Chapter 19
Religion, Spirituality, and Mental Health: Toward a Preventive Model Based on the Cultivation of Basic Human Values

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These are exciting times for our understanding of mental health. Our knowledge is expanding, and long-held views and assumptions are giving way as recent discoveries highlight the ability of mental practices (including religious and spiritual practices) to affect brain, body, and behavior in ways that would have appeared impossible—perhaps even magical—just a few decades ago. Our conception of mental health is widening to include flourishing and positive well-being, and we are beginning to recognize the interrelation between the promotion of flourishing and the prevention of mental illness and dysfunction.

These changes have numerous implications, implications that go beyond what most of us can foresee. In this chapter, I examine a few of the implications for study of the relationship between religion and mental health. My focus will be on research that suggests that a significant factor in the relationship between mental health and religious belief, practice, and communal belonging has to do with the cultivation of moral emotions and ethical values. The implications of this research extend beyond religious people, because moral emotions and values can be cultivated by anyone and are relevant to the flourishing of everyone. The relationship between religion and mental health, therefore, has wide relevance to the promotion of flourishing and in the provision of preventive mental health care on both an individual and public health level.

"Mental Health" and Cartesian Dualism

Following the legacy of Descartes, modern thought in the West has until recently drawn a rigid line between the mental and physical realms. While the body has been seen as part of the physical, material, and mechanistic order of the universe, following natural laws and therefore available to study through observation, the mind has been seen as the seat of the soul and of free will, something immaterial, mysterious, and not constrained by the causal, deterministic nature of external reality. The legacy of this thinking still affects our thought and our disciplines. It continues to inform our understanding of physical and mental health; it is the reason that we have the mind/body problem and the "explanatory gap" in the cognitive and neurosciences, and it lies behind our division of the *Geisteswisssenschaften* (the humanities, social sciences, and religious studies) from the *Naturwissenschaften* (the "hard" sciences).

But Descartes's division of the world into two "substances" of mind and body, one extended and one not, has been thrown into question in recent years.[1] It is now widely accepted that mind and body are deeply interconnected, and that this interconnectedness has deep implications for our understanding of mental and physical health.[2] Furthermore, rather than a distinct "substance" set apart from matter, consciousness can be understood as the subjective pole for the objective world of physical matter, meaning that subjectivity and objectivity mutually entail each other, like two sides of a sheet of paper. From a health perspective, thoughts, feelings, emotions, memories, hopes, and even the processes of meaning-making can no longer be considered exclusively mental phenomena; rather, they have a direct impact on our bodies and should therefore be incorporated into a holistic approach to health. We are similarly realizing that the conditions of our bodies affect our cognition, emotions, and decision-making processes in ways so powerful that they are calling into question our very notion of selfhood.[3]

The relationship between mind and body is relevant for understanding the relationship between religion and health for several reasons. For one thing, religion is typically placed within the realm of the *Geisteswissenschaften*. It is something we associate with culture, with societies, with beliefs and the mind, not typically with physical objects and physical laws—although there is, of course, a very material and embodied dimension to religion and religious practice, a reality to which many of the chapters in Part One of this book give testimony. But religion is also of interest in this context because most religions understand health not merely in a negative sense—as the absence of disease and dysfunction—but also in a positive and holistic sense—as a state of well-being and flourishing. Indeed, the ultimate goal of many religious traditions is the attainment of what we could conceptualize as a complete state of physical and mental health—be it referred to as a state of complete harmony, enlightenment, liberation, salvation, sanctification, or resurrection.

This is important because, especially in fields related to mental health, there is a growing sense that a purely negative definition of health—that is, one that defines mental health as merely the absence of mental illnesses and disorders—is too narrow.[4] An absence of illness, we are discovering, is only part of the picture. The other part is the cultivation of constructive mental states and traits—such as compassion, gratitude, forgiveness, and generosity—and the presence of positive social relations, which not only give life greater meaning and value but also appear to serve as preventive factors for both mental and physical disease. The remarkable reception that the subdiscipline of positive psychology has received from the public and the increasing number of studies on compassion, empathy, gratitude, and other constructive emotions appearing each year serve as a testament to this growing awareness. This move away from the diagnosis and treatment of disorders—important as that will remain—toward the promotion of flourishing and

positive mental health moves us into the realm of what *could* be, or what *should* be, for us as individuals and as societies. This begins to verge on territory that has long been considered the domain of religion and spirituality.

Religion and Spirituality

While numerous disciplines seek to envision a positive definition of health, a similar movement can be detected in medical anthropology and the medical humanities in the concern being shown for the increased medicalization of suffering, whereby existential problems such as loneliness, fear of death, dysphoria, and so on are seen as illnesses to be treated, rather than aspects of life to be confronted in a productive manner.[5] How, then, are we to recognize the relevance to our health of our minds and all that they entail—meaning, emotions, attitudes, ways of perceiving—without being limited to a negative definition of health?

Religions may offer resources to fulfill the basic emotional and social needs that are fundamental to our health and well-being as human beings and social animals. In examining these resources, it can be helpful to look not just at religion as an overarching concept, but also at the specific dimensions of religion that may contribute to or impede health.[6] When we do so, we may find that some of the benefits and disadvantages of religious membership and practice may be factors that are not unique to religion. The putative benefits of church attendance for mental health, for example, may be due to a number of factors, including the benefits conferred by membership in a community and a sense of belonging, the social support offered by the religious group, the group's nonreligious practices or beliefs, or religious practices or beliefs held by the community. All of these might be beneficial to the mental health of individuals who belong to the community, but only the last two would actually pertain directly to religion.

Many recent studies, such as Sharp's recent study on prayer,[7] have attempted to tease out the elements of religious membership and practice in just this way. In a longitudinal study of 114 Catholics and Protestants, Miller and colleagues found that those who reported that religion or spirituality was highly important to them had about one-fourth the risk of experiencing major depression ten years later compared with other participants; neither religious attendance nor denomination significantly predicted this outcome.[8] Remarkably, among those identified as being at high risk for developing depression (in this case due to having had a depressed parent), those who rated religion or spirituality as highly important had one-tenth the risk of experiencing major depression ten years on. If attendance at services and the type of religion practiced were not significant factors in this effect, then what aspect of religiosity or spirituality was protective?

As I have argued elsewhere,[9] it is quite possible that many of the protective and beneficial aspects of religious membership, practice, and belief for mental health may stem from what are essentially nonreligious factors that are effective because they tap into aspects of our embodied cognition—or "embodied cognitive logics"—that actually precede their adoption by the specific religion. Practices such as bowing and prayer, for example, are found across religious traditions; this is likely because they tap into aspects of embodied and grounded cognition that are cross-cultural and not irreducibly religious.[10] In other words, bowing (lowering oneself with regard to an object or person to whom one wishes to pay respect) is conducive to developing humility, respect, and devotion—values that most religions seek to inculcate in their members. It makes sense that religions would co-opt such practices or that particular practices would exapt—be drawn upon to fill a new purpose—in a religious setting; if so, they could also be once again removed from their religious contexts while still retaining some of their effects.

Some of these practices might have nothing to do with spirituality or religion, but others might be spiritual in a broad sense while not necessarily being religious—for example, the basic attitudes, values, and emotions that contribute to the mental health and flourishing of an individual may not necessarily be tied to a specific religion. In support of this view, McCullough and Willoughby argue that many of the health benefits of religiosity may be attributed to self-control and self-regulation, values that are taught by all major world religions but that are not, in themselves, necessarily religious values.[11]

This does not mean that religions have nothing to offer when it comes to our understanding of positive mental health. On the contrary, if religions have developed methods that foster the factors that promote flourishing, then there is all the more reason to study them. Moreover, although the study of these beneficial factors has increased in recent years, for example in the rise of positive psychology, there remain interesting disparities between the ways religions (and secularized practices drawn from religion) bolster these factors and the way they are promoted through positive psychology interventions. The mental states and emotions considered constructive and beneficial in religious traditions are not necessarily the same as the "positive emotions" identified by psychology—at least if we understand those emotions in terms of positive affect. Indeed, religious traditions are often suspicious of the pursuit of *hedonia* (understood as good feelings, pleasure, and positive affect), and instead promote the pursuit of a vision of *eudaimonia* (a state of positive functioning, of being in right relationships with others and oneself). Moreover, negative affect, such as feelings of shame and sadness, are often intentionally induced in religious practices; while these feelings and practices produce a short-term reduction of hedonia, they ultimately—in the eyes of their adherents—lead to an increase of eudaimonia. The Japanese practice of *Naikan*, in which practitioners reflect on what they have

received from others, what they have given to others, and what trouble they have caused others—a process that creates strong feelings of guilt and regret, and yet leads to physical and emotional healing—is but one example.[12] These practices appear to spring from an understanding that some constructive emotions, such as compassion, depend on the ability to experience negative affect (sadness at seeing the suffering of another). Therefore, the paradigm of constructive vs. destructive emotions in religious traditions does not correspond to the paradigm of positive vs. negative emotions in contemporary psychology, and future research should attend to this difference.

More recently, the Dalai Lama has argued that certain constructive emotions and traits, such as self-control, compassion, gratitude, and forgiveness, comprise universal basic human values that can be drawn upon in constructing a "secular spirituality" or "secular ethics" for our pluralistic world.[13] These values, which are also skills that can be embodied and cultivated through training, are basic for human survival and contribute to both individual and social flourishing; moreover, they can be cultivated by individuals regardless of their religious tradition or lack thereof. For this reason, the Dalai Lama would likely be sympathetic to McCullough and Willoughby's argument. He has also urged scientists and researchers to examine the nature of these constructive values and emotions and their impact on health, focusing in particular on compassion.

It is important to note that the term *secular* here refers to a nonpartial attitude toward all religious and spiritual traditions, and not to the rejection of religion. Secular in this sense is not the opposite of religious and does not mean not religious; rather, it is the opposite of the promotion of one religion over and above other viewpoints. We may distinguish between what could be called a full or pluralistic secularism model, in which members of diverse religious and

cultural traditions are encouraged to show and express their distinctiveness in the public arena and diversity is acknowledged and celebrated, and a minimal secularism model, in which religious and cultural expressions and identities are kept out of public spaces. Both versions of secularism have their challenges: the challenge of a full secularism is to accommodate all religious and cultural views in a respectful way that does not privilege some over others; the challenge of a minimal secularism is that it may end up merely masking the values and beliefs that shape this supposedly religion-free space. Which route a society decides to take likely depends on how its history has been marked by religion.

Compassion, Social Cognition, and Mental Health

In order to evaluate whether the basic human values promoted in religions can contribute to flourishing, we need to engage in research that asks whether such values and moral emotions can be cultivated and whether their cultivation results in measurable physiological, psychological, and behavioral changes. Such research contributes not only to positive psychology and our understanding of physical and mental health, but to the study of religion, since these values are of central importance to all of the world religions.

In 2005, Emory University launched a research program designed to address this question by examining the benefits of actively cultivating one such value, compassion, through a meditation protocol created by Geshe Lobsang Tenzin Negi. Drawn from a specific religion, Tibetan Buddhism, the practice was secularized by excluding any aspects that would be considered specifically Buddhist, such as belief in past and future lives, rebirth, enlightenment, divine or enlightened beings, spiritual teachers, the idea of *karma*, and so on. The protocol, called Cognitively-Based Compassion Training (CBCT), can be seen as normative in that it

promotes the cultivation of compassion for oneself and others and sets this cultivation as the goal of the practice.

Two studies by Pace and colleagues, one published in 2009 and the other in 2010, suggest that the practice of the CBCT protocol among undergraduates reduced neuroendocrine, inflammatory, and behavioral responses to psychosocial stress that are linked to the development of a large number of mental and physical illnesses.[14] Since this initial study, additional studies with adults, foster children aged 13–16, and elementary school children aged 5–9, suggest that compassion can be cultivated as a trainable skill and doing so may lead to a number of positive benefits, including increasing empathic accuracy and feelings of hopefulness, improving immune function, and reducing reduced symptoms of depression.[15]

The idea of secular compassion training is of broad interest, because it reflects an attempt to draw from a religious tradition a specific practice that can contribute to mental and physical well-being and that can be employed by most , regardless of religious affiliation. The values of compassion, a sense of connection with others, forgiveness, gratitude, and responsibility towards others and the skills involved in intentionally cultivating these values can indeed be seen as religious in the sense that they lie at the heart of most, if not all, major religious traditions. At the same time, because they are not the exclusive domain of any one religion, and because they can be cultivated by anyone, including nonreligious individuals, they can also be seen as entirely secular or as related to spirituality but not (necessarily) religion, if spirituality is understood as being comprised of the basic human values that are shared by diverse humanistic and religious traditions. This is not the most common definition of spirituality, but it is a useful one. Nancy Ammerman notes that spirituality is commonly understood in one of four ways: through a "theistic" package, an "extra-theistic package" of transcendence, an "ethical spirituality"

focusing on everyday compassion, or a "belief and belonging" package tied to cultural notions of religiosity.[16] Secular programs like CBCT can be seen as cultivating "ethical spirituality." This aligns with the Dalai Lama's claim that the cultivation of compassion can serve as the basic for a "secular ethics" or "secular spirituality."[17]

The advantage of drawing upon contemplative practices in the teaching of ethical spirituality, or basic human values, is that it allows an approach that builds emotional and social skills that people can use for themselves, rather than simply telling them which values they should or should not have. In other words, it is about enhancing skills for moral decision making, rather than simply telling people to be compassionate, generous, or kind. For example, in the CBCT programs for elementary school children, participants are taught basic mindfulness meditation so that they can notice thoughts, emotions, and feelings as they arise. The program then goes beyond basic mindfulness approaches by teaching children to recognize these mental events as being potentially destructive or constructive. Children are asked if they know what causes a forest fire, and whether a forest fire can be easily put out before it causes destruction. Just as a spark can be easily put out if noticed early enough, they are taught, so can a destructive emotion be dealt with if one catches it early, before it results in harm to oneself and others. By learning to notice their inner mental states with greater clarity, and to attend to what is helpful or harmful (which they are encouraged to choose for themselves), children learn skills that can contribute to their well-being and gain confidence in their ability to regulate their emotions and behaviors. This is how self-compassion is understood in the CBCT protocol. The participants learn to be forest rangers of their own minds, identifying and watching out for harmful sparks that could cause problems.

After one such class, a five- or six-year-old boy spontaneously commented, “I have a lot of forest fires in my life.” One thirteen-year-old boy participating in another class explained the difference between noticing and putting out a forest fire (something harmful) and seeing a campfire that one wouldn’t need to put out (something that wasn’t necessarily harmful). In a similar way, games, plays, and stories are used to discuss other CBCT topics like impartiality, empathy and interdependence, which are then further reflected upon and internalized through meditation. The ability of young children to grasp topics like this, which have been the subject of religious practices for centuries, is most encouraging, and ongoing research is exploring the effects of these programs.[18]

Religious belief and belonging may play an important role in the establishment and cultivation of these values, but may not be the only dimensions of religion we wish to consider when examining the relationship between religion and mental health. After all, religious belief has been linked over the years with both mental health and mental illness, and religious belonging in groups with extremist or cult tendencies can be very harmful. Graham and Haidt[19] rightfully point out that a great deal of the attention paid to religion across various disciplines—not including religious studies itself, but evident particularly in subdisciplines such as the cognitive science of religion[20]—has concentrated on the role of belief. Religions are understood as belief systems, and to be religious is to be someone who holds certain beliefs about the world. They note, however, that this comprises only one dimension of religion, and that it misses the communal aspect of religion (being religious also typically means *belonging* to a community) and the element of religious practice (it also means *doing* certain things). Interestingly, Graham and Haidt stress the moral dimension of community membership: religion involves not being part of just any type of community, like participating in a book club or supporting a particular

sports team, but rather being part of a *moral* community, one that espouses certain values and aspires to embody them. In examining the health impact of such belonging, we should pay attention therefore not merely to the fact of belonging to a moral community, but to the particular values held up by that community.

Cultural psychologists who have examined morality across cultures argue for five fundamental moral dimensions: harm/care, fairness/reciprocity, in-group/loyalty, authority/respect, and purity/sanctity.[21] Of these, the central and most universal would appear to be the dimension of harm/care, because this is the most basic moral dimension of human existence, one that we can easily translate not only across cultures, but across species as well. As Frans de Waal has argued, the evolutionary roots of morality cannot be seen as uniquely human but extend outward to include at least all bird and mammal species, because these species all rely on maternal care for their survival.[22] It is therefore no wonder that we see what may be the basis for higher-level morality and moral emotions such as compassion in the behaviors non-human primates. As a result, care and protection from harm do not represent a moral dimension separate from the most basic issue of survival, but rather one that is absolutely central to it—regardless of religious belief or lack thereof. Without compassion and an emotional bond, we would simply not be able to exist. Mothers would have no reason to bear their unborn children for nine months, or to care for them after they were born. It is no wonder that our need for social connection runs so deep in our bodies and minds, and that without it we languish and suffer, both mentally and physically.

While de Waal's approach is based on our evolutionary history and comparative psychology, Philippe Rochat arrives at conclusions very much aligned with de Waal's from a developmental psychological perspective.[23] Humans do not come into the world as fully formed

adults with cognition that later takes into account other individuals and develops into social cognition; rather, our developmental trajectory begins in the womb and continues in infancy, where all cognition is inherently social. Ideas of selfhood and individual cognition emerge out of this fundamentally social matrix (of fetus in the womb and later infant dependent on caregiver), and not the other way around. Based on his research, Rochat argues that we have a basic affiliative need from birth that continues developmentally and that is central to our very conception of self. This need is so fundamental that our greatest fear is that of social rejection and social isolation, since these represent threats to our very survival.

In fact, a growing body of research is underlining the dangers of social isolation and social rejection for our mental and physical health, including a recent study of group suicides in Japan.[24] The fact that individuals would choose to commit suicide due to (or out of fear of) social rejection lends support to the argument that for many of us our greatest drive, even greater than the drive for physical survival, is for social connection, and our greatest fear, even greater than the fear of death, is social rejection. In other words, the fact that for many social death is worse than physical death means that social bonds of love, compassion, acceptance ,and care transcend concerns of mere physical survival. This is supported by evidence showing that populations who face parental and social rejection and discrimination have suicide rates much higher than the national average; in the case of gay, lesbian, and bisexual individuals, for instance, the rates can be two to eight times higher, and in the case of transgender and transsexual individuals, two hundred to three hundred times higher.[25]

The medical anthropologist Arthur Kleinman's recent work addresses concerns about the medicalization of human suffering, and his strong concern for social suffering leads him to address questions of morality and subjectivity, which for him, in line with Rochat's work, is

inherently intersubjective. For Kleinman, experience itself is both inherently interpersonal and moral. It is interpersonal because, he writes, "It is a medium in which collective and subjective processes interfuse. We are born into the flow of palpable experience. Within its symbolic meanings and social interactions our senses form into a patterned sensibility, our movements meet resistance and find directions, and our subjectivity emerges, takes shape, and reflexively shapes our local world)."[26] It is furthermore moral, he writes, "because it is the medium of engagement in everyday life in which things are at stake and in which ordinary people are deeply engaged stakeholders who have important things to lose, to gain, and to preserve."[27]

This perspective brings a richer context to the results of the studies on compassion reported previously: cultivating a greater sense of connection with others appears to affect us on a deep biological level because it touches upon something at the foundation of our survival as individuals and as a species. For too long, we have seen compassion and positive social interaction as fringe elements of what it means to be an individual human being, instead of realizing that it is the other way around: healthy individuals arise out of compassionate and caring social interactions, beginning—but not ending—with maternal care. Mental health therefore has to examine that basic need for connection, love, empathy, and compassion much more strongly. As research creates a more solid understanding of our need for such social connection and the emotions that support it, we will increasingly need resources that help repair social connection where it is missing and strengthen it where it exists. This is where religions can help, and not only for those who are religious.

Although all major religious traditions emphasize the care/harm dimension of morality in injunctions to love one another, care for the poor, and live nonviolently, we must also remember that the inclusion by religions of a variety of other moral concerns and dimensions can mask this

central core of morality, or even subvert it. As Harris points out, "Religion allows people to imagine that their concerns are moral when they are not—that is, when they have nothing to do with suffering or its alleviation."[28] In other words, religious belief, membership, and practice can reinforce basic moral emotions like compassion, but they can also subvert those moral emotions if the religion's specific code of morality overrides the basic morality of care/harm. It is precisely when this happens that outsiders to a religious group look on its members with horror: because the group condones violence against people in the name of religion (suicide bombers, stoning of women for infidelity) while violating the basic morality of harm/care, a morality so basic that it is not even unique to humans.

Ethics and Values

Exploring the connection between religion, ethical spirituality, and positive mental health is valuable from multiple perspectives. Research on how religious practices, beliefs, and communities contribute to the mental health of individuals in a "this-worldly" or secular sense improves our understanding of mental health itself. Furthermore, whereas psychology and psychiatry have typically focused on how to treat disorders and diseases, thereby bringing people from what we might call a subnormally functional state to a normally functional state, religions have typically attempted to lead believers and practitioners to states of well-being that go beyond the ordinary—to salvation, sainthood, enlightenment, liberation, for example—and to states of community that go so far beyond the ordinary that they may even appear utopian from a nonreligious perspective. This means that religions can be valuable resources for exploring the upper limits of human flourishing on both individual and collective levels.

At the same time, religions see a clear connection between the moral life and the fully healthy, flourishing life, a connection that has not been explored nearly enough in either the

health sciences or emerging subfields like positive psychology. If we conceive of morality only through a religious lens, this connection becomes obscured, because religious morality is complex, multifaceted, and different across traditions. But if we see the issue of morality as being fundamentally about suffering and its alleviation—the harm/care dimension—the connection becomes clearer.

Current measures of flourishing look at emotional, social, and psychological well-being, but these measures could be improved by reflecting the importance of the harm/care dimension to individual and social flourishing—in other words, by including the dimension of ethical spirituality. Otherwise, such measures could fail to differentiate between genuine flourishing and facsimiles of flourishing. Take, for example, the instance of a young individual who feels alone and alienated but then joins a religious cult, an extremist group, or a violent gang. Many, if not most, of the current measures in positive psychology would rate such a person as showing a marked increase in flourishing, life satisfaction, and happiness after joining the group. His mood would be elevated, and he would feel more social support, a stronger sense of meaning and direction in life, greater self-esteem, and so on. On almost all measures of emotional, social, and psychological well-being, he would show a strong improvement. Most of us would agree, however, that a diagnosis of this individual as flourishing or as exhibiting positive mental health would be incorrect. We certainly do not consider members of cults and extremist groups to be flourishing, because we naturally rebel against the idea that someone who is engaging in activities that are harming or will harm others (and that will ultimately, therefore, harm themselves), and who is therefore leading a life that violates the most important dimension of morality—the care/harm dimension—could be truly flourishing. In this way, we implicitly include ethical spirituality in our practical assessments of others' well-being. Therefore it would

be helpful to include this dimension, and all that goes with it, in formal assessments and research.

Developing a Culture of Compassion that Promotes Flourishing

Arguments over the costs and benefits of religion in the abstract for health and mental health are unlikely to be terribly fruitful. A top-down approach that sees religions as monolithic systems and mental health as a catalogue of mental illnesses may not allow much rapprochement between religion and mental health, because religions at this level are not typically concerned with the treatment of mental illness or the this-worldly promotion of mental or physical health. I have attempted to outline a bottom-up approach that sees religions as complex systems that include nonreligious elements (some of which may draw upon embodied cognitive logics), and that sees the role that the cultivation of basic human values can play in promoting positive mental health, which in turn may protect against mental illness, suicide, and other problems. On this level, we see a close connection between the resources that religions have to offer and the pressing mental health needs that face us.

The vast majority of people in the world are religious, and—despite what many proponents of the secularization thesis thought a few decades ago—that seems unlikely to change in the near future. A way forward, therefore, is to identify the underlying features of religions that are beneficial for health and those that are not, especially those features that in themselves do not require religious belief or membership. The value of such an approach is that what we learn from it has practical implications: if certain practices in a religion contribute to the cultivation of basic human values such as compassion, gratitude, self-discipline, and a sense of connection with others, then those practices can be celebrated when they occur in religious

contexts and can be adapted to nonreligious contexts where they can contribute to health beyond the confines of the religion.

This trend has already begun, of course. Yoga is now a popular practice engaged in by millions of people in the West, almost none of whom were born into a religious tradition associated with yoga or see it as a religious practice. That it began as a part of religious practice in specific religious contexts is commonly accepted. It has become, however, a secular practice. Moreover, the fact that it is a secular practice does not mean that its benefits are limited to physical health alone. Yoga practitioners—even those who are not religious—often see it as beneficial for achieving mental health and well-being as well, and for cultivating positive values such as a sense of peace, stability, acceptance, forgiveness, and so on. Similarly, the practice of meditation techniques such as mindfulness meditation or CBCT adapted from Buddhism are becoming popular primarily among non-Buddhists. Although the earlier forms of meditation that became popular in the West were not explicitly normative, practices like CBCT explicitly aim to help practitioners cultivate moral emotions like compassion, and they do so while remaining secular in orientation.

Hopefully, this means that western societies are beginning to realize that the category of religion need not be cordoned off from the rest of society. Rather, religions can contribute to our practice and understanding of well-being, even if what we take from them ends up in a secular form once it enters the public sphere. It also hopefully points to a recognition that issues of morality, ethics, and spirituality (understood as a basis of universal human values) need not be religious *per se*. The former are all likely to be essential components of a completely flourishing life and a flourishing society—something we cannot say (at least without giving up impartiality) of any one religion.

Because positive mental health appears, on the basis of a growing body of research, to play a strongly preventive role in future mental illness,[29] the most practical step of all would be to introduce the cultivation of basic human values in education. This would help children to develop resilience and aid them in leading truly meaningful and flourishing lives. At Emory, researchers have already begun adapting practices like CBCT for use in settings such as elementary schools, foster care facilities, hospitals, and prisons. The preliminary findings from such programs and interventions are promising.[30]

The use of such practices in public settings raises important questions that we must address collectively as a society. Are we comfortable with the teaching and training of moral emotions and values like compassion and empathy in secular settings, when such education is inherently normative? Are we able to separate out ethical spirituality from the practice of religion? Can we use science, reason, and collective experience and dialogue to come to a consensus on these issues, overcoming religious differences and ideologies for the purpose of promoting flourishing in a diverse, pluralistic society? Although these are very difficult questions, the alternative would appear to be worse: ignoring research that shows how important basic human values and moral emotions are for our physical and mental health and for our relationships, and pretending that we can leave the question of ethics completely out of the public sphere—something that many, including myself, think is impossible. We already have a sense of secular ethics enshrined in our society in the form of the laws and norms by which we collectively abide; in future, these should reflect our fullest scientific understanding of mental health and well-being as well.

Notes

1. Works in this area that have been highly influential for the arguments presented in this chapter include Antonio Damasio, *Descartes' Error: Emotion, Reason and the Human Brain* (New York: Penguin Books, 2005) and *The Feeling of What Happens: Body and Emotion in the Making of Consciousness* (Boston, MA: Houghton Mifflin-Mariner Books, 2000) and Francisco J. Varela, Evan T. Thompson, and Eleanor Rosch, *The Embodied Mind: Cognitive Science and the Human Experience* (Cambridge, MA: MIT Press, 1992).
2. Chikako Ozawa-de Silva and Brendan Ozawa-de Silva, "Secularizing Religious Practices: A Study of Subjectivity and Existential Transformation in Naikan Therapy," *Journal for the Scientific Study of Religion* 49, no. 1 (2010): 147–161.
3. Damasio, *The Feeling of What Happens*.
4. Corey L. M. Keyes, "Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health," *Journal of Consulting and Clinical Psychology* 73, no. 3 (2005): 539–548, and "Promoting and Protecting Mental Health as Flourishing," *American Psychologist* 62, no. 2 (2007): 95–108.
5. Arthur Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger* (New York: Oxford University Press, 2006).

6. One problem we face in drawing a connection between religion and mental health is that there is no such thing as "religion" in the singular independent of our historical and cultural conception of that term, which is not shared universally. The failure of numerous religious studies scholars to come up with an acceptable definition of religion led Jonathan Z. Smith to conclude that "while there is a staggering amount of data, phenomena, of human experiences and expressions that might be characterized in one culture or another, by one criterion or another, as religion—there is no data for religion. Religion is solely the creation of the scholar's study. It is created for the scholar's analytic purposes by his imaginative acts of comparison and generalization. Religion has no existence apart from the academy." Jonathan Z. Smith, *Imagining Religion: From Babylon to Jonestown* (Chicago, IL: University of Chicago Press, 1988), p. 9. We can say a lot about the relationship between actual religious communities and mental health—say, for example, the relationship between church attendance and mental health—but "religion" is an analytical concept not shared by many other cultures, including, incidentally, many subcultures that we consider "religions" (see, for instance, Chikako Ozawa-de Silva's discussion of Shintoism in Chapter 8 of this volume).
7. Shane Sharp, "When Prayers Go Unanswered," *Journal for the Scientific Study of Religion* 52, no. 1 (2013): 1–16.
8. L. Miller, P. Wickramaratne, M. J. Gameroff, M. Sage, C. E. Tenke, and M. M. Weissman, "Religiosity and Major Depression in Adults at High Risk: A Ten-Year Prospective Study," *American Journal of Psychiatry* 169, no. 1 (2012): 89–94.

9. Brendan Ozawa-de Silva and Brooke Dodson-Lavelle, "An Education of Heart and Mind: Practical and Theoretical Issues in Teaching Cognitive-Based Compassion Training to Children," *Practical Matters*, no. 4 (2011): 1–28.

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26. Arthur Kleinman, "Experience and Its Moral Modes: Cultural, Human Conditions and Disorder." In *The Tanner Lectures on Human Values,* vol. 20 (Salt Lake City: University of Utah Press, 1999), 358–359.

27. Ibid., 362. I do not know whether Kleinman would subscribe to the possibility of the "secular ethics" or "ethical spirituality" suggested by the Dalai Lama, but I am sure that if he were to, he would insist that it be grounded in an attention to ethnographic realities and a recognition of the diverse moralities of local worlds—that is, to shared "human conditions," as he puts it, rather than to a singular human nature. Without such attention, any secular ethics we prescribe as universal may simply reflect our own unexamined assumptions and biases; the negative public health and clinical consequences of this error would likely be significant. If we simply use the term "human nature" to refer to those shared human conditions that can be investigated empirically (scientifically and ethnographically), rather than from some *a priori* notion of what a universal human nature must be, then I see no problem in the usage of this term. We should, however, recognize that it is often not used in this way.

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