhist might want to take into account might be wider than those commonly addressed by Western medical science. This wider perspective means that Buddhism approaches Culliford's notion of holism, although perhaps in a slightly different way. In some cases, physical conditions might be critical. In others, psychological ones. Buddhism aims to give individuals the kind of outlook on life (wisdom) that enables them not to be defeated by its vicissitudes, from whatever quarter these may emanate.

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