

Mindfulness and the Myth of Mental Illness: Implications for Theory and Practice

Published in *Contemporary Buddhism*, 13 (2), 2012, 177-192

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Abstract

Over the past 60 years Thomas Szasz (1960, 1961/1974, 2008) has forcefully argued that mental illnesses are mythical since all medical diseases are located in the body and, thus, have somatic causes. This has been accompanied by a scathing and coruscating critique of the whole mental health profession – particularly, those psychologists, psychiatrists and psychotherapists who collude in and exploit the alleged mythology of counterfeit mental disorders and often (unwittingly or deliberately) justify coercion, oppression and pharmacological manipulation of so-called ‘mental patients’ in the name of ‘treatments’. Since mindfulness practitioners – perhaps especially teachers of mindfulness-based cognitive therapy (MBCT), mindfulness-based stress reduction (MBSR) and related programmes – may, by association, be partially implicated in Szasz’s allegations, this article seeks to explore and examine the implications for theory and practice in the field. It will be suggested that the strong foundational, theoretical, research and teaching bases of mindfulness-based interventions (MBIs) offer practitioners a solid defence against the general critique offered by Szasz, and more specific challenges advanced by critics such as Boysen (2007) and Whitaker (2010). However, there may still be potential pitfalls for those MBIs which are too closely allied to the psychiatric/psychotherapeutic establishment, and some suggestions for avoiding such obstacles will be offered through recommendations for maintaining connections between mindfulness and its Buddhist origins.

Key Words: Szasz, myth of mental illness, MBCT, neuroscience, mindfulness-based interventions (MBIs), Buddhist origins of mindfulness

Contextual Background

At a symposium to celebrate Thomas Szasz’s 80th birthday in 2000 held at the State University of New York Health Science Centre, the co-chairs Borelli and Schaler (2000) declared that Szasz had:

done more throughout his life to help us comprehend the relationship between liberty and responsibility than many people have done over the past two hundred years. His writing, teaching, speeches, and mentoring continue to influence and change the way we think about psychiatry, medicine, disease, mind, behaviour, law, liberty, justice, responsibility, psychotherapy, philosophy, suicide, drug policy, addiction, economics, and the seemingly endless manifestations of the “Therapeutic State.” By exposing the difference between literal and metaphorical disease when he wrote *The Myth of Mental Illness* in 1961, Professor Szasz threw psychiatrists and psychotherapists into an ethical identity crisis: Since mental illness is a myth, it cannot be treated! (p.1).

The basic thesis propounded by Szasz fully satisfies the criteria of Occam’s razor by being simple, lucid, unambiguous and accessible to any person who cares to examine it. In its original exposition, Szasz (1961/1974 edn) helpfully summarises – in the manner of Spinoza’s *Ethics* or Wittgenstein’s *Tractatus* – his principal arguments in the form of propositions and assertions which he obviously wants to establish as axioms. The key ones can be summarised as follows:

Strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness.

"Mental illness" is a metaphor. Minds can be "sick" only in the sense that jokes are "sick" or economies are "sick".

Psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behaviour annoys or offends others.

Those who suffer from and complain of their own behaviour are usually classified as "neurotic"; those whose behaviour makes others suffer, and about whom others complain, are usually classified as "psychotic".

Mental illness is not something a person has, but is something he does or is.

If there is no mental illness there can be no hospitalization, treatment, or cure for it...

Personal conduct is always rule-following, strategic, and meaningful...

In most types of voluntary psychotherapy, the therapist tries to elucidate the inexplicit game rules by which the client conducts himself; and to help the client scrutinize the goals and values of the life games he plays.

There is no medical, moral or legal justification for involuntary psychiatric interventions. They are crimes against humanity.

(pp.267-8)

Szasz's substantive argument is that:

Mental illness is a myth. Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social and ethical problems in living...the concept of mental illness also undermines the principle of personal responsibility..For the individual, the notion of mental illness precludes an inquiring attitude toward his (sic) conflicts which his "symptoms" at once conceal and reveal. For a society, it precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients (ibid.,p.262).

In later work, Szasz explains that, when we claim that a person has a mental illness, we 'misidentify his strategic behaviour as a bodily disease' (2008, p.25). Consequently, he continues:

If we limit the use of the term *illness* or *disease* to observable biological – anatomical or physiological – phenomena then, by definition, the term *mental illness* is a metaphor. Mind is not matter, hence mental illness is a figure of speech. The idea of two kinds of diseases, one bodily, the other mental, is an unintended product of the scientific revolution: the imitation of science called "scientism". *Hysteria, schizophrenia, mental illness* and *psychopathology* are scientific, not scientistic, terms (ibid, p.25, original italics).

In all his work, Szasz is concerned to point out *ad nauseam* that activities of allegedly mentally ill people such as malingering, faking, lying and impersonation have been successively condemned, sanctioned, reified and medicalised (and de-/re-medicalised) by professionals in the field. He is particularly scathing about pioneers such as Charcot and Freud who – in the case of the former – founded a whole practice on the testimony of confessed malingerers and – in the case of the latter – endorsed faking and lying as mental illnesses (1974, 2007, 2008).

What needs to be added to this trenchant critique of aspects of psychiatry/psychotherapy and mental health practice is the long history of changing concepts, styles, diagnoses and paradigms about mental illness which often appears arbitrary and non-rational compared to other disciplines. As Stone (1998) points out, what is now labelled 'personality disorder' exhibits the 'same conditions that earlier generations of psychoanalysts treated under the heading of "character disorders" or "psychoneuroses" (p.357). Moreover, some of these disorders – for example 'sadistic personality' – is 'now not considered

to be an illness so much as an offensive “way of being” and was dropped from the DSM-IV [the American Psychiatric Association’s Diagnostic and Statistical Manual of mental illness] lest it be misused by defence attorneys as demonstrating diminished capacity’ (ibid.,p.405). In this context it is worth remembering that homosexuality was listed in the DSM until as recently as 1973 (Bayer & Spitzer, 1982).

In the natural sciences, as Kuhn (1962) has shown, dominant paradigms do change over time – as in the shift from the Ptolemaic to the Copernican views about the earth, and the supplementing of Newtonian physics by Einsteinian relativity – but this happens on the basis of empirical, observational or experimental evidence which indicates that the old paradigm is untenable in the light of new evidence. Changes in, for instance, ideas about schizophrenia, hysteria, anxiety, or depression typically come about – not because new empirical evidence has been brought forward – but as a result of different constructions by psychiatrists and therapists (or the influence of the pharmaceutical industry). Thus, hysteria may at one stage be seen as an instance of ‘malingering’ and at another as ‘psychogenic illness’ (Szasz, 2008,pp.26-8), and manic depression becomes bi-polar disorder caused by imbalances of neuro-transmitting chemicals, even though there is very little empirical evidence to support this thesis and growing evidence that the use of pharmaceuticals may actually worsen the health of patients diagnosed with depression or psychosis (Whitaker, 2010, pp.66ff). Similarly, in the case of schizophrenia, the diagnoses and suggested treatments have been revised regularly over the years. The world famous expert in this field, Robin Murray, admitted in a recent interview (BBC, 2012) that:

Fifteen years ago he believed schizophrenia was a brain disease. Now, he's not so sure. Despite decades of research, the biological basis of this often distressing condition remains elusive. Just living in a city significantly increases your risk (the bigger the city the greater the risk); and, as Murray discovered, migrants are six times more likely to develop the condition than long term residents (p.1).

In fact, this ‘social’ explanation of mental illness is becoming increasingly popular – Stone (1998), for instance, notes the recent ‘social skills training for schizophrenic patients’ (p.339) – and it is interesting to note just how close this new paradigm is to Szasz’s 1960 proposal that mental illnesses should be re-classified as simply ‘problems in living’ (1960,p.116).

Mental Illness and Personal Conduct

Against the background of this thesis, what can we conclude about people who are suffering from phobias, stress of various kinds, instability of mood, anxiety, chronic fatigue syndrome (CFS), obsessive-compulsive disorder (OCD) or any of the other complaints that appear to have increased in recent years? The review of evidence survey which accompanied the UK Government report *Mental Capital and Wellbeing* noted that the most recent available national survey indicated that 16.4% of the UK population has some form of mental illness, and that this figure would be greatly increased if we looked at mental health or flourishing as opposed to illness (Government Office for Science, 2008,p.12). Estimated costs of mental illness have been placed at ‘£77 billion per year for England when wider impacts on wellbeing are included, and £49 billion for economic costs alone’ (ibid; p.21), not to mention the untold suffering to individuals and families of untreated or mistreated mental illness.

In a number of writings over the last few years, Oliver James (2007,2008) has argued that levels of emotional distress in industrialised, urbanised societies are much higher for English-speaking countries such as Britain, United States, Canada and New Zealand than they are in other nations such as France, Spain, Belgium, Japan and the Scandinavian states. Using the World Health Organisation (WHO) definition of emotional distress to include illnesses such as ‘depression, anxiety, substance abuse and impulse disorder’ James (2008,p.10) contends that – contra recent fashionable notions about genes – such distress has little genetic causation but is directly linked to both parental upbringing and the impact of ‘selfish

capitalism' which expounds radically materialistic values in conjunction with bringing about a deterioration of income levels and working conditions for millions of ordinary people in mainly English-speaking countries over the last thirty years or so. Gerhardt (2010) presents similar arguments in her survey of the 'selfish society' brought about by neo-liberal economic policies.

Wilkinson & Pickett (2010) have demonstrated the impact of such careless self-interest on the world's richest nations in indicating direct correlations between inequality of income and levels of mental illness, addiction, rates of imprisonment, levels of trust and the general health and well-being of nations. In all cases the data are unequivocal: 'most of the important health and social problems of the rich world are more common in unequal societies' (p.173). We might safely assume that the global economic meltdown and recession which has occurred in the last few years has exacerbated these problems. Indeed, in a UK survey in March 2010 by the mental health charity *Together—UK* (<http://www.together-uk.org>) it was revealed that 62% of British people had recently experienced mental health problems. Moreover, such problems seem to be increasingly affecting younger people (Warwick, et al, 2008; Hyland, 2011).

How can we understand all this in the light of Szasz's arguments? I would suggest that – rather than denying that any of these problems exist – he would ask us to examine them in a new and different light. Almost all of the afflictions that tend to be labelled as mental illnesses or disorders (excluding, of course, those which have an etiology in the body, in brain lesions, paresis or damage which affects the central nervous system and are, thus, more properly to be classified as somatic diseases) can be reinterpreted as examples of the rich diversity of conduct which make up the human condition.

Szasz emphasises that all human action and behaviour takes place in a social context characterised by rules realised through ethical codes (general systems of procedural rules) and ultimately justified and judged in terms of fundamental moral values such as justice and benevolence (or their opposites). Furthermore, behaviour may be usefully analysed in terms of a game-playing model which Szasz takes from the work of Mead (interestingly, although the widely influential philosophical work on 'language games' outlined by Wittgenstein [1953] was available when Szasz originally formulated his thesis, this is not cited anywhere; see also Berne [1964]). We are then invited to reflect on an account of human action defined by social games which are grounded in ethical codes and moral values. As he puts it:

The social situation in which a person lives constitutes the team on which he (sic) plays and is, therefore, important in determining who he is and how he acts. Man's so-called instinctual needs are actually shaped – and this may include inhibiting, fostering or even creating "needs" – by the social games prevalent in his milieu (1974, p.199).

Against the background of this model, all aspects of human conduct – including those which are labelled as forms of mental illness – are analysed in terms of game-playing according to certain rules and moral values.

Many people who present themselves as or are diagnosed by others to be mentally ill can, therefore, be understood to be playing roles of various kinds which can be assumed, impersonated or genuine. Applying this to the history of psychiatry, Szasz, argues that:

In the beginning...psychiatrists were violently opposed to those who impersonated the sick role. They wanted to see, study and treat only "really" sick – that is, neurologically sick – patients. They believed, therefore, that all mental patients were fakers and frauds...

Modern psychiatrists have swung to the opposite extreme. They refuse to distinguish impersonated from genuine roles – cheating from playing honestly. In so conducting themselves, they act like the art expert who decides that a good imitation of a masterpiece is also a masterpiece (ibid., p.247).

Given all this, how are mental health workers to proceed? Szasz is clear and direct on this matter. The 'principal alternative to this dilemma lies...in abolishing the categories of ill and healthy behaviour, and the prerequisite of mental sickness for so-called psychotherapy'. This

implies candid recognition that we "treat" people by psychoanalysis or psychotherapy not because they are sick but, first, because they desire this type of assistance; second, because they have problems in living for which they seek mastery through understanding of the kinds of games which they, and those around them, have been in the habit of playing; and third, because, as psychotherapists, we want and are able to participate in their "education", this being our professional role (ibid., p.248).

Recent Neuroscientific Developments

The connections between MBIs and psychological/psychotherapeutic theory and practice have become well established over the last few decades (Aronson, 2005; Segall, 2003; Epstein, 2007; Williams, et al, 2007), and practitioners have welcomed the advances in neuroscience demonstrating the brain's plasticity and the possibilities of creating new neural pathways to overcome problems linked to mood instability, stress and anxiety. Siegel (2007) asserts that the brain 'is an integrated part of the whole body'. He goes on to elaborate this statement:

Because the mind itself can be viewed as both embodied and relational, our brains actually can be considered the social organ of the body. Our minds connect with one another via neural circuitry in our bodies that is hard-wired to take in others' signals (p.48).

What needs to be added to this is that 'attention to the present moment, one aspect of mindfulness, can be directly shaped by our ongoing communication with others, and from the activities in our own brains' (ibid.,p.50). Recent neuroscientific work indicates that, on the one hand, neural networks in the brain can be altered by experience and, on the other, that mindfulness practice can help to bring about such change. As Doidge (2007) observes, the 'idea that the brain can change its own structure and function through thought and activity is...the most important alteration in our view of the brain since we first sketched out its basic anatomy and the workings of its basic component, the neuron' (pp,xv-xvi). He goes on to describe a wide range of cases – from physical ailments to emotional disorders – in which brain changes have been demonstrated to be connected with improvements in mind/body health and well-being. All this contributes to the development of what, in recent work, Siegel (2010) has referred to as an all-encompassing 'mindsight' which is defined as:

a kind of focused attention that allows us to see the internal workings of our own minds. It helps us to be aware of our mental processes without being swept away by them, enables us to get ourselves off the autopilot of ingrained behaviours and habitual responses, and moves us beyond the reactive emotional loops we all have a tendency to get trapped in. It lets us "name and tame" the emotions we are experiencing, rather than being overwhelmed by them (pp.xi-xii).

All such developments offer a solid theoretical foundation for MBIs but how do these discoveries in neuroscience fit with Szasz's critique? In general, the reactions to the 'myth of mental illness' thesis have ranged from professional ostracism to astonishment, obfuscation and bewildered dismissal on the part of the psychiatric/psychotherapeutic establishment (Borelli

& Schaler, 2000; Boysen, 2007). In more recent years this has been refined through what has been termed the 'remedicalisation' of mental illnesses as forms of brain diseases or disorders (Pasnau, 1987). As Szasz (2008) puts it:

The zeal for remedicalisation culminates in physicians claiming all of human life for a medicalised psychiatry and psychiatrised medicine, epitomised by the demand for the abolition of the term mental illness and the quasi-theological faith in the claim that mental illnesses are, *eo ipso*, brain diseases (p.88).

Thus, we have Baker & Menken (2001) declaring that:

It is harmful to millions of people to declare that some brain disorders are not physical ailments. By 2020, diseases arising from nervous system disorders will make up 14.7% of all diseases worldwide (up from 10.5% in 1990), according to the Global Burden Disease Study recently carried out by the World Health Organisation and other institutions (p.937).

Szasz (2008) argues that to 'treat deviant behaviours as diseases and disliked persons as sick persons is, of course, (re)medicalisation pure and simple' and 'also mendacity on a grand scale and the source of psychiatric cheating on a scale to match' (pp.88-9). Commenting on these arguments that 'the term mental illness should be eliminated because so-called mental illnesses are all brain disorders', Boysen (2007) correctly noted the 'irony of reframing Szasz's claim that mental illness is a myth in its converse has not been lost on its commentators' (p.169).

In the midst of all this controversy, we are reminded by Whitaker (2010) never to lose sight of the long-standing and massive collusion between the pharmaceutical industry and mental health professionals. As was observed earlier, the 'epidemic' of mental illness documented by Whitaker is almost entirely iatrogenic and unequivocally connected with the development of new drugs. As he concludes in reflecting on these issues:

First, by greatly expanding diagnostic boundaries, psychiatry is inviting an ever-greater number of children and adults into the mental illness camp. Second, those so diagnosed are then treated with psychiatric medications that increase the likelihood that they will become chronically ill. Many treated with psychotropics end up with new and more severe psychiatric symptoms, physically unwell, and cognitively impaired. That is the tragic story writ large in five decades of scientific literature (p.209).

Even if we set aside the powerful role of the pharmaceutical industry in all this, it is difficult to avoid the conclusion that the labelling of alleged mental illnesses such as anxiety, depression, CFS and OCD as brain disorders has served to fuel this disturbing epidemic.

Implications for Mindfulness Theory and Practice

At first glance, MBIs appear to be particularly well-placed to withstand any criticisms of the kind identified by Szasz and Whitaker. Although MB practitioners and teachers are *de facto* working with people who present themselves (as a result of self-referrals or referrals by medical/mental health professionals) as suffering from stress, anxiety or depression, no labelling or diagnosis is made by teachers and, thus, no 'treatment' of such states is being offered (at least, ideally, no such labelling or treatment is involved). On further inspection, however, it could be argued that MBIs are aiding and abetting the re-medicalisation process described above simply by using such labels in describing their programmes. Many MBCT and MBSR courses set out to attract specifically people who may be suffering from stress, anxiety or low mood (Kabat-Zinn, 1990; Crane, 2009; Hyland, 2011) and general texts on MB strategies refer to applications for people with generalised anxiety disorders, eating disorders, chronic pain sufferers, cancer patients (Baer, 2006; Bartley, 2012) and – most commonly – mention the efficacy of MBIs in preventing relapse amongst people with anxiety and depression (Williams, et al, 2007).

Self-help books on mindfulness also make large claims about alleviating insecurity, anxiety and unhappiness (Brach, 2005; Germer, 2009; Neff, 2011).

Although the evidence base for many of these MB applications is quite strong – in both general mental health fields (Baer, 2006; Siegel, 2007) and in terms of learning and education (Langer, 1989; Schoberlein & Sheth, 2009; Huppert & Johnson, 2010; Hyland, 2011) – there remains a danger that the labelling and (re-)medicalisation developments criticised by Szasz and others are unwittingly smuggled into MBIs by the use of terms such as anxiety and depression. Programmes which involve pre-course interviews and applications forms which request information about potential participants' medical history in these areas might be particularly vulnerable in this respect. It would be useful to outline the potential strengths and weaknesses of MBIs in relation to the general lines of criticism before proposing the strengthening of connections between MB approaches and the Buddhist origins of mindfulness as a way of avoiding any potential problems.

Strengths

It is possible for MB practitioners to accept the thesis that all illnesses are somatic by stressing the holistic mind/body principles which underpin practice. There is little evidence of Cartesian dualism in mindfulness theory and practice (Hyland, 2011), and every indication that MBIs foreground the idea that, as Hanson (2009) puts it, 'the mind is what the brain does' (p.11). As noted earlier, Siegel's conception of 'mindsight' is underpinned by the idea of the brain as embodied and operating as a 'social organ of the body' (2007,p.48). Not only is this in line with current educational thinking – as Goswami (2008) puts it, 'learning is social...we have social brains'(p.391) – this holistic approach which is exemplified in MBCT theory and practice addresses fully the critique of Szasz. Mindful movement in particular brings out this mind-body integration which plays such an important role in MBIs. Just as in breath meditation, mindful walking or moving helps us to discover (or often uncover) the connections between bodily sensations, thoughts and feelings thus allowing us to escape from the experiential avoidance and rumination that often lies at the heart of emotional pain and suffering. Crane (2009,pp.109-113) offers a useful list of the key aspects of learning linked to mindful movement; these include:

(Re)learning how we can bring attention and be present with bodily experience – this can help to move us to the felt bodily experiences and away from unhelpful ruminative thought

Embodying life experiences and processes through movements and postures

Seeing our habitual tendencies played out – through the deliberate, slow and methodical engagement in movement practice acquaints us with patterns of striving and intensity which we automatically adopt

The experience of present-moment acceptance – accepting the limitations and felt sensations of the body as we find them in the here and now can help to empower us to cultivate responsibility and autonomy in relation to all aspects of mind/body health and self-care

Szasz invites us to view the work of mental health professionals as a form of education, and this is exactly in keeping with the theory and practice of MBIs. Langer's (1989, 1993) writings on mindfulness and older people contain clear guidelines for avoiding mindlessness; we need to avoid false beliefs about our limited abilities and resources, stop acting from a single perspective, and eschew automatic behaviour. The emphasis on active, autonomous and experiential learning is expressed in the attitudinal features of MB practice by Kabat-Zinn (1990), and underpins the principles of MBCT/MBSR and related MBIs described by Williams, et al (2007). They note that mindfulness is (ibid; p.48):

1) *intentional* – concerned with cultivating an awareness of present moment reality and the choices available to us

2) *experiential* – focussing directly on present moment experience rather than being pre-occupied by abstractions

3) *non-judgmental* – it allows us to see things as they are without a mental assignment of critical labels to our thoughts, feelings and perceptions

The central place of *learning* in these practices is brought out fully in recent work on the use of MB strategies with people suffering from addictive behaviours, particularly alcohol and cigarette addiction. As the researchers Bowen, Chawla and Marlatt (2011) observe in explaining the efficacy of the approach:

Mindfulness provides a state of metacognitive awareness in which one can see more of the “big picture” instead of giving into one’s usual conditioned, habitual behaviour. This awareness provides a greater sense of freedom and choice (p.ix).

Such ‘metacognitive awareness’ is exactly what Siegel (2007) is seeking to describe in terms of the concept of ‘mindsight’. Its educational significance in promoting that process of reflection which Siegel calls the ‘fourth R of education’ (p.259) cannot be stressed too much.

Weaknesses

There is a danger that MBIs become a panacea for those aspects of behaviour which are medicalised as anxiety, neurosis, depression, and the like – or re-medicalised as brain disorders which cause such problematic behaviour – and, thus, becomes a default alternative for those people who have not found relief through orthodox medicine. On the face of it, this danger seems less likely to occur in taught programmes – which involve the learning and education mentioned above – than in the use of self-help manuals. However, whether in books or on taught courses any therapeutic intervention which promises, for instance, the escape from low mood, unhappiness or constant self-criticism, needs to ensure that its claims are linked to the stress on the individual autonomy and responsibility of clients/course participants.

MBCT/MBSR approaches are based on modifications of CBT and other behavioural approaches which have at times been – as Smeyers, Smith & Standish (2007) put it in their examination of connections between therapy and education – associated with ‘doing things to people’. They go on to observe that ‘many therapists in fact are concerned precisely to distinguish therapy as a relationship between autonomous human beings from therapy as a set of techniques’ (pp.1-2). Standard MBCT/MBSR programmes abound with techniques – the body scan, three-minute breathing space, listing pleasant/unpleasant thoughts, and so on (Crane, 2009; Hyland, 2011) – so it will be important to emphasise at all times the independent agency of MB practitioners in using these techniques.

Moreover, it is crucial that the standard texts on anxiety, depression, addiction, and the like foreground the rejection of reified labels and categories in favour of learned behaviour which can be modified and changed through MB practices. This approach is exactly in keeping with the Buddhist approach which suggests that all human afflictions can be understood in terms of the noble truths and transcended by following the eightfold path. Investigating the links between Buddhist practice and psychoanalysis, for example, Rubin (2003) explains the ‘similarities between both traditions’ and observes that:

Both are concerned with the nature and alleviation of human suffering and each has both a diagnosis and ‘treatment plan’ for alleviating human misery. The three other important things they share make a comparison between them possible and potentially productive. First, they are pursued within the crucible of an emotionally intimate relationship between either an analyst-analysand or a teacher and student. Second, they emphasise some similar experiential processes – evenly hovering attentions and free association in psychoanalysis and meditation in Buddhism. Third, they recognise that obstacles impede the attempt to facilitate change (pp.45-46).

Conclusion: Mindfulness , Suffering and Human Conduct

In order to avoid the pitfalls noted above connected with the re-medicalisation of mental illness, MB teachers and practitioners need look no further than the Buddhist origins of the concept of mindfulness which give meaning to every facet of theory and practice in the field. Because of the wide efficacy of mindfulness in modern therapeutic applications, there may be a tendency to overlook the fact that – in the context of the *Dharma* (literally the fundamental nature of the universe revealed in the Buddhist canon of teachings and precepts, Keown, 2005) – mindfulness is of crucial and overriding importance. Thich Nhat Hanh (1999) – the renowned Vietnamese Buddhist teacher and campaigner for world peace and justice – describes mindfulness as being ‘at the heart of the Buddha’s teachings’. It involves ‘attention to the present moment’ which is ‘inclusive and loving’ and ‘which accepts everything without judging or reacting’ (p.64). Kabat-Zinn (1990,1994) and associates have been largely responsible for transforming the original spiritual notion into a powerful and ubiquitous therapeutic tool based on forms of meditation and mindful practices. Mindfulness simply means ‘paying attention in a particular way: on purpose, in the present moment and non-judgmentally’ in a way which ‘nurtures greater awareness, clarity, and acceptance of present-moment reality’. Such practice – whether this involves breathing or walking meditation or giving full non-judgmental attention to everyday activities – can offer a ‘powerful route for getting ourselves unstuck, back in touch with our own wisdom and vitality’ (Kabat-Zinn,1994, pp.4-5).

In both modern therapeutic contexts and older Buddhist spiritual traditions the concept of mindfulness cannot be divorced from the idea of human suffering and attempts to alleviate suffering. Salzberg (1995) chose to emphasise the famous saying of the Buddha that he taught ‘one thing and one thing only: that is, suffering and the end of suffering’ (p.102) since

this foregrounds the dynamic intentional aspects of mindfulness practice. Thich Nhat Hanh (1999) stresses the centrality of mindfulness in the *dharma* by observing that when right mindfulness is present:

The Four Noble Truths and the Eightfold Path are also present. When we are mindful, our thinking is Right Thinking, our speech is Right Speech, and so on. Right Mindfulness is the energy that brings us back to the present moment. To cultivate mindfulness in ourselves is to cultivate the Buddha within (p.64).

The links between mindfulness and the alleviation of human suffering in all its forms is highlighted by all Buddhist commentators (Gunaratana, 2002; Batchelor, 2011) Brazier (2003) explains that the ‘teaching of the Four Noble Truths is a cornerstone of Buddhist understanding’ which ‘offers an analysis of the basic human process of responding to life’s afflictions and a framework for understanding and working with the pain in our own lives and in the world’ (p.8). These fundamental tenets of Buddhism provide all that is required to explain and justify the nature and purpose of MBIs in relation to mind/body health and human conduct. There are clear and direct parallels between the Buddhist approach to suffering contained in the four noble truths and the theory and practice of MB strategies.

It is worth examining the truths in detail as expressed in the Buddha’s original words in a translation of the *Samyutta Nikaya* (one of the early Pali – the original language spoken by the Buddha – *sutras* or teachings; Bodhi, 2000). Of the first truth of *dukkha* the Buddha observes:

The noble truth of *dukkha*, affliction, is this: birth, old age, sickness, death, grief, lamentation, pain, depression and agitation are *dukkha*. *Dukkha* is being associated with what you do not like, being separated from what you do like, and not being able to get what you want (Samyutta Nikaya, 61.11.5).

When we encounter such suffering, certain instinctive and seemingly universal and inevitable responses arise within us. About this, it is said that:

The noble truth of *samudaya*, response to affliction, is this: it is the search for self re-creation that is associated with greed. It lights upon whatever pleasures are to be found here and there. It is thirst for sense pleasure, for being and non-being (ibid., 56.11.6).

In the flight from suffering and pain, a natural impulse in humans is to run away, to seek refuge in materialism and sensual pleasures. As this refuge crumbles in the inevitable disappointment and striving of the will leading to an unquenchable thirst for ever new diversions and experiences, illusions are shattered and compulsive patterns and habits are formed in the never-ending cyclical struggle to escape from the human condition. As an alternative to this, the Buddha taught:

The noble truth of *nirodha*, containment, is this: it is the complete capturing of that thirst. It is to let go of, be liberated from and refuse to dwell in the object of that thirst (ibid.,61.11.7).

The final stage is *marga*, the path or method of escaping this apparently endless cycle of strife:

The noble truth of *marga*, the right track, is this: It is the noble eight limb way, namely right view, right thought, right speech, right action, right livelihood, right effort, right mindfulness, right *Samadhi*[concentration] (ibid.,61.11.8).

If we compare these concepts and processes with, for example, the key aspects of MBCT practice outlined above by Kabat-Zinn, Siegel, Crane and others, the points of contact between ancient contemplative and modern therapeutic notions of mindfulness become evident. As Crane (2009) expresses it, mindfulness practice invites us to move from a 'doing' mode to a 'being' mode as a way of appreciating the ways in which our mind deals with thoughts and feelings. In this way our 'attention is intentionally placed on present-moment experiencing' and 'experience is held within an attitudinal framework characterized by kindness, interest, warmth and non-striving (p.44).

All this is in keeping with the theory of human conduct and the importance of individual autonomy, personal responsibility and education highlighted by Szasz. The Buddhist origins of mindfulness demonstrate clearly the fundamental educative functions of MBIs and show how MB processes can have a potential impact on both the means and ends of education. Not only do they provide the foundations for productive learning, but also offer a blueprint to guide the direction of that learning. As Hanh (1999) observes:

Mindfulness helps us look deeply into the depths of our consciousness . . .When we practice this we are liberated from fear, sorrow and the fires burning inside us. When mindfulness embraces our joy, our sadness, and all our mental formations, sooner or later we will see their deep roots . . . Mindfulness shines its light upon them and helps them to transform (p. 75).

References

- Aronson, H.B. 2004. *Buddhist Practice on Western Ground*, Boston, MA: Shambhala Publications
- Baer, R. A. (ed). 2006. *Mindfulness-Based Treatment Approaches*, San Diego, CA: Elsevier
- Baker, M.G. & Menken, M. 2001. 'Time to Abandon the Term Mental Illness', *British Medical Journal*, 322, 935-9
- Bartley, T. 2012. *Mindfulness-Based Cognitive Therapy for Cancer*, Oxford: Wiley-Blackwell

- Batchelor, S. 2011. *Confession of a Buddhist Atheist*, New York: Spiegel & Grau
- Bayer, R. and Spitzer, R. L. 1982. 'Edited correspondence on the status of homosexuality in DSM-III', *Journal of the History of the Behavioral Sciences*, 18, 32–52.
- BBC 2012. *The Life Scientific – Robin Murray*, London: British Broadcasting Corporation, Radio 4 broadcast 7/2/12
- Berne, E. 1964. *Games People Play – The Basic Hand Book of Transactional Analysis*, New York: Ballantine Books
- Bodhi, B. 2000. *The Connected Discourses of the Buddha*, Boston, MA: Wisdom Publications
- Borelli, N. & Schaler, J.A. 2000. *Liberty And/Or Psychiatry? 40 Years After the Myth of Mental Illness*, Syracuse, NY: State University of New York Health Science Centre, mimeo
- Bowen, S., Chawla, N. & Marlatt, G.A. 2011. *Mindfulness-Based Relapse Prevention for Addictive Behaviours*, London: Guilford Press
- Boysen, G.A. 2007. 'An Evaluation of the DSM Concept of Mental Disorder', *Journal of Mind and Behaviour*, 28, 157-174
- Brach, T. 2003. *Radical Acceptance*, London: Bantam
- Brazier, C. 2003. *Buddhist Psychology*, London: Robinson
- Crane, R. 2009. *Mindfulness-Based Cognitive Therapy*, London: Routledge
- Doidge, N. 2007. *The Brain that Changes Itself*, London: Penguin
- Epstein, M. 2007. *Psychotherapy Without the Self: a Buddhist perspective*, New Haven: Yale University Press
- Gerhardt, S. 2010. *The Selfish Society*, London: Simon & Schuster
- Germer, C.K. 2009. *The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions*, New York: The Guilford Press
- Goswami, U. 2008. 'Principles of Learning, Implications for Teaching: A Cognitive Neuroscience Approach', *Journal of Philosophy of Education*. 42(3/4) 381-399
- Government Office for Science 2008. *Mental Capital and Wellbeing: Executive Summary*, London: Government Office for Science
- Gunaratana, B.H. 2002. *Mindfulness in Plain English*, Boston: Wisdom Publications
- Hanh, Thich Nhat, 1999. *The Heart of the Buddha's Teaching*, New York: Broadway Books
- Hanson, R. 2009. *Buddha's Brain*, Oakland: Harbinger Pubs Inc
- Huppert, F.A. & Johnson, D. 2010. 'A controlled trial of mindfulness training in schools: the importance of practice for an impact on well-being' *Journal of Positive Psychology*, 5(4), 264-274

- Hyland, T. 2010. 'Mindfulness, Adult Learning and Therapeutic Education: integrating the cognitive and affective domains of learning', *International Journal of Lifelong Education*, 29(5), 517-532
- Hyland, T. 2011. *Mindfulness and Learning: Celebrating the Affective Dimension of Education*, Dordrecht: Springer
- James, O. 2007. *Affluenza – How to be Successful and Stay Sane*, London: Vermilion
- James, O. 2008. *The Selfish Capitalist*, London: Vermilion
- Kabat-Zinn, J. 1990. *Full Catastrophe Living*, London: Piatkus
- Kabat-Zinn, J. 1994. *Mindfulness Meditation for Everyday Life*, London: Piatkus
- Keown, D. 2005. *Buddhist Ethics*, Oxford: Oxford University Press
- Kuhn, T.S. 1962. *The Structure of Scientific Revolutions*, Chicago: Chicago University Press
- Langer, E. 1989. *Mindfulness*, New York: Addison Wesley Publishing Co.
- Langer, E. (2003). 'A Mindful Education', *Educational Psychologist*, 28(1) 43-50
- Neff, K. 2011. *Self Compassion: stop beating yourself up and leave insecurity behind*, London: Hodder & Stoughton
- Pasnau, R.O. 1987. 'The Remedicalisation of Psychiatry', *Hospital and Community Psychiatry*, 38, 145-151
- Rubin, J.R. 2003. 'Close Encounters of a New Kind: Toward an Integration of Psychoanalysis and Buddhism', In Segall, S.R.(ed)(2003). op.cit. , 31-60
- Salzberg, S. 1995. *Loving-Kindness*, Boston, MA: Shambhala Publications
- Schoeberlein, D. & Sheth, S. 2009. *Mindful Teaching and Teaching Mindfulness*, Boston: Wisdom Publications
- Segall, S.R.(ed).2003. *Encountering Buddhism: Western Psychology and Buddhist Teaching*, Albany: State University of New York Press
- Siegel, D.J. 2007. *The Mindful Brain*, New York: W.W. Norton & Co.
- Siegel, D.J. 2010. *Mindsight*, Oxford: Oneworld Publications
- Smeyers, P., Smith, R. & Standish, P. 2007. *The Therapy of Education*, London: Palgrave Macmillan
- Stone, M.H. 1998. *Healing the Mind: A History of Psychiatry from Antiquity to the Present*, London: Random House
- Szasz, T.S. 1960. 'The Myth of Mental Illness', *American Psychologist*, 15, 113-118.
- Szasz, T.S. 1961/1974 edn. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York: Harper & Row

Szasz, T.S. 2007. *Coercion as Cure: A Critical History of Psychiatry*, Syracuse: Syracuse University Press

Szasz, T.S. 2008. *Psychiatry: The Science of Lies*, Syracuse, NY: Syracuse University Press

Together-UK 2010. 'Six out of ten Britons find it difficult to cope mentally', <http://www.together-uk.org> accessed March 9, 2010

Warwick, I., Maxwell, C., Statham, J. Aggleton, P. & Simon, A. 2008. 'Supporting Mental Health and Emotional Well-Being Among Younger Students in Further Education', *Journal of Further & Higher Education*. 32(1) 1-13

Whitaker, R. 2010. *Anatomy of An Epidemic*, New York: Crown

Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. 2007. *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness*, London: The Guilford Press

Wilkinson, R. & Pickett, K. 2010. *The Spirit Level: Why Equality is Better for Everyone*, London: Penguin

Wittgenstein, L. 1953. *Philosophical Investigations*, Oxford: Basil Blackwell