CONCEPTS OF MENTAL HEALTH AND MENTAL ILLNESS:
A COMPARISON OF DEFINITIONS AND CHECKLISTS
IN THE ABHIDHARMAKOŚABHĀSYA AND THE
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
(DSM-III-R)

by

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ABSTRACT

This study examines concepts of mental health and mental illness in Vasubandhu's *Abhidharmakośabhāṣya* (AKBh), and the American Psychiatric Association's *Diagnostic And Statistical Manual Of Mental Disorders* (third edition, revised) (DSM-III-R). The choice of these texts was made based on their importance and influence.

Two general problems are encountered in this study. There are great philosophical differences between the texts. These differences are most problematic in regards to terminology. Buddhist terminology is used wherever appropriate and possible. Unfortunately, sometimes North American terminology and categories infiltrate this. The translation of the AKBh poses a second problem. Due to time constraints, the english translation was used, however this translation is faulty in a number of places. Corrected translations are offered in square brackets.

This study is conducted on two levels. One is content-oriented, exploring the relevant concepts in each text and examining the cultural, historical, religious, and theoretical influences that form or underlie these concepts. The second level is exploratory and more like hypothesis testing. Both texts use the format of lists, and a primary aim of this study is to identify and compare, not details, but broad structural similarities and differences between such lists. In such a way, the phenomenon and use of lists in such texts may be better understood.
Through this approach one finds that concepts of mental health and mental illness in each text are influenced by values and norms. In particular, DSM-III-R reflects largely secular values, while the AKBh contains a soteriological psychology. These differences are linked to basic concepts of the norm—against which mental health and mental illness are measured—as average or ideal.

Due to such differences in values and norms, a comparison of individual items on the lists is not possible. However, as these same values and norms form or underlie the lists, a comparison of such broad influences or structures is methodologically justifiable. The finding that DSM-III-R shows the influence of values and norms, indicates that it may be impossible to formulate any concept of mental health or mental illness without such influences.
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I. INTRODUCTION

When people have information that they need to remember, such as groceries that have to be bought, books to be read, or terms to be memorized for an exam, they often put that information into the form of a list. Lists help people to organize information and such organization is an aid to memory. As well, if people wish to communicate the information to others, lists provide useful summaries that may be quickly understood and employed.

Once a list has been made, however, it often does not reveal the underlying information and organizational principles that were integral parts in its construction. For instance, even the simple grocery list, a necessary fact of existence for most people, requires some degree of thought, choice and organization. First a person looks in the refrigerator and cupboards to see what needs to be bought. Items are chosen or not depending upon a number of factors that may include menu plans, seasonal availability, personal preference, finances, etc. Finally, having made some choices based on these factors, the person constructs a list and may even organize the list itself according to some scheme such as, "dairy products," "produce," "meat and poultry," etc. Thus a grocery list is only deceptively simple, for it actually requires examining, planning, choosing and organizing.

Both the Indian and North American traditions of thought have produced lists that summarize information in order to help people remember, communicate and use that information in an efficacious manner. For instance, the Abhidharmakośabhāṣya (AKBh), a Buddhist philosophical-psychological
text dating from around the fifth century of the common era, gives a list of the kleśamahābhūmika-s, or principal (mental) states existing in all defiled minds, as: delusion (moha); non-diligence (pramāda); idleness (kausīdya); disbelief (āśraddhya); torpor (stvāna); and dissipation (auddhatya) (AKBh, ii.26a-c, 193).

An example from the North American tradition is a list of the diagnostic criteria for a major depressive episode (only part of which will be given here) taken from the Diagnostic And Statistical Manual Of Mental Disorders (Third Edition - Revised) (commonly referred to as DSM-III-R):

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)
(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear
of dying), recurrent suicidal ideation
without a specific plan, or a suicide attempt
or a specific plan for committing suicide
(DSM-III-R, 222).

Separated by centuries and cultures, the sample lists from
AKBh and DSM-III-R are, of course, very different. Singly, they may appear
quite straightforward, yet side by side the differences due to topic, scope,
stance, time, and culture, are highlighted. Examining both lists together then,
enables one to identify the various underlying theories, choices, and
organizational principles that, like the grocery list, might not have been
apparent from a cursory glance. As Paranjpe in Theoretical Psychology: The
Meeting of East and West, has noted:

An attempt to compare two different systems
necessitates "stepping out" of both systems
now and then, since this enables us to assess
each of them as a whole. Temporary distancing
from a system of ideas enables us to stop and
question whether things which we have taken for
granted are indeed unconditionally true. Thus,
our implicit assumptions become explicit in the
process of comparison...We tend to exaggerate
our strengths and discount our weaknesses when
working within only one system, while a comparative
perspective enables us to see the strengths and
weaknesses of our own as well as other systems
in their real proportions (1984, 2).

Such a comparison of concepts of mental health, mental
illness, and lists, in the AKBh and DSM-III-R reveals a series of both broad
cultural and more specific factors that are valuable aids in understanding and
explaining each system or tradition, and that might be overlooked without a
comparative perspective. Thus the purpose here is not to say "this" is equal to
"that," but rather to see each list or concept as part of a whole tradition, history, and culture, embodying a specific approach to, or way of theorizing about, a problem. In the same way, pictures of one flower may be taken by two different cameras, and those pictures compared to identify the nature, scope, strengths and weaknesses of each camera.

With regards to the specific lists, this approach then, is exploratory and more like hypothesis testing. Although this present study may not find two lists that can be tellingly or conveniently compared, this does not mean such lists do not exist. The Indian list literature is vast, being the result of long periods of thinking, experimentation, and refinement.

One of the primary aims of the present study therefore, is comparative experimentation with list literature. That is, the study seeks to identify and compare, not details, but broad structural similarities or differences between lists; as well as to unravel the factors underlying those structures and lists. That the lists considered here are psychological (psychiatric), or religious, in nature is due to what the present writer considers herself able to handle and elucidate.

Before any comparison is possible though, one must gain some understanding of the general background and history of each tradition. Immediately, difficulties arise because of terminology. The term "psychology" comes from the Greek words "psyche" and "logos," meaning the treating or study of the soul or mind. Currently it is sometimes contrasted with "psychiatry" which is, "the branch of medicine dealing with the diagnosis and
treatment of mental disorders" (iatreia in Greek meaning "cure"). While there is overlap between the two terms, or at least their object(s) of study and treatment, they are usually regarded as separate, and sometimes rival, fields in the West.

Further complications arise when applying the Western term "psychology" to Eastern traditions, for the Eastern, and in this specific case, Indian, traditions have very different approaches to, and understandings of, the study of the soul or mind. Such differences have led some to regard psychology as a purely Western invention and to overlook the important contributions of Indian thought. Unfortunately, this has even been true in India (Paranjpe 1984, 16). However, the philosophical and religious traditions of India reveal a great wealth of psychological theory and therapeutic techniques. Therefore, even though the material arising from such traditions was not labelled as psychology per se, and even though psychology never developed as an autonomous discipline within India (until, perhaps, recent times), some of the content is obviously psychological and should be recognized as such, despite the absence of this label (Paranjpe 1984, 4).

To avoid further complications with terminology, particularly with regards to psychology-psychiatry disputes, one may use the term "mental healing." Mental healing,

in its broader sense includes the humble origins of contemporary psychology and psychiatry in the dawn of recorded history as well as the latest exploits of scientific psychotherapy as it is practiced in the major
centers of treatment (Ehrenwald 1976, 17).

In the West, organized psychiatry and clinical psychology are scarcely two hundred years old (Bromberg 1975, v), while, as noted, there has been some reluctance applying such terms to Eastern thoughts and practices. The term, "mental healing," allows one to view issues of mental health, mental illness and therapeutic interventions from a historical perspective. This reveals that North American psychology-psychiatry is a recent off-shoot of a long tradition of interactions between Western religion, philosophy and science, while its Indian counterparts emerge from their own philosophical and religious traditions (Safaya 1975, 4).

Mental Healing In The West

As Walter Bromberg in his book From Shaman to Psychotherapist notes, no one can say when, in the early history of humankind, a shift took place from attention to physical pain to recognition and treatment of psychological suffering (1975, 2). The earliest mental healers though undoubtedly would have been shamans (as well as priests, teachers, elders, etc.) using amulets, charms, words and rituals, as well as insight into the fellow human beings, to treat physical and mental illnesses (Bromberg 1975, 3). While some of these shamanistic practices were preserved in indigenous native populations, Greek philosophy was the earliest significant influence for the tradition of mental healing in the West.
Greek philosophy was based on the ideas that there were universal laws, and that nature was orderly rather than chaotic (Paranjpe 1984, 60). Any systematic inquiry into the nature of the human being or the mind begins with, and depends upon, these fundamental concepts (Paranjpe 1984, 59). Greek thought emphasized rationalism and the spirit of reason, and from early times regarded the rational ability of human beings as somehow separate from intuition and feelings (Paranjpe 1984, 19). Since that time, the West has had a fascination with the human being as a supreme and unique rational animal, a fascination reflected in the Latin term *homo sapiens* (Halbfass 1991, 266).

Apart from such general ideas, three Greek thinkers, in particular, were tremendously influential in shaping the development of the mental healing tradition in the West. Pythagoras (6th-5th century B.C.E.) and his philosophy of numbers provided a basis and rationale for the classification of bodily humors (blood, phlegm, yellow bile, black bile) and natural elements (fire, air, earth and water) that lasted in medical practice until relatively modern times (Bromberg 1975, 8). As well, the Pythagoreans applied their idea of the mean to medicine, and their concept of health as the "attunement and harmony of opposites" (for example, the body is regarded as healthy when it is neither too cold nor too hot) has been a lasting influence (Jones 1970, 36).

Hippocrates (c. 460-377 B.C.E.), commonly known as the Father of Medicine, was dissatisfied with the emphasis on supernaturalism that existed in medical theory during his time (Bromberg 1975, 12). He maintained that
diseases arose from bodily, natural sources, and Bromberg notes that this type of perspective contained in his writings,

exerted a lasting influence on medicine for a millennium or more. [Hippocrates] contributed a high moral tone to the therapeutic aspect of medicine. Though his clinical observations were more medical than psychiatric, his influence proved to be significant in the evolution of psychiatric thinking (1975, 12).

Plato (427-347 B.C.E.), whose thought has had enormous impact in the West, suggested that mental disorders were "partly somatic, partly moral, and partly divine in origin" (Bromberg 1975, 13). He advocated what might be considered an early form of cognitive therapy, namely the "curative effect of words," of "beautiful logic" (Bromberg 1975, 13).

Greek thought and medicine were brought to the Latin world, as classical culture flowed from Greece to Rome. The Romans resisted Greek medicine at first, but accepted it around the first century B.C.E. (Bromberg 1975, 14). However, in spite of the fact that Latin authors dealt with many aspects of medicine, nutrition, etc., interest in psychotherapy, to judge from extant literature as explored by experts, was quite minimal (Bromberg 1975, 15). It was not until Christianity gained influence (c. 392 C.E.) that attention again became focussed on ideas of mental health, illness, and healing (Bromberg 1975, 17).

While Greek thought emphasized rationality, the Christian tradition emphasized faith (Paranjpe 1984, 19). The Church of Rome was the most powerful force in the field of mental healing in the West until the eighteenth
century (Bromberg 1975, 21). That its influence is perceived to have retarded the growth of science in general and psychology-psychiatry in particular, is noted in the very first paragraph of Kaplan and Sadock's influential Comprehensive Textbook Of Psychiatry (1989, 1:vii). This perceived conflict between science and religion has resulted in the modern emphasis on value-free, objective and empirical methods in Western psychology and psychiatry, and has consequently dictated the appropriateness of certain fields of study (Paranjpe 1984, 6, 23-24). The importance of this perceived conflict between science and religion cannot be underestimated, for many of the differences regarding mental healing in the North American and Indian traditions have their basis in the fact that no such similar conflict developed in India, and therefore their scientific or psychological theories and religious ideas remained intermixed (Paranjpe 1984, 30).

As mentioned, the Christian church was the single most powerful influence in the Western mental healing tradition for approximately 1400 years. Popular medical folklore existed, as did the humane treatment of mental patients in a few hospitals during the eleventh to thirteenth centuries, but the church's theories about, and treatment of, mental illness were far more powerful and pervasive (Bromberg 1975, 25, 27). With the Council Of Toledo's teaching in the fifth century that "demonic seizures" could only be cured by miracles (as opposed to natural diseases that could be cured by human medical effort), nervous or mental disorders ceased to be regarded as diseases (Bromberg 1975, 27). The Malleus Maleficarum in 1484 was the culmination of
this tradition that viewed mental illness as a form of demon possession, and that advocated exorcism, including torture to make the "demon" confess, as the sole cure (Bromberg 1975, 27, 43).

It was in opposition to such a dangerous combination of ignorance and power that the Western sciences developed. In the sixteenth century, the doubts, the questionings, and the challenges to the teachings and commands of organized religion helped to foster empiricism, which is essentially a belief in the value of understanding our world and increasing our knowledge of it through sensory experiences and a conviction that all we know is what we have learned (Reisman 1991, 4).

René Descartes (1596-1650) furthered this trend by asserting that the human body and mind/soul are separate entities that interact with each other (Fancher 1979, 19). This mind-body dualism has been tremendously influential in the West, and can be seen in the current theories and questions regarding possible biological versus psychological factors in the etiology of mental illness. Descartes also tried to show how certain physiological processes might parallel some psychological phenomena, and although few of his ideas on this topic are accepted today, his attempts helped to set the stage for psychology to emerge as one of the sciences (Fancher 1979, 19).

In the seventeenth and eighteenth centuries, Spinoza, Locke and Hume developed theories that provided a reasoned approach to the understanding of the mind, while others focussed on developing a physiology of the brain and nervous system (Bromberg 1975, 69). With this combination of work, mental
disorders again came to be accounted for on naturalistic grounds (Bromberg 1975, 63). Such a development resulted in more humane treatment of the mentally ill. For example, Pinel (1745-1826), often called the "father of scientific psychiatry," brought about a "therapeutic revolution" by liberating the mentally ill from their chains, and insisting on better forms of treatment (Bromberg 1975, 94). Pinel also introduced the practice of keeping records and taking case histories for patients, and tried to form a systematic classification, or nosology, of mental illnesses (Reisman 1991, 7).

In the nineteenth century, there was great progress in the fields of physics, chemistry, biology and medicine (Reisman 1991, 13). It was at this point that psychiatry and psychology proper developed. Scientific work in brain anatomy and physiology provided a foundation for psychiatry, and this led to a shift in emphasis and attention from asylums to departments of psychiatry in university medical schools (Reisman 1991, 14). The goals of psychiatry became to "identify specific diseases, to determine their particular etiologies, and to develop methods of treatment appropriate to each" (Reisman 1991, 14).

Scientific psychology emerged as Wilhelm Wundt (1832-1920) and William James (1842-1910) established the first psychological laboratories in universities (Leipzig and Harvard respectively) (Fancher 1979, 126). Wundt and his contemporaries defined psychology as the "study of consciousness," the soul not being regarded as an appropriate or even possible object of study (Reisman 1991, 15). The psychoanalytic school--Freud (1856-1939), Adler (1870-
1937), Jung (1875-1961), and others—though, emphasized the unconscious mind. Then Watson (1878-1958) and the behaviorists stressed the importance of biology and of understanding, predicting, and controlling overt behavior (Fancher 1979, 319). Behaviorism was at least partially succeeded by what became known as the "Third Force," humanistic psychology, represented by the work of Maslow (1908-1970), Rogers (1902-1987), and others. Of course, each of these schools of psychology developed its own ideas of the etiology of mental illness, and devised its own methods of therapeutic intervention. Raghunath Safaya has humorously summarized these many developments and changes in Western psychology as: "first psychology in the West lost its soul, then its mind, then its consciousness and lastly all its behaviour" (1975, 6).

Much could still be written on developments in psychiatry and psychology in the twentieth century, particularly in the area of neuropsychiatry. However, the purpose here has been to identify some of the major factors that shaped current approaches to mental healing. Given this, one last factor needs to be mentioned. Since the 1960s, Western psychologists and psychiatrists have become interested in Eastern approaches to the mind and mental healing. Although much of the work of those known as "transpersonal psychologists" is of questionable scholarship, or at least is at a very basic level, some fine and useful work is being produced by many others. This recognition of the great wealth of Eastern psychological theories and mental healing techniques is long past due.
Mental Healing In India

It is a difficult undertaking to trace the development of mental healing (or for that matter, nearly any other aspect of thought or practice) in India, for Indian thought is not monolithic (Halbfass 1991, 267). Statements often accepted in the West, such as "all Indian thought is monistic," or "all Indians believe the world is an illusion," etc., only reflect Western illusions and naivete regarding Indian philosophy and psychology. At most, one may only speak of dominant trends in Indian thought (Paranjpe 1984, 57). Accordingly, some of these dominant trends will be examined here to see how they might have shaped the tradition(s) of mental healing in India and, specifically, of Indian Buddhism before the common era. Such an approach, limited in scope, necessarily leaves out the many impressive contributions of Indian thought in the areas of perception, motivation and cognition.

It seems natural to begin a study of Buddhist mental healing with the Buddha himself, and yet this, perhaps, is not the best place to start. The Buddha is credited with achieving great insight through his enlightenment experience, and while this may be true, it is also undeniable that he inherited rich traditions of psychological thought and practice (Reat 1990, 282). Some speculate that the cumulative knowledge the Buddha directly or indirectly inherited, was a result of a synthesis of the Vedic and Upaniṣadic traditions with the indigenous yogic traditions of India (Reat 1990, 143) (although it is by no means certain that yoga is not Vedic or Upaniṣadic). Thus in order to trace
the development of mental healing, one must begin with the *Veda-s* and their view of the human being.

Halbfass, in *Tradition and Reflection*, notes that unlike the West, there is no tradition in India of "explicit and thematic" thought that tries to define some essence of human beings as completely separate and different from, or superior to, other forms of life (1991, 266). Generally, and in a basic sense, the Vedic texts classify the human being (*manuṣya, puruṣa*) as a domesticated animal (*paśu*), albeit a special and distinguished one (Halbfass 1991, 268). In the *Veda-s*, and particularly the *Brāhmaṇa-s*, correspondences between the human being and the cosmos are identified, for example, between breath and the wind (Reat 1990, 80). This early interest in micro-macrocosm connections was developed further in the *Upaniṣad-s*, some of which sought to identify an essence in human beings, such as the ātman, with a common, ultimate, macrocosmic essence, such as *brahman* (Reat 1990, 206).

This type of speculation formed in conjunction with the development of ideas about *karma*. The fact that belief in the law of *karma* (literally meaning "action") is common in India, reflects a pervasive underlying belief in, or philosophy of, the lawfulness of nature and the cosmos (Paranjpe 1984, 61). Generally speaking, the law of *karma* may be summarized as, "yathā karma tathā phalam," "just as the action, so also the fruit" (i.e., you reap what you sow). In other words, for much of Indian philosophy and religion, the law of *karma* involves the concept that the nature of acts—including acts of thought—impacts and, eventually, transforms the nature of the doer (Reat 1990, 276).
This type of perspective on *karma*, which has great psychological implications, is examined further by Paranjpe:

the theory of karma implies that human behavior is lawful in every way. It is controlled by laws of physical nature which nobody can violate; each action is systematically related to the individual's entire past; and finally, in a moral sense, no one can escape experiences of joy or suffering as the fruits or consequences of his own past action (1984, 61).

Given this, it is not surprising that ideas of *karma*, coupled with micro-macrocosm speculations, resulted in views of the human being that were, and are, very different from Western views, and which form the basis of Indian psychologies and mental healing traditions.

As mentioned previously, in Indian thought the concept of the human being as completely separate, different, reasoning, reckoning, and planning "animal rationale," is not emphasized to the degree that it is in the West (Halbfass 1991, 281). Instead, the potential of human beings to attain liberation (*moksa*) is stressed, as Halbfass summarizes well:

[In the *Mahābhārata*] Man's potential for intelligent planning, for applying tools and techniques, for subduing other creatures and for dominating the earth, that is, his potential as a rational animal ("animal rationale"), appears as a temptation to be resisted. Exploiting this potential would be a misuse of a unique soteriological opportunity. The true privilege of man is not to be the master of his world, but to be liberated from it; his mandate is not to employ other creatures as instruments for his own needs and desires,
but to use himself, his own human existence, as a vehicle of self-transcendence (1991, 272).

This emphasis on self-transcendence, and acceptance of such a religious or soteriological goal, are key elements in Indian psychology and mental healing. Indeed, many of the mental healing techniques and psychological concepts were developed by those who were seeking self-transcendence, or by those who had already attained it (Paranjpe 1984, 5, 31). Because the quest for liberation was a common concern crossing philosophical and religious boundaries, certain techniques and psychological concepts came to be shared by people, or groups, of many different persuasions (Paranjpe 1984, 31).

In this way there existed, to some extent, at the time of the Buddha the perspective that people could, and should, strive for psychological or spiritual self-transcendence, as well as a variety of yogic techniques that had been developed to aid in the attainment of such a goal. The Buddha himself is said to have tried a number of these techniques before finally becoming enlightened.

Many scholars today acknowledge that we cannot know, for certain, the exact nature of the Buddha’s teachings. There is even debate over the dating of the time he lived, although 563 BCE to 483 BCE, or the shorter chronology of 463 to 383 BCE, are the most common dates given. The Buddha became fully enlightened and then taught others until his death. Traditionally it is said that his words and teachings were remembered and collectively rehearsed, until finally they were preserved not only orally, but in manuscripts (Warder
However since the preserved material shows some differences in doctrines, we are unable to know for certain what the Buddha taught.

Nevertheless, the general character of the earliest teachings of Buddhism reveal a number of things. The Buddha and early or primitive Buddhism, seemed to accept some ideas common during the time, for example the concept of *karma*, but rejected certain kinds of philosophical speculation. The characteristic feature of the teaching was that it "admitted no esoteric truths, and was meant for all who were not satisfied with leading a life of natural inclinations. It was a 'folk-gospel'" (Hiriyanna 1949, 73).

Although the earliest teachings rejected such speculation and esotericism, they did not necessarily represent a movement against the predominant religion of Hinduism. Some scholars even maintain that the fundamental Buddhist doctrine of *anātman* was a later development (Hiriyanna 1949, 73). Instead, the focus at this point in time was primarily pragmatic—examining one’s experiences within the universe, rather than defining the essence of the self and universe (Reat 1990, 22). This phenomenological-psychological focus remained, although it became more analytical over time.

The basic doctrines of Buddhism that are usually (but, as we have seen, not necessarily) attributed to the Buddha, are contained in the four noble truths. The first truth, recognizes that frustration, dissatisfaction, and suffering are a part of normal living. This truth is often translated as life is suffering (*duḥkha*), but suffering should be understood in a very broad sense (Johansson 1969, 15). The second truth states that suffering or
unsatisfactoriness originates in desire (त्रश्ना; P. 탕하 - meaning "thirst" or "craving") which later was understood as being based in ignorance (avidyā). Thus if desire and ignorance are eliminated, then suffering too will be eliminated (third truth). The fourth truth delineates the path or method by which desire and ignorance can be eliminated. This is known as the eightfold path.

The eightfold path consists of right views, right intentions, right speech, right conduct, right livelihood, right effort, right mindfulness, and right concentration. From a modern Western psychological perspective, one can see that this path involves cognitive and behavioral elements. Right views, right intentions and right effort are all strongly cognitive, while right speech, right conduct and right livelihood are behavioural. Right mindfulness and right concentration though, which involve meditation, go beyond most Western forms of mental healing.

The four noble truths and the eightfold path are thus interesting, for they reveal a distinctly therapeutic paradigm (Halbfass 1991, 246). In the truths, "we have what corresponds to a physician's treatment of a disease--ascertaining the nature of the disease, discovering its cause and setting about its cure by adopting appropriate means thereto" (Hiriyanna 1949, 75). In other words, these truths offer concepts of diagnosis (suffering); etiology (desire or ignorance); prognosis (abolition of desire and ignorance); and therapeutics (the eightfold path).
The traditional Western medical paradigm is diagnosis, etiology, therapeutics and recovery. Thus given the above, which only changes or combines the last two elements, one might wonder whether such a medical paradigm existed in India as well, and provided a basis for these truths. However, there is no evidence that such a scheme existed prior to the Buddha (Halbfass 1991, 245). This type of approach to problems is practical and logical, so the Buddha, or early Buddhists, need not have borrowed it.

Although the paradigm was not necessarily borrowed, it is obviously therapeutic. It is not surprising then that medical metaphors and comparisons are common in Buddhist literature (as well as in other Indian philosophical and religious literature) (Halbfass 1991, 244). For instance, the Buddha is compared to a doctor; his teachings to medicine or a remedy; and his followers to patients (AKBh, vi.75b, 1033).

Given this, one can see that there is recognition, even within the Buddhist community, of the therapeutic nature of Buddhist practices and teachings. An early and enduring goal of Buddhism, as stated in the truths, was the alleviation of suffering. Since the etiology of this suffering (desire or ignorance) was located within the person, one may regard such suffering and its cause as being primarily mental. Then, since the remedy for this suffering was mainly cognitive and behavioural, one might consider the eightfold path to be, among other things, a form of therapy designed for mental healing.

The idea of the eightfold path as a form of therapy must be qualified, since the goals, doctrines, practices and philosophies of Buddhism certainly go
far beyond concerns for mental health. However, one of the main goals of Buddhism, as in other Indian psychologies, is self-transcendence or enlightenment, and this, as we shall see, includes some elements that are psychological or therapeutical. Therefore, the state of enlightenment might, at least for the purposes of this study, be viewed as representing some type of mental health.

The development of Buddhist doctrines and thought continued beyond these basic four noble truths and eightfold path. Over time, people formulated various theories regarding the nature of the self and the world. According to canonical Buddhism, there is no ātman. Instead, the person (pudgala) is only a "complex," consisting of body or form (rūpa), and mind (nāma) (Hiriyamma 1949, 75). Other views regard the person as an "interacting assemblage" of five skandha-s (P. khanda) or heaps (Rao 1962, 108). These skandha-s are: form (rūpa); feelings (vedanā); ideas, apperception, or sensations (saṃjñā) (P. saññā); volitions and other faculties (saṃskāra); (P. sankhāra); and consciousness (vijñāna) (P. viññāna) (Stcherbatsky 1923, 5).

Briefly, rūpa is form, matter, the material or physical aspect of things. Vedanā, feeling or affect, is classified as pleasant, unpleasant, or neutral (Conze 1967, 107). It is, "a basic psychological function which imparts to every conscious content, of whatever kind it may be, a definite value" (Guenther 1974, 37). Saṃjñā is the function of perceiving and the perceived image is transmitted to consciousness (Guenther 1974, 39). Saṃskāra-s, difficult to translate with one single english word, "are all active dispositions, tendencies,
impulses, volitions, strivings, emotions, etc., whether 'conscious' or repressed" (Conze 1967, 107). Finally, vijñāna is consciousness or awareness in its general sense (Conze 1967, 110-111).

Analyses such as these grew more complex over time as Buddhism defined itself against other philosophies and also underwent various schisms and divisions from within. In much of Buddhism it was clear that, whether the person was considered a complex of two or five factors, there was no permanent self (Hiriyanna 1949, 75). Rather, the person was undergoing constant change and therefore, like other things, was impermanent (anitya) (P. anicca). The elaboration of these ideas in particular, led to the rise of a number of Buddhist schools of thought.

Around 386 or 376 BCE, the Buddhist community became divided as Eastern, liberal, monks debated with those who were Western and more orthodox (Haldar 1981, xii). This took place at Vaiśālī and resulted in two main Buddhist sects, known as Mahāsaṃgha (great community), and Sthaviravāda (school of the elders) (Warder 1970, 208). Both sects, as time passed, underwent further divisions, only one of which shall be noted here since it concerns the nature of the person.

Circa 286 BCE, a monk named Vātsīputra and his followers (called Vātsīputrīyas) split off from the Sthaviravādins. Orthodox Sthaviravādins maintained that references in scriptures to "the person," were "no more than a kind of pronoun, a demonstrative like 'this' used when referring to a particular (philosophically speaking) collection of the elements or phenomena combined in
a living body with consciousness" (Warder 1970, 241). The Vātsīputrīyas, though rejecting the concept of an eternal soul or self (ātman), accepted some unity termed "person," as reality. For them, the living being was something more than simply five skandha-s and the senses (Warder 1970, 241). The first view, that of the Sthaviravādins "won," for it was accepted by most, if not all, other schools of later Buddhism (Warder 1970, 241).

Other notable developments in thought and schools, had their roots in the early doctrine of impermanence (anītya). This basic doctrine—that all things are subject to change, that everything has a beginning and an end—was developed into a theory of momentariness (kṣaṇika-vāda) (Chatterjee and Datta 1960, 136). This theory held that things do not last for even short periods of time, but exist for one moment only (Chatterjee and Datta 1960, 136). The "things" that exist are merely momentary elements called dharma-s, and the Sarvāstivādins (school of all exists) (who seceded from the Sthaviravādins circa 237 BCE) in particular emphasized that these dharma-s alone were "realities," every combination of them being "a mere name covering a plurality of separate elements" (Stcherbatsky 1923, 62).

The doctrines of anātman, momentariness, and dharma-s, were supported and elaborated upon by many later writers and Buddhist schools. From a psychological perspective, the result of such doctrines was largely a conception of the person as a series of momentary elements, and a realization that the perceptual world (what we know to be the world) is made up of material processes and "endless sequences of conscious processes" (Johansson 1978, 24).
Thus one can see two interesting "streams" within early Buddhist thought. One, having its basis in the four noble truths, eightfold path, and goal of enlightenment, has some emphasis on therapeutics, or as we are calling it here, mental healing. The other stream is more philosophical, but still has great psychological relevance, for it concerns the nature of the person and world. It therefore provides a specific religious-philosophical context for the more applied psychological practices.

Summary

No thinker develops his/her thought in intellectual isolation, no text or body of thought arises without a tradition. The purpose of this introduction has been to identify some of the major events and elements that shaped the traditions of mental healing in the West, and in Indian Buddhism before the common era. We have seen that the Western traditions were intimately connected with, and strongly affected by, the philosophies and religions of their time. Further, what might, in the West, be regarded as psychology and mental healing, were important parts of the Buddhist religion and philosophy. The implications of these influences and elements will be explored further as the concepts of mental health and mental illness in the AKBh and DSM-III-R are examined. Both of these texts may be regarded, in various ways, as representing the culmination of their traditions.
NOTES - INTRODUCTION

1Gage Canadian Dictionary, s.v. "psychology," "psychiatry."

2One might speculate that the Western tendency to use the norm or average as the standard of mental health against which mental illness is defined and measured (an idea to be examined in a later section), may be traced to this idea of the mean.

3There is some question whether or not the Western mental healing tradition is truly value free and objective. This will be examined in a later section.

4Halbfass describes avidyā as a "cognitive disease or affliction," and translates it as "nescience," "misconception." He notes that "this avidyā is deep-rooted metaphysical confusion, a radical misunderstanding of the world and one's true nature. It is essentially self-deception, self-alienation, apparent loss of one's own identity" (1991, 252).

5A key or defining doctrine for the Sarvāstivādins was the idea that all elements or dharma-s exist on two planes, which consist of "the real essence of the element (dharma-svabhava) and its momentary manifestation (dharma-lakshana)." The first was said to exist always, in the past, present and future. Past existence referred to past appearances of its phenomenal existence, and future existence referred to potential appearances of its phenomenal existence (Stcherbatsky 1923, 35).

Such concepts or doctrines are primarily philosophical and will not be examined in this study.
II. METHODOLOGY

In recent years, North American psychiatrists and psychologists have shown growing interest in the Indian mental healing traditions. Two groups in particular, the transpersonal psychologists, and physicians and psychologists in behavioural medicine, have been responsible for most of the studies done on the Indian traditions. However, there are some general problems with the studies of each group. Transpersonal psychologists tend to overemphasize the experiential aspect of their work, and to embrace Indian philosophies and techniques quite naively, leading to charges that they borrow too glibly and apply these techniques too superficially (Taylor 1988, 94). People in behavioral medicine may investigate specific Indian techniques, and their studies are usually quite objective, but they often demonstrate only limited understanding of the philosophical and psychological systems that underlie their object(s) of study (Taylor 1988, 94). Both groups may be further faulted on some of their text-based studies, for their use of questionable translations and for defining their subject matter far too broadly (Taylor 1988, 102-103).

Recently, one scholar has suggested that these problems may be overcome through "the systematic introduction into western psychology of objective methods in historical scholarship adapted from the western academic field of comparative religions" (Taylor 1988, 94). Use of such methods leads to: an emphasis on history and cultural relativity; an awareness, and examination, of changing thoughts or ideas over time; more careful linguistic analysis; and a
sensitivity to the advantages and problems inherent in using primary sources (Taylor 1988, 97).

In the present study, methods from the field of comparative religions will be employed to examine concepts of mental illness and mental health in the AKBh and DSM-III-R. The purpose of this, as stated in the Introduction, is not to equate one tradition with the other, for that would be methodologically unsound, nor to explore some Indian technique or method of meditation and consider its applications in North America. Rather, the purpose here is to explore concepts of mental illness and mental health as found in each text, and then to examine the cultural, historical, religious, and theoretical influences that underlie them.

Despite the centuries and cultures that separate them, DSM-III-R and the AKBh seem logical choices as texts for this type of study. Both examine concepts of mental health and mental illness--albeit not in identical senses or extents--using, at least at some points, the format of lists. This allows one to approach each text in a parallel way; facilitates what comparisons might justifiably be made; and, gives one the chance to explore the phenomenon and use of lists. Insight into the factors that influence and underlie the texts in general and the lists in particular, facilitates both the understanding of each individual text, and comparison between them. In other words, there is a built-in element of interdependence or circularity in such an approach.

Having already explored a general history of each tradition in the Introduction, this study shall first examine definitions and ideas of mental
illness and mental health, as found in DSM-III-R and the AKBh. The basic cultural and religious value systems underlying or forming these concepts will then be explored, with particular attention paid to the questionable existence of a "value-free" approach in DSM-III-R, and a recognition of the AKBh’s openly "value-laden" approach. The question of values leads to a consideration of norms, particularly, who or what is the norm against which mental illness and mental health are measured? The norms will be identified in each text and their implications discussed.

Having thus arrived at some understanding of the concepts of mental illness and mental health in the texts, as well as the values and norms influencing and underlying them, one list from each text will be examined and compared. In this way, the study moves from the general to the particular. Through this process, one will see that the lists given in each text contain a great deal of hidden information.

As indicated above, DSM-III-R and the AKBh are, among other possibilities, logical choices for this type of study. Using the comparative approach, it would be questionable and difficult (particularly due to philosophical difficulties) to examine more than one text from each tradition. Given this, the choice of texts was made based on their importance and influence, as well as their discussion of the relevant concepts and the use of lists. The individual lists chosen from these texts may not directly address the same field or phenomenon to the extent some may wish. However, as
explained in the Introduction, the present is an experiment in unraveling lists of a particular kind.

**The Diagnostic And Statistical Manual Of Mental Disorders (III-R)**

In Western psychiatry and psychology, many kinds of lists exist, created and used for various purposes by a great variety of movements and schools. In North America, perhaps the most widely used lists are those found in *DSM-III-R*. This text, its terminology, and concepts, are often extensively referred to in textbooks and journal articles that discuss psychopathology (Spitzer and Williams 1987, xviii). Although not universally accepted, or even liked, it has undeniably become "the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility" (Spitzer and Williams 1987, xviii). Patients who enter a psychiatrist's office are likely to be diagnosed according to *DSM-III-R* categories, and the same is often true for those going to psychologists.

As one might deduce from the title, *DSM-III-R*, published in 1987, is the third edition (revised) of a manual for diagnosing mental disorders. *DSM-I* was published in 1952 and listed 60 mental disorders; *DSM-II* was published in 1968 and listed 145; and *DSM-III* was published in 1980 with a listing of about 230 disorders (Reisman 1991, 36). The growth in the number of categories of mental disorders is said to reflect growing sophistication and knowledge in the field, rather than increasing insanity on the part of North Americans. The
changes in each manual not only include new categories proposed or added, but also some category modifications and omissions (Reisman 1991, 37).

Since **DSM-III-R** is a diagnostic manual, it does not generally discuss etiology, or therapeutic interventions. One reason for this is that the manual was designed to be used by persons of many different schools or approaches in the Western mental healing tradition. Since these schools offer differing concepts of etiology, therapeutics and recovery, a generally atheoretical descriptive approach, with operational criteria focusing only on diagnosis, was judged to be of greatest use to the greatest number of people (Spitzer and Williams 1987, xxiii).

Another reason for the narrow focus on diagnosis, is that:

> For most of the DSM-III-R disorders...the etiology is unknown. Many theories have been advanced and buttressed by evidence—not always convincing—attempting to explain how these disorders come about. The approach taken in DSM-III-R is atheoretical with regard to etiology or pathophysiologic process, except with regard to disorders for which this is well-established and therefore included in the definition of the disorder (Spitzer and Williams 1987, xxiii).

As ideas of therapeutic intervention and recovery are often dependent upon diagnosis and concepts of etiology, this lack of certainty about etiology thus necessitated that the manual deal only with identifying and diagnosing mental illness.

With regards to diagnosis itself, **DSM-III-R** is very specific. It has a multiaxial scheme that takes into account developmental and personality
disorders, levels of adaptive functioning, relevant physical diseases, social stressors, and, of course, syndromes or disorders of the mind (Akiskal 1989, 1:590) In this way, DSM-III-R is said to provide a "biopsychosocial approach to assessment" (Spitzer and Williams 1987, xxv).

The lists of disorders or syndromes found in DSM-III-R are descriptive. This means that:

the definitions of the disorders are generally limited to descriptions of the clinical features of the disorders. The characteristic features consist of easily identifiable behavioral signs or symptoms, such as disorientation, mood disturbance, or psychomotor agitation, which require a minimal amount of inference on the part of the observer. For some disorders, however, particularly the Personality Disorders, the criteria require much more inference on the part of the observer (Spitzer and Williams 1987, xxiii).

Given this final admission, some would question the reliability or validity of DSM-III-R as a diagnostic tool, and studies on this topic are always being conducted. Nevertheless, DSM-III-R remains the most widely used manual for the diagnosis of mental disorders in North America, and has had significant influence internationally (Spitzer and Williams 1987, xviii).

Although DSM-III-R is said to focus only on diagnosis, examination of this text also reveals that it contains discussions relating to concepts of mental health and mental illness in general. Further, regarding DSM-III-R as a primary text rather than as a manual one is using for diagnosing mental disorders, reveals considerable information about the cultural milieu that
underlies, gives rise to, and makes use of, this text. For these reasons in particular, DSM-III-R is a valuable source of information for a study such as this.

The Abhidharmakośabhāṣya

The AKBh, in many ways, represents a pinnacle of Indian thought and psychology, for it is an encyclopedic work, an almost exhaustive inventory of Hīnayāna scholastics. There is heated debate regarding authorship (since some maintain that there were two Vasubandhu's) and the dating of this author's life, although circa 400-480 C.E. is most often accepted. The influence of this particular text of Vasubandhu's, is reflected in the great Sanskrit romance Kādaṃbarī, which speaks of parrots in a Buddhist hermitage reciting verses from the AKBh (Rao 1962, 104). Scholars have described the AKBh as "a treasury of the fundamental doctrines of Buddhism" (Chaudhuri 1976, 11), and, "perhaps the most instructive book of early Buddhism" (Poussin 1913, 4).

From its title, one can see that the AKBh is part of the abhidharma (P. abhidhamma) tradition of early Buddhism. The word "abhidharma" in its narrow usage, refers to the third of the Tripitaka, Three Piṭakas, or collections, of scriptures that comprise the Pāli (=Theravāda) Buddhist canon (Pruden 1988, xxx). The Pāli canon consists of the Sūtra-s (or Ágama-s) (P. Sutta-piṭaka), which are the words of the Buddha; the Vinaya or monastic rules; and the Abhidharma Piṭaka, which contains analyses of the elements and nature of
reality and the world, and which was compiled later than the other two
(Pruden 1988, xxx).

More broadly, the word "abhidharma" may signify not only this third
Piṭaka, but also its type of contents, style of thinking, and manner of writing
(Pruden 1988, xxx). Abhidharma may thus refer to "a certain type of
commentarial literature, the Śāstras or commentaries on the Sūtras of the
Buddha" (Pruden 1988, xxx).

The precise meaning of the word abhidharma itself is not clear. With
the prefix abhi added to dharma it may mean "further dharma" or "supreme
dharma" (Conze 1951, 105). The AKBh gives several explanations of the word,
first stating that abhidharma is "pure prajñā [wisdom] with its following," and
defining "prajñā" as "the discernment of the dharmas" (AKBh, i.2a, 56).¹ It is
important to note that prajñā is usually understood as the methodical
contemplation of the essential elements (psychological, material, etc.) of
existence (Conze 1951, 105)(although there are other types of prajñā as well).
This is certainly a very specific definition or understanding of "wisdom," and
one that is needed to comprehend why the Buddhists would undertake the
sometimes long, dry, and seemingly insignificant (but very systematic)
discussions found in Abhidharma literature.

A second definition of abhidharma, is also found in the AKBh. While
the first definition stated that abhidharma is wisdom, the second (paraphrased)
notes that "In common usage, the word Abhidharma also designates all prajñā
which brings about the obtaining of Abhidharma in the absolute [first
definition] sense of the word" (AKBh, i.2b, 56). Here the text refers to other types of prajñā leading to that prajñā which is equated with the abhidharma of the first definition. With this understanding of abhidharma, a text such as the AKBh is also referred to as abhidharma:

One also gives the name of Abhidharma to the Treatise [the AKBh], for the Treatise also brings about the obtaining of pure prajñā (AKBh, i.2b, 57).

Compared with the first portion, the remaining words in the title Abhidharmakośabhāṣya are simple. "Kośa" means "sheath," or "treasury," so "abhidharmakośa" is a compound meaning the "sheath or treasury of the abhidharma." Vasubandhu explains that this refers to the fact that "the Abhidharma enters into it [the treatise] through its meaning [truly, really, as regards the meaning]; or because the Abhidharma constitutes its foundation" (AKBh, i.2c-d, 57). A bhāṣya is a commentary. Vasubandhu originally composed the Abhidharmakośa from the Sarvāstivāda point of view, and then later wrote a commentary from the Sautrāntika point of view, to accompany the original work. Thus the title, Abhidharmakośabhāṣya, means "commentary on the sheath/treasury of the abhidharma." As one might conclude from the preceding discussion, the word "abhidharma," is better left untranslated.

From the title of Vasubandhu's text, one knows that it is a study of the dharma-s, and thus that it embraces a great variety of topics and problems (Poussin 1913, 5). These include expositions on: analyses of the elements of
matter (*dharma*-s); the cosmos or spheres (*bhūmi*-s); *karma*; the path to enlightenment; etc. The text contains a number of heated debates between representatives of a number of Buddhist schools, and therefore can be quite confusing. Nevertheless, the fine philosophical-doctrinal disputes, may, for the most part, be ignored for the purposes of a study such as this, which seeks only to find some general information on basic psychological concepts.

Thus the main purpose of the *AKBh* is certainly not to discuss mental health or mental illness per se, much less to be a diagnostic manual of mental disorders. However, it is useful for this study because of its tremendous importance in Indian Buddhist thought; because of its format which uses lists; and also because, as is typical of *Abhidharma* literature, it contains (among many other things) a great wealth of psychological thought.

This last reason once again emphasizes the pragmatic nature of Buddhism. Investigation of the *dharma*-s leads to wisdom (*prañā*), and wisdom, in Buddhism, is not simply intellectual, but is the key element in psychological health. Conze is especially helpful in identifying this psychological nature of *Abhidharma* literature and studies:

The chief purpose of Buddhism is the extinction of separate individuality, which is brought about when we cease to identify anything with ourselves. From long habit it has become quite natural to us to think of our own experiences in the terms of ‘I’ and ‘mine.’ Even when we are convinced that strictly speaking such words are too nebulous to be tenable and that their unthinking use leads to unhappiness in our daily lives, even then do we go on using
them. The reasons for this are manifold. One of them is that we see no alternative way of explaining our experiences to ourselves except by way of statements which include such words as "I" and "Mine." It is the great merit of the Abhidharma that it has attempted to construct an alternative method of accounting for our experiences, a method in which the "I" and "Mine" are completely omitted, and in which all the agents invoked are impersonal dharmas. The Abhidharma is the oldest recorded psychology, and it is, I think, still sound for the purposes for which it was designed (1951, 106).

Conze further adds the caution that one should,

beware of assuming that the dharma theory is offered as a metaphysical explanation of the world, to be discussed and argued about. It is, on the contrary, presented as a practical method of destroying, through meditation, those aspects of the commonsense world which tie down our spirit. Its value is meant to be therapeutical, not theoretical (1951, 108-109).

With this understanding of the chief purpose of Abhidharma, one may assuredly regard Vasubandhu's AKBh as a psychological text in which one may seek (and find) pragmatic information about mental illness, mental health, and mental healing. In such a way, it thus becomes possible to compare this influential, brilliant and diverse early Buddhist text with a modern, more narrow, Western (psychiatric) text that is also tremendously influential. Such a comparison between the two is only possible due to the disciplined, intelligent, and consistent manner in which the authors of both texts approached their subject matter.
The word dharma is etymologically explained as "that which bears (dhāraṇa) self-(or unique) characteristics" [It is called dharma "because of the bearing (dhāraṇa) of self-characteristics"] (AKBh, i.2b, 57). The following of prajñā is the five pure skandha-s (AKBh, i.2a, 56).
III. CONCEPTS OF MENTAL ILLNESS AND MENTAL HEALTH

Since DSM-III-R and the AKBh have different cultural and historical backgrounds, it is not surprising to find that these texts have differing views on the nature of mental illness and mental health. These differing concepts are important for they are the foundations underlying the specific lists that will be examined below. As well, a thorough exploration of concepts of mental illness and mental health will provide one with the information needed to understand the religious and cultural values found in these texts as a whole, and the lists in particular.

Definitions Of Mental Illness

In the introduction to DSM-III-R it is noted that an adequate definition of "mental illness," or, more precisely, "mental disorder," doesn't exist (Spitzer and Williams 1987, xxii). Nevertheless, the committee responsible for DSM-III-R thought it useful to offer the definition of mental disorder that "influenced the decision to include certain conditions in DSM-III and DSM-III-R as mental disorders and to exclude others" (Spitzer and Williams 1987, xxii). From this one can see that the basic concept or definition of mental illness is the most important factor in a text of this nature, and indeed, in any discussion of mental illness, for how one defines mental illness, and mental health, is crucial for the development of further thought on related issues. In other words, one may regard such definitions as the fundamental substrata underlying each list in such texts.
In DSM-III-R, each mental illness or disorder is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person. Neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person, as described above.

There is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, or between it and no mental disorder (Spitzer and Williams 1987, xxii).

The implications of, and implicit assumptions in, this definition will be examined later. For now it is sufficient to make some general observations about the definition. Firstly, a number of terms are vague, for example, "clinically significant," "distress," etc. This vagueness is only partially remedied in DSM-III-R through the use of specific descriptions and criteria in the diagnostic lists.

Secondly, the term "expectable response" gives a sense that expectations, or value judgments, are going to be present in this text that arises from a
tradition which is supposed to be value-free. The caution that one should not view deviant behavior as mental illness, recognizes that value judgments in the past have led to misdiagnosis of mental illness (for example the "witches" in the Middle Ages, or, more recently, the controversy over homosexual orientation being included as a mental disorder in previous DSM's). As we shall see, in spite of statements such as the one in the introduction, this particular area of value judgments is still problematic.

Thirdly, the statement that mental disorders are not necessarily discrete entities with sharp borders, is interesting, given that DSM-III-R then describes each disorder as if the opposite were the case. Such a discrepancy may reflect, at least, arbitrary decisions on boundaries, and needs to be examined further.

Although these criticisms, and others, may be levelled at this definition, the definition is useful for giving some idea of how the A.P.A. (American Psychiatric Association) defines mental disorders. Particularly important is the idea that mental disorders, regardless of etiology, are considered to be manifestations of "behavioral, psychological, or biological dysfunction in the person." This is the core of the definition, representing both the tripartite influences on the North American mental healing tradition--namely behaviorism, psychology in general, and medicine--and the way in which a human being is understood--that is, as a combination of body and mind, with behavior being the result or action of the two.
As one can see then, this definition, which must have been challenging to compose, contains a number of key elements that need further study. It is not simply a definition, but rather a statement arising from a committee that is influenced by a society with particular values and norms. Moreover, as this definition is the "guiding principle" behind the development of specific criteria regarding the diagnosis of mental disorders, it is, therefore, very significant.

The AKBh does not give many definitions of mental illness, but a number of ideas about the nature of mental illness may be culled from discussions on other topics. Firstly, the term "mental illness" is not used, but rather the term "mental ruin" (kṣepa). Mental ruin is said to be produced "in the mental consciousness" (AKBh, iv.58a, 632). It is the ruin of consciousness or cognition itself--the senses are understood as not the primary cause of the ruin: "the five sense consciousnesses cannot be troubled [ruined] because they are free from imagining [conceptualization]" (AKBh, iv.58a, 632).

Mental ruin is thus understood as a disturbed moment or sequence of moments of mental consciousness itself. This type of ruined mental consciousness is described as confused or mixed up; not having power (over oneself), or not having one's free will; and being devoid of mindfulness, or of decayed or ruined mental consciousness (AKBh, iv.58c-d, 633-634). This description of mental ruin thus comes close to North American definitions of mental illness, however, understandings of the word "mental" would be very different for the Indian Buddhists and North Americans.
Other forms of suffering are also examined in the AKBh. These are certainly not regarded as forms of mental illness or ruin, however they are important, for they contain some information about mental suffering. The idea that concepts of, and attachments to, an ātman lead to some sort of suffering, which might at least partially be termed "mental," is found in a number of places in the AKBh. A basic Buddhist view of the human being (here from a school known as the Sautrāntikas) is presented in chapter two:

Blinded by ignorance, foolish persons imagine that the series of conditioned phenomena (saṃskāras) is a "self" or belongs to a "self," and, as a consequence, they are attached to this series. The Blessed One [the Buddha] wanted to put an end to this erroneous imagination and to the attachment which results from it: he wanted to show that the series is conditioned, that is to say, "produced through successive causes" [dependently].

[Blinded by ignorance, foolish persons are faithfully convinced that the series of conditioned phenomena (saṃskāras) is ātman or belongs to ātman, and, as a consequence, they are attached to this series. The Blessed One, for the purpose of putting an end to this erroneous faithful conviction, wanting to show that this series is conditioned, said the following...] (AKBh, ii.46b, 241).

Another quote then highlights the suffering or trouble that is produced through identification with these "series:"

Don't we see that certain persons, ignorant of the true nature of the conditioned dharmas (i.e., the saṃskāras) that constitute their pretended "self," are attached to these dharmas through the force of habit, as
completely devoid of personality as these dharmas are, and suffer a thousand pains by reason of this attachment?

[For just as, through the force of habit, certain persons, ignorant of the characteristics of the conditioned dharmas, with regard to conditioned elements which are not the atman, develop attachment (to them) as the atman, and suffer pains by reason of this attachment...] (AKBh, iii.93d-94a, 481).

Thus one can see that there is a brief description of mental ruin in the AKBh that comes close, in some ways, to North American understandings of mental illness. However, the idea that some types of suffering have a basis in the belief in the atman, indicates a much broader and more soteriological understanding of mental suffering than is seen in the DSM-III-R definition. As a number of passages indicate, if belief in the existence of, or identification with, the atman is viewed as a source of mental trouble or suffering, then most people would be regarded as, at least potentially, mentally troubled (according to this Buddhist definition). Indeed, further examination of the concepts of mental health and mental healing will show this to be the case, and highlight one of the most interesting differences between the North American and the Buddhist mental healing traditions.

Definitions Of Mental Health

DSM-III-R does not provide a clear definition or picture of mental health. This reflects a common tendency in the West, for psychologists or psychiatrists such as Abraham Maslow, who study the healthy or optimally functioning
person, are quite rare (Liebert and Spiegler 1982, 299). An indication of this rarity is found in the massive Comprehensive Textbook of Psychiatry/V, which, although consisting of over two thousand pages, has only one page on health (in the section on psychosomatic medicine) and no entries for mental health. The focus for much of the North American mental healing (and especially psychiatric) tradition, is clearly on diagnosis and removal of mental disorders. Health is thus often seen as the absence of certain symptoms rather than the possession of positive qualities that might characterize a state called "health."

The closest that DSM-III-R comes to offering a definition of health, is the Global Assessment of Functioning (GAF) Scale, which is designed to help the practitioner assess a person’s "mental health-illness" (DSM-III-R, 20). This scale focusses on the person’s psychological, social, and occupational functioning (DSM-III-R, 20). Functioning at an optimal level is characterized by:

Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members) (DSM-III-R, 12).

One may infer from this brief description, that mental health, according to DSM-III-R, consists of three components: firstly, the complete, or near complete, absence of certain symptoms--here symptoms associated with mental disorders; secondly, "good" or "effective"
functioning in everyday life—the behavioral aspect of health; and thirdly, the 

sense of being "satisfied with life," and "interested" in activities—which 

represent the subjective side of health. Again, the influences of medicine, 

behaviorism, and general psychology are present in this definition.

Other than this short description of healthy functioning given in the 

GAF scale, one finds no mention of mental health in DSM-III-R. Since the text 
is a manual of mental disorders, this is not surprising. However, as noted, the 
tendency to leave the concept of health almost unexamined is found throughout 

the North American, and especially psychiatric, mental healing traditions. 
Given this, one may conclude that the subject matter of DSM-III-R represents 

the influences of an underlying, and largely unstated, value system, and is not 

only the result of stated mandates or purposes.

In contrast to DSM-III-R, the AKBh offers a number of definitions of 

positive (mental) states which here will be considered as representing states of 

mental health. Although one might regard the characteristics of a Buddha as 

providing the best examples of this ultimate state of mental health, theological 

and historical considerations also play a role in the idea(s) of the nature and 

characteristics of a Buddha. Therefore, in this study, the enlightened person, 
or Arhat, shall be taken as the standard or example of one who has achieved 
this state of health. Moreover, one may gain a better understanding of AKBh 

concepts of mental health if one examines some of the psychological qualities 
gained, or abandoned, on the path leading to enlightenment.
Guenther notes that, "in the strictly Buddhist sense of the word, delusion is the conviction of one's own importance" (1974, 106). This supports the idea that general (mental) suffering has some source in the imagining of, and identification with, the ātman, which is said to not exist as an independent non-composite entity. With such a perspective, it is not surprising to find that the Buddhist path, which may be considered here as a form of therapy that brings about a healthier state, emphasizes insight, wisdom, and seeing reality as it is: impermanent (anītya); anātman; and unsatisfactory (duḥkha).

Psychological Changes On The Path

The path, or therapeutic process as one might consider it here, contains a number of parts, and, in the Buddhist scheme, may take several lifetimes to complete. There is the distant preparatory path, the preparatory path, and the path proper, which is further divided into two main paths: the path of seeing (darśanamārga) and the path of meditation (bhāvanāmārga). As one can see, the entire path represents a long process and one that is meant to bring about thorough and lasting changes in the person. Again, it is important to note here that the person is the bundle of five skandha-s which proceed in a series over various lifetimes.

The whole process towards soteriological health, or enlightenment, begins with the acquisition of some essential qualities, the roots of good (kusalamūla-s), which provide a foundation for everything that follows. Most important here is the development of "the force of the desire for deliverance," for a person must always be willing to change, and to reach a goal, before any
form of change can take place (AKBh, vi.25a, 943). This resolute desire for change or deliverance is brought about through exposure and commitment to Buddhist teachings:

This foundation of the good and wholesome is qualified as ‘conducive to and forming part of the process of liberation’ (mokṣabhāgīya) and comprises of listening to (śrūta) and pondering over (cintā) the message of the Buddha and of making the resolution (praṇidhi) to follow the Buddhist doctrine and discipline, this resolution overshadowing all our behavior in words and deeds (Guenther 1974, 216).²

If a person has done this and acquired the firm resolution to follow the path, it is expected that this will not simply affect the intellect, but the emotions as well:

It is recognized that whoever, understanding the sermons concerning the defects of Saṃsāra, the non-self, and the qualities of Nirvāṇa, has his hairs stand on end and who pours forth tears, possesses the mokṣabhāgīya roots of good.

[It is to be determined/ascertained that whoever, having heard the sermon illuminating the defects of Saṃsāra, the fact that there is no ātman, and the good qualities of Nirvāṇa, has his hairs stand on end and who pours forth tears, possesses the mokṣabhāgīya root of good] (AKBh, iv.125c-d, 707).

It is further expected that these "mokṣabhāgīya roots of good" will manifest themselves not only intellectually and emotionally, but in behavior also. These early qualities or tendencies being acquired are primarily mental, but,

Bodily action and vocal action are also
mokṣabhāgīya when they are embraced by the resolution (pranidhāna) for deliverance; this resolution is a type of volition (cetanā...): by giving alms, a bodily action, by obliging oneself to observe a rule, a vocal action, or by studying a stanza of four pādās, one projects a mokṣabhāgīya, when the force of the desire for deliverance comes to qualify those actions.

[Bodily action and vocal action are also mokṣabhāgīya when they are embraced by the resolution (pranidhāna) for deliverance; having given even one alm, having obliged oneself to observe even one rule, someone projects a mokṣabhāgīya, because he places (into these acts) the force of the desire for deliverance] (AKBh, vi.25a, 942-943).

It seems then, that this acquisition of the roots of good has both intellectual or cognitive and emotional components. Here it represents some sort of intellectual and emotional conversion that is needed to set the person on a new path toward health and enlightenment. Again, the critical element is the desire for change or deliverance. This can be expressed through specific behaviors such as giving alms, reciting verses, etc., which undoubtedly serve to reinforce that desire for deliverance.

The changes taking place in this early stage, the distant preparatory path, may seem similar to the Western idea that a person must first have the insight (cognitive, emotional, or both) that "something is wrong," in order for him/her to willingly seek psychotherapy. Here though, rather than such specific insight, there is a sense that something is wrong not just with oneself, but with life as a whole. Then the distant preparatory path not only identifies
the critical element for successful change and healing—the desire for deliveryance—but also notes ways that this might be brought about, nurtured, and strengthened. Again, since the Buddhist path aims at helping the person develop a clear understanding of reality as it is, it is not surprising that listening to, and pondering over, Buddhist teachings (that deal with the nature of reality) are important parts of this first stage.

Having secured the mokṣabhāgīya roots of good, the person must then acquire the "moral qualities which make a perfect monk," or the "lineages of the Aryans" (nobles) (āryavatā-s) (Poussin 1925, 3:xiv). Although the text presupposes that one must be a monk, this restriction does not matter much for the purposes of this study since psychological changes are being considered rather than specific religious requirements.

The qualities or lineages are brought about by: keeping the precepts; reading or hearing Buddhist teachings; reflecting on them; and applying oneself to meditation (AKBh, vi.5a-b, 911). The qualities that arise from these are characterized by non-greed, and are: contentment with clothing; contentment with food; and contentment with bed and seat (AKBh, vi.7c-d, 915). Thus one gains contentment here by abandoning greed for "worldly" goods and comforts. A fourth quality, to take delight in abandoning (namely, of the kleśa-s) and in the cultivation (of the path), is not referred to as contentment, but rather only as non-greed (AKBh, vi.7c-d, 915). This last quality is characterized solely by non-greed, because "it turns its back on
attachment to pleasure and attachment to existence" ["it turns away its face from desire for pleasure and desire for existence"] (AKBh, vi.7c-d, 915).

One can see that this stage involves both behavioral and emotional elements. It is expected that people at this stage have "renounced their old regimen and their old activities, [and] are engaged in searching out deliverance" (AKBh, vi.8a-b, 915). The first three qualities of contentment supply a new regimen that changes both the way one thinks of possessions and comforts, and the way one acts toward those things. This new perspective, and its qualities of contentment, gain force from the fourth quality, an emotional commitment to non-attachment and the path. At this early stage then, one gains contentment, whose nature is non-greed, which opposes the arising of further desires (AKBh, vi.8b, 915). Again the importance of the commitment or desire to change, is affirmed in the fourth quality.

Having acquired these qualities, the person then begins the cultivation of mindfulness, through which entrance into meditation is possible (AKBh, vi.9a-b, 916). Here, the method to be used is chosen by considering the basic personality type of the meditator. If the person is dominated by discursive thinking, reflection, and reasoning (vitarka), mindfulness of breathing is used, but if craving (rāga) dominates, then visualization of the loathsome is employed (AKBh, vi.9c, 917-918). Through practices such as these, the person becomes less driven by desire and less prone to distraction (Poussin 1925, 3:xiv). Concentration thus increases, and the person becomes capable of entering into deeper meditative states and absorption (samādhi) (Poussin 1925, 3:xiv).
In combination with the cognitive elements of the cultivation of mindfulness, the practice of the four divine behaviors (brahmavihāra), also called the "four immeasurables" (apramāṇa) is often begun as well (Guenther 1974, 106). These four immeasurables are: love or friendship (maitrī); compassion (karuṇā); joy (muditā) and equanimity (upekṣā) (AKBh, viii.29a, 1264). Cultivation of these qualities or attitudes opposes "ill-will (uvāpadā), the tendency or readiness to harm (vihiṃsā), dissatisfaction [apathy] (aratī), and sensual craving (kāmarāga) and hostility (uvāpadā)" respectively (AKBh, viii.29b, 1264).

Love (maitrī), is defined as non-hatred or non-malice (AKBh, viii.29c, 1265). Unlike ordinary love it is constant, not based on passion, and therefore counteracts feelings of ill-will and hatred (Guenther 1974, 107). The nature of compassion (karuṇā) is also non-hatred or non-malice (AKBh, viii.29d, 1265), and as such, it counteracts the tendency or readiness to harm (vihiṃsā) (AKBh, viii.29b, 1264). One can see from this that it is largely cognitive and emotional rather than behavioral at this point, representing (along with the other immeasurables) more of a philosophical generalized intellectual stance that encourages compassion, rather than a set of behaviors or actions (AKBh, viii.30a-c, 1266). The nature of joy (muditā) is satisfaction [sympathy] (AKBh, viii.29, 1265). This sympathy, a state of being well-disposed towards others, counteracts apathy (aratī) (AKBh, viii.29b, 1264). Finally, the nature of the fourth immeasurable, equanimity (upekṣā), is non-greed, and therefore non-ill-will, for ill-will has its roots in greed (AKBh, viii.30a, 1265). As such,
equanimity opposes sensual craving (kāmarāga) and hostility (vyāpadā) (AKBh, viii.29b, 1264).

The four immeasurables are said to "oppose" mental defilements (AKBh, viii.29b, 1264). However, this does not mean that these defilements are permanently overcome or abandoned through the immeasurables, particularly at such an early stage of the path. The immeasurables are cultivated in the preparatory path, but only fully achieved or acquired later (AKBh, viii.31d, 1268-1269).

Given this, Conze describes the immeasurables as being not only qualities one gains, but "methods for cultivating the emotions," and notes that their main purpose "consists in reducing the boundary lines between oneself and other people" (1951, 102). Thus as one uses meditations or exercises to develop love, compassion, joy and equanimity, more negative egotistic tendencies in thought, emotion and behavior are disrupted. When these negative tendencies or defilements (kleśa-s) are permanently overcome (abandoned) through meditation further along the path, the four immeasurables are then able to shine forth purely and fully, without any defilements to darken or limit them.

Following these types of meditations (visualization of the loathsome, mindfulness of breathing, cultivation of the immeasurables) and having attained absorption (samādhi-see note 4) through them, the person begins to cultivate the foundations [concentration/fixation] of mindfulness (smṛtyupasthāna-s) (AKBh, vi.14a-b, 925). This is done by "considering the
unique [specific] characteristics (svalakṣaṇa) and the general characteristics (sāmānyalakṣaṇa) of the body, sensation, the mind, and the dharma-s" (AKBh, vi.14a-b, 925). The specific characteristics are those that compose the self-nature (svabhāva), for instance the unique nature of the body is to be composed of "primary elements and physical matter derived from [based on] these primary elements" (AKBh, vi.14a-b, 925). Considering the "general characteristics" means developing further insight or wisdom (prajñā) into the nature of conditioned things (AKBh, vi.14c-d, 925). For example, Guenther describes well this process as it applies to emotions, attitudes, and the world:

> Inspection of our feelings reveals the unsatisfactoriness of even pleasurable feelings, because the unpleasurable feeling-tone releases a new cycle of activity with all its harassing aspects of finding a solution to the problem. Inspection of our attitudes shows that there is nothing static and nothing permanent about them; and inspection of the elements that constitute our world, internally as well as externally, makes it abundantly clear that nowhere is a Self to be found (1974, 219).

Such consideration or inspection thus leads to a deeper, yet still imperfect, understanding of the general and particular characteristics of the person and the world (Poussin 1925, 3:xiv). In other words, although not perfect or complete, a clearer, more accurate, view of reality develops during this stage.

The process of cultivating the concentration of mindfulness is designed to oppose four basic distortions or perversions, which are "to hold that which is impermanent to be permanent, that which is suffering to be happiness, that which is impure to be pure, and that which is not [ātman] to be [ātman]"
(AKBh, vi.15c-d, 929; v.8-9a-b, 780-781). It thus involves many cognitive changes and demands deep concentration or absorption. Once the concentration of mindfulness is achieved, the person then begins to acquire the four "roots of good" (kuśalamūla), which are also called "leading to penetration" (nirvedhabhāgīya) (Poussin 1925, 3:xiv). These form the preparatory path [path of application] (prayogamārga) proper, as contrasted with all that came previously, known as the distant preparatory path (Poussin 1925, 3:xiv-xv).

According to Guenther, prior to the preparatory path people split their existence into mental and physical aspects (1974, 220). Cultivation of the concentration of mindfulness leads to a reintegration of these, since both the body and mind are seen to be conditioned, impermanent, unsatisfactory, and anātman (Guenther 1974, 220; AKBh, vi.14c-d, 925). Therefore, given this reintegration and the energy needed to produce it, it is not surprising to find that heat (uṣman) represents the first indication of its successful completion (Guenther 1974, 220).

The first nirvedhabhāgīya root of good is a kind of heat (uṣmagata), which is both physical and mental (Guenther 1974, 220). It is "similar to [a kind of] heat (uṣma), being the [early form] of the Noble Path, a fire which burns the fuel which are defilements" (AKBh, vi.17a, 930). This heat then may be felt both bodily and mentally, as it "burns away" emotional instabilities, and later, the defilements (Guenther 1974, 220). This heat goes
through three stages--weak, medium, and strong--until finally the "summits" (mūrdhan) arise (AKBh, vi.17c-d, 930).

Although they have a similar focus, the summits are said to differ from heat because they are "more elevated" (AKBh, vi.17d, 931). As well, even though one can regress or "fall away" from them, one may also move beyond them to the next stage (AKBh, vi.17d, 931). The summits have weak, medium and strong states, and a person who moves through these reaches the next stage, called patience [patient acceptance, receptivity] (ksānti) (AKBh, vi.18c, 931; vi.19b, 933).

Guenther describes the stage of patient acceptance (ksānti) as being an extremely important event, namely accepting "the validity of the Truths which have been directly experienced" (1974, 220). This would seem to emphasize the acceptance of some insight regarding the new world view, five skandha-s, four noble truths, etc., that have previously been developing. This acceptance is thus a turning-point, and once reached, some maintain that one cannot fall away from it (AKBh, vi.18c, 932). This is perhaps similar to Plato's myth of the cave, where once the cave-dweller has seen the brilliance of light, there is no returning to the darkness of previous ignorance.

Out of this patient acceptance comes the experience called "supreme worldly dharma-s" (laukika agradharma-s) (AKBh, vi.19c, 933), or "highest worldly realization" (Guenther 1974, 220). This is momentary and one cannot fall away from it (AKBh, vi.19b, 933; vi.20a-b, 935). Here one gains highest realization, or understanding, of the suffering (duḥkha) that relates to the
world, to Kāmadhātu (the world or sphere of sensuality) (AKBh, vi.19c, 933).

This experience is termed "supreme worldly dharma-s" because these dharma-s that consist in insight (prajñā) are worldly, being impure; because they are supreme dharmas; and because they are supreme among the worldly dharmas. They are Supreme Worldly Dharmas because, in the absence of any similar cause (sabhāgahetu), by their own power, they manifest the Path of Seeing the Truths.

[are worldly, and they are supreme dharmas, because they are supreme among the worldly. Because, in the absence of any similar cause (sabhāgahetu), by their own power, they attract the Path] (AKBh, vi.19c, 933).

In other words, this experience marks the end of the preparatory path. The wisdom (prajñā) gained from this experience of absorption, and the experiences that preceded it, enables the person to begin the path proper (AKBh, vi.20a-b, 935-936). This last root of good, the supreme worldly dharma-s, is most important because it leads directly to this pure path (Poussin 1925, 3:xiv).

The four nirvedhabhāgiya roots of good represent stages of increased insight and understanding, as well as the acceptance of such understanding. This, along with the dharma-s that consist in insight (prajñā) that arise from it, is a turning-point for the person. One might say that the Buddhist world view has now become a part of the person, for the four noble truths have been thoroughly meditated upon, understood and accepted. As well, the person is now capable of sustained contemplation (samādhi). The result is someone who
possesses great concentration and insight—a person who is ready to permanently abandon soteriologically negative qualities and take possession of positive ones.

The path proper is composed of two main parts, the comprehension of the truths (satyābhisamaya), and the path of meditation (bhāvanāmārga) (Poussin 1925, 3:xv-xvi). Comprehension of the truths involves sixteen "moments" of thought (Poussin 1925, 3:xv). The first fifteen moments are called the path of seeing (darśanamārga), when the person is engaged in developing further insight (AKBh, ii.9a-b, 162-163). This marks the first pure (anāsrava) seeing of the truths (AKBh, vi.1c-d, 895). The sixteenth moment is also the first moment of the path of meditation (Poussin 1925, 3:xvi). The path of meditation may be worldly (impure), or pure (AKBh, vi.1c-d, 895). Since the pure path of meditation brings about the highest results, it will be the focus here.

The path of comprehension of the truths consists of sixteen mental states, or moments: eight of pure patience [receptivity] (kṣānti), and eight of perfect or pure knowledge (jñāna) (AKBh, vi.26d-27a-b, 946). The mental states of receptivity are pure because they are the "cutting off of the possession of the defilements" (AKBh, vi.28a-b, 949). The knowledges are pure because they "arise among the persons who are thus delivered from the possession of the defilements, at the same time as does possession of disconnection from the defilements" (AKBh, vi.28a-b, 949). Mental states of receptivity and knowledges differ from each other because at the moment of receptivity the defilement is not yet abandoned, while the moment of knowledge arises when
the defilement has been abandoned (AKBh, vii.1a, 1087). The relationship between the states of receptivity and the knowledges is thus likened to "two actions: expelling the thief, and closing the door" (AKBh, vi.28a-b, 950).

As one may remember, the supreme worldly dharma-s marked the end of the preparatory path. The first moment of the path proper, here the comprehension of the truths and the path of seeing, is a pure receptivity (kṣānti) whose object or focus is the unsatisfactoriness of the world of sensuality (Kāmadhātu) (AKBh, vi.25c-d-26a, 943; Guenther 1974, 221). This receptivity "expels all doubts [about the unsatisfactoriness of Kāmadhātu], because by nature it is an impassionate investigation into the nature of reality" (Guenther 1974, 221). It is called "pure" because its result is the arising of pure knowledge that has the unsatisfactoriness or suffering of Kāmadhātu as its object (AKBh, vi.26a-b, 943-945). Following this knowledge, there arises

one [Receptivity] of consecutive Knowledge...bearing on the Suffering of Rūpadhātu and Ārūpyadhātu...called duṣṭhe’nvayajñānakṣānti (the [Receptivity for] Consecutive Knowledge of Suffering).
From this [Receptivity] there arises a consecutive Knowledge which receives the name of Consecutive Knowledge of Suffering (AKBh, vi.26b-c, 945).

One can see then that there are four moments of receptivity (kṣānti) and knowledge (jñāna) that relate not only to the sensual world but also the higher meditative worlds and the cosmography. Here, the object is the nature of suffering or the unsatisfactoriness (first noble truth) of these worlds. This process of alternating states of receptivity and knowledges continues for the
other three noble truths as well, thus, in the end, there are sixteen moments (two moments of receptivity and two of knowledge for each of the four noble truths relating to Kāmādhātu, Rūpadhātu and Ārūpyadhātu) (AKBh, vi.26-27a-b, 943-946; Guenther 1974, 222).

The results of these sixteen moments are interesting. The result of the first moment, dispelling any doubt that the nature of Kāmādhātu is suffering, makes the person an Āryan (Poussin 1925, 3:xv), a "spiritual aristocrat" (Guenther 1974, 222). Doubt is one of the six "latent defilements" (anuṣaya-s) (AKBh, v.1a-d, 767-768). As we shall see in a later section, the defilements (kleśa-s) arise when these basic latent defilements (anuṣaya-s) are not abandoned (AKBh, v.34, 828).

Although there are a variety of ways of enumerating the latent defilements (so that their number ranges from six to ninety-eight) (AKBh, v.1d-3, 768-772), the basic six are: attachment or desire, anger, pride, delusion, false views, and doubt (AKBh, v.1c-d, 768). Doubt and false views are abandoned during this comprehension of the truths, or, more specifically, during the eight moments of receptivity (AKBh v.5a, 773; v.43b-44, 838-839; Guenther 1974, 224). Doubt, that is not being certain as to the basic unsatisfactoriness of all that one encounters, leads to false or wrong views (AKBh, v.32c-d, 826). There are five such views:

a belief in self (satkāyadrṣṭi), false views (mithyādṛṣṭi), a belief in extremes (antagrāhadrṣṭi), the esteeming of views (drṣṭiparāmarśa), and the esteeming of morality and ascetic practices (śīlavrataparāmarśa)
[a belief in self (satkāyadrṣṭi), false views (mithyādṛṣṭi), a belief consisting in taking up/holding onto extremes (antagrāhadrṣṭi), the over-esteeeming of views (drṣṭiparāmarśa), and the over-esteeeming of morality and ascetic practices (śīlavataparāmarśa) (AKBh, v.3, 772).

That "belief in self" is a wrong view is obvious given the context. "False view" here, is the taking up of, or holding onto, the idea that life is not suffering or unsatisfactory (AKBh, v.32d, 826). "Belief in extremes" is "the idea of the eternity or annihilation of the [ātman]" (AKBh, v.33a, 827). From such an idea arises the over-esteeeming of morality and ascetic practices, in other words, the valuing of things that are "considered to be a means of purification" (AKBh, v.33b, 827). From this arises the over-esteeeming of views, and from this, "attachment to one's views, and pride...in these views" as well as hatred with respect to different views (AKBh, v.33c-d, 827).

Comprehension of the truths thus enables a person to cut off or abandon doubt and such false views. As this is done, the person "takes possession" of this abandonment, therefore acquiring a clearer, more accurate, understanding of the nature of reality--the knowledge (jñāna) aspect of comprehension of the truths. Having done all this, in the final sixteenth moment of the comprehension of the truths, the person becomes a Srotāpanna (Poussin 1925, 3:xvi), or "one who has entered the stream" toward Nirvāṇa (AKBh, vi.34a-b). This sixteenth moment is also the first moment of the pure path of meditation (bhāvanāmārga) (AKBh, vi.28c-d, 950-952).
The Srotāpañña, although having abandoned doubt and false views, is still bound by four basic or latent defilements—attachment or desire, anger, pride, and delusion—which can only be removed or overcome through the path of meditation (AKBh, v.5a, 773). The path of meditation is a process of repeated contemplation or meditation, and may be of two types: pure (which will be considered here), and impure (Poussin 1925, 3:xvii). The pure path of meditation can only be cultivated by a person who has gone through the comprehension of the truths (Poussin 1925, 3:xvii). The impure path, or worldly path of meditation, yields results, but ultimately is said to only disturb or disrupt the defilements, and not to uproot them (Poussin 1925, ch. 2 note 33, 328).

On the pure path of meditation, the person does not have anything new to learn or to know, instead, in order to "cut off" the defilements that remain, that person repeats, or meditates upon, those truths into which they have previously developed insight (AKBh, ii.9a-b, 163). Through repeated contemplation of the truths, the person overcomes the defilements, moving from the coarser, stronger, and more obvious defilements, to ones that are more subtle, and therefore more difficult to abandon (Guenther 1974, 226-227). In the same way, it is said,

> when one washes a piece of cloth, the greater stains are washed out first and only lastly the subtle stains; so too a great darkness is vanquished by a small light, whereas a great light is required to get rid of a small amount of darkness
[when one washes a piece of cloth, the coarser stains are washed out first and only lastly the subtle stains; so too thick darkness is vanquished by a subtle light, whereas subtle darkness by a strong light] (AKBh, vi.33c-d, 957).

This process of overcoming defilements occurs in each of the nine spheres: Kāmadhātu; the four dhyāna-s or stages of Rūpadhātu; and the four states of the "formless' or nonmaterial absorptions which make up Ārūpyadhātu" (Poussin 1925, 3:xvii). In other words, the process is applied to higher and higher states of contemplation or consciousness and cosmic spheres, ensuring that the defilements are completely eradicated.

The assignment of different categories of attainment depends upon the extent to which the defilements, and the intensity of these defilements, are overcome. For instance, the person who has abandoned categories of Kāmadhātu defilements so that only the three weak categories of desire, anger and delusion exist, is called "the once-returner" (Sakṛdāgāmin). If even the weakest (i.e. weak-weak) categories of these defilements are abandoned, the person is a "non-returner" (Anāgāmin). When the last (weak-weak) category of defilements attached to even the fourth Ārūpya, or highest sphere of existence, is abandoned, the person has then completed the destruction of all the latent defilements and their outgrowths (AKBh, vi.44d, 981). The person then "takes possession" of this destruction, and gains the knowledge that they are destroyed, and is henceforth called an "Arhat" (AKBh, vi.44d-45b, 983).
The Buddhist Arhat is "the ideal man, the saint or sage at the highest level of development" (Conze 1951, 93). When Buddhism began, the term may have been applied to all advanced ascetics, but later, as a Buddhist technical term, it came to denote people who were "fully and finally emancipated," who, in other words, had attained enlightenment (Conze 1951, 93). Conze explains that the term Arhat may be etymologically derived in two ways,

The Buddhists themselves derived the word, 'Arhat,' from the two words 'Ari,' which means 'enemy,' and 'han,' which means 'to kill,' so that an Arhat would be 'A slayer of the foe,' the foe being the passions. Modern scholars prefer to derive the word from 'Arhati,' 'to be worthy of,' and meaning 'deserving, worthy,' i.e. of worship and gifts (1951, 93).

The first is really a context-dependent 'folk' etymology. The second, more "modern," explanation is similar to the AKBh explanation of this term. There is also a second term which is applied to the Arhats--aśaikṣa.

When this knowledge [of the destruction of the defilements] has arisen, the candidate for the quality of Arhat has acquired the state of Aśaikṣa, the state of Arhat: he no longer has to apply himself (śikṣ) with a view to another state; he is therefore an Aśaikṣa. For the same reason, having achieved his task with respect to himself, he is worthy (arhattva) to do good for others; he is worthy to receive offerings from all beings who are still subject to desire.

[When this knowledge has arisen, the one striving for/aspiring to, the quality of Arhat becomes an Aśaikṣa, and an Arhat, one who has obtained the fruit of Arhatship. There is nothing to be learnt for him with
a view to another fruit; he is therefore an Aśaikṣa. For the same reason, he is worthy
to do good for others; and he is worthy to receive veneration from all beings who are
still subject to desire] (AKBh, vi.45b, 983).

From these explanations, one can see that the state of Arhat implies not only the absence of defilements, but the presence of positive qualities in their place. Here, the direct knowledge that all the defilements have been destroyed is the most important of these qualities (AKBh, vi.44d-45b, 983; vi.75c-d, 1034; vii.46a, 1165). The Arhat is also said to win "complete sovereignty over his own thought" (Conze 1967, 167); and the AKBh describes the Arhat as one who is "free from delusion" (AKBh, iii.27b, 409). This lack of defilements, sovereignty over thought, and freedom from delusion, may be contrasted with earlier descriptions of the ruined moments of mental consciousness as confused, not having power (over oneself), and being of decayed or ruined mindfulness (AKBh, iv.58c-d, 633-634).

The idea that the state of health or enlightenment is characterized not simply by the absence of negative qualities but the presence of positive ones, is further supported by the statement that the Arhat's "series is pure, since his personality [basis=body] has just been renewed [turned around, changed]" (AKBh, iv.56, 631). Although it may seem strange to speak of the "personality" in the context of Buddhism, the process of becoming an Arhat involves a number of shifts or changes in what is commonly called the personality. These changes—representing movement from the bondage of desire, suffering, defilements, etc., to the freedom of calmness, insight, and
wisdom—are so extensive and thorough that the entire personality may be thought of as made "new."

The only beings in early Buddhism considered more perfect or complete than the Arhats, are the Buddhas (Conze 1951, 94). However, as indicated previously, since distinctions between Arhats, Pratyekabuddhas, and Buddhas are not entirely based on differences in psychological characteristics (but rather primarily have their roots in Buddhist historiography, mythology, and, in a sense, theology) they will not be examined here, although the AKBh's examination of the path goes on to include them.

One can see then that if the Arhat is taken as representing a person who has the ultimate state of (mental) health, this state is characterized not only by the absence of defilements, or even the absence of suffering, but also by knowledge (of oneself, others, the world, and various states of consciousness), love, compassion, joy, and equanimity. Thus, given these qualities, one may conclude that concepts of health in the AKBh go far beyond those found in DSM-III-R.

Summary

This examination of concepts of mental illness and mental health in DSM-III-R and the AKBh, reveals some basic differences. Firstly, one immediately sees that if the soteriological path in the AKBh is regarded as a therapeutic process bringing about (as a result rather than a primary purpose) some positive psychological changes in (what is commonly called) the person,
then the AKBh contains much more information about the nature of mental health than does DSM-III-R. Secondly, as if it were almost a mirror-image, DSM-III-R contains much more information about mental illness than does the AKBh, and its definition of mental disorder is more rigorous and thorough than the AKBh's definition of ruined mental consciousness. Finally, the definitions that are provided in each text contain elements that, if examined, reveal specific cultural and religious value systems. An analysis of these value systems is important for understanding these texts and the lists they contain.
NOTES - CONCEPTS OF MENTAL ILLNESS AND MENTAL HEALTH

1 Others also note this problem. For example, both Benjamin Pasamanick, M.D. in "What is Mental Illness and How Can We Measure It?" and John A. Clausen, Ph.D., in "Values, Norms, and the Health Called 'Mental;' Purposes and Feasibility of Assessment," express dissatisfaction with definitions of mental health and mental illness, and doubt whether it is possible to adequately define either. See The Definition and Measurement of Mental Health, ed. S. B. Sells, (U.S. Department of Health, 1968).

2 See also AKBh, vi.24c-25a, 941-943.

3 Mindfulness of breathing is said to cut off discursive thinking by turning attention inward and having an unvaried object with no color or shape. Visualization of the loathsome (a cadaver) counteracts cravings for color, shape, contact, and honors (AKBh, vi.9c, 917-918).

4 Conze notes that samādhi (concentration, absorption) corresponds etymologically to the Greek word "synthesis."
   To "concentrate" consists in narrowing the field of attention in a manner and for a time determined by the will. The result is that the mind becomes steady, like the flame of an oil lamp in the absence of wind.
   Emotionally speaking, concentration results in a state of quiet calm, because one has withdrawn for the time being from everything which can cause turmoil (Conze 1951, 100).

5 See also AKBh, viii.note 162 on page 1301 for the placement of the immeasurables on the path. The immeasurables are so called because, according to the traditional explanation, they "apply to an immeasurable number of beings" (AKBh, viii.29a, 1264).

6 See also AKBh, viii.29b, 1264. For methods of cultivating love (maitrī) see viii.31d, 1268-1270.

7 The "general characteristics" signifies the fact that "All conditioned things are impermanent; all impure dharmas are suffering; and that all the dharmas are empty (śūnya) and not-self (anātmaka)" (AKBh, vi.14c-d, 925).

8 The defilements are divided into nine categories or strengths. These categories are made up of three main categories, weak, medium and strong. Each main category is also subdivided into weak, medium and strong, thus
giving nine categories or subdivisions of defilements in total. See AKBh, vi.33c-d, 957.

9"Once-returner," because, "having gone to be among the gods, [that person] returns to be among humans, and has then no further rebirth" (AK Bh, vi.35c-d, 964).

10"Non-returner," because that person will not be reborn in Kāmadhātu again. Ibid., vi.36d, 965.
IV. VALUES AND NORMS

In the previous section we have seen that the AKBh and DSM-III-R contain very different ideas about mental illness and mental health. Many of these differences are simply due to differences in scope, or the perceived domain, of the texts. However, some of the differences are due to the influence of general cultural values. Although Western science is often said to be value-free, a closer examination of DSM-III-R shows that, at least in its case, this is not so. Buddhist values are explicitly stated in the AKBh. The existence, or influence, of value systems in each text means that certain standards or norms are being applied to arrive at concepts of what might be regarded as mental illness and mental health. It is therefore important to examine these sometimes subtle values and norms in order to gain a deeper understanding of the texts and their milieu, as well as to facilitate the later study and comparison of individual lists taken from each text.

Values

Values are "the established ideals of life." They are the dominant themes or assumptions of a given culture, religion, or world view (Paranjpe 1984, 57). Values, or value systems, are constructed through history, with each generation inheriting a certain value system. Although such systems may always be changed and adapted, inherited values have tremendous influence, even though they are often unstated and unrecognized.
Inherited value systems not only influence people, but science, religion, and many forms of knowledge, as well. The whole process of obtaining knowledge is often at least partially dependent on a particular history and value system:

In most cases, the formulation of a problem by anyone is based on the precedence of someone else having faced the same or a similar problem. So each generation inherits a set of problems formulated by the previous generation. The problems, as well as the data in light of which they are examined, are selected from among many that are known or available. The selection is normally based on experiences and values in the life of the investigator. The problem is seen in a certain "perspective," composed of the axiomatic assumptions and *a priori* categories with which an investigator begins to analyze a problem. These categories are independent of the nature of the data to be examined, and often predetermine the nature of the conclusions the investigator may draw (Paranjpe 1984, 38).

Clear examples of the above are found in both Indian Buddhism and modern North American psychiatry. For instance, Vasubandhu clearly inherited a specific idea of a problem--life is characterized by unsatisfactoriness or suffering--and describes various doctrines regarding the path through which suffering may be ended. These were based on the experiences of the Buddha and the Buddhist community. As we have seen, the Buddha in turn had inherited a number of concepts, techniques, etc., from his cultural and religious context.
In North America, this idea of inheriting a way of understanding, approaching and solving problems, may be seen most clearly in the current emphasis on psychopharmacology. Descartes' mind-body dualism is one foundation of the nature-nurture controversy in psychology and psychiatry. Drugs are therapeutic interventions aimed primarily at the body and "nature." Thus the prescribing of these drugs can be said to represent an approach to, and solution (for some) of, the earlier mind-body, nature versus nurture, problems.

The concepts of mental illness and mental health in DSM-III-R and the AKBh clearly reflect certain cultural or religious value systems. One may divide the perspectives arising from these systems into three broad categories: individuality versus self-transcendence; rejection or acceptance of religious goals; and a basic external versus internal orientation.

Both DSM-III-R and the AKBh focus, in some ways, on the individual. DSM-III-R is used to diagnose mental illness in individuals, and its definitions of mental health and mental illness are in reference to individuals as opposed to societies, groups, or families. Although the AKBh includes a great number of discussions on dharma-s, karma, etc., that cannot be regarded as referring to the individual, it also, as we have seen, details the path that an individual may follow to achieve enlightenment. However, even though both texts have some focus on the individual, they also have very different value systems that result in differing conceptions about individuality.
Greek thought emphasized rationalism and the spirit of reason, and these have remained dominant values in the West. As well, particularly in North America, the Protestant Reformation, and especially Calvinism, stressed the value of mastery and function. Given this, it is not surprising that DSM-III-R reflects these values of rationality and mastery in its definitions of mental illness and mental health.

Mental illness, probably in most cultures, is associated with some form of irrationality. DSM-III-R mentions a number of forms that irrationality might take. For instance, there may be: impairment in reality testing, in judging, or in thinking; and/or the presence of delusions or hallucinations (DSM-III-R, 12). Indeed, the entire manual is really a listing of various forms of behavior, thinking, and feeling, that are considered to be irrational. Or, in other words, that do not represent "merely an expectable response to a particular event" (Spitzer and Williams, 1987, xxii).

The emphasis on mastery is clearly seen in the Global Assessment of Functioning Scale, the closest that DSM-III-R comes to providing a definition of mental health. Health not only includes the absence of symptoms but also "good functioning in all areas," being "interested and involved in a wide range of activities," and also being "socially effective" (DSM-III-R, 12). In contrast, the general definition of mental disorders mentions "impairment in one or more important areas of functioning" (Spitzer and Williams 1987, xxii).

Thus the values of rationality and mastery are stressed in DSM-III-R. Emphasis on individuality in and of itself, is also seen in the association of
mental disorders with "an important loss of freedom" (Spitzer and Williams, xxii). Given such examples as these, one may conclude that the cultural and religious (in the case of Calvinism) values of individuality, rationality and mastery, both shaped, and are expressed in, DSM-III-R definitions of mental illness and mental health.

The AKBh contains a very different perspective on individuality. Paranjpe notes that one may regard Indian psychology as a whole as being individualistic, for "it focuses almost entirely on individual self-realization. The guiding principle of Indian psychology is to assist an individual in his own spiritual advancement" (1984, 77). However, the emphasis on individuality ends here, for the other "guiding principle" is that liberation, however it is conceived, and individuality--namely ego-based, ordinary individuality--are mutually exclusive (Reat 1990, 293).

This second principle, as we have seen, is particularly evident in the AKBh, and Buddhist psychology in general. The path, as presented in the AKBh, really involves gaining insight into, and experience of, the four noble truths as they relate to the world. This includes, of course, the acceptance and realization of the doctrine of anātman. Such acceptance and realization is termed wisdom (prajñā) and overcomes not only suffering or unsatisfactoriness, but all sorts of ego-based "defilements" such as attachment, anger, pride, ignorance, false views and doubt (AKBh, v.1c-d, 768). The result of this is the "renewed" state of the Arhat (AKBh, iv.56, 631).
Since the AKBh stresses the realization of the four noble truths, along with the doctrine of anātman, one may say that it strongly opposes individuality as something to be valued in and of itself. Since the text does emphasize self-transcendence and proposes some rigorous techniques to bring this about, mastery would seem to be highly valued. However, this mastery is mastery over oneself, in order to free oneself, and is, of course, very different from the value of mastery as reflected in DSM-III-R definitions.

The values in the AKBh of mastery over oneself and enlightenment are clearly religious goals. This must be understood then, as a soteriological psychology. Indeed, "Indian psychological theories are inseparable from the spiritual goals the theorists set out to pursue. Even brief accounts of Indian concepts often lead us to the values and ethical issues that legitimize their goals" (Paranjpe 1984, 62).

DSM-III-R lacks the presence of these obvious religious elements. Rejection of such elements is undoubtedly due largely to the aforementioned (perceived) conflict, in the Western traditions, between science and religion (Paranjpe 1984, 32). Since such a conflict was not present in India, "the dichotomy between science and religion and between logic and mysticism, or the issue of value-free science, have not influenced Indian psychological thought as they did in the West" (Paranjpe 1984, 32). The absence or presence of the science versus religion conflict, and the resulting acceptance or rejection of religious goals as part of the mental healing tradition, thus account for some of the major differences between texts such as the AKBh and DSM-III-R.
A final basic difference between the value systems of the two texts is their general orientation towards the external or internal. The external orientation of DSM-III-R is seen in its emphasis on the above-noted mastery of functions relating to the outer world. This stress placed on mastery of the external world is a general cultural value termed "Man Over Nature" by Paranjpe (1984, 66). It represents,

an ideal-typical mode of man's being in the world, which manifests itself not only in building dams on the rivers, highways on the mountains, and satellites in space, but a lot more...this type of attitude is now so pervasive that it influences the way the psychologist does his research and how he conceives his subject matter (Paranjpe 1984, 66).

In particular, the psychologist (or psychiatrist) views problems and solutions as being separate and "out there" rather than within (Paranjpe 1984, 68-69). This type of approach is particularly evident in behaviorism and biologically-oriented psychiatry (the body being "out there" as opposed to the mind). Biologically or medically oriented psychiatrists represent the branch of the Western mental healing tradition that makes greatest use of DSM-III-R.

In contrast, the AKBh emphasis on self-transcendence represents a more "internal" approach. Both the problem, unsatisfactoriness or suffering, and the solution, enlightenment, are tied to internal sources. Unsatisfactoriness, as noted, is linked to desire and ignorance, which must be eliminated. The methods used to eliminate them are largely internal—meditation, contemplation, visualization, etc. Morality, which is more externally oriented,
is also important, but the focus is primarily on introspective techniques. One should remember though that in the final analysis, this introspective-phenomenological approach in Buddhism is said to not only give one greater insight into the true nature of oneself, but the world as well (Reat 1990, 183).

The final state of enlightenment is also more internal than external, in that it is something the person experiences. However, as noted, compassion and love are two means used to help one reach the state of the Arhat. This means that there is some external orientation present. In the end, this type of compassion, though, is based on the absence of ignorance and the presence of insight or wisdom, which makes the nature of it more internal than external.

Overall then, one may say that understandings of mental illness and mental health in DSM-III-R reflect a primarily external orientation, while those in the AKBh are mostly, but not exclusively, internal. Differing values regarding individuality, mastery, and acceptance or rejection of explicit religious elements, are also reflected in the texts' definitions. Since the values evident in the definitions can be traced to previously existing cultural or religious value systems, one may conclude that these general value systems were important factors in shaping the definitions. In turn, the values present in the definitions of mental health and mental illness in important texts such as DSM-III-R and the AKBh, undoubtedly influence the value systems of those that come after.

The preceding discussion of values evident in the concepts of mental illness and mental health, calls into question the common idea of a value-free
Western science, and the purported objectivity and empirical nature of diagnostic manuals such as DSM-III-R. Values are evident not only in DSM-III-R's explanations of mental health and mental illness, but in the lists, which make up the bulk of the text, as well. As Paranjpe notes, "almost any descriptive account of personality involves a hidden message that conveys to us which characteristics of personality are idealized or sought after and which are vilified" (1984, 96). Again, in the case of DSM-III-R, this is only noteworthy because the text was supposedly designed to minimize inference and value judgments (Spitzer and Williams 1987, xxiii).

Some maintain that even the idea of classifying or categorizing mental disorders, and hence the people who suffer from them, represents a value system or judgment, and a negative one at that. It is stated in DSM-III-R that "there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, or between it and no mental disorder (Spitzer and Williams 1987, xxii). However, the presence, in the text, of a multitude of diagnostic categories largely contradicts this internal value (Rothblum, Solomon, and Albee 1986, 177). More importantly, having such specific categories of mental disorders results in people being labelled ("pigeon-holed"), and once this is done, particularly with the case of such labels as "schizophrenia," individuals are not seen as being on some sort of continuum with normal behavior or "no mental disorders," but rather, very often, are stigmatized instead (Rothblum, Solomon, and Albee 1986, 177-179).
The use of these specific diagnostic categories raises other concerns as well. Studies show that people "readily believe personality descriptions of themselves made by others," even if these descriptions are negative and fictitious (Rothblum, Solomon, and Albee 1986, 178). This means that once a specific diagnosis is made, the person is likely to believe it, even if the diagnosis is wrong. Whether right or wrong, the diagnosis may change the way a person perceives him/herself, and the way other people (if they are aware of the diagnosis) perceive him or her.

This problem with diagnosis is particularly worrisome in the case of children. DSM-III-R contains approximately fifty types of disorders that might be diagnosed in children. There are concerns that children given these diagnoses might limit themselves in some way because of them (a phenomenon called self-fulfilling prophecy). As well, diagnosis or labelling tends to focus people's attention on the individual child, rather than that child's environment (Rothblum, Solomon, and Albee 1986, 177). For example, if a "non-labelled" child complains about his or her teacher or school day, we are likely to consider environmental factors as having caused this child's distress. If, on the other hand, we know that this child has been diagnosed as having a learning problem or as being hyperactive, we tend to disregard the problematic environment and attribute the source of the problem within the child (Rothblum, Solomon, and Albee 1986, 178).

The same, of course, may also be the case for adults who are diagnosed with some form of mental disorder.
As previously stated, this focus on the individual represents a strong cultural value. The result is that DSM-III-R, and particularly the more biologically-oriented psychiatrists that use it, tend to only focus on diagnosis of mental illness in individuals, and ignore important non-individualistic factors:

> Psychopathology clearly is associated with poverty and powerlessness, but these relationships are not acknowledged by the model that seeks and finds causal defects in individuals rather than societies (Rothblum, Solomon, and Albee 1986, 168).

In effect, the emphasis on individualism may perpetuate mental distress in some individuals, because the social injustices that play a part in their distress are ignored.

A final concern over the basic value of having and using diagnostic categories, is based on the recognition that these categories will guide, rather than be guided by, future research. Evidence of this is already seen with respect to funding:

> As classification systems evolve, funds for research and intervention seem to follow. Ironically, the majority of funding awards by the National Institute of Mental Health (NIMH) are for specific areas of mental disorders, particularly for DSM diagnostic categories (Rothblum, Solomon, and Albee 1986, 183).

The trouble with this is that research into obscure DSM-III-R categories may be funded, while more frequent and unclassified problems, such as stress, do not receive as much funding and attention (Rothblum, Solomon, and Albee 1986, 183).
Thus the very existence of categories of mental disorders in DSM-III-R reflect certain perspectives, value systems, and judgments. Further, the results of these may sometimes be more negative than positive.

Values and value judgments are also implied in the terminology used in DSM-III-R. The word, "inappropriate," and other similar terms, are often used in the diagnostic criteria. For example: "feelings of worthlessness or excessive or inappropriate guilt" (Major Depressive Episode); "Unrealistic or excessive anxiety and worry" (Generalized Anxiety Disorder); "inappropriate, intense anger or lack of control of anger" (Borderline Personality Disorder).

It is expected that clinicians and researchers using DSM-III-R, will have specialized training in the proper use of the criteria (DSM-III-R, xxix), and therefore, that value judgments and subjectivity will be kept to a minimum. However, this is not necessarily the case, for:

Appropriateness depends heavily on context, and what is proper in a given context is often highly subjective. Appropriate behavior in California may be inappropriate in Boston. What one clinician views as inappropriate laughter, for example, may be anxious defensive laughter or a subculturally acceptable expression of tension or anxiety, as is peculiar to some Asian groups (Yager 1989, 1:556).

Use of vague or judgmental terminology in DSM-III-R thus creates barriers against arriving at value-free, objective, diagnosis.

Evidence of value systems is also seen in a number of specific diagnostic categories. The most obvious example of this was the presence of homosexuality as a category in DSM-II, and its subsequent deletion (or
modification to only ego-dystonic homosexuality) in DSM-III. This change was largely the result of a struggle waged by gay-rights groups and activists against the American Psychiatric Association between 1970 and 1973 (Bayer 1981, 153). Homosexuality was (and still often is), of course, vilified by many segments of North American Society and Christianity, and therefore its presence in DSM-II was, at least partially, due to cultural and religious factors. In turn, the deletion of, or change in, this diagnostic category was also the result of certain cultural values.

Feminists are currently waging their own struggle against certain categories of mental disorders in DSM-III-R which they perceive to reflect sexist or male-oriented values. Two categories in particular "come under fire," namely, Histrionic Personality Disorder and Dependent Personality Disorder.

Some of the diagnostic criteria for Histrionic Personality Disorder include: "constantly seeks or demands reassurance, approval, or praise;" "is inappropriately sexually seductive in appearance or behavior;" "is overly concerned with physical attractiveness;" and "expresses emotion with inappropriate exaggeration" (DSM-III-R, 349). The explanations of this disorder include statements that, people with this disorder "are typically attractive and seductive," and "often act out a role such as that of ‘victim’ or ‘princess’" (DSM-III-R, 348).

With criteria such as this, it comes as no surprise that the "disorder is apparently common, and is diagnosed much more frequently in females than in males" (DSM-III-R, 349). In fact, the prevalence and sex ratio are almost
guaranteed, given the wording of the criteria, and also that most psychiatrists today are male. Some also note that any woman who fulfills society's traditional view of women—and indeed the view of women as presented in the media—will be labelled Histrionic by the clinicians (Kaplan 1983, 789). Since this category relies so heavily on the value judgments of clinicians, it is not surprising that field trials indicate the category has poor diagnostic reliability (Cooper 1987, 290).

The second category, Dependent Personality Disorder, shows the same stereotyped, gender-biased view, and is also more prevalent in women than men. Diagnosis of this disorder is based on "a pervasive pattern of dependent and submissive behavior beginning by early adulthood and present in a variety of contexts" (DSM-III-R, 353). For example, the person: "is unable to make everyday decisions without an excessive amount of advice or reassurance from others;" "allows others to make most of his or her important decisions, e.g., where to live, what job to take;" "agrees with people even when he or she believes they are wrong, because of fear of being rejected" (DSM-III-R, 354).

Criteria such as this again express traditional stereotypes of women, and therefore women who fulfill these stereotypes will be diagnosed as mentally ill—an almost "catch twenty-two" situation. The main criticism of this diagnostic category, is that it "singles out for scrutiny and therefore diagnosis the ways in which women express dependency but not the ways in which men express dependency" (Kaplan 1983, 789). For example, while "feels devastated or
helpless when close relationships end" is part of the criteria (DSM-III-R, 354); there is no mention of "the dependency of individuals--usually men--who rely on others to maintain their houses and take care of their children" (Kaplan 1983, 789). In this way, both men's dependency and women's dependency are supported by society (and stereotypes), however, men's dependency is not labelled as a mental disorder, while women's dependency is (Kaplan 1983, 790).

Other controversies over diagnostic categories are also, at least partially, based on the issue of morality and its place in, or influence on, the DSMs. The conflict over homosexuality as a category was a good example of this. Such conflicts and concerns over the issue of morality continue, as DSM-III-R includes categories such as gambling, stealing (kleptomania), alcohol intoxication, and even "caffeinism," among its categories of mental disorders. DSM-III-R contains more of these socially-based behaviors, and less of the organic disorders than did its predecessors, and some consider this trend disturbing:

By labeling such social behaviors as psychopathological, we are revealing a lessening tolerance for deviation in our society. At best, we are observing a metamorphosis in which medical practitioners are appointing themselves the arbiters of deviant behavior that was once the province of religious or legal institutions. Individuals who centuries ago might have been excommunicated because of their behavior now face stigmatization by the psychiatric profession (Rothblum, Solomon, and Albee 1986, 179).
This shift to including socially-based behaviors that were once the province of morality and/or religion among the diagnostic categories of DSM-III-R, may reflect a trend toward secularism in North American society. Religion and morality may be losing some power to regulate behavior, while science is expanding its influence or "territory," and filling this vacuum.

Thus we have seen that values, and value judgments, are present in the lists, as well as in the general concepts of mental health and mental illness in DSM-III-R. Some of these values are criticized, and certainly the existence of categories such as Histrionic Personality Disorder refute any idea that this manual, taken as a whole, might be value-free.

As mentioned, the AKBh, and Indian psychological theories in general, embrace religious or spiritual goals. Thus values, ethics, and morality all play a large, and obvious, role in this text. This is seen most clearly by comparing some of the mental states (that is, dharma-s which belong to, and are of the type of, consciousness or cognition) accompanying all defiled moments of consciousness (kleśamahābhūmika-s), with the dharma-s found accompanying all good moments of consciousness (kuśalamahābhūmika-s). For instance, the defilements include: ignorance or delusion (moha); idleness (kausīḍya); and disbelief (āśraddhya) (AKBh, ii.26a-c, 193). The dharma-s found in good moments of consciousness include: faith (śraddhā); diligence (apramāda); and respect (hri) (AKBh, ii.25, 191). These are openly religious and cultural values.

Another discussion on ruined moments of consciousness in the AKBh also highlights this important, and open, role of morality and values:
The person who troubles and deranges the mind of another through curses and formulas; the person who causes another to drink poison or alcohol when he does not want to drink it; the person who frightens game, either in the hunt, or by setting the jungle on fire, or by the hollowing out of traps; and the person who, by whatever means, troubles the memory and the presence of mind of another, will have his own mind troubled.

[People who ruin the mind of others through substances and formulas; people who cause another to drink poison when he does not want to drink it; who frighten in the hunt etc., or set fire in forests, or let fall from a cliff; and the people who, by whatever means cause to be ruined/decay the presence of mind of another, will have their own mind ruined by the ripening of this karman in the future] (AKBh, iv.58b, 633).

This quote indicates, in accordance with the law of karma, that the person may be responsible in some way for his/her own moments of ruined consciousness. As well, here one can see the emphasis placed on non-violence (avihimsā), which is also one of the dharma-s found in all good moments of consciousness (AKBh, ii.25, 191), and which is a value upheld by many Indian traditions.

The whole process in the path, representing movement from ignorance to wisdom, reflects a strong cultural and religious value. Knowledge and wisdom are valued, not solely for their own sake, but rather because they serve a spiritual and soteriological purpose; they are the means to an end (Halbfass 1991, 243). The North American mental healing traditions also stress the importance of gaining knowledge or insight; however, this stops with knowledge into one's own psyche, behavior, etc. The knowledge or insight is
an end in itself, or only a means of improving one's mental health. Knowledge as a means to achieve some religious or spiritual goal plays little, if any, role.

Thus values, morality, and ethics, are all important influences on the AKBh, and are openly recognized and stated in the text. Not all of these values may be regarded as "positive" today. For example, while a woman may attain the state of supreme worldly dharma-s, it is expected that this attainment will lead to her (better) rebirth as a male (AKBh, vi.21a-b, 937). Many modern women would find this idea of "necessary" rebirth as a male disturbing.

As we have seen, values and value judgments exist in both DSM-III-R and the AKBh. Each text contains values that some might regard as negative, as well as upholding values that many would view as positive. The largest difference between the two texts, again seems to be a result of the acceptance or rejection of religious goals. DSM-III-R contains values, but these are less openly stated than those in the AKBh, and they do not really include obvious religious or soteriological elements, although some influence(s) from Christian morality may exist. While some would regard the DSM-III-R approach as objective and sophisticated, one might wonder whether the AKBh approach does not represent itself more fairly, for its values are openly stated and recognized, rather than hidden or embedded.
Norms

If, as we have seen, values are present in the two texts and their concepts of mental health and mental illness, then we must logically conclude that some standards or norms are being applied to arrive at such concepts. An understanding of the nature of mental illness depends on some understanding of the nature of mental health, and vice versa. Illness, of any kind, is usually perceived when there is some change, or shortfall, from what is considered to be normal. The interesting issue in the case of DSM-III-R and the AKBh is this idea of "normal." Or, specifically, who or what is the norm against which mental illness and mental health are measured and understood?

DSM-III-R, and most of the North American mental healing tradition, use the concept of the "average norm," to determine mental illness. That is, "whatever is markedly deviant is abnormal" (Wig 1990, 196). The idea of normality as average, "is based on the mathematical principle of the bell-shaped curve. This approach...conceives of the middle range as normal and of both extremes as deviant" (Offer and Sabshin 1980, 1:609). Related to this, is the perspective that normality is healthy, which is basically the traditional medical approach to health and illness. Most physicians equate normality with health and view health as an almost universal phenomenon. As a result, behavior is assumed to be within normal limits when no manifest psychopathology is present. If one were to put all behavior on a continuum, normality would encompass the major portion of the continuum, and
abnormality would be the small remainder (Offer and Sabshin 1980, 1:608).

**DSM-III-R** reflects this definition of normality. For example, a number of criteria for various diagnostic categories mention that specific behaviors or beliefs would be "inconsistent with subcultural norms," (Schizotypal Personality Disorder), or, in the case of events, that they would be "stressful to almost anyone in similar circumstances in the person's culture" (Brief Reactive Psychosis) (**DSM-III-R**, 342, 207).

This definition of normal as average and healthy is also found in the introduction to **DSM-III-R**:

> When an experience or behavior is entirely normative for a particular culture--e.g., the experience of hallucinating the voice of the deceased in the first few weeks of bereavement in various North American Indian groups, or trance and possession states occurring in culturally approved ritual contexts in much of the non-Western world--it should not be regarded as pathological (Spitzer and Williams 1987, xxvi).

As these quotes indicate, this concept of the norm is culturally dependent, although more extreme cases of mental illness are almost universally recognized (Kendell 1986, 38). Consequently, a great number of ethnographical studies are conducted in order to test the validity of **DSM-III-R** diagnostic categories and criteria, and, of course, to find out what is "normal" for particular cultural and sub-cultural groups. Clinicians are thus cautioned about using **DSM-III-R** to diagnose mental disorders in people from ethnic or cultural groups different from their own (Spitzer and Williams 1987, xxvi).
A further difficulty with the DSM-III-R approach of the norm as average, is that the idea of the norm, or average, may not only be culture-specific, but gender-biased as well. Some maintain that categories such as Histrionic Personality Disorder, may be largely based on the use of male behavior as the norm or standard for health (Kaplan 1983, 788).

In contrast to the idea of the norm as average, the AKBh upholds the ideal as the norm or standard. In this approach, "whatever is less than ideal is inadequate and thus, in a sense, abnormal" (Wig 1990, 196). We have seen that the Arhat is upheld as the ideal in the AKBh, and certainly as representative of a state that one should strive to attain. For instance, with regards to fasting, the text speaks of "embracing a way of life conforming to that of the Arhats" (AKBh, iv.28.i, 596).

This idea of the norm as ideal is found not only in the AKBh, but in the Indian traditions generally. Liberation, whether termed mokṣa or enlightenment, is considered to be the "ultimate potential of the human being" (Reat 1990, 25). The people who attain such states are fulfilling their potential and are therefore regarded as the standard against which others are measured, although this does not mean that those who have not attained the ideal are considered to be mentally ill or abnormal. Again we see here the primary emphasis on religious or soteriological goals.

While the norm as ideal approach is frequently found, there is also some suggestion or recognition, in different contexts, of the norm as average as well. For instance, in a discussion on karma, it is noted that "when a person walks,
stands still, eats, or dresses himself in a manner other than that which he
should, this action...is improper, for this person acts contrary to received usage
(ayoga) (AKBh, iv.94c-d, 677). An opinion presented in the AKBh such as this,
may reflect those more universally recognized cases of mental illness, or may
simply uphold the status quo.

Understanding the norm as average or ideal leads to a number of
implications. Some problems with the norm as average have already been
noted--the possibilities of being culture-bound and gender-biased. As well, the
minority (by definition) who are not the norm or average may face
stigmatization. Even more serious is the possibility that the norm or average
itself may not be healthy or "normal." This possibility has been addressed,
perhaps most eloquently and forcefully, by Erich Fromm:

It is naively assumed that the fact that
the majority of people share certain ideas
or feelings proves the validity of these
ideas and feelings. Nothing is further
from the truth. Consensual validation as
such has no bearing whatsoever on reason or
mental health....The fact that millions of
people share the same vices does not make
these vices virtues, the fact that they
share so many errors does not make the
errors to be truths, and the fact that
millions of people share the same forms of
mental pathology does not make these
people sane (Fromm 1955, 23).

If what is average is not healthy or sane, the norm which is defined as average
will be negatively skewed and will not represent true health or sanity.
Consequently, all concepts or criteria of mental health and illness will be similarly affected.

Positive results of defining the norm as average are seen in DSM-III-R's strengths. Namely, those (people, behavior, or mental states) that fall short of the norm, or are not average, may receive a greater amount of attention. The diagnostic categories of DSM-III-R are a result of focusing on differences from the norm, and reflect a specific understanding of various mental disorders. This understanding may encourage more precise diagnosis and treatment.

In contrast to this, if the ideal is upheld as the norm or standard, then the majority who fall short of this standard are "lumped together" despite differences. Such an approach may ignore differences between disorders, and differences in the severity of specific disorders. It would be naive to conclude though that, simply because the AKBh sometimes upholds the ideal as the norm or standard, these clinical deficiencies are found in the Indian tradition as a whole. Rather branches of the Indian healing tradition, such as Ayurveda, may have examined specific disorders and their severity and treatment in greater depth. Indeed there is little likelihood that Buddhism ever opposed the Ayurvedic system of medicine (Demiéville 1985, 92). As well, some problems are culturally taken care of within the family, extended family, or community in a way that may not necessitate clinical diagnosis and treatment.

The most positive implication of having the norm as ideal, is that, while it may also be culture-bound, etc., it offers a clear picture of the ideal state, in
this case health. One would assume that something is easier to achieve if there is a clear view or perception of it. As well, since the standard is the ideal, and not the average, it would not be as easily influenced or corrupted by negative societal changes.

Summary

We have seen that values and norms influence conceptions of mental health and illness in the AKBh and DSM-III-R. Perhaps the most important element we have examined here is the presence or absence/rejection of religious values in the texts. This presence or rejection seems to account for the greatest differences in language, scope, and content of the texts. Connected with this is the understanding of the norm as average (for DSM-III-R, which rejects religious values) or as ideal (for the AKBh, which is based on religious values). The Arhat or the average becomes the standard against which mental health or mental illness are measured (although, as stated, in the case of the Arhat as ideal this does not mean that the majority are abnormal or mentally ill), and thus we may regard religious values and goals, or the absence of such, as primary influences on texts of this nature.
NOTES - VALUES AND NORMS

1Gage Canadian Dictionary, s.v. "values."

2DSM-III-R diagnostic criteria for: Major Depressive Episode (A-7, p. 222); Generalized Anxiety Disorder (A, p. 252); and Borderline Personality Disorder (4, p. 347).
V. THE LISTS: MAJOR DEPRESSIVE EPISODE, ANUŚAYA-S AND KLEŚA-S

We have now explored the historical background of DSM-III-R and the AKBh; examined their concepts of mental illness and mental health; and found that these concepts (as well as some specific diagnostic categories in DSM-III-R) were influenced by certain cultural or religious values and norms. The previous section in particular noted that, not surprisingly, the acceptance or rejection of religious elements led to many differences in topic, scope, goals, etc., between the two texts.

It is now time to narrow the study and focus on one or two lists from each text. One may remember that, in some ways, this study has been like hypothesis testing, unraveling the historical backgrounds and cultural/religious influences present in the texts (on the topic of mental health and illness), in order to find out if one may observe such influences in specific lists, and also to learn if this type of methodology or approach facilitates understanding of, and comparison between, the lists.

If evidence of the influences of general cultural/religious values and norms can be found in the specific lists, then we have learned something (certainly not everything) about the formation of lists. Further, even if comparison between the lists is not justifiable, the approach of this study will have given us some clues as to why this might be.
Major Depressive Episode: DSM-III-R

The term, "depression," is used frequently, and may variously describe "an emotional state, a syndrome, and a group of specific disorders" (Yager 1989, 1:574). None of these terms is exclusive: a person may experience a depressed emotional state; have a number of other symptoms accompanying that state; and be diagnosed as having a depressive disorder.

Depression has been called "the world's number one public health problem," and is so widespread "it is considered the common cold of psychiatric disturbances" (Burns 1980, 9). Some have noted that the "experience of depression is so common as to be almost part of the human condition" (Stern and Drummond 1991, 172).

Since this disorder is so common, "almost part of the human condition," it seems best to choose the diagnostic criteria for this disorder as the representative list from DSM-III-R for the purposes of this study. As we shall see, anuśaya-s and kleśa-s are thought to be found in most moments of consciousness which are defiled. Therefore, given the extreme differences in the topics and mandates of DSM-III-R and the AKBh, a list from the former which represents the greatest number of people is the most logical choice, and perhaps the only one, if any comparisons are to be made. For, although not dealing with the same disorder or topic, at least the lists are both addressing common, and negative, human conditions.

Most people have the experience, at some time(s), of feeling sad. When sadness becomes "severe it merges into depression" that may require treatment
(Stern and Drummond 1991, 172). In this case, some classification is needed to decide if the depression is severe enough to warrant treatment, and also, to determine the type of depression (Stern and Drummond 1991, 172). In North America, this is the point when DSM-III-R may be used by a clinician.

DSM-III-R divides the general category, Mood Disorders,\(^1\) into two basic subclassifications: Bipolar Disorders and Depressive Disorders (DSM-III-R, 214). The essential difference between the two is the presence of "one or more Manic or Hypomanic Episodes (usually with a history of Major Depressive Episodes)" in the former, while in the latter the essential feature is "one or more periods of depression without a history of either Manic or Hypomanic Episodes" (DSM-III-R, 214).\(^2\)

Once this basic distinction has been made, the subclassification of Depressive Disorders is further divided. There are various subtypes of Depressive Disorder which take into account whether or not the depression is: episodic or chronic; associated with seasonal changes (Seasonal Affective Disorder); contains psychotic features; etc. (DSM-III-R, 218-233). Here, for reasons stated above, we shall consider the most common and basic category of Depressive Disorders, namely, the diagnostic criteria for a Major Depressive Episode.

The Diagnostic criteria for Major Depressive Episode are found in Appendix 1. Following these criteria, are codes noting the severity of symptoms, presence of psychotic features, and whether or not the episode is in partial or full remission (DSM-III-R, 223).
As one can see, most of the criteria for a Major Depressive Episode are clear and need little explanation or elaboration. The preamble to the criteria though, offers some rather useful examples of the symptoms associated with depression. Its explanations of two of the criteria, namely, "depressed mood" (A-1), and "diminished interest" (A-2), are worth examining, for at least one of these two must be present in order for the diagnosis of Major Depressive Episode to be made (DSM-III-R, 222).

Depressed mood is usually, but not always, experienced by the person with this disorder as some sort of negative or aversive emotional state. A person with such a mood,

will usually describe feeling depressed, sad, hopeless, discouraged, "down in the dumps," or some other colloquial equivalent. In some cases, although the person may deny feeling depressed, the presence of depressed mood can be inferred from others' observing that the person looks sad or depressed (DSM-III-R, 219).

The feelings associated with this state (sad, hopeless, discouraged, etc.) are common ones. It is the severity and duration of these feelings (as well as the presence or absence of some of the other diagnostic criteria), that determine whether or not the person is suffering from a Major Depressive Episode. Here it is important to note that others may observe or infer the presence of a depressed mood from a person's behavior and demeanor. It is not essential that the person be aware of the depressed mood, or be willing or able to state its presence.

Loss of interest or pleasure is considered to be
probably always present in a Major Depressive Episode to some degree, and is often described by the person as not being as interested in usual activities as previously, "not caring anymore," or, more rarely, a painful inability to experience pleasure. The person may not complain of loss of interest or pleasure, but family members generally will notice withdrawal from friends and family and neglect of avocations that were previously a source of pleasure (DSM-III-R, 219).

This description highlights two elements of this criterion. The first is the subjective feeling or emotion, which may actually include a lack of feeling, such as the "inability to experience pleasure." This lack of feeling itself is experienced, in some way, as painful. The second element present is behavioral. Again, whether or not the loss of interest or pleasure is stated, generally this mood is manifested by the presence or absence of certain behaviors (for example, a withdrawal from activities and people) and may be inferred from such.

One can see that the above two criteria, and their explanations, consider both subjective-psychological and external-behavioral elements of the disorder. These aspects are also present in the rest of criterion A.

One may divide the subjective or psychological elements into affective and cognitive categories. Specifically, depressed mood (A-1); diminished interest or pleasure (A-2); and feelings of worthlessness and guilt (A-7); are primarily emotional or affective in nature. Diminished ability to think, concentrate, or make decisions (A-8), and recurrent thoughts of death or suicide (A-9) are more cognitive. Of course, feelings and cognitions are often
intertwined and influence each other greatly, so these divisions should not be considered absolute.

The more behavioral or external elements are: the loss or increase of weight (A-3); insomnia or hypersomnia (A-4); and psychomotor agitation or retardation (A-5). Fatigue or loss of energy (A-6), seems to involve both subjective-psychological and behavioral elements.

Thus elements of general psychology (dealing with the subjective person—feelings, thoughts, etc.) and behaviorism, which are two of the basic influences on DSM-III-R that we have noted in previous sections, are found in section A of the diagnostic criteria for a Major Depressive Episode. The third general influence, medicine, may be seen in section B-1 of the criteria, which establishes that an organic factor did not initiate or maintain the depression (DSM-III-R, 223).

Regarding specific values and norms, these criteria do not seem to be glaringly culture-bound or gender-biased in nature. As we saw with concepts of mental health and illness in DSM-III-R as a whole, the criteria are individualistic in nature and do not appear to include any religious elements. However, the internal versus external orientation is not as clear.

One may regard the criteria for the Major Depressive Episode as individualistic because they certainly focus on the individual, and measure the individual and his/her feelings, cognition, behaviors, etc., against some norm. As stated earlier, this norm is understood as the "average" in DSM-III-R. Here one can clearly see that deviations in either direction from the norm or average
are regarded as negative. For instance, there is significant weight loss or gain; insomnia or hypersomnia; and psychomotor agitation or retardation (DSM-III-R, 222). Consequently, two people who have Major Depression may appear very different from each other (Kupfer and Thase 1987, 33). However, both people would be similar in that they would exhibit some of the above noted deviations from the norm (as well as depressed mood and/or loss of interest).

The cognitive and behavioral elements of the criteria highlight the values of rationality and mastery or function respectively. As well, in regards to mastery and function values, the preamble to the criteria notes that "there is always some interference in social and occupational functioning" (DSM-III-R, 221). Thus one can clearly see that the criteria are part of the over-all individualistic approach, or values, of the text in general.

As mentioned, the criteria for a Major Depressive Episode do not include any religious elements (unless one regards the emphasis on mastery and function as having roots in Calvinism). The issue of an external versus internal orientation is less clear. The subjective, or cognitive and emotional, elements relate to the "inner person," and so may be considered internal in orientation. The criteria that deal with behaviors, mastery and function, are more external in orientation. Given this, and particularly since etiology and therapeutics are not considered here, one cannot, from the criteria alone, determine a clear external or internal orientation.

Examination of the list of diagnostic criteria for a Major Depressive Episode thus reveals a number of interesting factors. This list (unlike some
others we have briefly examined), in accordance with the stated mandate and purpose of DSM-III-R, truly seems objective and descriptive. It does not contain elements that are theoretical, religious, or gender-biased, in nature. However, we have previously seen that the rejection of religious goals can be considered as part of a cultural value-system. The criteria also reflect individualism, rationality, mastery and function--other important and basic values. The norm as average also clearly provides a basis for this list.

Therefore, we might make one of two conclusions. The first conclusion would be that, due to the presence of cultural values and norms, the list is not truly objective and descriptive. For the criteria examined here, this conclusion does not seem plausible, particularly since studies have shown that this category has excellent diagnostic reliability (Klerman et al. 1987, 8). Instead, we may conclude, more accurately, that an objective and descriptive approach does not necessarily preclude the presence of cultural values and norms. Indeed, it may well be impossible to form any type of list on a topic of this nature without being influenced by values and norms of one form or another.

*Kleśa-s And Anuśaya-s In The AKBh*

Throughout this study, the defilements (anuśaya-s or klesa-s) have been mentioned. Out of the numerous lists provided in the AKBh, the lists of these defilements will be examined. The reason for this is due more to the nature of DSM-III-R than the AKBh. Since DSM-III-R lists focus on descriptions of mental disorders, or what may be regarded as negative mental states,
comparison--or even parallel analysis--will only be possible if similar types of lists are chosen from the AKBh. Even given this condition, one may still find numerous AKBh lists regarding negative consciousness-related factors or elements. However, here only the basic lists of kleśa-s and anuśaya-s will be considered.

Consciousness or cognition (citta, manas, viññāna) and its consciousness-related factors or elements (caitta) are generated together, they are interdependent (AKBh, ii.34a-b, 205; ii.23a, 188). In the AKBh, five types of consciousness-related elements are enumerated, of which the kleśamahābhūmika-s are one (AKBh, ii.23c-d, 189). "Bhūmi" is "sphere," meaning place of origin or occurrence. This sphere is called "great" (mahat) because

it is the sphere, the place of origin, of great dharmas (that is, dharmas of great extension, that are found everywhere). The dharmas that are inherent in the mahābhūmi are called mahābhūmika, that is, the dharmas that are always found in all minds.

[it is the sphere, the place of origin, of dharmas (that is, dharmas of great extension, that are found everywhere). The dharmas that have a mahābhūmi are called mahābhūmika, that is the dharmas that are found in every (moment of) consciousness] (AKBh, ii.23c-d, 189).

The term, "kleśamahābhūmika" thus refers to the mental factors or elements (which are dharma-s) that belong to all moments of consciousness which are therefore defiled (AKBh ii.23c-d, 189).
In the AKBh, the six *dharma*-s which are basic defiled consciousness-related elements (*klésamahābhūmika*-s) are: delusion (*moha*); non-diligence (*pramāda*); idleness (*kausīdyā*); disbelief (*āśraddhya*); torpor (*stūnya*); and dissipation (*auḍḍhatya*) (*AKBh*, ii.26a-c, 193). Delusion is defined as ignorance (*avidyā*), non-knowledge and non-awareness (*AKBh*, ii.26a-c1, 193). Non-diligence (*pramāda*) is "the opposite [counteractive] of diligence, is the...non-cultivation of good *dharmas*" (*AKBh*, ii.26a-c2, 193). Idleness (*kausīdyā*) is the counteractive of energy (*vīrya*), which is the endurance of the mind (*AKBh*, ii.26a-c3, 193; ii.25.10, 193; see also note 135 on page 337). Disbelief (*āśraddhya*), is the counteractive of faith (*śraddhā*), which is variously defined as: clarity, translucency of consciousness; or, belief and trust in: the doctrine of the results of actions; the Buddha, the Dharma and the Sangha; and the four noble truths (*AKBh*, ii.26a-c4, 193; ii.25.1, 191). Torpor (*stūnya*) is the opposite of dexterity, agility (*praśrabdhī*) (*AKBh*, ii.26a-c5, 193; ii.25.3, 191). Finally, dissipation (*auḍḍhatya*) is non-calmness of the consciousness (*AKBh*, ii.26a-c6, 194).

The second chosen list is composed of the *anuśaya*-s or latent defilements (*AKBh*, v.1, 767). Various *kleśa*-s may arise from *anuśaya*-s which are lying dormant and have not been abandoned through the Path (*AKBh*, v.34, 828). The *anuśaya*-s are thus basically proclivities or latent dispositions of the consciousness (Chaudhuri 1976, 163). Stcherbatsky explains how these *kleśa*-s and *anuśaya*-s affect our moments of consciousness:

The elements of moral defilement (*klesā*) are
always present in a life \( (santana) \), in a latent or patent condition. When latent they have the form of "residues" \( (anusaya) \), they stick to the other elements, pollute them, bring them into commotion and prevent their coming down to rest. This influence of the disquieting elements in life is termed "general cause" \( (sarvatraga-hetu) \) because it affects the whole of the stream of life \( (santana) \), all its elements become soiled. The primary cause of this unhappy condition is "illusion" \( (avidya) \), the first fundamental member in the wheel of life \( [pratityasamutpada] \) (1923, 30).

From the above discussion, we can now see why delusion \( (moha=avidyā \text{ or } \text{ignorance}) \) is listed first among the \textit{klésamahābhūmika-s}, and also why the Buddhist path places so much emphasis on acquiring wisdom and insight. These are "antidotes" to the \textit{kleśa-s} and \textit{anuśaya-s}.

There are six basic \textit{anuśaya-s}, although, as stated, other enumerations are given as well. The six basic ones are: desire \( (rāga) \); anger or hostility \( (pratigha) \); pride \( (māna) \); ignorance \( (avidyā) \); false views \( (dṛṣṭi) \); and doubt \( (vicikitsā) \) (AKBh, v.1c-d, 768; Chaudhuri 1976, 163). Ignorance and doubt have some overlap with delusion \( (moha) \) and disbelief \( (āśraddhya) \), on the \textit{klésamahābhūmika} list. It must be remembered though that the \textit{anuśaya-s} are \textit{kleśa-s} which are non-manifested, "in a state of sleep," thus overlap between the lists is no cause for concern.

It seems only logical that, when so much emphasis is placed on ignorance \( (moha, avidyā) \) as a root cause of suffering, unsatisfactoriness, etc. \( (duḥkha) \), ignorance at least would be acknowledged as both a latent and more active element.
Analysis of the lists of kleśa-s and anuśaya-s immediately reveals that the elements on the lists are all consciousness-related. If there is any obvious difference between the two lists (other than, as mentioned above, the distinction between anuśaya-s and kleśa-s), it would be that the anuśaya list seems to include elements that relate more strongly to the emotions--anger, pride, doubt (to a certain extent), and attachment. The klésamahābhūmika-s, especially as defined in the AKBh, are more strongly cognitive.

The klésamahābhūmika list again shows that this is psychology (if it can be called that) within a soteriological and religious framework, and the same holds true for the anuśaya list. Guenther has noted though that while this is true for lists that consider healthiness and unhealthiness, there are also lists that give a more purely descriptive and phenomenological view of the mind (1974, 95). An example of such a list would be the consciousness-related elements that are said to accompany all momentary states of consciousness (mahābhūmika-s): sensation (vedanā); volition (cetanā); concepts or notions (saṃjñā); desire for action (chanda); contact (sparśa); discernment or wisdom (prajñā); memory (smṛti); the act of attention (manaskāra); approval [faithful conviction, liking] (adhimukti); and absorption or concentration (samādhi) (AKBh, ii.24.1-10, 189-190). With the exception of prajñā and adhimukti, none of these elements are largely religious.

The lists we have examined though, do contain elements that strongly relate to religious and soteriological goals. Most notable here is the inclusion of ignorance or delusion on both lists. While the lists may be
phenomenological, and in that way might be considered as focussing on the individual, the fact that these states are said to exist in all defiled moments of consciousness, etc., shows a less individualistic approach. General (although negative) moments of consciousness are emphasized in these lists because, having the ideal or Arhat as standard, most "normal" people would have these (defiled) consciousness-related elements. This again relates to the ideas of seeking transcendence and the acceptance of religious or soteriological values and goals in the text.

From the phenomenological approach of these lists, one can see that the internal orientation is very strong here. No behavioral or external elements are included. These lists focus on the consciousness-related factors or elements which arise in the moments of consciousness of people who have not yet reached the ideal state of the Arhat.

**Summary - Comparison Of The Lists**

We have now come to the last part of this study. Having examined the specific lists and the values and norms that form and/or underlie them, we are ready to see if any direct comparison (i.e. identifying similarities) between the lists is justifiable.

A surface level comparison of the lists in DSM-III-R and the AKBh would indeed show some similarities in items. For instance, diminished ability to think or concentrate (DSM-III-R, A-8, 222) might be likened to dissipation (auddhatya) or torpor (styāna) (AKBh, 26a-c, 193-194). Fatigue or loss of energy
(DSM-III-R, A-6, 222) might be compared to idleness (kausīḍya) which is said to be the opposite of energy (AKBh, ii.26a-c3, 193).

However, by doing this type of surface level comparison, one can immediately see that the only result is a "hash," a mixture of items that, if they were examined more closely, within the context of their systems or traditions, would be recognized as not having any similarities at all. The basic reasons for the lack of similarity in items is, as we have seen repeatedly in this study, that both lists and texts come from very different traditions. These traditions have certain value systems and norms that are quite different from each other. The values and norms, along with other factors, influence the texts and their lists. Unless these values and norms are identified, and the lists understood within this context, then mistakes such as the "surface level comparison" given in the paragraph above, would be all too easy to make.

This discussion, however, reflects only one narrow understanding of the word "comparison." If comparison means comparing one item with another, then this is not justifiable. But if comparison means comparing broad structural similarities and differences, then this is justifiable and possible. Indeed, this entire study reflects this second understanding of comparison. We have examined or compared historical backgrounds of the texts, their concepts of mental health and illness, the values and norms found in the texts as a whole, and in this last section, have identified some of these values and norms in the lists. It is possible then to compare the lists if broad structural
similarities and differences are examined, rather than specific items on each list.

The specific lists from DSM-III-R and the AKBh have provided good examples of the general concepts, influences, values and norms that were examined earlier. The diagnostic criteria for a Major Depressive Episode highlight the values of individualism, rationality, mastery and function, a somewhat external orientation, and a rejection of religious or soteriological goals. The criteria also, quite obviously, reflect the concept of normal, or the norm, as average. The criteria, as we saw, also showed elements of general psychology, behaviorism, and medicine—the three basic influences on the North American mental healing tradition.

The AKBh lists were also congruent with the concepts, values and norms that were previously identified. The lists were phenomenological, reflecting an internal orientation. Unlike DSM-III-R, no behavioral elements were listed. The kleśa-s and anuśaya-s, as defilements, are obviously consciousness-related elements or factors that one should strive to transcend. This emphasis on transcendence, as we saw, is very common in the Indian traditions, and, of course, is due to the presence of religious or soteriological goals. Since we find that transcendence is the goal, we may conclude that the value-laden terminology (eg. defilement, idleness, dissipation, etc.) used in the lists, reflects the idea that the norm is the ideal. Whatever is not included in this ideal is, indeed, negative and may validly be expressed as such.
There are no clear similarities between the lists, except for the fact that both focus on unwanted or aversive mental states which are common to many people. Even this bit of similarity must be qualified, for although the criteria for Major Depressive Episode apply to a great number of people, these people, by definition of the norm as average, form a minority in society and the world. In contrast, the lists of anuṣaya-s and kleśa-s would apply to the majority of people who have not attained the ideal norm of enlightenment.
NOTES - THE LISTS

1DSM-III-R defines Mood Disorder as the following:
The essential feature of this group of [mood]
disorders is a disturbance of mood, accompanied
by a full or partial Manic or Depressive Syndrome,
that is not due to any other physical or mental
disorder. Mood refers to a prolonged emotion
that colors the whole psychic life; it
generally involves either depression or
elation. In DSM-III this diagnostic class was
called Affective Disorders (DSM-III-R, 213).

2Explanations of Manic and Hypomanic Episodes are given in DSM-III-R
and might be useful here as a contrast with the other subclassification of Mood
Disorders (Depression).
Regarding the Manic Episode, the essential feature is,
a distinct period during which the predominant
mood is either elevated, expansive, or irritable,
and there are associated symptoms of the Manic
Syndrome. The disturbance is sufficiently
severe to cause marked impairment in
occupational functioning or in usual social
activities or relationships with others, or to
require hospitalization to prevent harm to self
or others. The associated symptoms include
inflated self-esteem or grandiosity (which may
be delusional), decreased need for sleep,
pressure of speech, flight of ideas,
distractibility, increased involvement in goal-
directed activity, psychomotor agitation, and
excessive involvement in pleasurable activities
which have a high potential for painful
consequences that the person often does not
recognize. The diagnosis is made only if it
cannot be established that an organic factor
initiated and maintained the disturbance

A Hypomanic Episode includes,
a distinct period in which the predominant
mood is either elevated, expansive, or irritable
and there are associated symptoms of the Manic
Syndrome. By definition, the disturbance is
not severe enough to cause marked impairment
in social or occupational functioning or to require hospitalization (as required in the diagnosis of a Manic Episode). The associated features of Hypomanic Episodes are similar to those of a Manic Episode except that delusions are never present and all other symptoms tend to be less severe than in Manic Episodes (DSM-III-R, 218).

One could consider in the AKBh, for example, an expanded list of the kleśamahābhūmika-s (ii.1, 194); of the anuśaya-s (v.3-5d, 772-774); or the wrappings (parīvavasthāna-s) (v.47-48, 841-843) and the filth of the kleśa-s (kleśamala-s) (v.49c-50b, 844), which are both produced following the kleśa (upakleśa - literally meaning found near the kleśa) (v.46, 84).

Stcherbatsky, in his analysis of the kleśamahābhūmika-s helps to further clarify these explanations and definitions. He defines the term kleśamahābhūmika-s, slightly differently, calling them the universally obscured elements present in every unfavorable moment of consciousness. Stcherbatsky notes that error (moha), as ignorance, is the primordial cause of "commotion" (duḥkha-unsatisfactoriness, suffering, etc.) in the world. He translates non-diligence (pramāda) as the faculty of carelessness; idleness (kausāḍya) as mental heaviness and clumsiness; disbelief (āśraddhyā) as the disturbed mind; torpor (ṣṭyāna) as sloth, indolence, inactive temperament; and dissipation (auddhatya) as being addicted to pleasure and sports, or having a sanguine temperament (Stcherbatsky 1923, 87).

This is Vasubandhu's own standpoint (Sautrāntika) which, in this section of the AKBh, is termed the "best" (AKBh, v.1, 770).
VI. CONCLUSION

This study has focussed on two texts: DSM-III-R, which is a North American, largely secular, manual dealing with mental disorders; and the AKBh, which is a Buddhist text that contains what might be regarded as a soteriological psychology. As consequences of the fundamental differences between the texts, comparisons, and even the use of contextually appropriate terminology, have been difficult. Some North American terminology and categories have been applied to the AKBh, and this should be avoided if at all possible in future studies. The difficulty of using contextually accurate and appropriate terminology highlights one of the main problems of comparative work. Nevertheless, in spite of such difficulties and differences, some conclusions from the present study may be drawn.

Throughout this study, we have seen that the general topic of mental illness and mental health in the AKBh and DSM-III-R may be addressed on two levels. The first level deals with content--the ideas and concepts of mental illness and mental health as presented in the texts. The second level is more general and structural--an attempt to unravel the broad factors that form and underlie list literature. These two levels of analysis continually overlap, which is interesting in and of itself.

If, as has been done in the present study, we restrict the focus on the AKBh and DSM-III-R to (what might be regarded as) concepts of mental health and mental illness, we find that the contents of these texts are nearly mirror images of each other. DSM-III-R identifies and delineates a great variety of
mental disorders. The AKBh, on the other hand offers only brief statements about, and lists of, soteriologically negative consciousness-related factors. Conversely, if we presuppose that the Global Assessment Of Functioning Scale in DSM-III-R, and the characteristics of the Arhat in the AKBh, are representative of some states or concepts of mental health, we discover that the AKBh contains a great wealth of information while DSM-III-R contains very little.

We have also seen repeatedly that the concepts of mental illness and mental health in the texts, whether presented in the form of statements or lists, are formed and/or influenced to a great degree by values and norms. This indicates that it may well be impossible to formulate any concept of mental health or mental illness without such influences. If this is the case, then the largely atheoretical, empirical, and descriptive approach which DSM-III-R aims to offer, is not necessarily any more accurate or less value-laden than the approach taken by texts such as the AKBh.

The issue of values and norms present in the texts and their concepts of mental health and illness had great relevance for the second level of analysis which dealt with the phenomenon of list literature of this particular kind. We saw that, for these two texts, it is methodologically and conceptually unjustifiable to attempt a direct comparison of items given in the lists. However, three broad categories of values, which may be regarded as part of the structure of the lists, were identified and here some comparison was possible. These values or structures were: individuality versus self-
transcendence; rejection or acceptance (presence) of religious or soteriological goals; and a basic external versus internal orientation.

Of these three, rejection or acceptance (presence) of religious or soteriological goals accounted for the greatest differences between the texts. This, of course, is because the AKBh contains a soteriological psychology, while DSM-III-R represents a more secular approach. We saw that this secular or soteriological approach is linked to basic concepts of the norm (against which mental illness and mental health are measured) as average (in the case of DSM-III-R), or ideal (in the case of the AKBh). Lists and concepts of mental illness and mental health, are both based on some sort of normative concept(s), so here we see the primary reason for this study’s overlap in analysis of content and broad structural factors.

This final point leads to one last observation about the two texts, their lists, and their concepts of mental health and mental illness. It is interesting to find that a text such as DSM-III-R, which presupposes the norm as average, focuses overwhelmingly on characteristics of the minority (that is, the characteristics, behaviors, etc. of those who are afflicted with mental disorders). Similarly, at least on the topics examined here, the AKBh, which has the ideal as the norm or standard, also focuses on characteristics of the minority. However, here the minority might be viewed as representing a state of mental health rather than illness.

In this sense, both texts, at least with regards to the areas examined in this study, may be said to focus on "minority groups." The reason for this is,
undoubtedly, largely due to the perceived scope, mandates, etc. of the texts, as well as the underlying values and norms that we examined here. However, human nature might also play a role in this, for we--no matter in which culture or century we live--seem always more curious about those things which are "out of ordinary," as opposed to those which are mundane.
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APPENDIX 1

Diagnostic Criteria For Major Depressive Episode
(DSM-III-R, 222-223)

Note: A "Major Depressive Syndrome" is defined as criterion A below.

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others
(2) markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)
(3) significant weight loss or gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance
(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)

Note: Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation, or prolonged duration suggest bereavement complicated by Major Depression.
C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.