Buddhist Philosophy and the Treatment of Addictive Behavior

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The purpose of this paper is to provide an overview of how Buddhist philosophy can be applied in the treatment of individuals with substance abuse problems (alcohol, smoking, and illicit drug use) and other addictive behaviors (e.g., compulsive eating and gambling). First I describe the background of my own interest in meditation and Buddhist psychology, followed by a brief summary of my prior research on the effects of meditation on alcohol consumption in heavy drinkers. In the second section, I outline some of the basic principles of Buddhist philosophy that provide a theoretical underpinning for defining addiction, how it develops, and how it can be alleviated. The third and final section presents four principles within Buddhist psychology that have direct implications for the cognitive-behavioral treatment of addictive behavior: mindfulness meditation, the Middle Way philosophy, the Doctrine of Impermanence, and compassion and the Eightfold Noble Path. Clinical interventions and case examples are described for each of these four principles based on my research and clinical practice with clients seeking help for resolving addictive behavior problems.

I FIRST became interested in the clinical applications of meditation in 1970, while I was teaching at the University of Wisconsin. As an assistant professor faced with the publish-or-perish stress of academic life, I was diagnosed with borderline hypertension. My physician recommended that I first modify my lifestyle in an attempt to lower my blood pressure, including diet modification (less salty fast food), regular exercise (walking, biking), and increased relaxation. After he discovered that I had never tried any specific relaxation technique, he advised me to enroll in a Transcendental Meditation (TM) course. His advice was based on review of the hypertension treatment literature showing that TM appeared to be an effective intervention for some patients. I was at first skeptical about signing up for a course that appeared to be based on a mystical, Eastern philosophy, with its emphasis on training the "mind" to relax. The philosophy embraced by TM practitioners was in sharp conflict with my training as a budding behavioral psychologist, in which overt behavior was considered more scientifically objective than anything to do with subjective mental states, much less the "mind."

After walking out of the introductory TM lecture presented by white men in black suits (in sharp contrast with the informal dress favored by everyone else living in Madison, Wisconsin, during this era of Vietnam protests on campus), I returned to my lab and the academic safety of my Ivory Tower office. One of my graduate students asked, "Well, did you try TM?" After I replied that I left the introductory lecture in frustration before trying the meditation technique, she said, "Well, I thought you were an empiricist—shouldn't you at least try it once before you reject it out of hand?" Reflecting on her wisdom, I returned to the TM center and registered to take the meditation course. During my first meditation experience, I was given a Sanskrit mantra and asked to repeat it silently during the 20-minute meditation period. After meditating for about 10 minutes, I was surprised to find myself feeling more relaxed, both mentally and physically, than I had ever felt before. Feeling more motivated and encouraged by this experience, I began to meditate on a regular basis (two 20-minute periods daily). The results were impressive, even for a behavioral empiricist: I felt more relaxed and centered during this period, and my blood pressure dropped to the point that my physician decided that I would not need any hypertension medication. "Sometimes meditation works better than medication," he said, pleased with the results.

I continued to practice TM for the next year or so, and my ability to relax in the face of continued academic pressure improved considerably. I also began reading the developing research literature documenting that the practice of meditation elicited a physiological "relaxation response," defined by Benson (1975) as a deep hypometabolic state associated with decreased reactions of somatic stress (documented by drops in stress hormone levels, synchronized EEG responding, etc.). As a scientist, I was impressed with the empirical findings supporting meditation as a practical method of inducing relaxation and reducing stress. As a clinical psychologist, however, I found myself disappointed with the lack of theory in the TM literature about meditation as a technique to alter psychological and behavioral problems. My disappointment disappeared one day in the fall of 1971, when a friend and colleague gave me a copy of a book, entitled

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Meditation in Action, written by the Tibetan Buddhist teacher Chogyam Trungpa (1968).

TM continues to be practiced worldwide and has generated considerable research, including studies documenting the effectiveness of TM in the treatment of addiction problems (O'Connell & Alexander, 1994). My own interest in meditation was stimulated even further by my immersion in the works of Trungpa and a developing understanding of basic Buddhist philosophy. As I continued my reading, I became aware that the Buddhist literature offers considerable insight into the basic nature of addiction, how addictive behavior develops, and how meditation can be used as a method of transcending a wide variety of addiction problems. After moving to the University of Washington in 1972, several of my graduate students and I began conducting preliminary studies designed to investigate the effectiveness of meditation as a preventive intervention for high-risk drinkers (Marlatt & Marques, 1977).

In our first study (Marlatt, Pagano, Rose, & Marques, 1984), we randomly assigned college student volunteers who met our screening criteria as heavy drinkers to one of three relaxation techniques: meditation (a mantra-based meditation technique similar to TM), deep muscle relaxation (based on Jacobson's technique as used in systematic desensitization), or daily periods of quiet recreational reading. Compared to those in the control group (self-monitoring of daily drinking only), participants in all three relaxation conditions showed a significant reduction in daily alcohol consumption. Those in the meditation group, however, showed the most consistent and reliable reductions in drinking over the 6-week intervention period (with an average decrease of 50% in daily alcohol consumption). These findings were replicated in a subsequent study, also conducted with heavy drinkers, that compared meditation with aerobic exercise. The results showed that both meditation and exercise were associated with significant drops in daily alcohol consumption (Murphy, Pagano, & Marlatt, 1986). These findings prompted me to include meditation and exercise as potential alternatives to addictive behavior in helping clients develop a "balanced lifestyle." Lifestyle balance later became an integral component in the development of our relapse prevention model (Marlatt, 1985).

In the years that followed, I became increasingly interested in studying Buddhist philosophy as a model of understanding both the roots of addiction and its remedy through meditation practice. As the impact of cognitive psychology on behavior therapy increased throughout the 1980s, I became more aware of the parallels between Buddhist teachings and the emerging field of cognitive-behavioral therapy. As a means of directly observing the "behavior of the mind," meditation offered many advantages as a technique for self-monitoring thoughts and feelings in an atmosphere of acceptance and nonjudgmental objectivity. Encouraged by my reading, I made a commitment to take additional meditation training by attending a series of 10-day Buddhist meditation retreats. Participation in these courses requires intensive meditation practice (both sitting and walking meditation) for many hours each day. These retreats are usually held in total silence, except for brief talks by the teachers, who provide both meditation instructions and evening dharma talks (based on the Buddha's teachings) to highlight the essentials of Buddhist philosophy.

Beginning in 1978, I attended a series of these 10-day retreats based on Vipassana meditation, a Buddhist practice that dates back to the Buddha's original teachings some 2,500 years ago. The retreats I attended were directed by outstanding Buddhist teachers, including Ruth Denison, S. N. Goenka, Joseph Goldstein, and, most recently, Pema Chodron (a former student of the late Chogyam Trungpa and author of the influential Buddhist text *When Things Fall Apart*; Chodron, 1998). I also attended a 5-day retreat taught by the renowned Vietnamese Buddhist teacher and author, Thich Nhat Hahn, on the topic of integrating meditation and psychotherapy practice. I will always remain indebted to these teachers for opening my mind to the dharma and the practice of Buddhist meditation. At the end of one retreat, I asked my teacher, S. N. Goenka (influential for his teaching of Vipassana) about the nature of addiction. I first told him that in the U.S., addiction is usually defined as a biological disease, based on genetic inheritance and other biomedical vulnerabilities. He smiled when I asked him how Buddhists view the problem of addiction. "Yes, addiction is a disease—a disease of the mind." According to Goenka and other Buddhist teachers, the roots of addiction are in the mind, even though the consequences of addiction often include considerable damage to the body, including such disease states as cancer (from smoking), cirrhosis of the liver (from drinking), or even AIDS (via transmission of HIV by shared needle-use among injection drug users). The following section provides a more detailed account of the Buddhist model of addiction.

The Buddhist Model of Addiction

The following material is based on a review article by Groves and Farmer (1994), "Buddhism and Addictions." These authors point out that from the Buddhist perspective, addiction represents a "false refuge" from the pain and suffering of life. In accordance with the First Noble Truth, as outlined by Kumar (2002), "suffering is ubiquitous" and is experienced in multiple ways as pain, misery, and the anxiety associated with life change or existence in general. In addition to the actual here-and-now experience of suffering, Groves and Farmer also include the

experience of "potential suffering, the fear that something may happen to mar current happiness or cause some future displeasure, perhaps worry over where the next 'fix' will come from" (p. 184). According to this perspective, engaging in drug use or other addictive behaviors is a "false refuge" because it is motivated by a strong desire or "craving" for relief from suffering, despite the fact that continued involvement in the addictive behavior increases pain and suffering in the long run. The immediate consequences of engaging in addictive behavior provide only a temporary refuge by enabling the user to avoid or escape suffering and other negative emotional states. Addictive behaviors provide "temporary refuge" because of their promise for relatively immediate relief from suffering, either by enhancing positive emotional states (the positive reinforcement of getting "high") and/or eliminating negative emotional states (the negative reinforcement of escaping or avoiding feeling "low").

The potential for addiction is enhanced to the extent that the individual becomes increasingly dependent on or "attached" to the behavior that appears to offer refuge and relief from suffering. As this attachment to the addictive behavior or substance grows, the individual is likely to experience increased "craving" for the anticipated relief associated with engaging in the addictive behavior. Craving can be experienced either as a desire to continue or prolong a pleasant experience (continue the "high") or to avoid or escape an unpleasant state (alleviate the "low"). Because craving is directed toward the future (anticipation of immediate positive or negative reinforcement), the addict becomes trapped in his or her attachment or "clinging" to the addictive behavior as the only source of relief from present or potential suffering. The addicted mind becomes fixed on the future ("When will I get my next fix?"), and the individual is less likely to accept what is happening in the present moment. As one experienced meditator explained to a skeptical novice, "In meditation, nothing happens next. This is it!"

Buddhism provides an alternative to the moral or disease models of addiction. It is assumed that the individual is trapped in this "false refuge" because of their "ignorance" or lack of understanding of how the dependency developed and how to become free of its grasp of attachment. As stated by Groves and Farmer (1994, p. 187):

> According to Buddhism people resort to false refuges not out of sinfulness, but rather out of ignorance—they believe they will make them happy whereas in reality they tend to lead to more suffering. Thus people are not to be blamed; rather Buddhism promotes an attitude of compassion which may be helpful when working with people with problems of addiction.

The Four Noble Truths can be applied to understanding both the roots of addiction and the pathway to recovery and eventual enlightenment. Suffering and pain, essential to the life experience (First Noble Truth), are caused by craving and attachment (Second Noble Truth). Addiction is viewed not as a physical disease, but as a particularly intense form of the attachment process, which in turn is based on an incorrect understanding (ignorance that the addictive behavior is only a temporary or "false" refuge). The Third Noble Truth states the possibility of the cessation of suffering, based on "the complete fading-away and extinction of this craving, its forsaking and abandonment, liberation from it, detachment from it" (Groves & Farmer, 1994, p. 186). The pathway out of craving, addiction, and suffering is spelled out in the Fourth Noble Truth, which describes the Eightfold Noble Path leading toward enlightenment: right vision, conception, speech, conduct, livelihood, effort, mindfulness, and concentration (Kumar, 2002). Meditation provides the vehicle to follow this pathway from the heavy burden of addiction to the freedom of enlightenment. Ignorance can be replaced by a combination of "right conception or understanding" as to the true nature of addiction and the development of new coping skills (right conduct, or "skillful means"). As such, the practice of meditation and following the Eightfold Path offers a clear and distinctive alternative to the 12-steps approach and the disease model of addiction:

> Buddhism offers a spiritual but non-theistic alternative to the theism implicit in the 12-steps approach. This may be important for not just Buddhists with an addiction problem, but also the many addicts who reject a theistic approach. Also unlike the disease model, people are seen as having the ability to choose and take responsibility for their actions. The attempt to change, unlike much contemporary therapy, is not primarily problem orientated. The main focus is creating well-being through practicing skillful behavior and cultivating skillful mental states. (Groves & Farmer, 1994, p. 191)

Clinical Applications

In my work with clients with addictive behavior problems (in the context of individual private practice), I often draw upon my knowledge and experience of Buddhist philosophy and meditation. In some cases, I have taught clients how to meditate using awareness of the breath as the center of attention. In my practice, I offer clients a menu of stress-management options as part of the lifestyle balance intervention (Marlatt, 1985). A typical choice includes meditation, muscle relaxation/yoga, walking and aerobic exercise. All techniques are recommended on the basis of their relative empirical support

and practicality in terms of the client's background and current lifestyle. Meditation and yoga are described as effective in terms of enhancing a "positive psychology" approach associated with Buddhist teachings (Levine, 2000). For clients who continue to utilize and benefit from the practice of meditation, I describe how it links to certain Buddhist principles that might be helpful in managing their addictive behavior. In the section that follows, I describe four topic areas that provide a clear link between basic Buddhist principles and their application to cognitive-behavioral interventions. A more detailed account of how meditation can be used as an adjunct to psychotherapy is provided elsewhere (Marlatt, 1994; Marlatt & Kristeller, 1999).

Mindfulness Meditation

The practice of meditation is an antidote to addiction because it enhances mindfulness, or awareness of the behavior of the mind. As described by Kumar (2002), mindfulness is described as a "nonjudgmental, present-centered awareness. . . . This awareness is directed toward all thoughts, feelings, and sensations that occur during practice" (p. 42). Others have described mindfulness as "attentional control" (Teasdale, Segal, & Williams, 1995) in which the meditator develops a metacognitive state of detached awareness. The goal of mindfulness training is not to change the content of thoughts (as in cognitive therapy), but to develop a different attitude or relationship to thoughts and feelings as they occur in the mind:

> Unlike CBT [cognitive behavior therapy], there is little emphasis in MBCT [mindfulness-based cognitive therapy] on changing the contents of thoughts; rather, the emphasis is on changing awareness of and relationship to thoughts. . . . The focus of MBCT is to teach individuals to become more aware of thoughts and feelings and to relate to them in a wider, decentered perspective as "mental events" rather than aspects of the self or as necessarily accurate reflections of reality. (Teasdale et al., 2000)

Mindfulness meditation is similar to the traditional behavioral technique of self-monitoring (Thoresen & Mahoney, 1974) or, in this case, "thought monitoring." Meditation practice helps clients with addictive behavior problems to develop a detached awareness of thoughts, without "overidentifying" with them or reacting to them in an automatic, habitual manner. Urges and cravings can be monitored and observed without "giving in" and engaging in the addictive behavior in an impulsive manner. Meditation creates a space of mindful awareness and enhances the cultivation of alternatives to mindless, compulsive behavior. As stated by Groves and Farmer (1994), "In the context of addictions, mindfulness might mean becoming aware of triggers for craving . . . and choosing to do something else which might ameliorate or prevent craving, so weakening this habitual response" (p. 189).

One of my clients, a woman who sought help for her co-occurring problems of alcohol dependence and depression, described the effects of mindfulness meditation as follows: "I still have urges to drink excessively, but when this thought occurs, I tell myself that I do not have to be dictated to by my thoughts. I just accept that the urge is occurring, but I don't have to act on it automatically. I just focus on my breath until the urge passes."

I reminded her that the term "addiction" has the same Latin origin (*decere*, translated as "diction") as the term "dictation" or "dictator." She responded by saying that she was beginning to feel a new form of freedom and was no longer subject to the dictation of her addictive thoughts and feelings.

Other clients have described the successful use of "urge surfing" as a mindfulness technique (Marlatt, 1985, 1994). Clients are taught to visualize the urge as an ocean wave that begins as a small wavelet and gradually builds up to a large cresting wave. As the urge wave grows in strength, the client's goal is to surf the urge by allowing it to pass without being "wiped out" by giving into it. I tell clients that urges are often conditioned responses triggered by cues and high-risk situations. Like a wave, the conditioned response grows in intensity until it reaches a peak level of craving. Giving in to the urge when it peaks only serves to further reinforce the addictive behavior. Not acting on the urge, on the other hand, weakens the addictive conditioning and strengthens acceptance and self-efficacy. Like any skill, learning how to "urge surf" takes practice and improves over time as the client attains greater balance on the mindfulness surfboard.

The Middle Way

In the description of the historical origins of Buddhism, Kumar (2002) notes that Siddharta Gautama was "born and raised in a sheltered life of luxury and ease" until he later was "confronted by the ubiquity of suffering evident in the forms of poor, sick, aged, and dying people" (p. 41). In response to this realization, the future Buddha resolved to renounce his worldly life and spent the next 6 years as a wandering ascetic who engaged in extreme forms of self-mortification (self-starvation and avoidance of all bodily pleasures). It was only after his experience of enlightenment under the banyan tree that he gave up both the extremes of self-indulgence on the one hand, and ascetic self-mortification on the other, and adopted a "middle-way" position. This middle way represents a position of mindful balance or moderation between the otherwise polarized extremes and continues to be a centerpiece of the dharmic teachings.

The addiction field is also marked by a polarization between opposites. In traditional treatment programs, cli-

ents are told that they have a choice between total abstinence or giving in to the clutches of an irreversible, progressive, and ultimately fatal disease. From this polarized perspective, there is no room for the middle way of moderation. This dichotomy between abstinence (success) and relapse (failure) often contributes to the client's being caught in a vicious cycle of restraint (control) and drug use (loss of control), leading to a revolving-door pattern of abstinence and relapse. The inability to maintain total abstinence often pushes clients to the other extreme of uncontrolled relapse, especially if they blame themselves for their failure (as in the "abstinence violation effect"). For clients who are unable to maintain abstinence, it is helpful to distinguish between a single episode of the addictive behavior (defined in the relapse prevention model as a "lapse") and a full-blown relapse. In this terminology, experiencing a lapse can be viewed as a middle-way alternative between total abstinence and uncontrolled relapse. Clients can be taught coping skills to regain balance and recover from lapses before they escalate into a greater pattern of relapse.

The middle-way philosophy is also congruent with a harm-reduction approach for clients who are unable or unwilling to adopt an abstinence goal. Harm reduction techniques are designed to reduce the harmful consequences of addictive behaviors (Marlatt, 1998). One such method involves teaching clients how to successfully moderate their alcohol or drug use in order to reduce the risk of adverse or harmful effects. In our own research, we have successfully applied a cognitive-behavioral moderation training program for young adults who have engaged in frequent binge drinking behavior, often associated with a wide range of harmful consequences (i.e., injuries, accidents, blackouts, sexual assault and violence). Although the majority of these high-risk drinkers reject abstinence as a personal choice, they show significant improvement in reducing excessive drinking and its negative consequences through their participation in a brief harm-reduction prevention program (Baer et al., 2001; Dimeff, Baer, Kivlahan, & Marlatt, 1999; Marlatt et al., 1998). For many of our clients, harm reduction offers an attractive middle-way alternative between either abstinence or continuing to drink in a chaotic and uncontrolled manner.

The Doctrine of Impermanence

Addiction can be defined as an inability to accept impermanence. At one level, the addict seeks a permanent high. As stated by Kumar (2002), "It is in trying to hold on to the stability of a passing moment . . . we struggle against the natural impermanence of all phenomena. . . ." (p. 41–42). The impermanence of all phenomena needs to be contextualized in the impermanence of life itself. As stated earlier, clients with addiction problems are fixated on the future ("When will I get my next fix?") and are often dissatisfied with the here-and-now of ordinary life experiences. Dependence on the addictive behavior locks the individual into a state of attachment to an activity or substance marked by an anticipation of continued and future satisfaction. Without continued access to the addictive substance, the experience of ongoing activities in the present moment is rendered unsatisfactory, a reaction that may be exacerbated by withdrawal symptoms and/or exposure to stressful situations previously associated with drug use. As a result, the addicted client desires to prolong the high, to make the addictive experience last as long as possible. Along with this desire for a permanent high, clients have little patience for enduring negative emotional states without engaging in the addictive behavior as a form of escape or avoidance.

The practice of mindful meditation helps the client accept the basic impermanence of all human experiences. In observing the mind's behavior, the meditator comes to realize that thoughts, feelings, and images are constantly changing. Pleasant thoughts arise and pass away, as do negative thoughts and emotions. Nothing remains the same over time in this atmosphere of constant change. Clients who gain this knowledge of impermanence are often liberated from their psychological dependency on the addictive behavior as a means of regulating or controlling their mood. As one client told me, "If things are always changing, my negative moods will also change over time. Meditation helps me to let go and allow these natural changes to occur, without worrying about how I will try to control them through my drug use. The same goes for feeling high. I cannot stay high all the time, so I get caught in planning where and when I will be able to get high again. The truth is, I'll never achieve permanent satisfaction. Just knowing that things are always changing is a big load off my mind." For this client, the practice of meditation allowed him to accept the basic impermanence of existence and facilitated his acceptance of the here-and-now of daily life experiences. As stated by Groves and Farmer (1994):

> An important right view and a central theme in Buddhism is the omnipresence of impermanence—all things change, be they trees, mountains, people or relationships, which opens up the possibility of beneficial change. Similarly change is an important concept in explaining and altering addictive behavior. . . . [T]he stress on potential for change shifts emphasis from overly static concepts of personality which can lead to therapeutic nihilism in the addictions field. (p. 187)

Compassion and the Eight-Fold Path

Buddhist philosophy holds that the pathway to liberation and enlightenment lies in following the Noble Eight-

Fold Path. Progress along the path involves the development of a new set of attitudes or beliefs as well as engaging in behaviors that heighten awareness and balance. Several steps along the path refer to developing the "right" attitude toward all life experiences, including right vision, right conception, and right mindfulness and concentration. Other steps focus more on behavior, such as "right speech, right conduct, right livelihood, and right effort" (Kumar, 2002). Each of these steps refers to various aspects of the dharma and essentials of Buddhist philosophy (e.g., right mindfulness). For example, understanding the concept of impermanence is considered an essential component of right conception (or right understanding). Spiritual seekers are encouraged to follow these principles in order to attain enlightenment, but they are also useful guidelines for directing the progress of therapy.

Right mindfulness is also linked with an attitude of compassion toward the suffering experienced by oneself and others. As stated by Kumar (2002):

> Compassion involves cultivating an attitude of universal, unconditional acceptance. With this attitude, essentialist boundaries that define self and other tend to dissipate as one develops compassionate equanimity toward all living beings . . .
>
> . . . Indeed, mindfulness and compassion are frequently discussed as two intertwined aspects of practice in Buddhist literature. . . . (p. 42)

The development of mindful compassion is helpful for both the client and therapist in addiction treatment. Clients can foster an attitude of acceptance toward themselves and their behaviors. Therapists who show compassion and empathy for their clients are more likely to succeed than those who adopt a critical and confrontational approach (Miller & Rollnick, 1991). Recent advances in the cognitive-behavioral treatment of addictive behaviors are consistent with a more compassionate approach than many traditional "intervention" approaches. The moral model, as exemplified by the current War on Drugs, is particularly lacking in compassion.

From the Buddhist perspective, several new and emerging treatment programs offer clients a compassionate and pragmatic alternative. In harm reduction therapy (Denning, 2000; Marlatt, 1998), therapists attempt to meet clients "where they are at" in terms of their current addictive behavior to provide empathic and understanding support for any positive changes in the client's behavior. Small steps to reduce harmful consequences are encouraged (e.g., participation in a needle-exchange program, enrollment in a methadone program, training for moderate drinking, etc.) rather than insisting upon total abstinence as the first step. Harm reduction is characterized by compassionate pragmatism, an approach that is also compatible with Buddhist teachings. As Groves and Farmer conclude, ". . . the Buddha's attitude to the relevance of his teaching was one of pragmatism—if it helped, then use it" (p. 191).

The impact of right effort, or right motivation, in the Eight-Fold Path is also implicit in the influential stages-of-change model of addictive behavior change proposed by Prochaska, DiClemente, and Norcross (1992). Clients often move through these various stages depending on their motivational level, from little or no motivation to change (precontemplation), to ambivalent or conflicted motivation (contemplation), before entering the action stage of taking specific steps to change their addictive behavior. Again, therapists who match their intervention strategies to the client's current stage of change appear to be more successful than those who insist on "action" (commitment to abstinence) when clients are not ready or able to benefit from a confrontational approach. In recent years, motivational enhancement therapy (MET) has been increasingly used as a method of enhancing movement through these motivational stages (Miller & Rollnick, 1991). MET is characterized by an attitude of compassion and acceptance on the part of the therapist as the client is guided through the stages-of-change process.

Conclusion

Buddhist philosophy has much to offer the addictions treatment field. The parallels between the dharma and cognitive-behavioral treatment approaches suggest that these two disciplines have much in common. Traditional treatment programs are based on the disease model (i.e., that addiction is a disease of the brain). This approach is based on the assumption that addiction is rooted in biological factors beyond the individual's control. The 12-step philosophy requires acceptance of personal "helplessness" and that abstinence and the need to rely upon an external Higher Power are the only means of resolving the problem. In contrast, Buddhist philosophy teaches us that although addiction can have debilitating disease consequences (e.g., cancer, cirrhosis, central nervous system disorders), the roots of addiction are in the mind. Meditation and other Buddhist practices are essential to understanding how the mind behaves and how thoughts and expectations can either facilitate or reduce the occurrence of addictive behavior.

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Zen Principles and Mindfulness Practice in Dialectical Behavior Therapy

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Dialectical behavior therapy (DBT; Linehan, 1993a) was developed as a treatment for borderline personality disorder (BPD). It involves a dialectical synthesis of the change-oriented strategies of cognitive-behavioral therapy with more acceptance-oriented principles and strategies adapted primarily from client-centered therapy and from Zen. In this paper, I note both similarities and contrasts between cognitive-behavioral therapy and Zen. I then highlight the role of Zen principles in DBT's assumptions about patients, theory of BPD, selection of treatment targets, and treatment strategies. Finally, the article describes the value of mindfulness practice for patients with BPD, how mindfulness skills are taught to patients in DBT, and benefits of mindfulness practice for therapists.

BEHAVIOR THERAPY and Buddhist thought might appear to be radically different, perhaps even contradictory, in their approaches to understanding and changing behavior. For example, behavior therapy traditionally has focused on overt behavior and other observable variables and the Western scientific method of advancing knowledge, whereas Buddhist thought and most other religious traditions have been concerned primarily with mental and spiritual phenomena and propose an experiential path to understanding and changing behavior. However, as this series attests, there is growing interest among behavior therapists and cognitive behavior therapists in the potential contributions of spiritual traditions, particularly Buddhism.

At least one form of behavior therapy, dialectical behavior therapy (DBT; Linehan, 1993a) for persons diagnosed with borderline personality disorder (BPD), ex-

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