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**Buddhist Teen Worldview: Some Normative Background For Health Professionals**

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## **Buddhist Teen Worldview: Some Normative Background For Health Professionals**

### **Abstract (130w)**

Although there are dangers in essentializing religious practice, to be able to typify the worldviews of healthy Buddhists becomes advantageous when health professionals need to recognize atypical worldviews that are potentially pathological. The paper is an anthology of potentially ambiguous claims expressed by healthy Buddhist teenagers during UK research including outlook on karma, rebirth, meditation, mindfulness, contact with spirit presences, renunciation, spiritual teachers and superstition. The testimony helps clarify diagnosis of identity, well-being and conformity issues, social withdrawal, anxiety and psychotic disorders in Buddhist teens while offering advice on management of ADHD, OCD, substance abuse and depression. While offering normalized background against which health professionals can evaluate spiritual wellbeing of young Buddhists the paper offers advice for how treatment can be made more culturally sensitive for Buddhists.#

## **Buddhist Teen Worldview: Some Normative Background For Health Professionals**

### **Introduction**

In a real-life clinical case, the 19-year-old Buddhist son of a Thai mother and a Swiss father, who had a shy and introverted disposition and whose worldview included a sensitivity to spiritual presences, travelled to Thailand to spend two weeks as a novice monk.<sup>1</sup> When he returned to Switzerland after the novice training, owing to stress from jet lag, the spirits he believed he saw, now frightened him. His father bundled him off to a doctor who, hearing his symptoms, had him put on a course of anti-psychotic drugs as a matter of urgency, institutionalizing the boy from time to time thereafter. Being confined to an institution only served to frighten him further. Ten years later, the young man has made almost a complete recovery, but is left emotionally scarred, not so much by his ‘supernatural experiences’ as by his withdrawal from medication and the stigma of having spent a decade labelled ‘mentally ill’. He blames a medical system insensitive to differences in cultural worldview for overreacting to his symptoms. Diagnosed differently, today he might have enjoyed an independent and fulfilling life. This case is an illustration of how, cultural dissonance (as defined by Fitzgerald 2000, 186) can be a stumbling block for mental health treatment of Buddhists in countries where they are a minority.

Religious implications of mental health treatment generally can present problems for clinician and patient alike. For mental health professionals, problems may include limited understanding of religious normality and feeling ill-equipped to

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<sup>1</sup> Temporary ordination is a widespread practice for young Thai and Burmese males where they ‘adopt the robe’ as a fully-ordained monk or as a novice monk for a period intentionally limited to a few days, weeks or months, to allow them to deepen their understanding of Buddhism, later returning to the lay life.

adjust treatment to harness spiritual capital in speeding their recovery. Perceptions of mental health in relation to religious worldviews are filtered through the reality constructed for the clinician by the social mainstream. Worldviews considered healthy to one religion might appear abnormal to another — for example, behaviours put down to demonic possession might be considered normal in Haitian society whereas behaviours attributed to libidinal imbalance might be taken for granted in the West (Berger and Luckmann 1991, 197) as would a paradigm of mental health which tends to be positivist-empiricist (Honer and Hunt 1987). Most notions of ‘madness’ and ‘mental abnormality’ on which the mental health systems in the West are based are linked to western ways of thinking – and these may conflict with the worldviews of non-western cultures, such as Buddhism (Fernando 2002; Parker et al. 1995). For mental health, the Indic cultures tend to emphasise pursuit of an inner differentiation while keeping the outer world constant, whereas the notion of freedom in the West is related to an increased potential for acting in the outer world, enlarging the sphere of choices while keeping the inner state constant to that of rational, waking consciousness from which other modes of inner experiences have been excluded as deviations (Kakar 1984, 272). The cultural dissonance between western and eastern definitions of mental health are brought into relief by the words of a thirteen-year-old Thai Buddhist girl Thongthida:

“if they were to institutionalize every Thai person who believed they had seen a ghost, there would not be enough space (inside) for everyone.”

At the same time, due to clinicians’ familiarity, claims a sceptical bystander might consider utterly fantastic in mainstream religions, are slow to arouse suspicion. For

example, the position of a Christian minister as vicarious intermediary between ordinary members of society and the creator of the universe could reasonably be mistaken, by clinicians unfamiliar with Abrahamic religions, for psychotic belief. It is only general cultural familiarity with the Abrahamic religions that makes aspects of those belief systems clinically unremarkable.

There is an argument for basing mental health, where possible upon the attainment of a degree of well-being based on standards and values chosen by the people of a certain culture for themselves (Diener and Suh 2000). Unfortunately, with few exceptions (e.g. Scotton 1998), research on Buddhism in the context of the health professions is rare. The lack of guidance on ideal type<sup>2</sup> has meant health professionals dealing with Buddhist patients can be left in a dilemma as to whether supposed “peculiarities” constitute abnormality. Although not every clinician might want to include religious beliefs in assessment and therapy, there is evidence to suggest that those who do, feel ill-equipped to offer appropriate spiritual help (Neeleman and King 1993; Nolan and Crawford 1997). Some psychiatric practitioners place religion as a whole in the category of irrational, self-therapeutic belief. The general lack of familiarity with even basic Buddhist beliefs makes adherents vulnerable to suspicion of abnormality earlier in the diagnostic process than would be the case for patients adhering to Abrahamic traditions.

From the client side, problems include possible reluctance to discuss religious issues with clinicians, the alienation of having been labelled “mentally ill” and pathologization of Buddhist spiritual experiences as diverse as seeing ghosts, believing in the outcomes of karma, heaven and hell, meditation experience, or

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<sup>2</sup> Ideal type is a sociological hermeneutic that helps make a working description of abstract concepts (in this case Buddhist normality) stressing certain elements common to most cases of the given phenomenon.

reliance on a spiritual teachers. Buddhists are not immune to mental illness or other extremes of behaviour, despite parallels drawn between Buddhism and psychiatry (e.g. Brazier 2002, 258). Nonetheless, although as many as 60% of patients feel religiosity is relevant to their recovery, it has been shown that 38% felt unable to discuss this with their psychiatrists (Lindgren and Coursey 1995).

Clinician's decisions are important since on their basis a patient may be sectioned under the Mental Health Act or subjected to a course of mood- and behaviour-altering medication. Such decisions may be based largely on professional experience of clinicians with no firsthand knowledge of what it means to be Buddhist. Those decisions could be made more culturally sensitive if clear guidelines were made available as to "typical" Buddhist thinking and behaviour. Ideal typing of religious worldviews can help lighten the burden on health professionals seeking to reduce the cultural gap between themselves and spiritual clients. For some religions ideal typing is relatively simple — especially where creed or homogeneity of identifiers allows simple linear measurements of religious attitude to be made, running on a continuum between nominalism and piety. For Islam, Iversen, for example, has proposed a 'sliding scale of Muslimness' (2012, 146). In such cases, clear correlations can be calculated between attitude to religion, practice, belief and self-identification. For such religions, it might even be possible to identify borderlines beyond which religious fervour errs into fanaticism or poor mental health. It should be pointed out that standardizing such measures of religiosity for Buddhism is still at an early stage.

This paper is a position paper that hopes to draw the attention of health professionals to empirically collected data on how Buddhists typically behave, as a viable alternative to anecdotal evidence or the possibly less relevant vignettes

contained in Buddhist scriptures. It is a collaboration between a Buddhist insider-researcher who makes available thick<sup>3</sup> description of typical Buddhist religiosity and a Buddhist psychiatrist who interprets this data in relation to mental health. For the record, in respect of interpretive data, it should be stated that one researcher is a “convert” to Theravāda Buddhism and the other a heritage Buddhist. The article will hopefully bridge the gap of cultural dissonance providing normative background for health professionals based on qualitative data for Buddhist minorities in western society, by pointing to research where ‘healthy’ teen Buddhists have narrated religious worldviews that could potentially be mistaken as abnormal by clinicians. It aims to portray, by offering a depth of detail concerning attitudes of young Buddhists, how Buddhists typically view the world. The article also seeks to highlight by elimination, what might be considered abnormal worldview for Buddhists in a way useful to health professionals. #

**Provenance of illustrative examples**

The data used to inform the view of typical Buddhist worldview in this article is derived from a series of studies on a well-defined population of Buddhist teens growing up in Britain. The illustrative data in this paper are based on the experiences of teenagers. It might be argued that this age group has particular problems which make it limited in the degree to which conclusions could be extrapolated to adults, since adolescence is known to be a time of rapid physical change and a period of emotional, educational and social pressure, with heightened emotions, and idealistic thinking, sometimes leading to conflict. Thus, the choice of young people rather than

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<sup>3</sup> #Wk lfn#ghvfulswlrq#lv#d#w|dn#i#txddvdyh#lhog#gdw#xiilflhqwo|#ghwldng#r#uhp hg|#dp eljxlwlv#q#txdqwldwlyh#wdwlvlfv#derxw#vrfld#vflhqwilf#skhqrp hqdE irørz lqj#wk#xvdjh#fkdudfwul}hg#lq#lqwhusuhwlyh#wkqrjwdsk|#h1j1#hhuw}#<<7,#

adults for this research may have some features that would differ from an adult sample. Current mental health issues that are regularly highlighted for teenagers in the UK media include issues concerning identity, sexuality, sexual orientation, conformity, bullying, suicide, substance abuse, eating disorders, ADHD, various degrees of anxiety disorder, OCD, social withdrawal and the more functional end of the autism spectrum.

Data were gathered between July 2011 and August 2012. The young people were of similar age and self-identified as Buddhist. The qualitative items quoted arose in focus group discussion with Buddhist teens using partly open-ended questions that had previously been fielded amongst religiously-undifferentiated teenagers (e.g. Francis 2001; Halsall 2004; Loundon 2001) and partly from Thanissaro's (2011) Scale of Attitude towards Buddhism (TSAB). Quantitative items that identify percentages were derived from dissertation research of a sample of 417 Buddhist teens living in the UK in the age group 13-20 years (Thanissaro 2015 [*in press*]).

Since previous research on Buddhists in the West (e.g. Baumann 2002; Numrich 1996) has shown there to be two distinct styles of religiosity, termed "convert" and "heritage," special efforts were made in sampling to include both styles. The relative difficulty in finding willing convert participants of the specified age range is reflected in the stratified nature of the sample. Apart from convert Buddhists, teenagers were drawn from Britain's Sri Lankan, Thai, Burmese, Cambodian and Nepalese communities, and included teenagers of mixed race from intermarriage of Asian and Black or Asian and White parents. These latter would comprise *heritage* Buddhists and mostly adherents to Theravāda Buddhist practice. The remaining ten were self-identifying Buddhists brought up in *convert* Buddhist families. The conclusions drawn from these teenagers can certainly be extrapolated to

approximately 20,000 teenagers self-identifying as Buddhist according to the most recent national census,<sup>4</sup> and possibly further to Buddhists of the same age in other countries and to some extent to the adult Buddhist population.

Although the scope of the research on which this article is based does not allow examples to be found for all the potential worldviews found in adolescents, the authors were able to pick seven areas illustrative of issues liable to confusion by health professionals. Equally, although not covering all the possible mental disorders mentioned above as prevalent in UK teens, the data *do* allow observations to be made where clinicians suspect issues of substance abuse, identity, conformity, well-being, ADHD, anxiety disorder, OCD and psychotic disorders.#

### **Illustrative Examples**

The structure of each subheading of this findings section will be likely differences between Buddhist teen worldview and the worldview of teenagers in general, giving illustrative examples and management guidance for where ‘typicality’ might have been compromised or where ironically the worldview may be harnessed in management of a condition. Examples in this section are arranged under the subheadings of karma, rebirth, meditation and mindfulness, contact with spirit presences, longing for silence and solitude, spiritual teachers and superstition.

#### ***1. Karma***

A recent quantitative survey found a significantly greater proportion of Buddhist teenagers (66%) tend to believe in the law of karma than non-Buddhists (36%)(Thanissaro 2014b). An example of how karma might fit into

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<sup>4</sup> The UK national census dataset for 2011 (CT0116\_tcm77-335860.xls) totalled 22,715 teens between the ages of 10 and 19 who self-identified as Buddhist.

teenagers' causal logic is that of Ma Phyu a fourteen-year-old Burmese Buddhist girl who told of having, "shouted back at . . . (her) mother, and then . . . (breaking her) arm . . . (by falling) down the stairs." Another example was that of Zaw Htet, a 13-year-old Burmese Buddhist boy who reasoned:

I once talked back to my mother and my hand was injured by accidentally slamming it in the door straight after. I think this is proof of bad karma.

Some health professionals may be tempted to categorize belief in karma as indicative of irrational belief. Indeed, in certain psychiatric conditions such as depression, the belief in karma may contribute to the patient's reluctance in seeking help, leading them to think that the suffering is due to their past karma and therefore causing them to accept it too easily. A further aspect of karmic causality that can possibly hinder proactivity in problem-solving with the Buddhist tendency to take the blame for problems on themselves rather than seeking to ameliorate external problem sources or the tendency not to deal with problems but deal with the attitude to it. Indeed, four-fifths (71%) of Buddhist teenagers on the quantitative survey agreed with the statement that enjoying life or hating it depends on how we see the world. Applying this principal to depression, according to Maung Pyar Zang, a 14-year-old Burmese Buddhist boy, "if a person is depressed about the world, they cannot really see what the world would be like in a bright light – and ... the best means of helping them would be to deal with their attitude to the world rather than ... dealing with the problem that is upsetting them.

## ***2. Rebirth and beliefs concerning heaven and hell***

Some health professionals may be tempted to categorize belief in rebirth as indicative of irrational belief but it seems that this worldview corresponds to that of the majority of Buddhists – with on average of 52% of Buddhists teens supporting belief in life after death. In the words of Rosaly, a 13-year-old convert-raised Buddhist girl, “if you are Buddhist you don’t have to believe in it [life after death] but you can” (Thanissaro 2014d, 318). According to Tea, a 15-year-old heritage Buddhist, rebirth meant “that when people die, they are reborn, except for a few people who are on their final lifetime” (Thanissaro 2014d, 318). In another example, given by Annie, a 13-year-old Thai girl, karma was also expected to affect lifetimes to come. She asserted, “If you do good, you will go to heaven. If you do bad, you go to hell.” According to Sam, a 19-year-old Thai Buddhist boy the outcome of the karma, “sticks . . . in your afterlife (too).”

## ***3. Meditation and mindfulness***

Scriptural sources might lead Buddhists to expect extraordinary experiences from practising meditation including inner visions [*nimitta*] or hearing an inner voice [*dibbasota*] and trance-like mental states [*jhāna*]. Indeed some Buddhist teens were able to relate some meditational experiences from first hand experience. Almost half (48%) of Buddhist teens had had some sort of religious or spiritual experience and these experiences fell into the category of meditation experiences such as that described by Anton, an 18-year-old White Buddhist boy (Thanissaro 2013):

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Intense waves of pleasant tingling sensations spanning throughout the whole body. A long-term lessened effect of any sort of physical

discomfort; general equanimity and openness to sensations, regardless of their content.

Similarly, Aung Kaung, a 15-year-old Burmese Buddhist boy described his meditation experience:

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Very (relatively) long meditation: head rising, inner joy – couldn't feel my back and legs, during and after meditation – felt very refreshed afterwards

Rather than claiming other-worldly implications, meditational experiences remained very much something the teens were in control of, rather than being overwhelmed by, their meditation experiences. They treated their experiences with pragmatism since they were often claimed to be a refuge in coping with stress or anxiety. According to Maung Kyaw, an eighteen-year-old Burmese Buddhist boy, meditation is:

. . . something that can help you in tough times when you have lot of stress. Like, I had exams a few months ago and, like, I was just really stressed with it. If I just meditated, I would be better, like straight away.#

Meditation, far from being pathological can actually form part of 'spiritual capital' that lends resilience against ADHD and various degrees of anxiety disorder.

From a clinical perspective however, boasting about one's meditation experiences would not be deemed typical of Buddhists – especially concerning transcendental states such as Nirvana. A client's dogmatic assertion that they have attained enlightenment or will definitely reach Nirvana might indicate a grandiosity of thought that would need further exploration. Some young people could be attracted to

meditation by idealistic thinking – however, shutting oneself in a room and totally isolating oneself in the guise of meditation is *not* normal and could be regarded as pathological social withdrawal. Also, clinicians should remain cautious about involuntary hallucinations that are obviously psychosis and be aware that certain forms of meditation that have been shown to exacerbate medical conditions if encouraged indiscriminately in those with a history of anxiety (Garden 2007).

The term mindfulness [*sati*] being derived from Buddhist tradition might lead clinicians to assume that mindfulness-based cognitive therapies would be recognized as particularly appropriate to Buddhist patients. It should be pointed out however, that the way ‘mindfulness’ has come to be understood in clinical circles would be regarded by many Buddhists as unhelpfully narrow. Clinicians tend to interpret mindfulness as ‘being non-judgmental about mental states arising’, but in a Buddhist context it needs to be decidedly judgemental insofar as it differentiates between wholesome [*kusala*] and unwholesome [*akusala*] mental states and behaviours. An example of how a Buddhist teenager utilized mindfulness (in its broad Buddhist definition) to overcome peer pressure is described by Maya, a 15-year-old Srilankan Buddhist girl, as:

Li#z hu#jrlqj#r#guln#jfrkrc#####q#p |#p lqg#lz rxg#eh#klnlqj/#  
ŠWk.lv#lv#z urqj#Li#p |#p xp #vdz #p h#Li#z rxg#eh#gndgč#####dqg#wkdw#  
z rxg#wkhq#lvxow#lq#p |#####jrlqj#Šúč#####kdyh#vrp h#rudqjh#xlfh#  
wkqgn#rx#hu|#p xfk.\$#

Mindfulness a Buddhist would recognize and possibly be able to harness to help with convalescence would not mean ‘going with the flow’ of unwholesome states of mind, but perhaps incorporating proactive efforts to ameliorate negative circumstances

rather than merely observing them, becoming aware of their own thoughts and using them to take action in life, in a way not dissimilar to that encouraged during Acceptance and Commitment Therapy.

#### ***4. Contact with spirit presences***

Although a high proportion of Buddhists are atheists (quantitative research (Thanissaro 2015 [*in press*]) suggests that over two-fifths [41%] do not believe in God), clinicians may be surprised to learn the openness of many Buddhists to belief in other spirit presences. Maya, for example, asserted that Buddhists ... don't believe in God, but ... believe in the philosophy of life and how [it can be improved] through education and stuff" (Thanissaro 2014d, 318). Quantitative research (Thanissaro 2015 [*in press*]) suggests that 35% of Buddhist teenagers believe in the existence of ghosts. Roughly a sixth (15%) of Buddhist teens with religious experiences claimed contact with spirit presences, such as ghosts or, less commonly, angels. Tea, a 15-year-old Thai Buddhist girl described a childhood encounter in Thailand:

When I was young, I was on the back of a motorcycle at night and they were in pursuit — ...they were black shadows, tall and thin...as if they'd been dried out...I was terrified, but I kept looking back at them. I can't remember anything else from that time, but the picture of those ghosts is still clear in my mind. (Thanissaro 2014a, 7)

Similarly, in the experience of Amaya, a 13-year-old Sri Lankan Buddhist girl:

There was a time when we were playing dare-devils and I was freaking them (my friends) out in the dark and then there was a knocking on the window in the night – and it was scary, and then I went into my dad’s room and there were like loads of mirrors – like there are mirrors everywhere and I was hiding from them to scare them – so all the lights were off and I looked and like, there is a (dressing-table) mirror – one in the middle and two others – one on each side – I looked and I could be seen in the one on this side and then in the middle of the ... there was a lady there....really tall....compared to me... and all you could see was her nose.

Or in the experience of Thongthida,

At night I saw ghosts many times at my own or friends’ houses. One was the deceased mother of a friend who was sitting bowed over a book and flicking through it. Another time I saw a ghost lady I didn’t know, dressed in traditional Thai costume. Only half of her was visible from the waist up (the rest of her was beneath the floor). I covered my head with a blanket. When I took it off again, the ghost had gone.

Or on a slightly different note, in the experience of Bob, a 16-year-old White Buddhist boy (Thanissaro 2013):

My mum received an email saying that we could welcome angels into our home. I didn't believe this until one day where I saw an angel in my room

The usual sociological explanation of such 'encounters' is some sort of projection of denial concerning the decease of a loved one (Day 2013) – but in most cases for the Buddhist children, such encounters did not concern a recognizable loved one. Clinicians would have to take care with such individuals not immediately to flag up suspicions of psychotic hallucinations.

### ***5. Longing for silence and solitude***

Buddhists tend to have a positive attitude towards and respect withdrawal from the confusion of modern materialistic living. In Buddhism the main role models of such lifestyle are world-renouncing monastics. A quantitative survey of Buddhist teenagers (Thanissaro 2015 [*in press*]) showed that 65% liked how some Buddhists spend time as monks or nuns, while 20% would seriously consider becoming a monk or nun themselves. Renunciation in Buddhism is the practice of intentionally simplifying one's relationships or seeking out solitude as a way of life, to practise meditation more intensively. It can be achieved by ordaining temporarily (as with the case described at the beginning of this article) or permanently as a monk or nun or by practising celibacy/continence for a longer or indefinite period of time. Contemporary mental health is often construed in terms of achieving 'healthy human relationships' and has little place for solitary, inward and reflective experiences – and is therefore at odds with Buddhist worldview where solitude may be actively sought or encouraged. While Yalom acknowledges psychotherapy might be focussed on concerns rooted in

existence (existential psychology) most mental health is construed in terms of developing and maintaining gratifying interpersonal relationships (Yalom 2002, xv, 23). Such exclusive focus on gratification through relationships seems to be less the case for Buddhists. Mike, a 13-year-old White Buddhist boy commented:

It is easier to do something (Buddhist practice) if you are by yourself ...  
just after going to ... [an event], when you are on your own.

Buddhist teachings are seen as useful to the teens in resisting unwelcome peer pressure and giving strength in issues of conformity, as illustrated by the comments of Rhiannon, a 14-year-old White Buddhist girl (Thanissaro 2014d, 322):

“It’s like, I just be myself and I don’t really care if they judge me, because I’m just ‘me’.”

Often the longing for silence and solitude in young people can be misunderstood as escapism or pathologised as the symptoms of social withdrawal – but educators particularly have identified such behaviour as a necessary precursor of understanding transcendence (Kessler 2000, 17; Stern 2012, 4) and in Buddhism such behaviours would be encouraged as part of a spiritual journey. Nonetheless, from a clinical perspective, an apparently sudden decision to enter the monastic order may indicate a wish to escape day to day stresses in life with the possibility of underlying depressive feelings.

## **6. *Spiritual teachers:***

A quantitative survey of Buddhist teenagers (Thanissaro 2015 [*in press*]) showed that 42% felt the need for a spiritual teacher. By contrast, Storr (1997) places reliance on a guru on a spectrum with mental illness. The Buddhist teenagers thought supporting monks who were their spiritual teachers was a worthy cause – according to Ma Phyu, giving food and money to Buddhist monks is,

. . . a good thing because they've given up the rest of their lives so that they can like do good for the world and so they won't be able to get (earn) the money because they're too busy concentrating on the right things that they are doing.

For Anusha, a 13-year-old Sinhalese Buddhist girl:

. . . it's a way of paying them back, because they're . . . sort of giving you their knowledge . . . They're giving it to you and to pay them back, you are giving them the food which is something they need. #

## **7. *Superstition***

A quantitative survey of Buddhist teenagers showed that 22% believed in the Devil, 23% believed it possible to contact the spirits of the dead, 27% believed in angels, 12% believed in black magic and 14% had a fear of going into a church alone (Thanissaro 2015 [*in press*]). Further analysis of these results found that the more introverted (lacking self-esteem and neurotic) seemed to believe more strongly in the supernatural side of Buddhism (Thanissaro 2014c). From a clinical perspective, although generally Buddhists do not tend to dismiss (and some faithfully believe in) supranormal (miraculous) occurrences in the story of Buddha, an absolute conviction

that such occurrences still happen today might indicate the possibility of delusional belief.

## **Discussion**

As mentioned at the outset, the deliberately evocative examples in this paper have been selected for their relevance to health care of Buddhist patients, since although belonging to healthy young people, they occupy a grey area where unfamiliar clinicians might have ‘warning bells’ set off about abnormal behaviour where none exists. It should be borne in mind that where one single ‘atypical’ worldview would not constitute abnormality, several such instances might warrant suspicion.

### ***Implications for mental health care & counselling***

The data presented in this paper, at least within the teen age-range, accords with the demand for increased qualitative research to inform systematic health policy reviews (Dixon-Woods and Fitzpatrick 2001), and responds to the recommendations of Ross (1994) and McSherry & Draper (1997) to familiarize mental health professionals with the attitudes, knowledge and skills of spiritual issues — in this case familiarity with the religious norms of teenagers within the Buddhist tradition as background in the treatment of the medical conditions of substance abuse, identity, conformity, well-being, social withdrawal, ADHD, anxiety disorder, OCD, psychotic disorders or depression. Since adolescence can be a time for onset of more serious mental illnesses, it is of paramount importance for clinicians to reach an early diagnosis and provide appropriate treatment in order to improve the prognosis of such illnesses. Early and aggressive treatment of symptoms by administration of antipsychotic drugs — something which may not allow time for full consideration of the real nature of the

patient’s symptoms requires prior familiarity concerning the patient’s background — since the side effects of some medications used in the treatment will affect their day-to-day functioning. Knowing a patient’s spiritual history will allow psychiatrists to make decisions quickly, while at the same time avoiding unnecessarily labelling a young person with a serious mental illness — since the accompanying stigma would affect the progress of a young person for the rest of their life. In their assessment, it is therefore recommended that a psychiatrist should take a “spiritual history” (Culliford 2007) so that the symptoms of the patient can be seen in the context of the spiritual background that has gone before and in addition, to areas such as emotional, social and cultural aspects. This highlights the necessity of understanding typical attitudes of Buddhist teenagers in order to reach an opinion about their mental health.

**Table 1. Summary of recommendations**

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***Problems***

*Clinician-side*

- Need to make snap decisions in spite of limited understanding of Buddhist ‘normality’ and possible blinkering by mainstream cultural paradigm.
- Ill-equipped to offer appropriate spiritual help.

*Patient-side*

Reluctance to discuss religious issues with clinicians. Alienation at an early age from the label of being ‘mentally ill’.

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***Possible Solutions***

- Taking a spiritual history.
  - Familiarizing themselves with Buddhist norms specific to the patient’s member group.
  - Being well enough informed to avoid pathologizing *bona fide* Buddhist spiritual experiences.
  - Not over-reacting to *single* instances of unfamiliar claims.
  - Involving faith consultants as intermediaries where appropriate.
  - Harnessing Buddhist practices including, but not limited to mindfulness, as a coping mechanism.
- 

Some recommendations for health professionals, based on understanding of what Buddhists normally practice are summarized in Table 1 above. A familiarity with the

traditions practiced by Buddhist patients can additionally help caregivers to know where to harness faith as a coping mechanism for recovering mental health. A heightened empirical interest in mindfulness-based therapies (Williams and Kabat-Zinn 2011) has perhaps caused clinicians to understand that meditation might be the main method of harnessing Buddhist religiosity in support of health, but from this vignette of young Buddhists it is apparent that meditation is just a *part* of a whole variety of practices that might have relevance to a Buddhist's spiritual well-being and mindfulness can usefully be extended beyond its narrow definition in the case of Buddhists. Participating in monastic rituals performed at significant life events or making ritual offerings have also been noted as healing strategies used in Buddhist communities (Pugh 1983). Familiarity can also help clinicians to avoid pathologizing Buddhists' spiritual experiences, so that spiritual experiences can be discussed with a genuinely open mind. Clinicians should bear in mind how Whitehead (1929) pointed to the inverse relationship between what is amenable to measurement and what is meaningful to patients, to adapt the *modus operandi* of mental health to "two ways of knowing" — seeing mental illness as not merely falling short of someone's standard of "normality" but also as part of a uniquely personal way to facilitate spiritual growth (Benning and Khokhar 2007, 395; Laing 1971, 14). Such familiarity on the part of the clinician will help to reduce the social opprobrium already experienced as part of the patient's alienation (Powell 2001, 321), opening the way to mental health that minimizes cultural dissonance between health professionals and their Buddhist clients.

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(5087 words [with footnotes])

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