

‘Mind Cure’ and Mindfulness-Based Interventions (MBIs)

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Abstract

How did meditation, traditionally a monastic discipline, move from the fringes of American religious culture to the biomedical mainstream? This chapter sketches the process, then offers critical appraisals of contemporary mindfulness-based interventions (MBIs) from various religious, scientific, and political perspectives. Advocates say ‘mindfulness’ is non-religious. Yet MBIs emerged from a particular blend of American metaphysical religion, modernist Buddhism, and Hindu neo-Vedanta. They have adapted well to Western and scientific worldviews and to consumer capitalism. Secularised meditation and yoga clearly can be helpful, but they are no panacea, and clinical research on these practices has been rife with methodological and interpretive problems.

Biographical Note

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Overview

The contemporary ‘Mindfulness movement’ encompasses an array of programs and media promoting meditation and yoga for therapeutic purposes. These include reducing stress, improving physical and emotional health, and enhancing performance in various activities. Over the past three decades, mindfulness has become a multi-billion-dollar industry: a kaleidoscope of mindfulness-based interventions (MBIs) have emerged to help treat problems such as depression, anxiety, addiction, eating disorders, post-traumatic stress, chronic pain, psoriasis, and side effects of chemotherapy. Other MBIs claim to enhance productivity and resilience in school or at work, or to improve sex, parenting, and elder care. Instruction is offered in books, articles, videos, online and face-to-face courses, conferences, workshops, and smartphone apps. Psychologists, mental-health and addiction counsellors, and social workers incorporate MBIs into their therapeutic work. Mindfulness has become the basis for academic programs and publications around the globe, and the subject of scores of government-funded research studies (Hickey 2019: 1–6; Wilson 2014).

Although the contemplative disciplines and physical postures taught in these programs have roots in Buddhism and Hinduism, advocates of mindfulness describe meditation and physical yoga as ‘universal’ practices that can be extracted from their religious contexts and taught in secular settings such as public schools, medical and mental-health facilities, global corporations, and the military. Interest in meditation among Western societies is usually traced to the 1960s and 1970s, but efforts to promote meditation and yoga therapeutically began a century earlier in the American ‘Mind Cure’ movement.

This chapter begins with an overview of early Mind Cure and its role in popularising Buddhist and Hindu forms of meditation from the late 1860s to the early twentieth century. Many leaders of the early Mind Cure movement were white women who have received relatively little scholarly attention. (Hickey 2019: 52–53). Some of them inspired the male leaders of African American religious movements that emerged during the 1920s and 1930s. Mind Cure became so popular and widespread that it alarmed many mainstream Christian clergy and medical doctors: elite white men who saw the Mind Curers as promoting bad religion and bad medicine. In response, a group of five such men launched the Emmanuel Clinic in 1906: a pioneering public-health and social-services endeavour in Boston’s Emmanuel Episcopal Church. They appropriated some of the Mind Curers’ methods and channeled them into fields they controlled: ‘scientific’ psychology, neurology, and mainline Protestant Christianity. The clinic spawned an international ‘Emmanuel Movement’ of similar collaborations between clergy and physicians, and several people associated with the original clinic became pioneers in the fields of psychosomatic medicine, professional chaplaincy, and pastoral counselling (Worcester, et al. 1908; Worcester and McComb 1909; Stokes 1985; Hickey 2019).

After tracing the process by which meditation became medicalised and mainstreamed, we will turn toward the contemporary mindfulness boom and explore its contested relationship to Buddhism. We will then consider recent clinical research on MBIs and critiques of the Mindfulness movement from various scientific, religious, and political perspectives.

Early ‘Mind Cure’: Quimby, Christian Science, and New Thought

The Mind Cure movement was rooted in the teachings of Phineas Quimby (1802–1866), a New England clockmaker and travelling showman who discovered that one’s beliefs and mental/emotional states can affect one’s physical health. Quimby ran an enormously successful mental-healing clinic and taught his methods to others. He seems to have developed an early form of hypnotic suggestion, derived from the medical theories of Franz Anton Mesmer (1734–1815), a physician and astronomer who practised in Paris and Vienna (see also Fuller, this volume), and the theology of Emanuel Swedenborg (1688–1772), a Swedish scientist and mystic whose teachings were widely influential in the United States (Podmore 1963; Crabtree 1993; Albanese 2007; Folk, this volume).

Quimby’s most famous student was Mary Baker Eddy (1821–1910), who founded the Church of Christ, Scientist (a.k.a. Christian Science) in 1879. She later repudiated Quimby, claiming to have received a unique revelation that matter is unreal and disease is an error of the mind that can only be corrected by divine grace. Other important students of Quimby were Warren Felt Evans (1817–1889) and Julius (1838–1893) and Annetta Dresser (1843–1935). Evans wrote six books about mental healing, operated a successful clinic for two decades, and developed the practice of ‘affirmations’: repeating positive statements to oneself to shift negative attitudes. In describing mental therapeutics, Evans drew in part upon Hindu and Buddhist ideas and practices (Evans 1869, 1873, 1886). The Dressers battled publicly with Eddy over what they claimed was her plagiarism of Quimby’s ideas and methods. Their son Horatio Dresser (1866–1964) earned a Ph.D. at Harvard, where he studied with William James (1842–1910) and went on to become an important historian, philosopher, and teacher of New Thought, the other major player in the Mind Cure movement besides Christian Science (Dresser 1919; Gottschalk 1988).

New Thought refers to a diffuse network of organisations and individuals interested in psycho-religious healing, many of whom incorporated ideas and practices drawn from Buddhism, Hinduism, and Theosophy (Jackson 1981). From the 1870s to the early 1910s, the boundaries between Eddy's church and various New Thought groups were porous, and some observers referred to them collectively as the Mind Cure movement. This chapter follows that practice. Eddy controlled her church strictly and ejected those who challenged her authority and teachings. A number of women who studied with Eddy then left her church or were expelled and went on to become important New Thought leaders (Materra 1997).

Mind Curers taught that by attuning oneself to the all-pervading presence of the divine, and realising one's unity with it, one could naturally experience happiness, health, and abundance. 'Abundance' could mean material prosperity, but the earliest and most influential teachers meant *spiritual* abundance. Because we are inseparable from our divine source, they argued, we already have access to all that is necessary for a happy, healthy, satisfying, prosperous life.

New Thought, Gender, and Race

The majority of important early Mind Cure teachers were middle- and upper-class white women. Emma Curtis Hopkins (1849–1925) founded a seminary for New Thought ministers and ordained more than one hundred, some of whom went on to found New Thought churches and denominations. (Harley 2002). New Thought women built careers as clergy, healers, public speakers, publishers, and writers at a time when their lives were quite restricted. They could not vote, control their reproduction, obtain advanced education, work in professions, own property, manage income they earned, divorce abusive husbands, or retain custody of their children if they left bad marriages. Many New Thought women were active in Progressive Era causes promoting women's suffrage, marriage reform, labour reform, temperance, hygiene, vegetarianism, service to the poor and incarcerated, and the prevention of cruelty to animals (Materra 1997).

Some white New Thought teachers, male and female, inspired the leaders of African-American religious movements that emerged during the Harlem Renaissance (1920s) and Great Depression (1929–1941). These included Marcus Garvey's Universal Negro Improvement Association (UNIA), the Nation of Islam, the Moorish Science Temple, Black Hebrew Israelism, and Father Divine's interracial Peace Mission movement (Satter 1996; Curtis 2002; Dorman 2013; Watts 1992; Weisbrot 1983). These groups sought to strengthen the self-esteem and economic self-sufficiency of black people suffering under white supremacy. The Peace Mission built a nationwide network of businesses serving black and white customers alike during the segregationist Jim Crow era, and lobbied for anti-lynching laws (Mabee 2008). For members of disenfranchised groups, the idea that one could change one's circumstances by changing one's thinking had real political, legal, and economic implications.

New Thought diverged in two directions: individualistic and community-oriented. The community-oriented stream includes the religious organisations founded primarily by white women and black men. The individualistic stream has been led primarily by white men promoting 'positive thinking' for personal and business success. It also has been studied far more extensively than the community-oriented stream (Braden 1963; Judah 1967; Parker 1973; Meyer 1988; Haller 2012; Bowler 2013).

New Thought Encounters with Buddhism and Hinduism

Many important early New Thought leaders were intrigued by Buddhism and Hinduism. They read texts translated into European languages by Orientalist scholars. Some studied Theosophy, which blends teachings from multiple Asian, European, Middle Eastern, and American religious sources. At the 1893 World's Parliament of Religions in Chicago, New Thought teachers encountered the first Buddhist and Hindu missionaries to address white audiences in the United States, including Sōen Shaku, a Japanese Zen teacher; Anagarika Dharmapāla, a Sinhalese lay Buddhist; and Swami Vivekananda, a Hindu monk of the Ramakrishna Order. These missionaries drew deftly upon Western science and philosophy to defend their so-called inferior and heathen religions and to portray them as more rational, reasonable, and profound than Christianity. Many of their hearers were looking for ways to reconcile spirituality with science (Houghton 1894; Ketelaar 1991; Seager 1995; Snodgrass 2003).

For twenty years after the Parliament, practitioners of New Thought, Buddhism, Hinduism, and other religions continued mingling annually at summer conferences held at the Greenacre resort in Maine (Cameron 1980; Perry et al. 2012). New Thought journals routinely carried ads for Buddhist and Hindu books and periodicals, and New Thought organisations hosted Asian missionaries on lecture and teaching tours around the country. New Thought practitioners thus learned meditation methods from Theravāda Buddhism, Zen, and Raja Yoga. Meditation became a staple of New Thought practice, sometimes in Christianised or Judaised forms. Commonly recommended methods included meditating on the breath, or on a repeated word or phrase, or cultivating an open, receptive state called 'entering the Silence,' to cultivate awareness of the divine (Dresser 1919; Hickey 2019: 63–99).

Mind Cure was one of many alternative healing methods popularised during the nineteenth century. Others included homeopathy (see Folk, this volume), hydrotherapy, naturopathy, osteopathy, chiropractic, and vegetarianism (Gevitz 1988; Whorton 2002). These alternatives were successful in part because the medical marketplace was unregulated and many 'orthodox' doctors relied on practices such as bloodletting, blistering, and purging the body with laxatives and emetics. They also prescribed poisons such as mercury and strychnine. For many women patients, orthodox doctors ordered hysterectomies, ovariectomies, or genital mutilation (Mattera 1997).¹

The Emmanuel Movement

Mind Cure, which did less damage to patients than such orthodox therapies, became so popular during its heyday that its proliferation alarmed two (white, male) Episcopal priests who had studied psychology in Europe. They saw Christian Science in particular as quackery and bad religion. In 1906 they collaborated with an internist and a neurologist from Harvard and a psychiatrist from Tufts, and launched a pioneering mental- and public-health clinic in the Emmanuel Episcopal Church of Boston, just a few blocks from the Mother Church of Christian Science. The Emmanuel Clinic treated people with nervous exhaustion, anxiety, melancholy,

¹ These procedures were performed without antiseptics because the germ theory of disease was not widely accepted until after World War I. Penicillin was discovered in 1928 but not widely used until World War II.

hypochondria, and phobias, as well as alcohol and drug addiction, using various methods of counselling and ‘suggestion’ derived from Mind Cure. Thousands of Bostonians applied for their classes in health education and hygiene, participated in rudimentary group therapy, and consulted individually with the clergy and physicians (Worcester et al. 1908; Worcester and McComb 1909; Baker 1909).

Through publicity in newspapers and magazines, the ‘Emmanuel Movement’ spread rapidly to other churches around the United States. Its visibility soon drew criticism from other clergy and physicians who wanted to keep their professions separate. However, the movement spawned people and organisations who continued exploring ways to meld modern, secular psychotherapy with the spiritual ‘cure of souls’ (Cunningham 1962; McCarthy 1984; Gifford 1997). These successors of the Emmanuel Movement promoted greater understanding of psychosomatic illness, pioneered Clinical Pastoral Education (CPE) for chaplains, and developed the psychological subfield of pastoral counselling (Stokes 1985). As mental therapeutics became increasingly medicalised, however, the community orientation and social-justice agendas of earlier New Thought organisations fell by the wayside.

Psychological Interest in New Thought and Meditation

During and after World War II the field of American psychology also expanded rapidly. European psychologists who had fled Hitler’s Third Reich taught university courses filled by (mostly white, male) beneficiaries of the US G.I. Bill. Some psychologists grew interested in Zen Buddhism, thanks to D.T. Suzuki, a Japanese Buddhist reformer who had taught Buddhism at the interfaith Greenacre conferences a half-century earlier, then taught Buddhism at Columbia University in the mid-1950s (Fromm and Suzuki 1960; Fields 1992; Iwamura 2011).

Psychology also converged with New Thought in the work of Norman Vincent Peale, a Protestant pastor who preached to thousands weekly in his Manhattan church, reached millions through a radio show broadcast for fifty-four years, sent his magazine *Guideposts* to four and a half million subscribers, and developed several organisations devoted to providing and teaching pastoral counselling. Peale’s book *The Power of Positive Thinking* recommended daily meditation and sold more copies than any book but the Bible in 1955, the same year the placebo effect first received serious attention in an American medical journal (Beecher 1955; Harrington 2008: 103–138). The therapeutic possibilities of meditation also intrigued Michael Murphy, who compiled an important bibliography of medical research on meditation (Murphy and Donovan 1999). In 1962 Murphy and Richard Price founded the Esalen Institute in California, which became another locus for interest in spirituality, alternative healing, and ‘East-West exchange’ (Kripal 2007).

After 1965, when the United States lifted a decades-long ban on immigration from Asia, new waves of Asian missionaries began touring Europe and the Americas, building organisations that taught meditation and physical yoga to eager audiences (Fields 1992). Transcendental Meditation (TM), a technique taught by the Maharishi Mahesh Yogi, attracted many celebrities, including the Beatles. Advocates described TM as accessible to anyone and sought to teach it in public schools and other non-religious environments. They encouraged scientific research on its physical and psychological benefits (Goldberg 2010; Williamson 2010). In 1975 Herbert

Benson, a Harvard medical researcher, discovered the ‘Relaxation Response’: measurable decreases in heart rate, respiration, and blood pressure among people practising TM. Benson went on to found Harvard’s Mind/Body Medical Institute and to demonstrate that a variety of activities, religious and non-religious, can evoke the Relaxation Response (Benson and Proctor 1985). All of this history forms the background for the contemporary Mindfulness movement (Hickey 2019: 100–136).

Mindfulness-Based Stress Reduction (MBSR)

Jon Kabat-Zinn, a microbiologist who spent years studying and practising Buddhism in various contexts, developed the first mindfulness-based intervention (MBI) in 1979: Mindfulness-Based Stress Reduction (MBSR). The eight-week programme includes weekly classes in which participants receive didactic instruction practise basic yoga postures and contemplative methods of sitting, walking, and eating; and discuss their experiences. Daily homework involves about forty-five minutes of meditation and yoga, guided by audio recordings. Students keep journals to log their practices and reflect on their responses to stressful situations (Kabat-Zinn 1991). Kabat-Zinn wanted to offer helpful resources to people falling through the cracks of a fragmented medical system, who might be alienated by a programme that was overtly religious, particularly if the religion were Asian.

Kabat-Zinn defines mindfulness as ‘paying attention in a particular way: on purpose, in the present, and non-judgmentally’ (Kabat-Zinn 2011: 294). Thus defined, ‘mindfulness’ refers to a mental activity one practises. In MBSR, students focus attention on their physical experiences, such as breathing, walking, sitting, tasting and chewing food, or holding a yoga pose. When their minds wander, they repeatedly return attention to their breathing and immediate physical sensations. Observing thoughts and sensations as they arise and pass away, without suppressing or indulging them, while repeatedly re-focusing attention on the body and breath, helps practitioners begin to notice their habits of mind *as* habits of mind—subconscious internal narratives and running commentaries about themselves and the world that affect their physical condition, behaviour, and moods. This recognition can help practitioners begin to refrain from immediately believing and reacting to habitual thoughts, particularly those that fuel pain, anxiety, depression, anger, etc.

Practitioners also begin to notice patterns of tension and avoidance associated with physical or emotional pain, and learn to explore their discomfort with an attitude of curiosity, which often reduces their distress. Turning attention *toward* one’s pain and meeting it with non-judgmental awareness, MBI advocates say, enables practitioners to transform their relationship to whatever unpleasant symptoms they experience and to develop new habits of mind and body that foster greater ease and wellbeing (Kabat-Zinn 1991, 1994, 1998, 2000, 2005, 2011). In 1995 Kabat-Zinn founded the Center for Mindfulness in Medicine, Healthcare, and Society to teach MBSR at the University of Massachusetts Medical Center. It claims to have trained more than 20,000 people and now operates a programme to train and certify MBSR teachers.

Although Kabat-Zinn has decades of experience meditating in explicitly Buddhist contexts, and credits a number of modern Buddhist and Hindu teachers with helping to shape his worldview and the MBSR programme (Hickey 2019: 159–160), he no longer describes himself as Buddhist.

He insists that the ideas and contemplative practices taught in MBSR and other MBIs are not Buddhist, either. They ‘are concerned with embodied awareness and the cultivation of clarity, emotional balance (equanimity) and compassion.’ Because these qualities ‘can be refined and developed via the honing and intentional deployment of attention,’ he argues, ‘the roots of Buddhist meditation practices are *de facto* universal’ (Williams and Kabat-Zinn 2011: 1–18). Because mindful awareness is a universal human capacity, he asserts, ‘it can be learned and practised, as we do in the stress clinic, without appealing to Oriental culture or Buddhist authority to enrich it or authenticate it’ (Kabat-Zinn 1991: 12). Nevertheless, he strongly recommends that MBSR *teachers* study Buddhism and practise intensive meditation in Buddhist retreats (Kabat-Zinn 2011: 284). He also says that MBSR reflects and teaches a ‘universal dharma that is *co-extensive, if not identical, with the teachings of the Buddha, the Buddhadharmā*’ (Kabat-Zinn 2011: 281–306, emphasis added).

Mindfulness (‘Sati’) in Buddhist Sources

The English word ‘mindfulness’ is a translation of the Pāli word *sati* (Sanskrit *smṛti*), which appears frequently in Buddhist scriptures and commentaries. Specialists in these texts have pointed out that Kabat-Zinn’s definition differs significantly from the way *sati* is described in early Buddhist sources. There, *sati* is not ‘non-judgmental awareness of present experience’; it means something like ‘remembrance,’ or ‘calling to mind.’ *Sati* is not a method or goal in itself, but a basic mental *faculty* that enables one to recall a past event or a story vividly, or to bring wandering attention back to focus on one thing. This faculty can be *strengthened* through various contemplative exercises (Bodhi 2011; Fronsdal and Erdstein 2016).

Sati also has an important ethical function in Buddhist teaching: it enables one to distinguish what is wholesome from what is not, what leads to *nibbāna* (Sanskrit *nirvāṇa*) and what does not. In Theravāda Buddhism, which predominates in Southeast Asia and for which the Pāli scriptures are authoritative, *nibbāna* means the total elimination of attachment, aversion, and ignorance; the complete cessation of suffering; and escape at death from *samsāra*, the endless cycle of birth, death, and rebirth.² The Pāli canon lists *sati* among several mental faculties (including faith, energy, concentration, and wisdom) necessary for *developing skill in the practices* that lead to *nibbāna* (Fronsdal and Erdstein 2016). Scholar of Theravāda Buddhism and President of the Pāli Text Society Rupert Gethin notes that mindfulness is ‘always presented as one among several qualities that need to be equally balanced’ (Gethin 2011: 275). He argues that Kabat-Zinn’s definition is simplistic, obscuring both *sati*’s ethical function and its role in helping Buddhist practitioners remember whole systems of thought and practice to which they commit themselves.

The *Satipaṭṭhāna Sutta*, the Buddha’s ‘Discourse on Establishing Mindfulness,’ recommends a number of methods for strengthening *sati* that are neither present-centred nor non-judgmental. They include contemplating basic Buddhist teachings, regarding one’s own body as a skin bag of repulsive substances, and observing corpses being devoured by animals or in various stages of decay, to cultivate detachment toward the body. Others include recalling the positive qualities of

² In Māhāyāna Buddhism, which predominates in north and east Asia and relies on scriptures in languages other than Pāli, *nirvāṇa* refers to a transformation of consciousness that gives one equanimity in the midst of *samsāra* and enables one to aid those still suffering in it.

the Buddha and actively cultivating lovingkindness, which requires one to hold images of oneself and other people clearly in mind. The Theravāda tradition teaches that *these* practices, not mindfulness *per se*, lead to liberation from suffering (MN 10, Ñāṇamoli and Bodhi 1995: 145–155).

The *Visuddhimagga* (Path of Purification), a classic Theravāda Buddhist meditation manual based on the Pāli Canon, recommends two broad types of meditation: *śamatha* (calming) and *vipassana* (insight). *Śamatha* involves focusing attention steadily on a single object. *Vipassana* involves dispassionately observing one's changing thoughts and physical sensations to develop insight into Buddhist teachings about the impermanence and interrelatedness of all phenomena and the causes and cure of suffering.

Buddhist Meditation: Monastic and Lay

The Theravāda tradition presumes that developing deep mental calm and Buddhist insight requires that one devote one's life to rigorous monastic training. Historically, only a small minority of monks and nuns have specialised in meditation, however; most have focused on scholarship, teaching, medicine, and ritual services to laypeople. The Japanese Pure Land and Nichiren schools of Buddhism dispense with meditation altogether, preferring chanting and devotion. Meditation was not widely promoted among laypeople—Buddhist or otherwise—until the latter nineteenth and twentieth centuries (Sharf 1995, 2016; Sharf and Cooper 2007; McMahan 2008; Williams 2005).

The specific methods that dominate MBIs derive from a few modern Theravāda monks who taught European and American students. The Burmese Mahāsi Sayādaw (1904–1982) emphasised 'moment-to-moment, lucid, nonreactive, nonjudgmental awareness of whatever appears to consciousness' (Sharf 2016: 142). This did not require monastic discipline or understanding of Buddhist philosophy, literature, or liturgy. Critics objected to Mahāsi's devaluation of concentration; his claims that laypeople could advance quickly on the spiritual path; and the ethical implications of characterising *sati* as 'bare attention,' thus obscuring its role in helping one distinguish the wholesome from the unwholesome. However, some of his American students propagated his approach to other laypeople through the Insight Meditation Society, founded in 1975 (Sharf 2016).

Scientific vs. Buddhist Understandings of 'Mindfulness'

Willoughby Britton, a psychologist at Brown University, observed that clinical research on meditation offers additional definitions of 'mindfulness' not found in Buddhist sources. It is variously described as a mental *state*, a personal *trait*, a *method* of practice, and the *goal* of practice (Britton 2012; Lindahl et al. 2017). One 2015 meta-analysis of mindfulness research begins, 'Meditation can be defined as a form of mental training that aims to improve an individual's core psychological capacities, such as attentional and emotional self-regulation' (Tang et al. 2015).

Buddhist meditators, however, are encouraged *analyse* and *interpret* their contemplative experiences by applying Buddhist teachings. For example: to see that their shifting thoughts,

emotions, inner monologues, and pain are—like all phenomena—impermanent (*anitya*) and lack any independent, unchanging essence or ‘self’ (*anātman*) (Bodhi 2011). In the *Paticca-samuppada-vibhanga Sutta* (‘Analysis of Dependent Co-arising,’ *Samyutta Nikāya* 12.2), the Buddha teaches that perception itself is a process of *interactions* among the sense organs, the consciousnesses that animate them, and the objects of perception, all of which are in a perpetual state of flux. Attachment to the idea of an essential, perceiving ‘self’ is what keeps us trapped in suffering and the cycle of rebirth. According to the Buddhist doctrine of no-self (*anātman*), ‘things’ that appear substantial are actually processes: temporary and ever-shifting confluences of circumstance. Thus, traditional Buddhist teachings reject the basic premise of mind-body dualism underlying the entire Western, scientific enterprise, including research on meditation: that there are ‘selves’ ‘in here’ studying ‘objects’ in the world ‘out there.’

Furthermore, the Buddha did not seek to *relieve* stress in his disciples, but rather to *induce* it, insists scholar Donald Lopez. By emphasising the pain of *samsāra*, he sought to motivate his followers to renounce the world and devote themselves entirely to seeking *nibbana* through monastic training. The Buddha’s teachings were grounded in an Iron Age understanding of the world, and Lopez wants to preserve the ways that early Buddhist worldviews are incompatible with modern scientific ones. Studying the differences, he says, helps to challenge our unexamined assumptions about ‘Buddhism,’ ‘science,’ and ‘reality’ (Lopez 2012).

Kabat-Zinn’s interpretation of mindfulness arises from a web of religious and philosophical influences, including modernist interpretations of Buddhism and Hinduism (Hickey 2019: 159–162). Modernist religious movements reinterpret traditional doctrines and practices for modern circumstances, particularly scientific understandings of the world. They tend to regard the divine as revealed through nature, rather than occupying a transcendent position beyond it. They typically shift authority away from ordained leaders toward laypeople, and present religious teachings in psychological and philosophical terms. They de-emphasise stories about miracles and supernatural powers. They downplay or eliminate pre-modern cosmologies, minimise ritual, and emphasise that their teachings are compatible with modern science (Hutchison 1976; Sharf and Cooper 2007; McMahan 2008; Payne 2008, 2009).

Clinical Research: Claims and Critiques

Tenzin Gyatso, the Fourteenth Dalai Lama, has done much to promote dialogue among scientists studying the brain, consciousness, and meditation; Buddhist teachers; and scholars in the humanities and social sciences. In 1987 he helped to launch the Mind and Life dialogues for this purpose. Researchers affiliated with the Mind and Life Institute (Charlottesville, Virginia, USA) that emerged from those dialogues have mapped meditators’ brains using Positron-Emission Tomography (PET) scans and functional Magnetic-Resonance Imaging (fMRI). Although clinical research has produced mixed results, some studies suggest that regular meditation can improve one’s immune system, increase the thickness of one’s cerebral cortex, and ‘rewire’ parts of the brain associated with positive mood. MBI training—sometimes *in conjunction with* medication and other supportive therapies—seems particularly helpful for people who have difficulty regulating their emotions, such as those suffering from post-traumatic stress, addictions, eating disorders, and mood disorders (Hutchison 1976; Bishop 2002; Leuchter et al. 2002; Davidson et al. 2003; Lutz et al. 2004). This is because mindfulness practices can

strengthen sufferers' ability to remain focused on present experience, rather than on painful memories or anxious ruminations about the future.

Critics have pointed to significant problems in neuroscientific research on meditation, however. Brain activity varies throughout the day, and because the scanning technology is expensive, the numbers of participants in studies are typically small, which affects the degree to which results can be generalised (Hickey 2010). Extraordinary results depend upon comparing study subjects' brains to a hypothetical 'normal' one, but 'normal' is difficult to define. The mathematical model describing it may vary from laboratory to laboratory (Hickey 2019: 173–176). Worse, a 2016 paper published by the *National Academy of Sciences* reported that 'the most common software packages for fMRI analysis (SPM, FSL, AFNI) can result in false-positive rates of up to 70%' (Eklund et al. 2016: 7900)—showing brain activity where there was none. This finding calls into question the reproducibility of results in some 40,000 published papers over the past two decades or more (Eklund et al. 2016). Nevertheless, this research appears to be extremely persuasive rhetorically, particularly among audiences untrained in neuroscience (Harrington 2008: 230–242; Britton 2012).

Data from brain scans are translated into coloured images, a process that is not always consistent from study to study, and that inevitably highlights some differences and downplays others.

A focus on activity in a particular area of the brain tends to obscure the ways that consciousness and cognition may be distributed simultaneously across multiple areas of the brain and body. The 'resting' state between periods of meditation may be defined inconsistently as well, which affects how results are compared (Hickey 2010: 176–177).

Psychologist Britton has observed that many neuroscientists do not understand qualitative differences between different types of contemplative practice, so they often default to defining 'expertise' in terms of the number of hours spent doing a particular type. Both canonical Buddhist texts and living experts in Buddhist meditation indicate that progress is not linear, she notes; therefore any study based on an assumption that it is so is flawed (Britton 2012).

Additional problems include the difficulty of designing studies with adequate experimental controls, a lack of longitudinal studies, and the risk that researchers will be biased in favour of meditation, which will colour how they interpret results. In short-term, cross-sectional studies, when differences are found between meditators and non-meditators, it is difficult to determine clear causal relationships between meditation and the differences measured. '[It] is possible that individuals with these particular brain characteristics may be drawn to longer meditation practice' in the first place (Tang et al. 2015: 214).

Other researchers use survey instruments to measure mindfulness, which typically ask people to rate themselves on qualities such as 'judgmental attitudes, openness to experience, attention to the present moment, and personal identification with present experience' (Grossman and Van Dam 2011: 221). However, people with meditation experience may understand the meanings of terms on such questionnaires differently than non-meditators do, and long-term meditators may understand them differently than short-term meditators. Moreover, results from self-report questionnaires may not match data obtained by more objective means (Rosenbaum 2016).

When Meditation Makes Matters Worse

Negative experiences are seldom assessed in MBI research, so Brown University (Rhode Island, USA) researchers undertook a study focusing specifically on experiences that practitioners found ‘challenging, difficult, distressing, or functionally impairing’ (Brandmeyer et al. 2019: 9). They identified fifty-nine types of these experiences across seven domains: physical, emotional, cognitive, perceptual, motivational, social, and related to a practitioner’s sense of self. Researchers also identified twenty-six influencing factors ‘that can impact the nature, duration, and trajectory’ of these experiences. While some meditators described positive effects (e.g., euphoria, increased energy, empathy), others—both new and long-term meditators across different Buddhist traditions—reported fear, paranoia, hallucinations, delusions, depression, suicidality, irritability, anger, and social or occupational impairments. These lasted from a few days to more than a decade, with a median duration of one to three years. Some of the study’s informants required hospitalisation. Such experiences were not limited to people with prior histories of trauma or mental illness, or to those on long-term retreats, or to those who were insufficiently prepared or supervised (Lindahl et al. 2017).

The study noted that some negative experiences occurred under conditions similar to those of MBIs: an hour or less of meditation daily, undertaken primarily for health or stress relief. It also noted that while MBI participants are frequently encouraged to undertake longer retreats after the formal programme ends, researchers seldom follow subjects for more than a year, so little is known about the long-term trajectories of their meditation practice. Meditation is generally contra-indicated for people with schizophrenia or other disorders involving delusional thinking.

Religious Critiques of Mindfulness-Based Interventions

The Mindfulness movement has been critiqued on various religious grounds, as well. Scholar Candy Gunther Brown served as an expert witness for Christian plaintiffs in a lawsuit opposing yoga instruction in a California public school, and calls mindfulness ‘stealth Buddhism.’ She argues that teaching meditation and yoga in public schools violates the US Constitution’s separation of church and state. Such practices should be taught only after school, optionally, and only if their religious roots are clearly explained and participants are allowed to give informed consent. She has written that many forms of complementary and alternative healing are inherently religious, regardless of how they are taught, and may threaten some people’s prior religious commitments, particularly Christians’. Critics say her understanding of ‘religion’ and ‘secular’ is too simplistic, and that she is mistaken to regard religious traditions as if they were bounded entities that might ‘contaminate’ one another (Brown 2013, 2016; Deslippe 2017).

Critics of MBIs who are Western Buddhists express concern that meditation has been uprooted from its religious, ethical, and communal contexts, and packaged for sale. Efforts to promote mindfulness in corporations, government, and the military have insidious consequences, they say. Treating stress as an individual problem also obscures systemic factors that fuel stress-related illness: poverty, stagnant wages, homelessness, racism, sexism, and so on.³ Many mindfulness products, classes, and conferences cost hundreds or thousands of dollars, which

³ Proponents argue that teaching and practicing mindfulness contributes to changing society for the better.

makes them accessible only to relatively affluent people. At major conferences, presenters are mostly white and have advanced academic degrees, executive jobs, or celebrity status. They are most likely to have access to good medical care already (Hickey 2019: 212–215).

Instead of asking *why* people are so stressed, mindfulness interventions simply serve as a balm to make people more efficient and complacent cogs in the capitalist machine, says Ron Purser, a fierce critic of what he calls ‘McMindfulness’ in corporations and the military.

[The] single-minded concentration of a terrorist, sniper assassin, or white-collar criminal is not the same quality of mindfulness that the Dalai Lama and other Buddhist adepts have developed. Right Mindfulness is guided by intentions and motives based in self-restraint, wholesome mental states, and ethical behaviors—goals that include but supersede stress reduction and improvements in concentration (Purser and Loy 2013).

Furthermore, Buddhist practice is grounded in community (the *sangha*) and includes many other practices that help to cultivate virtues such as devotion, humility, gratitude, generosity, perseverance, kindness, and respect (Senauke 2016; Magid and Poirier 2016; Purser 2019).

Gethin observes that arguments for and against MBIs can be made from different Buddhist perspectives. From a more conservative point of view, extracting mindfulness from its broader Buddhist contexts ‘might seem like an appropriation and distortion of traditional Buddhism that loses sight of the Buddhist goal of rooting out greed, hatred, and delusion.’ From a Māhāyana perspective, it could be seen as *upāya-kauśalya* or ‘skillful means’: an accessible way to help people take their first steps on the path toward freedom from suffering. From a modernist Buddhist perspective, it could be seen as a way of stripping away ‘unnecessary historical and cultural baggage, focusing on what is essential and useful.’ A non-Buddhist might see it as ‘revealing the useful essence that had hitherto been obscured by the Buddhist religion.’ Perhaps combining ‘practices derived from Buddhism with the methods of modern western cognitive science’ might be ‘a true advance that supersedes and renders redundant the traditional Buddhist practices.’ Or perhaps it is simply part of a cultural shift away from using religion ‘to heal our souls,’ toward science and biomedicine (Gethin 2011: 268).

Conclusion

This sketch of the Mindfulness movement’s early history and current reception reveals the plurality of its sources and of the challenges it faces today. Therapeutically oriented meditation first emerged in the West with the ‘Mind Cure’ movement of the latter nineteenth century, which sprang from even earlier sources in Western religious, philosophical, and medical history. Warren Felt Evans and others, including Asian missionaries to the West, added Buddhism, Hinduism, and Theosophy to the mix.

Mind Cure became popular because it did less damage to the body than many mainstream medical practices around the turn of the twentieth century. Mind-cure techniques helped practitioners to deal with anxiety and other personal issues, improving their mental health and physical conditions. At the same time, the movement gave white women and black men and

women unprecedented professional and economic opportunities and supported their efforts to promote social reforms such as women's suffrage, labour protections, temperance, and anti-lynching laws.

The contemporary Mindfulness movement has drawn diverse critiques, as well. Scientific studies claiming to validate the therapeutic value of meditation suffer from a wide variety of methodological and interpretive problems. Moreover, meditation can actually be harmful for some people. Among the movement's religious critics are both Christians who see MBIs as endangering their faith commitments, and Buddhists who fault such programmes for oversimplifying, de-contextualizing, distorting, misusing, and/or commodifying profound spiritual teachings and disciplines developed over millennia by monastic specialists. MBIs will likely continue to be promoted for their benefits and contested in the various ways described here, as well as in ways yet unseen.

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