Hong Kong Journal of Mental Health
2008, *34* 28-36

Christian-Buddhist Cognitive Schema and Mental Health

S K Cheung
Division of Social Studies
City University of Hong Kong

Abstract

In recent decades, research has indicated that intrinsic religious orientation and positive religious coping are useful predictors of one's mental health. A central concept is religious cognitive schema, which enables individuals to make sense of adverse experiences. However, due to its root in Christianity, the focus is mainly on the view of God. On the other hand, Buddhism suggests that one's view of existential phenomena, whether it is essentialism or enlightenment, forms the basis for one's suffering. The paper proposes a framework integrating the view of God and the view of existential phenomena and illustrates how religious clients can be helped more effectively with Zen methods applied in a Christian context.

Keywords: Christianity, Buddhism, mental health

Religion and spirituality have been neglected or avoided issues in mental health and clinical practice. Freud's early work conceived of religion as the universal obsessional neurosis, and for Albert Ellis, religion was considered a form of psychopathology (Marks, 2006). However, with the seminal works by Pargament (1997), Koenig (1998) and Koenig, McCullough and Larson (2001), the role of religion and spirituality has gained increasing attention in mental health literature. In these and later reviews, religious involvement has been found to be associated with mental health outcomes. However, when religion is incorporated into mental health practice, practitioners, especially Christian ones, mainly focus on exploring God's role in coping with life problems whereas other spiritual dimensions are not fully utilized.

In this paper, I would review the literature on the relations between religion and mental health and explain how the Buddhist ideas of enlightenment and suffering are helpful in assessment and counseling. In particular, I would discuss how the framework and the techniques borrowed from Buddhism can be applied to help Christians facing negative life events such as financial loss, terminal illness and interpersonal difficulties.

Religion and Mental Health Research

What is religion? Pargament (1997) defined it as "a search for significance in ways related to the sacred." Koenig and others gave a more elaborate definition, considering it as "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to

Correspondence concerning this article should be addressed to S K Cheung, Division of Social Studies, City University of Hong Kong, Kowloon Tong, Hong Kong
E-mail: s.k.cheung@cityu.edu.hk

the sacred or transcendent (God, higher power, or ultimate truth/reality) (Moreira-Almeida, Neto, & Koenig, 2006). In both definitions, the idea of "sacred" is paramount. This reflects a Western perspective where Christianity is dominant.

In the literature, religious orientation, religious coping and prayer have received much attention, and empirical studies have demonstrated their significance for mental health.

Religious Orientation

An early classification of religious orientation was offered by Gordon Allport (1954), who differentiated between extrinsic and intrinsic orientations. Persons with extrinsic orientation are disposed to use religion for their own ends… [and] find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification" (Allport & Ross, 1967, p.434). In contrast, persons with intrinsic orientation "find their master motive in religion. Other needs…are regarded as of less ultimate significance."

People with extrinsic and intrinsic orientations differ in their cognitive contents. Extrinsic religiosity is associated with a wrathful view of God and negative perceptions of death, including death as pain and loneliness and as failure. On the other hand, intrinsic religiosity is associated with a creative, gracious, and kindly perception of God and perceiving death in positive terms, as an afterlife of reward and courage (James & Wells, 2003). Regarding mental health, extrinsic orientation is associated with dogmatism, prejudice, fear of death, and anxiety; whereas intrinsic orientation is associated with psychological well-being, lower level of depressive symptoms, shorter remission times for depression, lower level of drug abuse, lower suicide rates, and higher levels of psychological adjustment to illness (James & Wells, 2003; Moreira-Almeida, Neto, & Koenig, 2006; Siegel, Anderman, & Schrimshaw, 2001).

Religious Coping

Another aspect of religiosity which has been extensively investigated is religious coping. Religious coping is defined as the use of religious beliefs or behaviours to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances (Koenig, Pargament, & Nielsen, 1998). In an early study, Pargament and colleagues (1988) identified three styles of religious coping, namely self-directing, deferring, and collaborative. Self-directing stresses the power of the person rather than the power of God as the major resources to solve problems. Deferring emphasizes the omnipotence of the deity and the individual refers responsibility for solving problems to god. In the third approach, collaboration, the responsibility for solving problem is held jointly by the individual and God. In contrast to the general expectation that religious coping is passive, the study found that collaborative coping is the most commonly used style to cope with problems.

Pargament (1997) examined coping styles in reaction to diverse life situations and identified patterns that were helpful and harmful. Through exploratory and confirmatory factor analyses, positive and negative patterns were identified. Positive pattern consisted of methods such as seeking spiritual support, religious forgiveness, collaborative religious coping, spiritual connection, religious purification, benevolent religious reappraisal, and religious focus. On the other hand, the negative pattern involves spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal, and reappraisal of God's powers. Positive religious coping strategies were associated with lowest rates of depressive symptoms whereas the opposite held true for negative religious

coping (Harrison et al. 2001). Harrison et al. also found that religious coping was commonly used among medically ill patients. Comparatively speaking, considerably more people used positive religious coping than negative coping across samples.

Prayer

Prayer is the third dimension of Christian religious activity that has been examined. Poloma and Pendleton (1989) identified four types of prayer: ritualistic, meditative, petitionary, and colloquial. Ritualistic prayer is mostly related to recitation of prepared prayers available through reading or from memory. Petitionary prayer is a request to meet specific material needs of self and friends. Colloquial prayer adopts a conversational style which involves thanking God for His blessings, or asking for forgiveness or guidance. Finally, meditative prayer is a state of being in which an intimate and personal relationship with the Devine is experienced. In a later study, Poloma and Pendleton (1991) found that colloquial and meditative prayers were positively associated with subjective well-being, life satisfaction, existential satisfaction and happiness.

Buddhism and Mental Health

In recent years, Buddhism has gained increasing attention in western societies. In contrast to Christianity, discussion of Buddhism and its implications for mental health has been mainly conceptual rather than empirical.

Buddhism is very psychological in nature, and its motivation is to facilitate beneficial growth and change on individual and societal levels. Unlike Christianity, Buddhism does not postulate the existence of a creator being, a god or divine power (Kumar, 2002). Instead of searching for ways related to the sacred, Buddhism leads us through a journey to examine our relation with our existence. Therefore, for some people, Buddhism represents more a philosophy than religion.

Kumar (2002, p.41) gave a concise introduction to Buddhism and discussed its relations to mental health. Central to Buddhism is the Four Noble Truths (四聖諦), which "state that (a) suffering is ubiquitous; (b) suffering is a consequence of the automatic tendency to cling to phenomena; (c) the cessation of suffering is possible; and (d) this cessation can be achieved by practicing the Eightfold Noble Path (八正道)." Suffering is generated by the mental tendency toward essentialism, which refers to the assumption of a discrete, fixed self and identity, independent of external environmental influences or internal physical processes. Ultimately essentialism results in self-cherishing and a tendency to cling to phenomena.

In Buddhism, all phenomena are temporary confluences of infinitely complex and interconnected web of causes and effects simultaneously shaping each other, thus the concepts of emptiness (空), selflessness (無我) and impermanence (無常). The cognitive ignorance of this truth of life is the root cause of all sufferings (Chen, 2006). Such ignorance leads to clinging or craving, and rejecting or aversion. Human beings hold on to whatever appears to be desirable such as pleasure and success, and reject whatever is seen as undesirable, such as pain and failure. Unfortunately, because of the universal law of impermanence, emotional craving or clinging to what is impermanent inevitably brings disappointment, which can accumulate and escalate into the distressing experience of suffering.

To emerge from suffering, the first step is to accept the reality of it as a fact or existence (Hayes, 2002). The next is to see its source in craving and attachment. Instead of rejecting pain and clinging to pleasure, people need to learn to accept both and to attain equanimity (Chen, 2006). As an individual achieves an insight into the nature of all phenomena – enlightenment – he/she is liberated from the

bondage of delusion. He/she learns that letting go of the needs for things or the expectation for things to be different is the ultimate way to end suffering.

Mindful meditation is the primary method in Tibetan Buddhism to purify mental defilements and attain enlightenment. In addition, the Zen (禪) narrative technique is also an often utilized method to assist students to achieve enlightenment (Christopher, 2003).

Religious Cognitive Schema

From the above discussion, we understand that religiosity is a multi-faceted phenomenon, among which religious beliefs occupy the most central position. In Christianity, the view of God – whether He is benign (intrinsic) or wrathful (extrinsic) – affects the development of mental health. On the other hand, in Buddhism, one's belief regarding existential phenomena –essentialism vs. enlightenment– forms the underlying roots of suffering or liberation.

Many individuals who experience adverse life events spontaneously undertake a search for meaning and ask "Why me?" (Siegel, Anderman & Schrimshaw, 2001). Religious beliefs serve as a valuable resource in the process by providing a template for the ordering and interpretation of human events. Koenig (1995) utilizing the concept of religious cognitive schema argued that religious schema influences appraisal of life events and could help make adverse experiences more understandable, infuse them with meaning and thus preserve a sense of cohesiveness. James and Wells (2003) postulated that religious schema (intrinsic vs. extrinsic orientations) provides generic mental models that influence appraisals, particularly those concerning stressful life events. However, it is obvious that due to the Western perspectives of the scholars, their conceptualization is limited to the Christian view of God, and contributions from other religions are neglected.

Despite the scarcity of empirical research, the Buddhist view of existential phenomena provides another useful dimension to religious schema. Christopher (2003) explained that the Eight Noble Paths of life are isomorphic with the Belief component in rational emotive behavioral therapy. It is my contention that an individual's view of existential phenomena is an important dimension that should be capitalized on when understanding and helping mental health clients in a religious context. Certainly the terminologies of emptiness and impermanence are alien to the Christians; however, recent scholars have attempted to relate Buddhist's ideas, especially Zen to those found in the Bible. Most notable is Jesus' saying that "Do not store up for yourselves treasures on earth, where moth and rust destroy, and where thieves break in and steal. But store up for yourselves treasures in heaven, where neither moth nor rust destroys, and where thieves do not break in or steal." (Matthew, 6:19-20). Is it tantamount to the Buddhist notion of emptiness and impermanence? Similarly, Jesus' teaching, "Therefore I tell you, do not worry about your life… Look at the birds of the air; they do not sow or reap or store away in barns, and yet your heavenly Father feeds them…Who of you by worrying can add a single hour to his life" (Matthew, 6:25-34) represents a strong "Living in the moment" focus. Leaving the question of God aside, the Christian and Buddhist's views of the world can be highly compatible.

If the image of God represents the idea of the source of help when facing a problem, the view of existential phenomena points to the perception of the nature of the problem itself. Together they form a schema that shapes the appraisal of a problem and God's role in coping with the problem. With this augmented understanding, practitioners helping Christian followers can work with them more effectively by drawing on the Buddhist techniques that aim at fostering enlightenment.

As depicted in the Figure 1, the two images of God and the two views of existential phenomena form a matrix describing four kinds of schemata. With an enlightened view of existential phenomena and a benign image of God (quadrant I), one is free from craving or attaching to the material world, and the individual is more able to accept or even feel grateful for the negative life events. The problem may be interpreted as part of God's plan or a challenge or opportunity to demonstrate one's faith. Theoretically speaking, this schema should help one find meaning in the negative events and maintain good mental health. On the other hand, in quadrant II, a wrathful image of God is espoused. The adversity is seen as a punishment from God. Though the event can be accepted as it is, one can easily fall into a fatalistic stance and relinquish his/her control.

If a person clings to the material world or "treasures on earth" (quadrant III), loss and adversity inevitably lead to suffering. The benign God is likely to be viewed as a helping resource in the process of recovering loss or overcoming practical or physical problems. The person would feel fearful, painful, or distressed, but thanks to the benign perception of God, he/she believes that "God will never give you more than you can handle and endure with His help."

Quadrant IV represents the situation with the poorest mental health potential. Here God is viewed as wrathful. The individual not only experiences the natural grief, distress and anxiety due to loss or illness but also the fear or even anger arising from the attribution of the negative life event to a punishing or angry God. He may question why God does not answer his prayers. He may further complain, "Why did God allow this to happen?" and "If He allowed this to happen to me, is He now deserving of worship?" The experience of "meaninglessness" of life may result in depression.

		View of Existential Phenomena	
		Enlightenment	Essentialism
Image of God	Benign	I. Accepting, letting go, celebrating, collaborative coping	III. Seeking support or surrendering control to God
	Wrathful	II. Fatalistic, relinquishing control	IV. Fearful, blaming, and complaining

Figure 1. Cognitive Schemata and Religious Coping Responses

This augmented framework not only enables practitioners to identify intervention points to help clients facing negative life events; it also broadens the perspective of practitioners to incorporate methods from Buddhist tradition to help clients achieve enlightenment and relief.

Achieving Enlightenment

In the last decade, mental health practitioners have begun to apply the concepts of religious coping to Christian counseling and psychotherapy. For example, Cole & Pargament (1999) in their treatment programme for cancer patients helped the participants to surrender their control to God and view God as a partner in their work towards conflict resolution. Meese (2002) added that it helped to reframe a negative event within the will of a sovereign, loving and compassionate God. However, the approaches so far have focused on reframing the view of God, and how the client or patient viewed his/her suffering was not adequately dealt with in these treatments.

Incorporating religion in mental health practice is contentious. In this connection, it is useful for me to declare my position. I am a Catholic but have a fondness for Buddhism. Regarding religious issues, I am a pluralist (Zinnbauer & Pargament, 2000). That is to say, I recognize the existence of a religious or spiritual absolute reality but allow for multiple interpretations and paths toward it. In adopting religious elements in counseling, I treat religiosity as a valuable resource in helping clients, but am aware of the importance of exercising self-knowledge and avoid letting respectful collaboration be perverted to become coercive missionary work.

The framework suggests that for a religious client or patient to be relieved of suffering, an important task is to see the impermanence of phenomena and accept things as they are. Zen Buddhists often use the technique of koans (公案) or narratives, which are presented as a paradox or riddle to help the novice attain an insightful experience. These methods often are carried out as question and answer sessions which involve sudden beatings or an awaking of the mind to the truth inside (Christopher, 2003). Certainly the use of koan may seem too alien to non-Buddhist and especially Christian practitioners. However, Jesus' parables indeed contain paradoxical elements which can serve similar purpose.

As Leong (2004) pointed out, Jesus' words possess many paradoxical elements which hold one's mind in puzzle. For example, in the Beatitudes, Jesus says, "God blesses those who are poor and realize their need for him, for the Kingdom of Heaven is theirs" (Matthew, 5:3). While the popular interpretation is that the poor will enter Heaven in the future, the enlightened interpretation is that Heaven is here for those who are poor spiritually. And as Luke (17:20-21) emphasized, "The kingdom of God is within you and among you." Leong interpreted that Heaven is not a place in the future. A person no longer holding on to earthly treasures is in Heaven. In Buddhist terms, a person free from craving, anger and other afflictive states achieves the perfect peace of the state of mind called nirvana. For clients who suffered from material loss, a deep reflection of the Beatitudes and related scriptures is helpful.

Similarly, John (12:25) also is paradoxical and intellectually perplexing: "Those who love their life in this world will lose it. Those who care nothing for their life in this world will keep it for eternity." Patients suffering from terminal illness can be encouraged to reflect on the impermanence of life. Only if one accepts this truth and embraces the present can one really attain eternal life.

In addition, prayer, which is highly emphasized in Christianity, can be utilized to

achieve enlightenment. Many people's prayers are of the petitionary type, which ask for something for one's material ends. "We have to learn to pray not with a sense of wishing, hoping, yearning or entitlement, but with a sense of trust, gratitude and purpose" (Jeffers, 2003, p.213). A discussion on why "when you are praying, do not use meaningless repetition as the Gentiles do" (Matthew, 6:6-8), and if "your Father knows what you need before you ask Him", why should one pray, will be useful. The client can also be led to examine closely the priority petition in Lord's Prayer – "Your kingdom come. Your will be done, on earth as it is in heaven." What is more important, God's kingdom and His will, or our material ends?

In Buddhism, there is a technique called reversed bodhisattva (逆增菩薩), which helps reframe life adversities and can be adapted to promote a positive interpretation of God. In Mahayana Buddhism, the bodhisattva is regarded as a person who already has a considerable degree of enlightenment and seeks to use his/her wisdom to help other human beings to become liberated themselves. A kind of bodhisattva—reversed bodhisattva—takes a scary and wrathful form despite his altruistic motivation, the aim being to awake others through creating difficulties and challenge. Leong (2004) described how one can reframe difficult people or enemies as reversed bodhisattvas who help one practice patience and tolerance. Cutler (1998) quoted Dalai Lama that the situation is analogous to a person seeking to tone and strengthen his or her body through weight training. The activity is uncomfortable initially, but the act of struggling against the resistance ultimately results in our strength.

Reframing our enemies as bodhisattva is a highly effective method to help one cope with interpersonal difficulties. In Christianity, the parallel is angel. The client can be guided to see difficult people as angels sent by God to provide him/her with precious opportunities for practicing patience and tolerance. This not only facilitates a positive interpretation of the event but also the view of God.

The Buddhist meditation practice is well-known for its function in developing mindfulness. People undergoing illness, pain or suffering can adopt some versions of meditation to ascribe suffering a more noble meaning. Cutler (1998, p.171) related Dalai Lama's introduction of Tong-len (自他交換) practice, in which the sufferer thinks "May my suffering be a substitute for the suffering of all other sentient beings. By experiencing this, may I be able to save all other sentient beings who may have to undergo similar suffering." Dalai Lama explained that such practice can make a significant difference in how one responds to the situation of illness in terms of the mental attitude. Instead of moaning about the situation and being overwhelmed by anxiety and worry, one can see it as a kind of opportunity to help others. The suffering takes on new meaning, and it is not as worthless and bad as one thinks. Despite its Buddhist origin, mental health practitioners would have little difficulties adapting it for use in Christian context.

Conclusion

Religion provides rich resources for people suffering from adversity. However, religious coping can be beneficial and also harmful. Current formulation of religious cognitive schema stresses the view of God, and neglects the perception of existential phenomena, which Buddhism can usefully contribute. Through techniques drawn from Zen practice, clients and patients can examine the Bible to achieve enlightenment, which is the ultimate way to eradicate the roots of suffering. It is recognized that incorporating religious dimensions in counseling and therapy must proceed with care; coercive preaching must be avoided. On the other hand, practitioners should not dismiss religion from the possible treatment resources

for specific clients. With this caution in mind, this paper attempts to suggest further vantage points to help clients emerge from their suffering and achieve better mental health.

摘要：

源自基督教和佛教的認知基模與精神健康

近數十年，不少研究指出內信仰定位及正面的宗教應付方式與個人心理健康有密切關係。文獻提出宗教認知基模的概念，指出它能讓個人在逆境中發掘當中的意義。但因這概念建基於基督教派，焦點主要集中個人對神的意象。反之，佛教卻著重個人的世界觀，強調個人對世事的執著正是痛苦的根源，唯有覺悟才能脫離苦海。本文提出一個結合對神和世界兩方面觀點的架構，說明如何借用禪宗的方法，加強對基督教受助者的輔導。

References

Allport, G.W. (1954). *The nature of prejudice. Cambridge: Addison-Wesley.*

Allport, G.W., & Ross, J.M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 5, 432-443.*

Chen, Y.H. (2006). Coping with suffering: the Buddhist perspective. In P.T.P. Wong & L.C.J. Wong (eds), *Handbook of multicultural perspectives on stress and coping (pp. 73 -89). Springer.*

Christopher, M.S. (2003). Albert Ellis and the Buddha: rational soul mates? A comparison of rational emotive behaviour therapy (REBT) and Zen Buddhism. *Mental Health, Religion & Culture, 6, 283-293*

Cole, B., & Pargament, K. (1999). Re-creating your life: a spiritual/psychotherapeutic intervention for people diagnosed with cancer. *Pycho-oncology, 8, 395-407.*

Cutler, H.C. (1998). *The art of happiness: A handbook for living. Coronet paperback.*

Harrison, M.O., Koenig, H.G., Hays, J.C., Eme-Akwari, A.G., & Pargament, K.I. (2001). The epidemiology of religious coping: a review of recent literature. *International Review of Psychiatry, 13, 86-93*

Hayes, S. C. (2002). Buddhism and acceptance and commitment therapy. *Cognitive and Behavioral Practice, 9, 58-66*

James, A., & Wells, A. (2003). Religion and mental health: Towards a cognitive-behavioral framework. *British Journal of Health Psychology, 8, 359-376.*

Jeffers, S. (2003). *Embracing uncertainty. London: Hodder and Stoughton.*

Koenig, H.G. (1995). Religion as cognitive schema. *The International Journal for the Psychology of Religion, 5, 31-37.*

Koenig, H.G., McCullough, M.E., Larson, D. (2001). *Handbook of Religion and Health. Oxford: Oxford University Press.*

Kumar, S.M. (2002). *An introduction to Buddhism for the cognitive-behavioral therapist. Cognitive and Behavioral Practice, 9, 40-43.*

Leong, K.S. (2004). The Zen teachings of *Jesus. Crossroad Publishing.*

Marks, L.D. (2006). Mental health, religious belief, and "the terrifying question". *Journal of Child and Family Studies, 15, 135-141.*

Meese, K.J. (2002). *Applications of Pargament's findings on efficacy of religious coping methods to Christian counseling.*

Moreira-Almeida, A., Neto, F.L., & Koenig, H.G. (2006). *Religiousness and mental health: a review. Brazilian Journal of Psychiatry [Revista Brasileira de Psiquiatria], 28, 242-250.*

Pargament, K.I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: three styles of coping. *Journal for the Scientific Study of Religion, 27, 90-104.*

Pargament, K.I. (1997). *The psychology of religion and coping: theory, research, and practice.* New York: Guilford.

Poloma, M.M., & Pendleton, B.E. (1991). The effects of prayer and prayer experiences on measures of general well-being. *Journal of Psychology and Theology, 19, 71-83.*

Poloma, M.M., & Pendleton, B.F. (1989). Exploring types of prayer and quality of life: a research note. *Review of Religious Research, 31, 46-53.*

Siegel, K., Anderman, S.J., & Schrimshaw, E.W. (2001). Religion and coping with health-related stress. *Psychology and Health, 16, 631-653.*

Zinnabuer, B.J., & Pargament, K.I. (2000). Work with the sacred: Four approaches to religious and spiritual issues in counseling. *Journal of Counseling and Development, 78, 162-171.*