A Close Reading and Analysis of Aversion Therapy in Śāntideva's *Bodhicaryāvatāra*

"Whoever longs to rescue quickly both himself and others should practise the supreme mystery: exchange of self and other" (Śāntideva 99). The exchange of self and other, as mentioned in this verse from the *Bodhicaryāvatāra,* is one of the many recondite teachings of the great *Mahayana* Buddhist monk, Śāntideva. Śāntideva's philosophy, while not entirely unique, is rather obscure. The idea of the exchange of self and other is a sort of radical notion in Buddhism that emphasizes the equality of all suffering and happiness in all beings, with an equal distribution of import. In order to achieve this exchange, it is necessary to practice compassion, happiness, and suffering without distinction or distraction through the process of meditative absorption. Śāntideva's philosophy uses radical medicine to kill the ego and destroy one's sense of self and achieve an enlightened state of meditative absorption.

Meditative absorption requires the unity of the two meditations, *śamatha* and *vipaśyanā*, calming and insight. *Śamatha* meditation is the preparation for *vipaśyanā* meditation, as its focus is the facilitation of tranquility and sequestration, which, according to Śāntideva, are imperative for the acquisition of insight. Additionally, Śāntideva emphasizes the destruction of anger and passions as the penultimate goal of meditative absorption, second only to the exchange of self and other (Crosby & Skilton 75). Śāntideva's process for the destruction of passions can be recognized as a primordial form of what psychology has come to know as aversion therapy. This paper examines the presence and explores the ethics of aversion therapy in Śāntideva's *Bodhicaryāvatāra.*

As described by Stanley J. Dirks in the *Stanford Law Review*, aversion therapy is "one of several psychotherapeutic procedures for the control of harmful deviant behaviors". Aversion therapy is a form of behavior modification that inhibits patterns of problematic and undesirable behaviors. Aversion therapy seeks to create a literal aversion to the problematic behavior pattern by repetitiously coupling the pattern with an unpleasant stimulus. By doing so, a conditioned response is conceived and the initial problematic behavior itself becomes undesirable ("Learning and Aversion" 60). Aversion therapy has been used for a variety of afflictions, so to speak, such as alcoholism, heroin addiction, smoking, homosexuality, exhibitionism, voyeurism, pedophilia, transvetism, overeating, psychotic fire setting, and shoplifting. There are four different types of aversion therapy that are categorized by the methods employed in the aversion process: pharmacological aversion, faradic aversion, imaginal aversion, and scoline aversion (Dirks 1329).

Pharmacological aversion utilizes chemicals such as apomorphine or emetine to induce uncontrollable nausea to condition an individual against a specific behavior. Pharmacological aversion has been used in the treatment of alcoholics by associating the sight, smell, taste, and thought of alcohol with intense, drug-induced nausea. Patients were given emetine or apomorphine and then given a glass of liquor. With the onset of the nausea inducing drug, vomiting followed immediately. This procedure was replicated until the smell and taste of alcohol were sufficient in producing nausea and vomiting without the application of the nausea inducing drug (1329).

Faradic aversion is colloquially referred to as electric shock therapy and has historically been used in the treatment of homosexuality. Faradic aversion employs electrical shock in

conditioning an individual against what was believed to be deviant sexual behavior. In Stanley J. Dirks' article in the *Stanford Law Review* on the use of aversion therapy in a criminal setting, psychologists Hallam and Rachman described the use of aversion therapy on homosexual patients. In treatment, the patient was instructed to imagine "provocative sexual fantasies of the deviant stimulus or deviant act" (1329). Having done so and indicated that the patient had successfully imagined such fantasy, "the patient received a painful but tolerable shock to the leg a few seconds later" (1330). Faradic aversion treatment began with the presentation of the least arousing scenes first and continued until the fantasy or stimulant ceased to be sexually arousing. The therapy discontinued when the most arousing stimuli no longer elicited arousal (1330).

Scoline aversion, also referred to as anectine aversion, was primarily practiced in the treatment of heroin addicts. Scoline is a drug administered for the sake of temporary paralysis; patients were told to prepare to inject themselves with a dose of heroin while discussing their pleasant experiences with the rug. At the precise moment that patients were instructed to inject themselves, scoline was instead administered, and the patient became paralyzed and unable to breathe. The patient is quickly and aggressively informed of the dangers of the drug, often being told, "This is how [heroin] can kill you, you may suffocate to death". After a moment, oxygen is administered and the patient is asked if they still desire heroin. Repetition of this process has found that patients invariably said no (1331).

The final form of aversion therapy is imaginal aversion. Imaginal aversion, also known as covert sensitization, utilizes verbal descriptions of imaginal stimuli to associate the problematic behavior pattern with a nauseous verbal description or image. The partnering of the desirable stimuli and the nauseating description or image links the initial behavior pattern to the images of

nausea and vomiting, much like pharmacological aversion utilizes nausea inducing medications to condition an undesirable response to the initial behavior pattern. Imaginal aversion treatment continues until the patient finds it impossible to imagine the initial behavior pattern without being overcome by feelings of nausea and disgust (1331). It is this form of aversion therapy that is identifiable in Śāntideva's *Bodhicaryāvatāra*

Śāntideva identifies the passions, or *kāmā,* as the preeminent danger of the mind, with special consideration placed on the dangers of the sexual passions. In an effort to destroy these passions for the sake of meditative absorption, Śāntideva coarsely attacks the sexual passions and their implications in the monastic community by explicitly describing the foulness of the source of sexual fantasies and their subjects. This attack, the *aśubbha-bhāvanā,* is designed to eradicate sexual desire and passions in members of the monastic community for the sake of clarity of mind and enlightenment (Crosby & Skilton 79). Śāntideva's attack on the sexual passions can be identified as a primordial form of imaginal aversion therapy.

Much like therapeutic imaginal aversion therapy, Śāntideva employs explicit imagery in the conditioning of *Mahayana* monks to suppress their physical attractions for the facilitation of *vipaśyanā,* insight, and meditative absorption. Isolation, or *viveka*, is an indispensable condition for meditative absorption; the aspiration of isolation is to exonerate one's self from the greatest distraction, desire (78). Śāntideva begins his Perfection of Meditative Absorption by explaining the import of isolation: "Distraction does not occur if body and mind are kept sequestered. Therefore, one should renounce the world and disregard distracting thoughts" (Śāntideva 88). Śāntideva suggestions for proper isolation is that, "he [the monk] should go forth into the forest" where "free from acquaintance, free from conflict, he is quite alone in his body" (91).

From isolation, Śāntideva moves to true imaginal aversion with a series of vile and disconcerting images meant to disavow the monks from their physical attractions. “She is nothing but bones, independent and indifferent,” Śāntideva writes (91). Śāntideva’s callous narratives of women for the sake of eradicating sexual desire in the monastic community condition the monks to relate women with the vile images described to them during their imaginal aversion treatment. Śāntideva’s narratives center on the repugnant representations of a woman’s body and her bodily functions: “They produce both spit and shit from the single source of food. You do not want the shit from it. Why are you so fond of drinking the spit?” (92).

The connection Śāntideva establishes between women and excrement is one he draws a second time in the following lines:

> If you do not want to touch something such as soil because it is smeared with excrement, how can you long to touch the body which excreted it?
>
> If you have no passion for what is foul, why do you embrace another, born in a field of filth, seeded by filth, nourished by filth? (93)

While this comparison is considered foul by most cultural considerations, the affiliation with excrement is particularly despicable in the Indian tradition because of the traditional caste system. In this system, the body’s excretions are avoided at all costs and regular contact with them can regulate an entire class of people to the lowest of social statuses (Crosby & Skilton 80).

By so despicably depicting the body of a woman, Śāntideva’s acute imaginal aversion conditions the members of the monastic community against distractions and defilements by intertwining sexuality and complete disgust. While vile, Śāntideva’s are effective in eliminating sexual desire in the monastic community. However, despite the ghastly and nauseating

descriptions permeating his Perfection of Meditative Absorption, Śāntideva finishes the passage beautifully by saying, "[…] one should recoil from sensual desires and cultivate delight in solitude, in tranquil woodlands empty of contention and strife" (95).

An Examination of the Ethics of Aversion Therapy in Śāntideva's *Bodhicaryāvatāra*

Aversion therapy has a contentious history rife with ethical ambiguities. There are many factors one must consider when examining the ethics of a practice, as well as stringent guidelines in place that dictate whether or not a practice is truly ethical. However, when considering the ethics of practices that are centuries old, it is important to consider both the time and location of those practices. With this in mind, I will be exploring the modern psychological ethics of Śāntideva's aversion therapy, as well as examining the implications aversion therapy has in Buddhist ethics

Ethics in psychology have developed rapidly in the last century. This rapid development is due, unfortunately, to the number of harmful and now-considered unethical experiments and therapies of the past. Psychology places a high value on ethical balance, meaning that the risk to the patients or participants must be relatively equal to the value of potential knowledge or success of the treatment or study. There are a number of ethical principles that have developed that dictate the ethics of psychology in America, most notably the Belmont Report and the American Psychological Association's Ethical Principles (Morling).

The Belmont Report identifies three core principles that must be applied to psychological research and treatments: the principle of respect for persons, the principle of beneficence, and the principle of justice. The principle of respect for persons mandates that patients or participants must be treated as autonomous agents and retain the ability to make their own decisions about

their participation in a practice. The principle of respect for persons also dictates that individuals with less autonomy such as children, prisoners, or people with intellectual disabilities must have additional protection to ensure a practice is in their best interest. The principle of beneficence states that participants must be protected from harm and it is the responsibility of the psychologist to ensure the well being of a participant. The third and final principle set in place by the Belmont Report requires a balance between the people who participate in an experiment and people who benefit from that experiment. The American Psychological Association's Ethical Principles also require beneficence, justice, and respect for persons. However, the APA has added the importance of integrity, fidelity, and responsibility in conducting an experiment or treatment on an individual (Morling).

While the above principles do apply to therapeutic techniques practiced on patients, higher focus is placed on the experimental ethics of involving human participants in psychological studies. One ethical aspect that is utterly unambiguous in its application to therapy, however, is the notion of informed consent. For autonomous agents, informed consent is critical for a psychologist to obtain. In individuals with a limited capacity for autonomy, special considerations must be made to ensure that consent is, in fact, beneficial (Morling).

Historically, aversion therapy has been used in the treatment of various conditions, both with and without the consent of the patients being treated. In Stanley J. Dirks' article on the use of aversion therapy in a correctional institution, Dirks identifies a likelihood that aversion therapy will fail in a correctional facility, despite its relative success in a clinical setting. In a correctional environment, aversion therapy has been used for the treatment of various afflictions, including alcoholism, addiction, homosexuality, and an assortment of other criminalized

behaviors. Dirks attributes this failure of aversion therapy to the correctional environment itself and to the coercion used to convince prisoners to subject themselves to aversion therapy as treatment, a direct violation of the ethical guidelines put in place for individuals lacking autonomy in a correctional setting (Dirks 1341).

Perhaps aversion therapy's most contentious use lies in the alleged curing of homosexuality by creating an aversion to the supposed unnatural sexuality. A 1962 letter of correspondence in *The British Medical Journal* congratulates a Dr. Basil James on his successful cure of a case of homosexuality. The author of the correspondence states that, "There is no doubt that this [aversion therapy] may prove a valuable addition to our armamentarium in dealing with this difficult disease" (Allen 1078). Aversion therapy was a common tool in the combating of homosexuality, especially in the twentieth century where homosexuality was considered to be a mental affliction. However, the author of our correspondence identifies aversion therapy as being so unpleasant, that he is sure people will still prefer psychotherapy and considers aversion therapy to be a "more drastic cure" (Allen 1078).

The ethical ramifications of combatting one's sexuality, or any affliction, for that matter, with aversion therapy are utterly dependent on the willingness of a patient to participate. One may infer that by belonging the the monastic community, the devoted *Mahayana* monks were consenting to the practices and teaching of Śāntideva and were undertaking their lessons in meditation and insight willingly. However, without consent or autonomy, aversion therapy is in no way ethical, by psychological standards.

Śāntideva, however, was not governed by the American Psychological Association. One must be careful in approaching non-western ethical thought with the ethical lens that has been

developed in the west. Michael G. Barnhart states that few scholars identify Buddhism as being driven by a sense of obligation or duty, and I attribute this supposition to the metaphysical equality Buddhism places on sentient beings and their lack of a soul. However, the Buddhist tradition is not devoid of obligations. For example, it is expected of a Buddhist to refrain from lying, stealing, killing, and to refrain from sexual indiscretions. These actions are considered unethical because they perpetuate the sentimentality that an individual is a self; these actions are often attributed to hate and hate is the ultimate self-delusion, according to Buddhism (Barnhart 19).

Ethical law in Buddhism seems enigmatic because true deontological ethic focuses on a systematic appraisal of normative judgement, which is inhibited by Buddhism's central lack of a self. Therefor, Barnhart identifies the explanation of acceptable behaviors in Buddhism as stemming from philosophical anthropology and psychological insight, allowed by Buddhism's acceptance of a conventional truth. Buddhism places a high value on moral reasoning and the fluidity of moral obligations. As is the convention with moral reasoning, complicating facts and circumstances must be considered in evaluating the morality of a situation before coming to a conclusion on the ethical nature of the situation (Barnhart 20).

When applying the ethical guidelines to Śāntideva's use of aversion therapy, one is able to identify the mitigating factors in Śāntideva's process as being outweighed by the value of insight the *Mahayana* monks are able to obtain by relinquishing their mind of distractions and defilements. Considering meditative absorption to be the penultimate goal of Buddhism, Śāntideva's use of imaginal aversion in conditioning the members of the monastic community can be identified as a coarse description of corporeality in which the promise of insight and

enlightenment justifies the ethical ambiguity of Śāntideva's actions, exemplifying the Buddhist practice of moral reasoning. Therefor, by the standards of morality in reasoning present in the Buddhist tradition, aversion therapy for the sake of enlightenment may be considered an entirely ethical practice.

Upon first consideration, my heart is filled with unease at the use of aversion therapy in psychology and in Buddhism. I believe it to be a reprehensible practice that conditions individuals against their very nature, too often with cruel and painful methods and without proper autonomy or consent. However, that is the decisive factor of the ethical nature of aversion therapy: autonomy and consent. Without proper autonomy or consent, aversion therapy is a barbarous torture designed to alter an individual's very nature by fostering sentiments of horror and disgust to become internal sources of depression and disgust. As it is, I believe the risks at creating such internal trepidation to be its own form of cruelty. Modern society knows the psychological risks that harmful therapy can impose on an individual, Śāntideva did not. Though I believe Śāntideva's practices to be technically ethically sufficient, I also believe that psychology has learned from its past mistakes and has a moral responsibility that Śāntideva did not to impose stringent ethical guidelines on therapy and provide a better service to the people it seeks to protect.

Bibliography

Allen, Clifford. "Aversion Therapy for Homosexuality". *The British Medical Journal* 1.5284 (1962): 1078. Web. 23 April 2016. http://www.jstor.org.ezproxy.uwgb.edu:2048/stable/20357484

Barnhart, Michael G. “Theory and Comparison in the Discussion of Buddhism Ethics”. *Philosophy East and West* 62.1 (2012): 16-43. Web. 28 April 2016. http://www.jstor.org/stable/41426829

Crosby, Kate and Andrew Kilton. “The Perfection of Meditative Absorption.” Introduction. *The Bodhicaryāvatāra.* Oxford: Oxford UP, 1996. 75-89. Print.

Dirks, Stanley J. “Aversion Therapy: Its Limited Potential for Use in the Correctional Setting”. *Stanford Law Review* 26.6 (1974): 1327-1341. Web. 23 April 2016. http://www.jstor.org.ezproxy.uwgb.edu:2048/stable/1227992

“Learning and Aversion”. *The British Medical Journal* 1.5688 (1970): 60-61. Web. 23 April 2016. http://www.jstor.org.ezproxy.uwgb.edu:2048/stable/20379133

Morling, Beth. *Research Methods in Psychology: Evaluating a World of Information.* New York, NY: Norton, 2012. Print.

Śāntideva. “The Perfection of Meditative Absorption.” *The Bodhicaryāvatāra*. Trans. Kate Crosby and Andrew Skilton. Oxford: Oxford UP, 1996. 88-104. Print.