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Mindfulness meditation: Do-it-yourself medicalization of every moment

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ABSTRACT

This paper examines mindfulness as a popular and paradigmatic alternative healing practice within the context of contemporary medicalization trends. In recognition of the increasingly influential role popular media play in shaping ideas about illness and healing, what follows is a discursive analysis of bestselling mindfulness meditation self-help books and audio recordings by Jon Kabat-Zinn. The central and contradictory elements of this do-it-yourself healing practice as presented in these materials are best understood as aligned with medicalization trends for three principal reasons. First, mindfulness represents a significant expansion in the definition of *disease* beyond that advanced by mainstream medicine. Second, its etiological model intensifies the need for *therapeutic* surveillance and intervention. Third, by defining healing as a never-ending process, it permanently locates individuals within a *disease–therapy cycle*. In sum, the definition, cause, and treatment of disease as articulated by popular mindfulness resources expands the terrain of experiences and problems that are mediated by medical concepts. The case of mindfulness is a potent illustration of the changing character of medicalization itself.

Introduction

Mindfulness represents one approach within the emerging field of mind-body or integrative medicine. Mindfulness is defined as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, pp. 3–4). The practice is loosely informed by Zen Buddhist meditation practices that emphasize the importance of achieving a particular state of conscious living. Some proponents of mindfulness meditation in the United States describe it as akin to Buddhist meditative practices without the Buddhism (Aubrey, 2007). Mindfulness is said to address a person's physical, mental and spiritual well-being. Proponents maintain that individuals have inner resources to recover from injury and illness, and, in some cases, prevent their onset altogether. Purportedly, these inner resources can be cultivated and mobilized through the systematic practice of mindfulness meditation.

During the last several decades, mindfulness has made notable inroads into mainstream Western medicine. Jon Kabat-Zinn, Ph.D. is arguably the person most responsible for this development. Searches for "mindfulness meditation" on *Web of Knowledge* and *Web of Science* reveal Kabat-Zinn's central role in generating a burgeoning area of clinical research. His works are the most cited on the topic; nearly 4000 other publications as of September, 11 2013 cite the author. Kabat-Zinn also founded the Stress Reduction Clinic at the University of Massachusetts Medical Center and subsequently developed its mindfulness-based stress reduction (MBSR) program in 1979. Other MBSR programs, where patients come together to sit in silence, focusing on their breath, now operate at more than 200 U.S. clinics, including several affiliated with prestigious academic medical centers.

But mindfulness has reached far more people than those who have attended an MBSR class. Whereas tens of thousands of individuals have enrolled in an MBSR program, several millions have read or listened to mindfulness self-help books or recordings (Center for Mindfulness, 2010). These self-help materials describe the practice and promise to steer individuals down their own path of awareness and health. Not only is Jon Kabat-Zinn the individual most responsible for introducing mindfulness into mainstream medicine, but he is also chiefly responsible for its introduction to a lay audience through his bestselling books and audio recordings. In his book *Full Catastrophe Living* ([1990] 2005b), Kabat-Zinn provides a detailed set of instructions so that readers can emulate an eight-week MBSR program in their own living rooms. *Wherever You Go, There You Are* (1994) and *Coming To Our Senses* (2005a) reflect on the general benefits of mindfulness for personal growth, as well as its specific transformative healing capacities. Kabat-Zinn teamed up with holistic health celebrity Andrew Weil to record *Meditation*

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for Optimum Health (2001), which, like Kabat-Zinn's more recent solo recordings, *Guided Mindfulness Meditation* (2005c) and *Mindfulness for Beginners* (2006), provides listeners with detailed instructions for using "the breath" as a powerful tool in self-healing. These books and recordings are owned by millions of Americans and are available at thousands of U.S. libraries; they are also available in libraries in more than twenty countries and have been translated into more than a dozen languages (Worldcat, 2013).

The popular appeal of mindfulness reflects two interrelated trends: the steady increase in consumer demand for alternative healing practices (Eisenberg et al., 1998), and the vast proliferation of popular health information in print and electronic media (Seale, 2003). Health researchers are keenly interested in what these trends portend. For example, it bears noting that the decades of increased consumption of alternative and health-related self-help resources have not been associated with a slowdown in the pace of medicalization. Despite a few isolated cases of demedicalization, Western societies continue to frame ever more personal and social problems as medical in nature (Clarke, Mamo, Fishman, Shim, & Fosket, 2003). Curiously, both self-help and alternative healing approaches have been identified as encouraging as well as resisting medicalization.

I address this contradiction using the case of mindfulness. Specifically, I present a discursive analysis of Kabat-Zinn's aforementioned bestselling books and audio recordings. I approach these sources with the following question: To what extent are the definitions of and explanations for health, disease and healing aligned with medicalization? Mindfulness is an especially illustrative case because its assumptions are paradigmatic of alternative practices more generally (Goldstein, 1999). Moreover, relaxation and meditation techniques are among the most commonly used forms of alternative healing in the United States (Eisenberg et al., 1998). Thus a close scrutiny of mindfulness is of considerable interest in a quest to understand the relationship between contemporary do-it-yourself alternative principles and the changing character of medicalization trends.

Medicalization and alternative healing

Medicalization commonly refers to the processes of "defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad, 2005, p. 3). The different types of human problems and experiences that have been medicalized include, deviant behavior (e.g., gambling and sex offending), natural life processes (e.g., pregnancy and aging), everyday problems of living (e.g., sadness and learning difficulties), and individuals' felt disappointments and desired enhancements (e.g., sexual performance and emotional attractiveness) (Davis, 2009). We have also witnessed the medicalization of *risk*, where the problem being medicalized is not a disorder *per se*, but a heightened potential for a disorder (Conrad, 2013). In contrast, demedicalization occurs when a heretofore medical problem no longer is construed in medical terms: the most oft noted examples include masturbation and homosexuality.

These broad definitions belie the complex character of medicalization and the development of the concept of *medicalization* itself: there are different degrees and dimensions of medicalization and demedicalization; there are multiple and competing forces (inside and outside the institution of medicine) contributing to and resisting medicalization; and these forces have changed and continue to change over time (Rose, 2007; Williams & Calnan, 1996). Even in the face of some emerging pockets of resistance and countervailing forces (Conrad, 2005; Light, 1993), the drive toward medicalization or biomedicalization (i.e., the technoscientific intensification and transformation of the process of medicalization) (Clarke et al., 2003) dramatically overshadows modest demedicalizing tendencies.

Since its introduction in the 1970s, a number of scholars have critiqued and revised the analytic concept of medicalization (Bell & Figert, 2012). These important amendments notwithstanding, the concept still carries significant analytic purchase with respect to describing broad trends wherein human experiences are framed as health and medical matters in contemporary western societies. As originally articulated by Irving Zola (1972), medicalization had two general meanings. The first and more established meaning refers to the expansion of the institution of medicine's jurisdictional authority and physicians' professional power. Medicalization of this type is somewhat less striking than it was in first three quarters of the twentieth century and is of less relevance to the empirical case at hand.

But Zola also used the term to apply to the process of making the "the labels 'healthy' and 'ill' *relevant* to an ever increasing part of human existence" (Zola, 1972, pp. 475–6, original emphasis). It consists of promoting "a belief in the omnipresence of disorder" and an eagerness to "feel, look, or function better" (Zola, 1972; pp. 475–476). Medicalization in this sense is ubiquitous in the contemporary context and it is of considerable salience with respect to alternative healing in general and mindfulness in particular. Medicalization of this sort also captures aspects of what has been called *healthism* and *healthization*, to denote beliefs and trends that emphasize the obligations of individuals to pursue health and avoid (or cure) illness through behavior and lifestyle modifications (Conrad, 1992; Crawford, 1980; Williams, 2004). The case of mindfulness provides us with an opportunity to explore how healthism and healthization are situated vis-à-vis contemporary processes of medicalization.

Before addressing the contradictory claims concerning the relationship between alternative healing and medicalization, it is necessary to acknowledge the problematic character of the label *alternative*. There is tremendous heterogeneity in the types of practices labeled alternative. The vast diversity in alternative practices is one reason a residual definition is sometimes used: alternative practices include all techniques not taught in most orthodox medical schools (Eisenberg et al., 1998). This definition has become problematic now that many orthodox medical schools include instruction in some heretofore-alternative practices. The introduction of the phrase *complementary and alternative medicine* (CAM) signifies orthodox medicine's more collaborative stance vis-à-vis previously marginalized approaches (Whorton, 1999). On the other hand, not all alternative practices collaborate with the medical mainstream; whether intentionally or unintentionally, some practices remain more marginal than others.

Despite these distinctions, a number of scholars have identified core assumptions held by most alternative practices. Michael Goldstein (1999) provides the following list: holism; the interpenetration of mind, body and spirit; the possibility of high-level wellness; the body as a vital system characterized by a natural flow of energy; and a participatory healing process. Others identify a similar set of beliefs aligned with various types of alternative practices (Lowenberg, 1989; Ruggie, 2004). I use the term "alternative" to refer to healing practices grounded in these core assumptions; and, as will be seen, mindfulness is a paradigmatic alternative practice.

According to practitioners and devotees, the core alternative beliefs represent a necessary corrective to those advanced by orthodox medicine (e.g., mind-body dualism, body-as-machine metaphor, etiological specificity) that result in targeted technological interventions to attack symptoms in a passive, diseased body. Alternative assumptions are said to counter a number of scientific medicine's ills: wellness is more than the absence of pathophysiology; individuals are unique and greater than the sum of their (standardized and diseased) parts; illness represents an

opportunity for personal growth, not just an instance of misfortune; and individuals are active agents in the promotion of their own well-being, rather than mere objects of normalizing technoscientific practices (Schneirov & Geczik, 2003).

The core assumptions of alternative healing clearly overlap with a critique of the medicalization of life, advanced in its most radical form by Ivan Illich (1976). According to Illich, orthodox medicine is our nemesis insofar as it destroys our capacity to deal with the inevitability of pain, disability and death, by turning these states into technical problems overseen by physicians and administered by medical institutions. By framing illness as an opportunity for personal development and authorizing individuals to manage their own suffering, it would seem that alternative ideals slay, or at least wound, our medical nemesis. The assumed natural abilities of the body to heal, a central premise of alternative healing, likewise suggests a nod toward demedicalization in the form of independence from medical experts, or new relationships to healers based on partnerships rather than hierarchical doctor–patient dyads (Lowenberg & Davis, 1994). Yet, at the same time that some alternative ideals challenge medical dominance and empower individuals, there are also indications that alternative tenets are tied to medicalization. A compelling argument can be made that alternative healing does not liberate the individual from medical domination, but rather represents new forms of medical social control (Crawford, 1980; McClean, 2005).

This both/and dynamic draws our attention to issues concerning the conceptual parameters of medicalization in the contemporary era. At the same time, it suggests the salience of Zola's (1972) definition of medicalization advanced more than forty years ago. Here I stress his emphasis on the applicability of *health* and *illness* to ever more aspects of the human experience, the promotion of an omnipresence of disorder, and the quest for optimal wellness. The principal purveyors of medicalization in this sense are not physicians *per se*, or even the institution of medicine more broadly. Instead, people routinely encounter ideas about health and illness that promote medicalization in discourses that circulate widely in the public, frequently disconnected, in full or part, from the institution of medicine (Furedi, 2004; Rose, 2007). Contemporary assessments of medicalization, therefore, are greatly enriched by the work of sociologists who underscore the role popular media play in shaping our ideas about health-related matters (Kroll-Smith, 2003; Seale, 2003; Williams, Seale, Boden, Lowe, & Steinberg, 2008).

What follows is an analysis of bestselling mindfulness materials with an eye toward their relationship to medicalization in the second sense described by Zola. A brief point of clarification is in order. Although Kabat-Zinn and Andrew Weil are not disconnected from the institution of medicine, their bestselling self-help materials are. Setting aside any discussion about the degree to which these individuals in their role as media figures are discredited by some in the medical mainstream, the production of these materials stands fully outside the demands of biomedicine's epistemological requirements (e.g., radical skepticism, peer-review, value neutrality). Lay people are increasingly informed by media health experts, and, whether or not these advice-givers are physicians or representatives of medical institutions, the production and consumption of their best-selling advice takes place "*outside* the traditional confines or intuitional parameters of the doctor–patient relationship" (Williams, 2004: 456).

Data and methods

The aforementioned bestselling books and audio recordings of Jon Kabat-Zinn serve as data for the following analysis. Three books (Kabat-Zinn, 1994, 2005a, 2005b) and three audio recordings (Kabat-Zinn, 2005c, 2006; Weil & Kabat-Zinn, 2001) were selected from the highest-ranked mindfulness titles on *Amazon.com*. *Amazon* rankings provide the most reliable, publicly available data on the *relative* sales of books and similar media (Kelley-Milburn, 2013; Milliot, 2013). As of March 17, 2013, these books and recordings were still among the most popular mindfulness titles on *Amazon*. I scanned and saved the books as electronic text files. I transcribed the substantive content of the audio recordings into electronic text files.

Although Kabat-Zinn is not the only contemporary advocate of mindfulness meditation, he is certainly the most influential and well known in the United States. A March 17, 2013 search for "mindfulness meditation" on *Amazon* lists Kabat-Zinn as the number one author in the area. And there are other indicators of Kabat-Zinn's central importance to the cultural production and dissemination of mindfulness. For example, there are more than two dozen mindfulness books listed on *Amazon* that include a foreword penned by Kabat-Zinn. A few examples of these are *The Mindfulness Solution to Pain*, *Mindful Birthing*, and *Here for Now: Living Well with Cancer through Mindfulness*. The prevalence of aspiring authors who hope to capitalize on Kabat-Zinn's notoriety provides additional evidence of his central role in the popularization of mindfulness and further justification for my empirical focus on his works.

Several studies provide helpful templates for the analysis of popular sources of health information (Kroll-Smith, 2003; Lyons & Griffin, 2003; Williams et al., 2008). Evelyn Ho's (2007) analysis of educational pamphlets distributed by practitioners at a holistic health fair is of particular relevance given its substantive and methodological overlap with the research I present here. It is worth noting that Ho recommends studying alternative texts that reach larger audiences than the pamphlets used in her research. The mindfulness sources studied here are in line with Ho's recommendations.

The method I use is best described as discourse analysis (Lupton, 1992). Commonly associated with the Foucauldian tradition, discourse analysis examines how 'texts' present *knowledge* and how that *knowledge* comes to mediate social experiences by circulating in a larger sociocultural milieu (Snape & Spencer, 2003). The task of discourse analysis is to explore the relationship between discourse and the social construction of reality, or how discourse presents particular ideas that become dominant or taken-for-granted (Phillips & Hardy, 2002, p. 3). Discourse analysis focuses not just on the form and content of texts, but it also pays attention to what texts do. A guiding assumption of discourse analysis is that "public texts… work to construct our understandings of the world" (Ho, 2007, p. 36).

In the following analysis I seek to explicate the key discursive elements of mindfulness. To this end, I systematically identified substantive themes that speak to the principal assumptions of mindfulness relating to its definitions of health, illness/disease, and healing. This was achieved by closely and repeatedly reading these materials. Because the materials were transcribed into electronic text documents, I also conducted keyword and phrase searches to ensure greater consistency and comprehensiveness in the identification of content related to definitions of health, illness/disease and healing. This latter technique proved especially helpful given the volume of text being analyzed. I then assessed the degree to which these definitions promote and/or contradict the core principles of alternative healing outlined earlier in the paper. Finally, I evaluated the degree to which these definitions relate to medicalization. Through an in-depth analysis of these books and transcribed recordings, I uncover a particular framing of reality that is promoted by mindfulness meditation and reflect on the

consequences of that reality vis-à-vis contemporary processes of medicalization.

Analysis

Dis-ease and the full catastrophe

Kabat-Zinn's explanation for the title of his book *Full Catastrophe Living* is a fruitful place to begin exploring the core assumptions of mindfulness.

> I keep coming back to one line from the movie of Nilos Kanzantzakis's novel *Zorba the Greek*. Zorba's young companion turns to him at a certain point and inquires, "Zorba, have you ever been married?" to which Zorba replies…"Am I not a man? Of course I've been married. Wife, house, kids, everything… the full catastrophe!" (Kabat-Zinn, 2005b, p. 5).

Although stress is the word we use nowadays to describe the full catastrophe, we are assured that Zorba's reply is not a lament. Instead it reveals "a supreme appreciation for the richness of life and the inevitability of all its dilemmas, sorrows, tragedies, and ironies" (Kabat-Zinn, 2005b, p. 5). The phrase *the full catastrophe,* according to Kabt-Zinn (2005b, p. 5), "captures something positive about the human spirit's ability to come to grips with what is most difficult in life and to find within it room to grow in strength and wisdom." Although the human spirit possesses the innate capacity to weather and grow from the inevitable stress and suffering of life, nearly all of us, we are told, have lost touch with this capacity. This leaves us in varying states of discomfort, dissatisfaction, and distress; most of us live in a state of "dis-ease" which "literally means a lack of ease or lack of comfort" (Weil & Kabat-Zinn, 2001, disk 1, track 7).

Mindfulness portrays our failure to pay attention as the principal reason we are *dis-eased*. The specific culprit is inattention to the present moment. Instead of paying attention to the here and now, we tend to compulsively worry about things that have already happened, and plan and fret for things that have yet to come. Like a dog might "worry a bone," we become compulsively attached to our thoughts (Weil & Kabat-Zinn, 2001, disk 1, track 7). Inattention is also the result of a cultural obsession with doing. Because we busy ourselves in a constant race to get more and more done, we never fully experience the moment in which we find ourselves. Rarely are we aware of what all the doing is about.

In short, both the cause and the consequence of our extreme state of busyness is the deficit of attention. Evidence of the widespread inability to pay attention is found in the alarmingly high rates of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, diagnoses that did not even exist thirty years ago. But the problem extends well beyond those diagnosed with these disorders: "the entire society is suffering from attention deficit disorder – big time…" (Kabat-Zinn, 2005a, p. 143). The relationship between obsessive mind states, frantic doing, and inattention to the present moment is summarized as follows:

> We come here and go there … running around to such a degree doing this and that that we forgot about the very essential dimension of our lives … called the domain of being. After all we are called human beings not human doings. … So we can go for days, weeks, months and virtual years conditioned to run on automatic pilot, as if on a treadmill, trying to get where we need to be… Much of this is focused on attaining particular states, goals or conditions at some future time, or being obsessed or absorbed with things that have already happened and are over in the past. And in the process… the present moment, which is the only time any of us are ever alive in … gets a little short shrift.
>
> Weil & Kabat-Zinn, 2001, disk 1, track 5

Mindfulness taps into a set of broadly familiar experiences: Do your daily worries and routine time demands consume much of your attention? Do you feel a sense of "dis-ease" or lack of ease? As such, mindfulness dramatically foregrounds one conceptual means by which alternative healing encourages medicalization (Lowenberg & Davis, 1994): by defining the common malaise of everyday life as a diseased state, mindfulness represents a significant expansion in the terrain of the pathological. Disorder is not limited to a discrete biophysical state but rather is amorphous and omnipresent. This all-too-familiar state of affairs is a lynchpin in the complex etiological model of disease presented in the books and recordings.

The cause of dis-ease: mind over matter

Like alternative healing generally, mindfulness emphasizes the mind-body connection. The consequences of this connection as an arbitrator of disease are elemental to mindfulness. As presented in these sources, not paying attention to the present moment is not just a matter of missing beautiful sunsets (Kabat-Zinn, 2005b, p. 25). Living on automatic pilot "can leave a wake of disaster behind us in terms of our own health and well-being" (Weil & Kabat-Zinn, 2001, disk 1, track 5). When we do not pay attention we miss important messages from our body. If we take antacids rather than changing our diet when our stomach aches from eating certain foods, we are not heeding our body's call. "Instead, we are unknowingly disconnecting from the body, overriding its efforts to restore balance and order" (Kabat-Zinn, 2005b, p. 229).

On top of aggravating existing health problems, a lack of attention is said to generate a class of physical problems, sui generis. "Dis-attention" can generate new "dis-ease" (Kabat-Zinn, 2005a, p. 120). Here mindfulness draws on a core precept of the mind-body link as articulated in behavioral medicine: our emotions and attitudes determine our susceptibility and resistance to illness. After summarizing the work of popular writers such as Norman Cousins and Bernie Siegel, as well as lesser-known researchers in the emerging field of psychoneuroimmunology, it is noted that having positive attitudes positively affects one's health. Conversely, pessimism has "particularly toxic consequences" (Kabat-Zinn, 2005b, p. 201). Various supporting research is cited, including a study of pessimistic cancer patients who died earlier than their optimistic counterparts, and a study that found that Hall of Fame baseball players who had gloomy attitudes in their youth, lived shorter lives than did those who had been more upbeat (Kabat-Zinn, 2005b, pp. 200–201). Readers are told about one spectacular case wherein a patient died of cardiac arrest immediately after mishearing her doctor describe her case as terminal. The woman's condition was not life threatening; what killed her was her own severe stress reaction to the false news that it was (Kabat-Zinn, 2005b, p. 190). The conclusion to be drawn from these and many other studies and stories presented in the books and recordings is that when we allow ourselves to be carried away with negative emotions and pessimistic attitudes, we open ourselves to illness and premature death.

Key to mindfulness is the supposition that stress is ubiquitous and a fundamental contributor to many disease states. On the surface, this supposition parallels sociological research that emphasizes the relationship between stress and poor health outcomes. But, whereas sociologists focus on the ways in which stress reflects and reproduces existing forms of social inequality (Thoits,

2010), mindfulness places primary emphasis on individuals' affective responses to the seemingly inevitable and widely shared stresses that typify modern life (i.e., the full catastrophe). Here again mindfulness roots itself in behavioral medicine, explaining how the sympathetic nervous system triggers a fight-or-flight response when we experience stress. To maximize our ability to run away from or confront a would-be predator, stress hormones are released into the body creating a state of hyperarousal commonly called the "stress reaction" (Kabat-Zinn, 2005b, p. 251). Although this natural response is adaptive in the case of acute stressors, it becomes maladaptive in the case of chronic stressors that characterize modern life. These days, it's "as if the Saber Tooth tiger never goes away" (Weil & Kabat-Zinn, 2001, disk 1, track 3). The list of health problems said to be linked to the stress–reaction cycle is far reaching (e.g., heart and vascular diseases; digestive, sleep, and functional somatic disorders; chronic pain and headaches; depression and anxiety) (Weil & Kabat-Zinn, 2001). Additionally, the cumulative effects of stress are said to be capable of causing almost any illness, the particular form of which depends on your biological weakness. If you have a family history of heart disease, then a heart attack might be your body's response to chronic stress; if you have an underlying immune dysfunction, cancer could be the likely outcome (Kabat-Zinn, 2005b, pp. 261–262).

As portrayed, not paying attention to the present moment can trigger a series of potentially life-threatening biochemical alterations. "Dis-attention" can sabotage our body's natural healing abilities. Our ancient biology, although well suited for responding to acute stress, sets us up for a potentially treacherous journey in the context of modern chronic stresses. Each person's journey is uniquely shaped by certain biological predispositions. Nevertheless, attitudinal dispositions are said to fundamentally influence the journey's level of peril. In short, the etiological framework is highly elastic, virtually boundless, and over-determined.

There are important consequences of such an ambiguous etiological framework. Somewhere lurking amidst the ambiguity is the implication that we play some role in creating our own illness. It has been duly noted that the flip side of emphasizing personal responsibility for well-being is a tendency to blame individuals for becoming sick (Lowenberg & Davis, 1994; Sered & Agigian, 2008). Kabat-Zinn provides a warning against drawing such a conclusion:

> [T]o suggest to a person with cancer that his or her disease was caused by psychological stress, unresolved conflict, or unexpressed emotions would be totally unjustifiable. It amounts to subtly or not so subtly blaming the person for his or her disease
>
> Kabat-Zinn, 2005b, p. 209.

This single cautionary statement sits in tandem with a long litany of research findings and anecdotes that accentuate a causal relationship between negative attitudes and poor health outcomes, and positive attitudes and good health outcomes. That our attitudes (for good and ill) impact our well-being is an inescapable conclusion of the mind-body principal to which mindfulness and alternative healing generally adhere. A consequence of the mind-body connection is that it makes significant demands on the individual concerning the scope of therapeutic action. This corollary will now be addressed.

The participatory healing process & contradictions of being

Whereas orthodox medicine commonly prescribes discrete technological interventions for a passive patient, most alternative regimes emphasize a participatory healing process. Individuals play an active and ongoing role in their own healing by changing their behavior, consciousness, and/or lifestyle (Lowenberg, 1989). In the case of mindfulness, individuals are called upon to marshal their inner healing resources by learning to pay attention on purpose. To that end, the books and recordings provide detailed instructions for formal and informal meditation techniques.

Mindfulness is a call to *be* rather than to *do*. "The basic idea is to create an island of being in the sea of constant doing in which our lives are immersed, a time in which we allow all the 'doing' to stop" (Kabat-Zinn, 2005b, p. 20). The experiences and writings of Henry David Thoreau are frequently evoked to describe the spirit of non-doing. Thoreau's still and mindful life as captured in *Walden* is juxtaposed to our non-stop world of "24/7 connectivity" and the attendant stress from living with continual time acceleration (Kabat-Zinn, 2005c). We are told that non-doing, non-striving, being in the present moment, is a way of freeing the self from the tyranny of time that characterizes our fast-paced lives.

Alternative healing regimes have been described as attempts to counter societal rationalization (Schneirov & Geczik, 2003). There are a number of ways mindfulness opposes what Max Weber (2002 [1904]) bemoaned as the *iron cage* of modern society, dominated by rationalized (i.e., means-ends oriented) thought and action. The spirit of non-doing is one significant example. Non-doing represents a rejection of key facets of rationalization, including the principle of efficiency (Ritzer, 2004). Take, for instance, the guided instructions for mindfully eating a single raisin, a practice that takes more than 17 minutes (Kabat-Zinn, 2005a, 2005c). The description of walking meditation is also instructive: "In walking meditation, you are not walking to get anyplace. … Literally having no place to go makes it easier to be where you are" (Kabat-Zinn, 1994, pp. 145–46). Mindfulness claims to disavow mean-ends calculations. It claims to have no agenda or goal beyond teaching us to be with things as they are.

But mindfulness requires more than walking without a destination or eating a single raisin with "spacious attention" (Kabat-Zinn, 2006). The practice of mindfulness calls for focused awareness in all one's daily activities.

> [W]e can bring moment-to-moment attention to the tasks, experiences, and encounters of ordinary living, such as setting the table, eating, washing the dishes, doing the laundry, working in the garden, mowing the lawn, brushing our teeth, shaving, taking a shower or a bath, drying off with a towel, playing with the children, cleaning the house, taking out the garbage, taking the car in to be fixed or fixing it ourselves, riding a bike, taking the subway, getting on a bus, talking on the phone, hugging, kissing, touching, making love, taking care of people who depend on us, going to work, working, or just sitting on the front steps or in the backyard
>
> Kabat-Zinn, 2005b, p. 134.

Posed to the reader, the following question reveals the vast mission of mindfulness. "Is there any waking moment of your life that would not be richer and more alive for you if you were more fully awake while it was happening?" (Kabat-Zinn, 2005b, p.139).

A paradox emerges: mindfulness allegedly opposes the rationalized life, and, yet, it is itself a highly disciplinary practice (Foucault, 1977). Indeed it brings the level of required therapeutic surveillance down to an ever-smaller increment of time: moment-to-moment or breath-to-breath. There are a host of phrases that capture these contradictory impulses: "One needs to try less and be more" and "intentionally cultivating the attitude of non-striving" (Kabat-Zinn, 2005b, p. 37). One must engage in "doing nothing, on a regular basis, on systematic basis, in a disciplined way" (Kabat-

Zinn, 2006). *Full Catastrophe Living* comes complete with an awareness calendar to facilitate the close monitoring of progress toward a path of awareness and health. When it comes to popular alternative practices and their mandates of self-disciplining, "there is no rest for the weary" (Clarke et al., 2003, p. 172). In this manner, alternative practices like mindfulness exemplify a key preoccupation of social theorists from Weber to Foucault, who, despite major differences in their substantive focus and theoretical approach, converge on a common concern with the rationalized and disciplinary practices to which humans subject themselves and the consequences thereof (O'Neill, 1986).

However, participatory healing has also been identified as central to the demedicalization impulse of alternative healing paradigms. These books and recordings unambiguously encourage individuals to become experts on behalf of their own health. "The whole point of mindfulness-based stress reduction … is to challenge and encourage people to become their own authorities, to take more responsibility for their own lives, their own bodies, their own health" (Kabat-Zinn, 1994, pp. 191–192). But, even as encouraging lay expertise suggests a call for demedicalization, this is more accurately described as an opposition to professionalization (Furedi, 2004). The essence of this distinction is found throughout the books and recordings:

> By involving people in this *expanding definition of medicine and health care* in a participatory way, behavioral medicine helps people to shift the balance of responsibility for their well-being away from an exclusive dependency on their doctors and closer to their own personal efforts, which they have more direct control over than they do over hospitals, medical procedures, and doctors.
>
> Kabat-Zinn, 2005b, p. 197, emphasis added

That mindfulness promotes self-responsibility is not inherently problematic given modern medicine's inability to address the complexity of many of the chronic conditions that ail us. Indeed this rhetoric can be seen as progressive insofar as it empowers individuals, challenges orthodox medical hegemony, and promises to demedicalize routine care. And yet, the "expanding definition of medicine and health care" also represents an ambitious form of medicalization by promoting a therapeutic transformation in one's very being. Individuals must manage, monitor, and regulate their physical, mental, and spiritual well-being as part of an enveloping lifestyle, thereby turning health into an ambitious and ongoing moral obligation. Mindfulness thus encourages what Rose (1999) dubs "the government of the self", or what has been called "healthism" (Crawford, 1980) and "healthization" (Conrad, 1992; Williams, 2004).

Healing: attitudinal determination

Like other alternative systems, mindfulness assumes that the body has an innate healing capacity. However the body's natural ability to regulate itself is undermined when we fail to pay attention. The books and audio recordings, therefore, promise to teach us how to pay attention in a particular way that will give us a greater "sense of ease" (Kabat-Zinn, 2005b, p. 168). It is important to note that a greater sense of ease does not imply the absence of illness or disease. Also, like other alternative systems, mindfulness does not define healing as synonymous with curing. "When we use the word healing to describe the experiences of people in the stress clinic, what we mean above all is that they are undergoing a profound transformation of view" (Kabat-Zinn, 2005b, p. 168). Healing means accepting things as they are "rather than struggling to force them to be as the once were, or as we would like them to be" (Kabat-Zinn, 2005a, pp. 136–137). As presented, healing is tantamount to embracing the full catastrophe, including the acceptance of pain, disability, and death.

Despite the poignant affirmation that one is healed through accepting things as they are, even (or especially) in the presence of illness, the books and recordings are brimming with descriptions of persons who have been cured (in the more conventional sense of the term) through the practice of mindfulness. Andrew Weil tells the story of a young man whose body was covered in painful and unsightly boils. The man was treated with antibiotics on several occasions but the boils would not abate. Weil took a different approach: he instructed the man to sit down and "meditate on his skin as an interface between himself and the universe" (Weil & Kabat-Zinn, 2001, disk 1, track 7). The man, Weil recounts, was cured. His boils disappeared and never returned.

There are scores of similar testimonials. A few examples include: a woman who regained her ability to sleep soundly after a year of debilitating insomnia; a disabled truck driver freed from the grip of chronic pain and able to return to work; and an arthritic man, unable to walk but a few steps with the aid of cane, restored to a life of activity. One particularly dramatic story is that of a woman who nearly died during surgery to remove a type of tumor that almost always quickly returns and becomes fatal. To the amazement of her doctor, the woman not only survived the surgery but her cancer has been in remission for ten years. A catalogue of similar stories intimates that mindfulness may hold the key to healing in the literal sense. Furthermore, readers and listeners are repeatedly urged to practice mindfulness as if their "life depended on it" because, "in a profound way, it surely does" (Kabat-Zinn, 2006, disk 1, track 3 and liner notes, p. 5). Although this phrase is used to evoke the philosophical sense in which living an aware life is dependent on mindfulness, for many chronically and terminally ill persons, the narrative cannot fail but to provide hope for restoration and survival, not just maximizing the quality of life with illness or gaining the wisdom to except life's end.

On one hand, mindfulness decouples healing and curing, claiming to privilege the former. Because healing is a state of mind, it is framed as always within our reach, independent of the level of disease or the degree to which we are cured. The importance of this form of empowerment and promise of transcendence in the face of terminal illness should not be trivialized. When nothing can be done, helping the individual accept what cannot be denied falls woefully outside orthodox medicine's jurisdiction (Illich, 1976). In the eyes of alternative healing advocates, an emphasis on transcendence addresses orthodox medicine's dehumanizing and aspiritual character (Goldstein, 1999; Schneirov & Geczik, 2003). Still a troubling conclusion can be drawn from this particular framing of healing. Although the cure you desire may or may not be within your grasp, your ability to self-heal is guaranteed, provisional only on your commitment to claim it. To paraphrase: "The only thing standing between you and being healed is you."

On the other hand, healing and curing are not consistently decoupled and the claim to privilege the former belies a strong emphasis on the latter. The conceptual lines between healing and curing are frequently blurred by using the terms interchangeably and/or leaving open the possibility that the audience will understand them as one in the same. This is not suggestive of deception. A fundamental premise of mindfulness and other mind-body techniques is that personal transformation and health outcomes cannot be conceptually disentangled. Nevertheless, the implications for individuals are significant in that they are empowered both to heal *and* cure themselves. Moreover, short of death, this dual project has no precise end point. It is a process not an outcome.

The conceptualization of healing as presented in these resources exposes a troubling consequence of medicalization; namely, the tendency to define problems or their solutions as abstracted from their social context (Conrad, 2013; Zola, 1972). To be fair, Kabat-Zinn recognizes the environment – including the physical, cultural, spiritual, and social milieu – as contributing to our dis-eased states. Poor working conditions, poverty, sexual abuse, and pollution are some of the health-compromising factors briefly mentioned (Kabat-Zinn, 2005a, 2005b). And yet, these claims set up the following paradox: although all manner of external factors impact an individual's health in negative ways, the individual is always capable of contributing to their own healing, irrespective of these externally-imposed hardships.

> We all have the potential for healing and transformation no matter what the situation we find ourselves in, of long duration or recently appearing, whether we see it as … hopeless or hopeful, whether we see the causes as internal or external. These inner resources are our birthright
>
> Kabat-Zinn, 2005a, p. 8.

In this fashion, albeit in different ways, both orthodox medicine and mindfulness overemphasize the individual and underemphasize the social. Orthodox medicine frames disease as *inside* the individual, thereby obscuring the social factors that produce ill health. Mindfulness frames *disease* and *healing* as states of mind thereby obscuring social factors that undermine health. Regrettably, awareness and positive thinking do not translate into an improvement in material conditions or the structural realities known to be consistently predictive of poor health outcomes (Barr, 2008). I am not suggesting that Kabat-Zinn denies the role social inequalities play in well-being. Rather it is the ambiguities found in mindfulness, including the tension between the vastness of what ails us and the internal process by which we are healed, which result in foregrounding the role of the individual. Additionally, and perhaps unlike mindfulness in a clinical context, the tendency to explicitly emphasize conditions over which individuals have immediate control reflects the very ethos of the self-help genre in which these books and recordings are situated (McGee, 2005).

Discussion

A central premise of discourse analyses are that texts (broadly defined) are more than mere cultural artifacts. Accordingly, a key goal is to examine "what texts do" (Ho, 2007: 29). I argue that one accomplishment of mindfulness books and recordings is that they inadvertently contribute to a broad cultural template that constitutes a regime of medicalization. Various contradictions within mindfulness confound its more radical critique of the biomedical model, and, in turn, perpetuate the potential for the medicalization of everyday life.

As presented in these popular resources, mindfulness is best understood as aligned with a regime of medicalization for three principal reasons. First, compared to orthodox medicine, mindfulness represents a significant expansion in the conceptualization of *disease* (i.e., what can be diseased). Paradoxically, this is the direct result of an expansive definition of health, which includes total wellness of mind, body and spirit. By ratcheting up what it means to be healthy, mindfulness intensifies a "belief in the omnipresence of disorder" (Zola, 1972, p. 475). Second, mindfulness puts forth an elusive and over-determined etiological model that increases the scope of therapeutic intervention. Because anything and everything can cause "dis-ease," individuals are adrift in a sea of conceptual confusion that nevertheless places responsibility for their sickness, or at least their path to wellness, squarely at their feet. In response, they must vigilantly surveil everything they do, think, and feel. Third, by defining healing as a never-ending process, mindfulness permanently locates individuals in the "kingdom of the ill" (Sontag, 1989, p. 3). Because mindfulness relies on ambiguously defined notions of what it means to be healed (i.e., it simultaneously leaves open the possibility that one is never fully healed in the broadest sense *and* that one can readily be healed – even when sick – by simply accepting things as they are) it traps individuals in an ongoing *disease–therapy cycle*. The result is an expansive notion of illness and a healing process with no end, or what Sered and Agigian (2008) refer to as "holistic sickening."

Given these assertions, some readers may wonder why I contend that mindfulness is aligned with medicalization rather than with *healthism* or *healthization* (Conrad, 1992; Crawford, 1980; Williams, 2004). In tandem with other scholars, I do not see this as a matter of either/or. Healthism is "the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, *with or without therapeutic help*" (Crawford, 1980, p. 368, emphasis added). As a social process or trend, healthization is seen when lifestyle and behavioral causes and interventions are proposed for previously medically defined problems, and, when health itself, is turn into a moral good (Conrad, 2013). To be sure, mindfulness is steeped in the ideology of healthism and extends the terrain of healthization.

These observations, however, do not ipso facto exclude mindfulness from being aligned with expanding medicalization. As Crawford laments, "healthism is a form of medicalization" because it expands a "medical way of seeing" (Crawford, 1980: 381). Specifically, "all behaviors, attitudes, and emotions considered to put the individual 'at risk' are *medicalized* – the labels health and illness become attached to them" (Crawford, 1980, p. 380, emphasis in original). Healthism and medicalization are distinct things; the former is an ideology, the latter a social process. Nevertheless, as described by Crawford, and as seen in the case of mindfulness, they can be kindred spirits. Other scholars have described how the processes of medicalization and healthization can co-occur, and further suggest that the distinction itself has blurred in recent decades (Kroll-Smith, 2003; Seale, Boden, Williams, Lowe, & Steinberg, 2007; Williams, 2004). The preceding analysis confirms these patterns. The most accurate way to describe the ethos of mindfulness is therefore as evidence of *both* medicalization *and* healthization, as well as an instance of the possible blurring of this distinction altogether.

To be clear, I am not arguing that mindfulness and medicalization are tied together because mindfulness grounds itself in the orthodox biomedical model, although to some extent this is the case vis-à-vis the partial assimilation of behavioral medicine's tenets into the medical mainstream. What makes mindfulness a form of medicalization is not an adherence to biological reductionism. Instead, the tie to medicalization showcased here is that the definition, cause, and treatment of *disease* as articulated by popular mindfulness resources expands the terrain of human experiences and problems that are defined and treated as an illness or disorder (*with or without therapeutic help*). This fact also helps contextualize the contradictory claims concerning the relationship between alternative healing and medicalization that have been proposed. The very alternative principles that push *against* medicalization in the one sense (i.e., challenge/limit medicine's professional and institutional authority) push *toward* medicalization in the other sense (i.e., apply the concepts of health and disease to ever more of the human experience). As is the case with medicalization trends in the main, the modest counter push is overshadowed by the potent drive toward medicalization.

Given that these assertions are based on the analysis of do-it-yourself alternative merchandise, a few comments about the character of contemporary processes of medicalization are in order. First, medicalization in its present form no longer takes place exclusively within clinic walls, and it can happen "with or without the (direct) involvement or expressed intent of doctors" (Williams, 2004: 454). Indeed, it has been noted that, "one of the most significant by-products of medicalization is the end of the professional dominance of the doctor" (Furedi, 2004: 18). Second, although it is not the only contemporary "engine of medicalization" (Conrad, 2005), the marketplace – in this case the multi-billion dollar market for alternative self-help products and practices (Marketdata Enterprises, 2010) – can and does advance medicalization at a broad cultural level. Third, contemporary medicalization often bears the imprint of what Giddens (1991) calls the late-modern project of the reflexive construction of the self. In this instance, mindfulness conflates processes of self-healing and self-construction by transforming selfhood itself into a protracted pursuit of well-being.

Nothing has been said here about how lay people interface with mindfulness or the degree to which the practice is personally or medically beneficial. These are important lines of inquiry in they own right. A central limitation of this research is that I do not address how mindfulness is actually experienced by socially situated individuals. This is a crucial omission as other scholars have shown the complex relationship between the ideology and practice of alternative healing. For example, although alterative healing ideologically emphasizes individual responsibility, patients are routinely absolved of responsibility by their alternative healers (Lowenberg, 1989; McClean, 2005). The ideology is, in effect, more punitive than the practice. However, when we turn to do-it-yourself alternative products, like those analyzed here, there is typically no practitioner to offer us absolution. In such instances, we may be stranded with only a punitive and medicalizing ideology.

One final reflection is in order. Nearly all individuals who use alterative and self-help practices do so in conjunction with, not in lieu of, orthodox medicine (Eisenberg et al., 1998). Add to this the continued expansion of orthodox medicine into previously unorthodox terrain. To give but one example, there is now a Mind-Body Medical Institute affiliated with Harvard Medical School. Whether collaborations of this sort represent a crass co-cooptation of alternative practices or a genuine reform of Western medicine, it is fair to say that some convergence between alternative and orthodox practices is underway (Whorton, 1999). Alternative ideals contribute to medicalization when they are adopted by mainstream health care providers who come to see controlling an individual's lifestyle as part of medicine's jurisdiction (Clarke et al., 2003). In sum, the growing use of CAM practices among lay people, as well as the increasing cooptation of alternative practices by the institution of medicine, could portend a situation in which individuals are concurrently the subject of their own therapeutic regulation *and* the object of formal medical management (Lowenberg & Davis, 1994). Such a situation would surely constitute an intensification of medical social control, an outcome that concerned Zola in the early 1970s.

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