

Mental Illness through the Lens of Mindfulness

Patricia Lynn Dobkin and Kaveh Monshat

The Oxford Handbook of Meditation

Edited by Miguel Farias, David Brazier, and Mansur Lalljee

Subject: Psychology, Cognitive Psychology Online Publication Date: Dec 2020

DOI: 10.1093/oxfordhb/9780198808640.013.33

Abstract and Keywords

The intention of this chapter is to re-envision mental illness within a paradigm that unites the biopsychosocial paradigm with a modern Buddhist spirituality, particularly associated with mindfulness. Emotion regulation, a balanced relationship with one's self-concept, and social connection are usually regarded as essential components of well-being within both systems of thought. Western psychology and mindfulness practice have, at times, been seen to have fundamentally opposing aims: one to strengthen the self and the other to arrive at "no-self" or "emptiness." This chapter purports that the two approaches may overlap and can be complementary both in their contribution to understanding the self and the regulation of emotions. Clinical narratives of depression, anxiety, obsessive-compulsive disorder, and psychosis are included to exemplify the application of a whole-person outlook to understand mental illness. While an orientation to well-being through a mindfulness perspective may be generally helpful, mindfulness meditation is not a panacea: for some patients, it may be contraindicated, applied in a modified format, or used alongside medication and/or psychotherapy. This chapter presents a "middle way" between the views of suffering that informs mindfulness practice and that which is drawn from psychology and psychiatry.

Keywords: mindfulness, mental health, biopsychosocial-spiritual, depression, anxiety, obsessive-compulsive disorder

Introduction: Modern Psychological and Psychiatric Views

The paradigms we use to understand mental illness have shifted over time and varied across cultures; they have included viewpoints from different disciplines (e.g. psychiatry, psychology, neuroscience) as well as interest groups, such as feminists, social reformers, and industry (i.e. pharmaceuticals). For the past decade or so, the neuroscientific perspective has overshadowed other important developments in psychiatry such as multidisciplinary, community-based care. The biomedical approach has gained prominence based on

Mental Illness through the Lens of Mindfulness

the assumption that mental health problems arise from “faulty mechanisms” within the person. The editorial of a special issue of the *British Journal of Psychiatry*, composed by twenty-nine eminent psychiatrists, highlights the importance of “non-technical aspects” of care: the nonspecific therapy factors such as the therapeutic alliance and patients’ hopes and expectations (Bracken et al., 2012). In the case of depression, for example, the evidence fails to support the common assertion that medications work by correcting a pre-existing “chemical imbalance.” Instead, the editorial authors advocate a “recovery approach” that takes into consideration the complex interplay of biopsychosocial forces underlying patients’ conditions. This argument can be taken further by envisaging a psychosocial model of mental illness that integrates factors such as poverty and domestic violence alongside social and community services (Kinderman, 2014).

Until recently, modern psychotherapy mirrored the medical model where the patient or client is considered to have *internal* emotional conflicts, irrational thoughts, and maladaptive behaviors that require “fixing.” In some cases, existential issues such as identity, meaning, and mortality may be addressed, but predominantly the focus is squarely upon the individual seeking care (except for couple or family systems therapy). Little to no attention is paid to the person’s context, culture, and religious or spiritual orientation.

Diagnostic Labels

Psychiatry has a history of categorizing people who suffer. This is intended to help but may inadvertently inflict harm. As Tsou (2016) points out in his review of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 1980), the third version was stripped down to a descriptive approach to *facilitate communication between researchers and clinicians*. It signaled a shift toward a “neo-Kraepelinian” outlook—a biological approach to psychiatry. The *DSM-V* goes further in its claim to be informed by genetics and neuroscience. Tsou offers the alternative term “natural,” referring to mental disorders (e.g. schizophrenia, major depression, bipolar) that share similar biological causation. Others disagree. Lakeman and Cutcliffe (2016) contend that the *DSM-V* is “merely the latest in a long line of failed, misplaced nosological attempts” that has contributed to the “unwarranted medicalization of everyday life” (p. 125).

Frances (2016), an editor of the *DSM-IV*, concurs, noting that the pharmaceutical industry has played a role in pathologizing and over medication. The diagnostic categories fail to acknowledge the heterogeneity of experience within all those labeled with a certain disorder. Jureidini (2012) states that psychiatric diagnoses are mostly “unexplanatory.” He underlines the breadth of “reasons to be sick” that see the whole person living within a community. For instance, he notes that in our society we are collectively intolerant of common emotions including sadness, anger, and fear. We hold being distressed as being “not myself.” Subsequently the label “depression” engages health care systems that locate the problem within the person, deflecting attention away from the social context that may be contributing to the individual’s experiences (see Neitzke, 2016).

Broadening the View: Mindfulness and Its Spiritual Background

Mindfulness within a secular context can be mistakenly perceived as a psychological technique meant to smooth the rough edges of life rather than transform the person living it. Kabat-Zinn (2003, p. 145) encourages clinicians and researchers to recognize “the unique qualities and characteristics of mindfulness as a meditative practice, with all that implies, so that mindfulness is not simply seized upon as the next promising cognitive behavioral technique or exercise, decontextualized, and ‘plugged’ into a behaviorist paradigm with the aim of driving desirable change, or of fixing what is broken.”

When authentic, mindfulness informs values, ethics, and the way one lives. To learn how best to meet needs, we begin by observing ourselves and those around us. If this exercise of observation generates judgmental guilt or anger, we remind ourselves that we are doing it because we care about ourselves—in other words, out of and with compassion.

Modern secular mindfulness has been influenced by Buddhism. The classical Buddhist scriptural text on the foundations of mindfulness asks the practitioner on twenty-nine occasions to observe phenomena “internally, externally and both internally and externally” (Ñāṇamoli & Bodhi, 1995, S10:43). This is often taken to mean being aware not just of oneself but of others as well. Although the lonely meditator may develop certain helpful qualities, the breadth of Buddhist practice recognizes mindfulness as being socially grounded. This reflects the principle of “inter-being,” an acknowledgement of our necessarily interdependent natures (Nhat Hanh, 1999).

The first aspect of mindfulness practice the Buddha highlighted was ethical conduct, particularly a non-harming orientation toward oneself and others born of compassionate awareness and the clarity of mind and wisdom it generates. Skillful actions, that is, those that a clear and compassionate mind sees as promoting mental and physical health in ourselves and others, calm the mind, which, in turn, promotes greater awareness and wisdom, thus forming a virtuous circle (Keown, 2013). As a basis for healing oneself and promoting healing in others, this view concurs with current psychology and psychiatry, which emphasize objectivity and empirical evidence but extend it by highlighting compassion and felt understanding.

Mental Illness through a Spiritual Lens

Cultural and religious mythologies have occasionally provided misguided or stigmatizing explanations of depressive or psychotic symptoms (e.g., as possession by unearthly beings). Although we have largely adopted the secular view of mindfulness advanced by authors like Kabat-Zinn (2003) and Batchelor (2015), we wish, nonetheless, and as they themselves encourage, to put mindfulness in its spiritual, rather than a religious context. By “spiritual” we refer to the sense of an underlying and self-transcendent reality. It is broader than religious beliefs and also differs from existential matters—the latter usually referring to suffering that is not relieved by treatment for physical symptoms, or that oc-

Mental Illness through the Lens of Mindfulness

curs in the absence of such symptoms. Examples of spiritual distress are the need to reconcile with “God,” or others, or oneself; or perceptions of being distant from one’s spiritual community. In contrast, sources of existential distress may be feelings of alienation, loss of sense of dignity, loss of meaning, or loneliness.

In contrast to a normative diagnostic model where a person tends to be considered as either ill or healthy, a humane awareness of emotional suffering advocates a spectrum model. At one end there are extreme experiences (e.g. schizophrenic psychosis) in which biological disturbances are evident and where biological treatments are usually necessary and sometimes lifesaving. Milder forms of disturbance (e.g. non-melancholic depression) lend themselves to a complementary mix of psychotherapeutic and biological treatments. At the other end of the spectrum is what is typically diagnosed as a psychiatric disorder, but may also be seen as an expression of distress born of psychosocial or spiritual challenge or deprivation. An example would be the difference between depression and burnout—burnout being the likely outcome of psychosocial or existential problems.

Spiritual needs, such as finding purpose in life, a sense of belonging to a community, or experiencing inner peace, are worthy of clinical attention across this spectrum of distress. Although mental health professionals are encouraged to apply a biopsychosocial model of care, patients with psychotic disorders tend to receive little more than antipsychotic medications and social support. At best, psychological techniques to deal with the distress associated with hallucinations may be introduced. Often no attention is paid to how the person’s sense of meaning or identity is affected by their altered perceptions of reality.

At times, the intense emotions and permeability of perceptual boundaries that arise in psychosis can allow patients access to spiritual experiences and insights that might have genuine value, but are usually dismissed as psychotic symptoms.

A Psychosis Case Study

Fred¹ is a man in his forties living with his frail, elderly parents and his twenty-year-old son. He receives a monthly injection of antipsychotic medication, which allows him relief from auditory hallucinations and religious delusions. He has become obese, lacks energy, and has blurred vision since commencing medication. Due to a chronic shortage of permanent medical staff in his rural public mental health service, psychiatric input tends to be intermittent and brief.

He feels devalued by psychiatrists who associate the spiritual experiences he reports with his illness. When explored in detail, two categories of experience emerge. He has at times felt that although he is a separate entity in some ways (in terms of physical boundaries), he is also intimately connected with and somehow one with all of existence. This pleasant experience is associated with a calming awareness of a benevolent unifying principle or force. At other times he has formed the belief, which he finds unpleasant, that he is called to a religious mission. In preparation for this he has felt compelled to cleanse himself through burning the palms of his hands with candle flames.

Mental Illness through the Lens of Mindfulness

Once the first set of experiences is acknowledged as spiritually meaningful, he is able to more readily distinguish the second as destructive and a product of a mental disturbance. He expresses gratitude for being heard and respected. A more collaborative and less patronizing approach to managing his antipsychotic medications becomes possible, which eventually results in a significant reduction of side-effects, and in turn greater motivation to take medication.

Buddhism: A Clinical Reading

Most Buddhist scholars agree that Buddhist scriptures have been influenced by local cultures and politico-religious institutions over the past 2,500 years (Batchelor, 2015; Nhat Hanh, 1999). As Nhat Hanh states, “we have to use our own intelligence” and take “an overall view of the teachings” (Nhat Hanh, 1999, p. 24) to apply what has been handed down to our modern, present circumstances. This is the stance we adopt in this chapter.

The Buddha maintained a pragmatic approach. He aimed to instill a felt sense of principles to help practitioners independently discern how to deal with any set of given circumstances and shunned proclaiming religious rules that told people how to live (Batchelor, 2015). This applies equally to the choice between different ways of cultivating compassionate awareness (i.e., mindfulness “practices”), where the practitioner is guided to develop and rely on her individual judgment in finding what best serves her and others’ well-being.

How can the vast Buddhist canon and its various interpretations, bodies of commentaries, and practices guide clinicians? They may be informed by the overall aims of the teachings, which are to diminish suffering and nurture well-being. Rather than equating mindfulness with sitting meditation or a scriptural view of the human condition, they encourage individuals to continually ask themselves: “What is kind and conducive to happiness?” (Fulton, 2009). In this way, patients can discover what is healing in each phase of life given their socio-cultural context and developmental strengths and vulnerabilities.

Let us take the cultivation of pleasant emotions, such as gratitude and joy, as examples. Western psychotherapy and certain traditional interpretations of mindfulness practice, particularly in Theravada schools, tend to focus on a pure observation of whatever is present. Other Buddhist traditions (e.g. Tibetan and Vietnamese) highlight the need for a compassionate, relaxed, and even playful attitude while witnessing what arises. Greater emphasis is placed on practices such as *mettā* (loving-kindness) and being in touch with joyous elements of moment-to-moment experience (Ricard, 2007; Nhat Hanh, 2009).

Buddhism and Western Psychology in Dialogue

The view of suffering in Buddhism has been likened to a clinician’s approach (Norman, 2003). In the exposition of the Four Noble Truths we progress from becoming aware of ill-being (symptoms); to identifying a discernable cause (underlying pathology); to a recognition that relief and well-being are possible; and an outline of the path towards health

Mental Illness through the Lens of Mindfulness

the(cure or healing). One is guided to bring a curious, caring awareness to suffering, which generates a felt understanding (i.e. not simply an intellectual or speculative one) of its causes. One is encouraged, in parallel, to notice, understand, and nurture moments of wholeness. Thus, one learns to be with suffering on the one hand (e.g. not drink to escape), and nurture peace of mind and joy on the other (Batchelor, 2015; Nhat Hanh, 1999).

Kelly (2008) summarizes Buddhist psychology and its pertinence to psychiatry and psychotherapy by introducing a distinctive view of distress and mental illness. For example, “conditionality” (“dependent arising”) describes how emotional and cognitive states are dependent on a limitless, inter-dependent, inter-generational range of causes and conditions. People are not singled out as individually disordered; instead, Buddhist psychology aims to address the human condition as a whole. Actions that harm us or others tend to naturally trigger unpleasant feelings. Meditation practice that incorporates ethical living protects us against unhelpful internal states taking hold.

Mindfulness practice emphasizes grounding awareness in the body as a way to heal emotional difficulties. For example, two basic emotions, fear and anger, can manifest as bodily tensions. These may be physical correlates of psychological pain. When chronic, and sometimes following acute severe trauma, a vicious circle of mind-body discomfort can develop. Mindfulness encourages exploring and letting go of tensions lodged in the body, which even if initially protective, have become maladaptive. Although there are several schools of Western body-oriented psychotherapy (Röhrich, 2009), the majority of evidence-supported interventions are based on psychodynamic or cognitive-behavioral paradigms. This is beginning to change with the popularity of Mindfulness-Based Interventions (MBIs) that introduce therapists to a more integrative view of the body-mind relationship. These interventions use mindfulness meditation, as well as ideas from Buddhist mindfulness regarding observing events and oneself in a neutral, non-judgmental way, in order to stimulate self-detachment from thoughts and emotions.

A Complementary View of the Self

In many spiritual traditions, especially in Buddhism, individuals are encouraged to let go of their attachment to the self. Western psychology and Buddhism may be viewed as having opposing aims: one aims to strengthen the self and the other to arrive at “no-self” or “emptiness” (Meadows, 2003). Here we propose that the two approaches may overlap and be complementary.

Like in psychotherapy, non-judgmental awareness in meditation strengthens the integrative function of the ego (e.g., to accept oneself in the presence of both wanted and unwanted feelings). This may be helpful, for instance, for people who have suffered neglect or emotional or physical abuse in early life. In addition, the sense of calm and connectedness often associated with concentration-oriented meditative practices can “provide a stabilizing force in the mind ... with a sense of ontological security” (Epstein, 2007, p. 129).

Mental Illness through the Lens of Mindfulness

It is a mistake to think that the aim of mindfulness practice is to annihilate the ego, even if *egoism* may lessen (Epstein, 2007). Rather, the objective is to see through the usual representations of the self. By sensing how one habitually constructs an image of the self out of a stream of experiences, we reduce identification with feelings (“*I am angry*”), which allows for greater freedom of action (what is usually referred to in the psychoanalytic literature as “mature defences” such as humor or sublimation). “No-self is the whole self functioning in a non-self-centered way” (Magid, 2002, p. 82). In other words, “The self is still present—but it is not self-preoccupied. It washes the dishes and puts them away” (Magid, 2002, p. 95; quoting Aitken Roshi, 1991).

“Emptiness” is specifically used in Buddhism to mean “devoid of an inherent, independent existence,” rather than not *at all* extant. It is to be differentiated from the sense of emptiness that plagues those suffering from borderline or narcissistic personality structures. Here a pathologic feeling of inner hollowness or “deadness” exists, due to a failure to develop or sustain a stable, cohesive self (Magid, 2002).

For mindfulness practitioners to develop “a more fluid ego able to constantly integrate potentially destabilizing experiences of insubstantiality and impermanence” (Epstein, 2007, p. 52), they need to be able to “let their mind rest in its natural state” (Epstein, 2007, p. 146). Also, to dismantle old structures during meditation, one must have the basic skills of affect regulation, that is, to be able to tolerate, endure, and organize in a meaningful way one’s experiences so as not to be overwhelmed by anxiety, pain, uncertainty, or other reactions as one sheds the light of awareness onto difficulties.

For some individuals, concentration-oriented practices quiet the mind, although they can be overused as defensive avoidance in relation to inner conflict or strong emotions (Magid, 2002). In addition, even in long-term practitioners of mindfulness meditation, core psychodynamic conflicts and deficits can remain intact. Nonetheless, the practitioner can become aware and less reactive to them and, as a result, suffer less frustration or narcissistic injury (Rosenbaum, 1999).

While psychotherapy can help a person discover the roots of an emotion, such as anger, understand how it is fueled in the present, as well as provide means to cope better, it may not offer a reason to let go of it. Insights gained through mindfulness practice (e.g., seeing through a rigid self-construct to be defended at all costs) can facilitate acceptance and allow thoughts and emotions to dissipate.

But we must also take into account that for many people struggling with mental illness, intense feelings of anxiety, rage, or despair serve as barriers to developing meditative insight; these can become even more overwhelming during sitting meditation practice, especially in silent retreat settings. For such individuals, psychotherapeutic methods, used in a long-term therapeutic relationship, are essential to help them regulate affect and arrive at a healthy sense of self.

Healing Versus Curing

Eradicating symptoms through a pharmacological or psychotherapeutic “cure” is perhaps the key aim in orthodox mental health care. A mindfulness perspective, in contrast, emphasizes coming to terms with symptoms or to exercise the capacity for healing as being central to well-being. In some cases, mental illness may be curable, but healing is possible in all cases.

Healing can be defined as “a shift in our quality of life away from anguish and suffering, toward an experience of integrity, wholeness, and inner peace” (Mount, 2006, p. 50). Healing involves openness, trust, hope, and acceptance. When a person lives according to what makes life meaningful, then he or she is less likely to suffer. Schmidt (2004) notes that self-awareness and compassion promote healing in both the therapist and patient. The non-specific elements of the healing environment, such as when the therapist acts as a healer within a safe space that allows patients’ novel understanding of the nature of their illness to arise, enables them to “re-perceive” their illness. Then life can be viewed as coherent and meaningful. This motivates patients to take responsibility for their well-being, not in a sense that blames them for their illness but by allowing them to understand how distress and mental illness have their origins in how people view themselves and their predicament, and how these perceptions impact the social aspects of their life.

Diagnostic Labels Revisited

Classification systems were originally conceived to *aid* or expedite rather than replace professional communication. To explain how and why a person is suffering, clinicians arrive at and communicate a “formulation” that even in concise form requires several paragraphs. Collapsing the myriad aspects of a patient’s suffering and its causes into a diagnosis stated in a few words is a necessary simplification.

Despite controversies surrounding both the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases classification systems, it is possible to use them skillfully. When the clinician is conscious of the benefits and limitations of using a specific diagnostic label, it is possible to maintain an open and flexible attitude to take into consideration the complexities underlying both the label and the person given the diagnosis. If, in addition, we bring into awareness of principles such as “conditionality” and “non-self,” then a diagnosis may serve to guide treatment decisions while considering the interconnected network of factors affecting the individual (Kelly, 2016).

For patients and their caregivers, diagnostic labels *can* be helpful especially in some cases (e.g. severe schizophrenia). Here the experience of “disease” is arguably comparable to diabetes or dementia. The label itself can then have a relieving explanatory power and reduce existential distress and confusion associated with a painful, bewildering experience.

However, when explaining less severe distress and dysfunction, diagnostic labels are a double-edged sword. The patient may be left with the notion that she is inherently disabled or incomplete as a human being. For example, when using the word “depression” a clinician reifies a vast network of interrelated phenomena from poor sleep to social rejection. Moreover, the word “intervention” itself reinforces this newly constructed identity of being inherently and personally damaged or disordered, and requiring to be fixed.

A Whole-Person Perspective on Selected Illnesses

Depression

Depression and anxiety are by far the most common diagnoses in mental health care. In a unified model of depression it is suggested that “depression represents an adaptation to the perceived loss of a vital resource investment that exceeds the individual’s competencies and capacities (e.g. resourcefulness, problem-solving, support), to mitigate the impact of the loss” (Beck & Bredemeier, 2016, p. 507). “Vital resources” are above all social relationships in which one has heavily invested and bear on the person’s identity and access to basic needs. This parallels the emphasis in Buddhism on healthy social relationships for both well-being and as a support for mindfulness practice (Batchelor, 2015).

Beck and Bredemeier review the cognitive triad (self-image, images of the world, and expectations for the future) that simultaneously operate to determine the meaning and value of life events and generate responses accordingly. Early traumatic experiences (e.g. child abuse, parental loss) as well as predisposing genetic factors put an individual at risk for depression. Acute (e.g. death of a child) and chronic stressors (e.g. unemployment) may precipitate a depressive episode mediated and maintained by psychological (e.g., undermining of supportive attitudes and beliefs) and biological (e.g. elevated levels of cortisol) reactions to stress. Once depressed, individuals selectively attend to negative information. Biases in information processing mediate the effects of genetic and environmental risk factors that bear on serotonergic neurotransmission.

How a person appraises and gives personal meaning to an event is critical to how it is dealt with. If there is great investment in a lost “vital resource” and it is perceived to be out of the person’s control, then the reaction is likely to be more pronounced. This becomes entrenched with repeated episodes of depression. “Depressogenic beliefs” (e.g. “I am a loser”; “Life will never get better”) are key mediators of recurrence.

Reversing these processes align well with Cognitive Behavior Therapy (CBT) and Mindfulness-Based Cognitive Therapy (MBCT). Engagement with the therapist is viewed as powerful in itself to help the patient alter distorted self and worldviews, and as a form of social support. Finally, the use of antidepressant medications can be effective in more severe cases.

Mental Illness through the Lens of Mindfulness

Marchand (2016) provides a comprehensive examination of how mindfulness practices, such as those learned in MBCT, may be helpful for people with depression. As in CBT, “stimulus-independent thoughts” that arise spontaneously and contribute to depressive symptoms are recognized. Such thoughts are typically oriented toward the past or future, and are based on negative self-schemas. Moreover, they involve stories about the self that do not match reality and have an unhelpful impact on functioning and may trigger distress. Much like physical pain, resistance to emotional pain exacerbates it.

While both have been shown to be beneficial, MBCT differs from CBT in many ways. First, rather than attempt to challenge or change thoughts, one’s relationship with them is altered. Second, motivation for practice may shift over time from relief of symptoms to a felt self-understanding and spiritual development. Both approaches promote healthier choices when responding to stressful situations by coping better with difficulties. In addition, MBCT fosters a sense of common humanity and connection. With the regular practice of meditation, the individual begins to “re-perceive,” that is, to be awakened to and accept how life really is in the present moment. Importantly, the concept of self may be altered when it becomes clear that stories about one’s life are selective reconstructions of memories.

While numerous studies provide evidence for the efficacy of MBCT comparable to other forms of therapy (Chiesa et al., 2015; Kuyken et al., 2015), here, we focus on the processes that appear to underlie positive changes. Lemmens, Müller, Arntz, and Huibers (2016) reviewed thirty-five studies (including MBCT and CBT, among others) that identified thirty-nine potential candidates for mechanisms of positive change. For the MBCT studies these mechanisms included rumination, mindfulness, and worry. While not specifying which type of therapy was responsible for improvements per se, studies of CBT and MBCT showed decreases in dysfunctional attitudes, negative (automatic) thoughts, rumination, and worry, and increases in mindfulness (defined as non-judgmental acceptance) were associated with decreased intensity or risk of depression relapse across studies. However, the methodology made it difficult to determine what came first and *how* variables impacted outcomes.

Van der Velden and colleagues (2015) reviewed twelve MBCT studies focusing on mechanisms underlying positive changes in depressed patients. Changes in mindfulness, worry, self-compassion, and decentering were associated with, predicted, or mediated the effect of MBCT on treatment outcomes. Kuyken and colleagues (2015) have noted that MBCT provided significant protection against relapse and recurrence for patients with increased risk due to childhood abuse. Why this happens is unclear. One possibility is that because mindfulness practice encourages one to stay in the present moment rather than the past, with body awareness being used as an anchor, one’s sense of self may change so that feelings of self-blame resulting from childhood abuse are released (Marchand, 2016).

Dobkin, Zhao, and Monshat (2017) examined a mixed group of patients with chronic illness, some of whom remained depressed post-MBSR. These patients were unable to perceive stressors in another light (as reflected by high stress post-MBSR), engaged in more

Mental Illness through the Lens of Mindfulness

often in emotional coping strategies (e.g. overreacting), and had less of a sense that life was manageable and comprehensible. Palliative coping (e.g. engaging in actions to alleviate the unpleasantness of a situation), which may be an expression of self-compassion, lessened from pre- to post-MBSR. This finding is noteworthy as it has been suggested that self-compassion partially mediates the relationship between mindfulness and well-being.

It is difficult to define the boundary between “true illness” and healthy distress or painful adjustments to socio-cultural contexts that may be unhealthy or spiritually unfulfilling (Hassed, 2000). There are qualitative and biologically demonstrable differences (Rothermundt et al., 2001; Baumeister, 2012) between severe, melancholic, or psychotic depressive illness and the variety of helpless, resigned, or withdrawn expressions of inner distress that also fulfill the DSM criteria for “major depressive disorder.”

At the more severe end of the spectrum it may be judicious to limit a mindfulness “intervention.” At the other end, depending on the phase of distress, what may be called for is not only meditation training, but also gradually engaging with the deeper spiritual underpinnings of mindfulness practice, which may lead to inner peace and contentment that surpass mere symptom alleviation.

Depression Case Study

Josephine is an intelligent woman in her fifties who has suffered with a variety of vague physical symptoms, anxiety, and low mood for many years. She has begun and given up a number of career paths over the years, despite her considerable talents. Not knowing her own mind has been a barrier to finding a long-term partner, which has robbed her of the chance to have children. When she was a child, her parents showed extreme favoritism toward her much older brother, who was an international sports star. Not only were Josephine’s needs and aspirations not taken into account, but she was often asked to help her brother fulfill his relentless training requirements.

In the past few years, she has been in a committed relationship with a man she loves and respects, she’s now financially secure, and she has the chance to work part-time and invest in her singing hobby. Nonetheless she has been suffering from depression and started therapy following a trial of antidepressants and training in breath-focus meditation—which only partially helped her.

Ongoing therapy has been informed by mindfulness principles, including the primacy of self-compassion; her inherent value; her non-separateness from others; as well as her past and future selves. She is able to experience these principles through mindfulness practices such as loving-kindness/compassion meditation, and establishing a caring connection with her sense of self as a young child.

Anxiety

Vøllestad (2016) describes anxiety disorders as a set of clinical conditions characterized by excessive fear, worry, and anxious apprehension. Mindfulness-based interventions appear to alleviate suffering across diagnoses through similar effects in cognitive, behav-

Mental Illness through the Lens of Mindfulness

ioral, and emotional domains. This is consistent with the “transdiagnostic” approach to anxiety disorders suggested by the overlap between symptoms, physiological disturbances, temperamental underpinnings, as well as by the efficacy of treatments across diagnostic categories (Barlow & Kennedy, 2016).

Not only do anxiety disorders overlap, but emotional dysregulation manifests in other ways as well, such as depression, either concurrently or sequentially. Barlow and Kennedy (2016) propose a formulation for anxiety along seven dimensions: (1) depressed mood; (2) autonomic arousal; (3) somatic anxiety; (4) social anxiety; (5) intrusive cognitions; (6) traumatic re-experiences and dissociation; and (7) avoidance. As cornerstones of a treatment approach informed by this model, they suggest training in objective, present-focused, non-judgmental awareness of emotions and recognition, and letting go of emotion avoidance and emotion-driven behaviors.

These are, of course, core mindfulness practices. Rather than avoid situations one learns to be in touch with discomfort and allow exposure to alter conditioned responses. Rumination is reduced when attending to the present moment, and the perpetuation of fear and worrying thoughts can be disrupted. Rather than being hypervigilant (associated with sensations such as a racing heart), one notices the transiency of negative feelings and thoughts. Ultimately, one’s perception shifts from thinking “I am anxious” to “I notice anxiety.”

Mindfulness of anxiety enables people to loosen their grip on the object of anxiety (i.e., what they are worrying *about*) and to accept the feeling of fear itself. In addition, insight regarding what lies underneath the emotion may arise. This can promote healing of long-ignored wounds and point the way to meaningful actions and the opportunity to live more fully.

Anxiety Case Study

Luke is a twenty-five-year-old man living with his sister who began feeling intensely anxious and worrying substantially about everyday matters a year ago. His difficulties arose soon after a year-long travel, which culminated in his coming out as gay to his family and friends, and finding a decent job. He feels bewildered and ashamed about his anxiety after such a successful and happy year.

He was brought up in a loving family and has had a passion for drama from an early age. Throughout his schooling in a religious institution, he was severely bullied and often felt depressed. This all changed at university where he completed a business degree, and felt that he had “got over” his school experience.

He came to therapy after having gained only limited relief from psychiatric medications. His stated goal was simply to feel less anxious so that he could get on with his life. He was instructed to pay caring attention to feelings of fear and recognize rumination and worry as expressions of avoidance that fuelled further anxiety. This was balanced with an awareness of neutral and pleasant sensations, such as the breath.

Mental Illness through the Lens of Mindfulness

While attending in this way, he was invited to be curious as to what may underlie his anxiety, without resorting to analytical thought. This helped him recognize the deep wounds and the deficit in self-confidence due to bullying. Additionally, he came to see that he had chosen a business career to appear productive and successful to his now-internalized tormentors. In his heart he lived with an unfulfilled longing for the creative expression that he had only allowed himself to experience in drama classes. Having understood the roots of his anxiety, as well as following the mindfulness strategies he learned, led to an alleviation of anxiety.

Being able to experience anxiety with a caring curiosity about its nature is markedly different from being caught in the thoughts it triggers: “Why do I feel this way? I don’t want to feel this way? What can I do to not feel this way?” When overwhelmed by strong painful feelings, the mind may be caught in endless self-analysis. At first this seems to offer some relief as it allows distancing from unpleasant feelings, but in the long term it reinforces the negative feelings. A caring non-analytical curiosity, by contrast, allows understanding, healing, and lasting relief.

Obsessive Compulsive Disorder

Obsessive compulsive disorder (OCD) is characterized by persistent ego dystonic thoughts and associated anxiety, leading to behaviors that seek to reduce the latter. From a behavioral viewpoint, this condition is maintained through negative reinforcement. For example, if one fears contamination and washes one’s hands in reaction to that threat, anxiety may be momentarily reduced. Behavior therapy was therefore designed to decondition the person with OCD via exposure and response prevention. Cognitive therapy aims to identify and challenge intrusive, inaccurate appraisals in order to reduce the urge to engage in compulsive behaviors.

Mindfulness-Based Interventions (MBIs) invite people with OCD to pay attention to their thoughts and urges with curiosity and non-judgment. Thoughts are not seen as facts, allowing for dis-identification. Hale, Strauss, and Taylor (2013) compared outcomes between Cognitive Behavior Therapy (CBT) and MBIs, while examining the processes that might have contributed to these changes. Both approaches were helpful. Preliminary results for the MBIs suggest that thought-action “defusion” (i.e., bearing witness to thoughts; not acting upon them as if they are true) was a potential mechanism of change, but the sample sizes were small and further studies are needed to replicate this finding.

In a qualitative study, twelve patients with OCD were interviewed after taking a tailored Mindfulness Based Cognitive Therapy (MBCT) program. Seven patients found the course helpful and reported an increased ability to let unpleasant emotions surface, a willingness to entertain insights into the nature of the mind, and living more consciously in the present moment (Hertenstein et al., 2012). These changes were accompanied by the ability to refrain from compulsive behaviors and increased self-acceptance, improved mood, and sleep. In another qualitative study of MBCT for residual symptoms of OCD, 60 percent of thirty-two patients indicated improved cognition and acceptance of negative

Mental Illness through the Lens of Mindfulness

thoughts, as well as resorting less to automatic reactivity patterns (Sguazzin, Key, Rowa, Bieling, & McCabe, 2017).

If we examine these findings from a Buddhist-psychology perspective, we see that patients become more impartial observers of their thoughts, feelings, and actions. Rather than reason with or resist the obsessions, much like pulling on the strings of a knot to untangle it, one simply notices them with a non-judgmental attitude. This allows space for other—positive and helpful— thoughts to arise. Osborne and Bhugra (2003) point out that most people ruminate regularly and what distinguishes individuals without OCD from those with OCD is that the latter act upon their thoughts. The emphasis on noticing the impermanence of all perceived phenomena in mindfulness practice can help a person with OCD realize that thoughts are transient and insubstantial events, which are allowed to come and go.

Obsessive compulsive disorder points to how a mindfulness approach can be beneficial beyond a cognitive-behavioral paradigm. On the one hand, MBIs may offer specific cognitive or behavioral skills that are particularly suited to altering maladaptive patterns in OCD. On the other, if a patient adopts mindfulness as a way of being and a path of spiritual development, some of the psychodynamic, existential, or spiritual conflicts that may underlie the OCD may be understood and resolved.

Obsessive Compulsive Disorder Case Study

Walter is a man approaching mid-life. He is in good physical condition and sought a “mindful therapist” to deal with his long-standing OCD. He had been treated by a psychiatrist, but discontinued medication prescribed as he believed mindfulness meditation and yoga had the potential to cure him. He has read extensively on the topic while using audio tapes to learn how to meditate. He was living on social assistance, had not worked as an artist for several years, and had some support from his ageing parents. Walter had a series of roommates that were “challenging” to live with for various reasons. He regretted and ruminated extensively about a failed romantic relationship.

He attended several years of psychotherapy. Progress was slow in part because his daily meditation and yoga practice had become compulsive behaviors that failed to relieve his anxiety. Shame and disgust regarding his violent sexual fantasies contributed to his self-loathing. Rituals surrounding sleep contributed to insomnia and exhaustion.

The first phase of therapy was based on Acceptance and Commitment Therapy, which aimed to help him define how he intended to live his life (e.g., work part-time, sleep normal hours) and identify his values (e.g., honesty, integrity). Since he was practicing yoga, we integrated body-wisdom into his repertoire. For example, when he felt overwhelmed by obsessions, he stood up and dropped his attention into his feet. The therapeutic relationship enabled him, slowly, to face and accept his emotions.

Rather than focus on the content of his obsessions, he worked on becoming aware of them as events of the mind; then he examined how he related to them. Instead of feeling ashamed by his OCD, he was able to understand how it affected him.

Psychosis

Various psychotherapeutic approaches have been found to be useful adjuncts to psychotropic medications for people with psychotic disorders (Dickerson, 2000; Lysaker, Glynn, Wilkness, & Silverstein, 2010). A recent review and meta-analysis of MBIs found moderate short- and long-term effects on positive outcomes and duration of hospitalization, while negative symptoms and affect appeared unchanged (Cramer, Lauche, Haller, Langhorst, & Dobos, 2016).

Chadwick, Newman-Taylor, and Abba (2005) pioneered this field with a pilot study in which eleven patients with unremitting psychotic experiences attended a weekly ninety-minute group MBI intervention for six weeks. This consisted of ten-minute guided mindfulness exercises (e.g., brief body scan, mindful breathing), along with psychoeducation. Improvements found in this group were replicated in a small randomized clinical trial with twenty-two patients in another intervention lasting ten weeks. In both studies they found that patients were able to respond better to distressing thoughts and images.

In a longer, larger randomized clinical trial with 107 outpatients in China, Chien and Thompson (2014) compared three groups: six-month mindfulness-based psychoeducation (including elements of CBT), conventional psychoeducation, and routine care. The mindfulness group reported significantly greater improvements in psychiatric symptoms, psychosocial functioning, insight into illness/treatment, and duration (albeit not frequency) of hospital readmissions over a two-year period. Cultural factors seemed to facilitate understanding of Buddhist psychology principles: self-compassion was used as a way to resolve self-identity threats (i.e. shame among extended family and the need to save face; self-blame for having a mental illness); and inviting more communal support among group members served as a positive expression of interdependence.

Langer, Carmona-Torres, van Gordon, and Shonin (2016) reviewed the qualitative literature on MBIs for people with schizophrenia and other forms of psychosis, shedding light into what was perceived as most helpful. Like MBCT for depression, patients' relationship with symptoms changed as a function of metacognitive awareness. Voices, images, and thoughts were viewed as transitory. Self-acceptance emerged and patients found working in groups safe and supportive, allowing for the creation of "shared meanings."

It is important to highlight that these programs were designed so that meditations were brief and carefully guided; therapists were experienced with psychosis and capable of establishing a strong therapeutic alliance; patients continued to take their medications; groups were relatively small; and sessions were shorter than in other MBIs. Modifications were crucial for feasibility and acceptability of mindfulness training with this population (Chadwick, 2014).

Being at the extreme end of the spectrum of mental disorders, psychosis is an excellent illustration of how mindfulness may be helpful or ill-advised for certain populations. As with patients who suffer with dissociative phenomena (e.g., post-traumatic stress disorder), the "inner space" accessed during formal sitting meditation may give rise to dis-

Mental Illness through the Lens of Mindfulness

troubling images or sounds. It may, therefore, be preferable to emphasize movement practices (e.g., walking meditation or yoga) or awareness of external auditory (e.g., birds singing) or visual stimuli to help patients feel more grounded in concrete aspects of their experience.

Psychosis Case Study

Claire is a personable twenty-two-year-old woman with a diagnosis of schizophrenia who lives with her parents. For a number of years, she has suffered from a perception that the skin of her face and her hair look dreadful. She uses various creams and shampoos with little perceived effect and needs to be talked out of more invasive dermatological interventions. A related fear is that others look at her in an intrusive way, judge her unfavorably, and may have malign intentions toward her. She tries to maintain various courses of study and part-time work, but finds it difficult to see it through, given her fears. She occasionally experiences a vague sense of a shadow out of the corner of her eye along with hearing her name being called. She appears to have no inherent difficulty organizing her thoughts, save for the distractions that her symptoms evoke.

Since receiving a low dose of antipsychotic medication, the frequency and intensity of her unusual experiences have lessened, and she can better tolerate being out of the house and interacting with others. However, she continues to doubt whether she is actually ill and is reluctant to make changes to the type and dose of medication. She is deemed suitable for adjunctive mindfulness-informed psychotherapy.

The importance of her relationship with her symptoms (examining whether they are “true”) is discussed and following a trial of various techniques she settles on taking her dog for daily walks in the park as her mindfulness “practice.” She is guided to notice pleasant body sensations and cultivate appreciation and gratitude for the ways in which her body is functioning well and is aesthetically pleasing. When she sees others, she is instructed to pay a kind attention to the body sensations associated with her fears. In this way, she is able to gradually place her fears in greater perspective and able to live better in spite of their continuing presence.

Conclusion

A Middle Way Toward Integration

Mindfulness practice rests on a dynamic balance of polarities and can be described as a “Middle Way” between the perspectives offered by modern science and Buddhist psychology. Spiritual traditions help us to understand our common humanity and interconnectedness, as well as the existential malaise that we may *all* suffer from—to a greater or lesser degree. In contrast, psychology and psychiatry have historically focused on the sickness of the *few*, and they have generated a body of knowledge oriented toward understanding and treating mental illness. Contemplative practices emphasize the subjective and personal, while the Western medical approach focuses on what is objective, generalizable,

Mental Illness through the Lens of Mindfulness

and verifiable using the scientific method. The biopsychosocial-spiritual formulation highlighted here aims to integrate these perspectives.

The relationship between the perceived phenomenon of mind and the physical nervous system reflects this complementarity. When both patient and clinician view the subjective and the objective as inseparable phenomena, they will not fall prey to a false mind-body dichotomy. When oriented toward the whole person, the search for physical causes and the underlying psychodynamic conflicts is no longer an either/or exercise. Instead, the symptoms work as a starting point for understanding and caring for all aspects of the person.

For instance, an integrative view can help the clinician detect and treat thyroid hypofunction in a patient with depression, while concurrently honoring her feelings of dejection and despair. In this way, the strain on the patient's emotional equilibrium brought about by a physical illness is acknowledged, instead of it being rejected as meaningless or of little relevance.

Intentions and Methods

The *intention* in mindfulness practice is to cultivate qualities of the mind that promote greater well-being. The ability to regulate emotions, have a balanced relationship with one's self-concept, and be embedded within a social network has been highlighted as central to well-being in this chapter. Mindfulness, conceived of as an aspiration to live with greater compassionate awareness, may be supportive for most people in this regard. However, each particular *method* is not to be confused with or over-valued at the expense of these qualities themselves.

Formal mindfulness meditation is by no means a panacea. For some individuals, alternatives to sitting with breath awareness meditation promote inner calm more effectively (e.g., yoga in those with a tendency to dissociate). For a subset of people, an inflexible emphasis on a particular approach may be harmful. Adverse outcomes such as psychotic episodes in schizophrenia and bipolar disorder, suicidal ideation in depression, or re-traumatization in post-traumatic stress disorder have been documented, particularly during long meditation retreats (Lindahl, Fisher, Cooper, Rosen, & Britton, 2017; Magid, 2002).

As Magid (2002, p. 102) states, "For the dismantling of old structures of subjectivity to result in a breakthrough rather than a breakdown, the student must have basic skills of affect regulation at his or her disposal ... In the absence of this capacity, a student may panic, feel pointlessly or sadistically tortured by painful sitting, or evolve quasi-delusional grandiose fantasies of enlightenment as a way of making sense of what's happening." Furthermore, meditators whose core neurotic conflicts and deficits have not been adequately addressed may find that the practice of meditation reinforces defensive patterns.

Mental Illness through the Lens of Mindfulness

Medication and psychotherapy treatments may serve overlapping and complementary roles in relation to mindfulness practice. The long-term psychotherapeutic relationship and the illness-specific knowledge base are essential for many patients, as is presenting a context for mindfulness practice. Concurrently, skills and perspectives gained by mindfulness practitioners can enrich psychotherapy experiences (Epstein, 2007). Broadly speaking, mindfulness practice includes *techniques* to support emotion regulation, as well as a *perspective* and a *way of being* that allows for a different relationship with oneself and the difficulties experienced. Kabat-Zinn (2015) calls these the *instrumental* and *non-instrumental* aspects of the practice. These mirror psychotherapy models like Cognitive Behavior Therapy where one is asked to do a certain exercise or learn a skill, or the interpretive work offered by long-term interventions such as psychodynamic or analytic therapy. Here the individual senses a way of being that opens them to a deep, felt understanding of their situation and its origins.

The Buddha is said to have lauded spiritual friendship as containing within it the entire path of spiritual development (Batchelor, 2015). A sense of well-being results when mindfulness practice is embedded in one's connection with others; this is similar to emphasis on social factors for mental health, mentioned earlier. The presence of like-hearted individuals who share similarly salubrious aspirations can be healing, whatever formal practices one engages in. Thus, secular-trained clinicians can recommend patients seek companionship on the path of healing and growth. In this way, the focus in formal therapy or medication treatment for symptoms of illness can be balanced by an explicit emphasis on positive emotions and connectedness.

References

- Aitkin, R. (1919). *The gateless barrier*. San Francisco: North Point.
- American Psychiatric Association. (1980). *The diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: APA. <https://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.145.10.1301>
- Barlow, D. H., & Kennedy, K. A. (2016). New approaches to diagnosis and treatment in anxiety and related emotional disorders: A focus on temperament. *Canadian Psychology* 57(1), 8–20.
- Batchelor, S. (2015). *After Buddhism: Rethinking the dharma for a secular age*. New Haven, CT: Yale University Press.
- Baumeister, H., & Parker, G. (2012). Meta-review of depressive subtyping models. *Journal of Affective Disorders* 139(2), 126–140.
- Beck, A. T., & Bredemeier, K. (2016). A unified model of depression: Integrating clinical, cognitive, biological and evolutionary perspectives. *Clinical Psychological Science* 4(4), 596–619.

Mental Illness through the Lens of Mindfulness

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health* 13(1), 119.

Bracken, O., Thomas, P., Timimi, S., et al. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry* 201(6), 430–434. <https://doi.org/10.1192/bjp.bp.112.109447>

Chadwick, P. (2014). Mindfulness for psychosis. *British Journal of Psychiatry* 204(5), 333–334.

Chadwick, P., Hughes, S., Russell, D., et al. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomised feasibility trial. *Behavioural and Cognitive Psychotherapy* 37, 403–412.

Chadwick, P., Newman-Taylor, K., & Abba, N. J. (2005). Mindfulness groups for people with psychosis. *Behavioural and Cognitive Psychotherapy* 33, 351–359.

Chien, W. T., & Thompson, D. R. (2014). Effects of a mindfulness-based psychoeducation programme for Chinese patients with schizophrenia: 2-year follow-up. *British Journal of Psychiatry* 205(1), 52–59. <https://doi.org/10.1192/bjp.bp.113.134635>

Chiesa, A., Anselmi, R., & Serretti, A. (2014). Psychological mechanisms of mindfulness-based interventions. *Holistic Nursing Practice* 28(2), 24–148.

Chiesa, A., Castagner, V., Andrisand, C., et al. (2015). Mindfulness-Based Cognitive Therapy vs. psycho-education for patients with major depression who did not achieve remission following antidepressant treatment. *Psychiatry Research* 226, 474–483.

Cramer, H., Lauche, R., Haller, H., Langhorst, J., & Dobos, G. (2016). Mindfulness- and acceptance-based interventions for psychosis: A systematic review and meta-analysis. *Global Advances in Health and Medicine* 5(1), 30–43. <https://doi.org/10.7453/gahmj.2015.083>

Crowe, K., & McKay, D. (2016). Mindfulness, obsessive-compulsive symptoms and executive dysfunction. *Cognitive Therapy and Research* 40, 627–644.

Dickerson, F. B. (2000). Cognitive behavioral psychotherapy for schizophrenia: A review of recent empirical studies. *Schizophrenia Research* 43(2), 71–90.

Dobkin, P. L., Zhao, Q., & Monshat, K. (2017). Who experiences depressive symptoms following Mindfulness-Based Stress Reduction and why? *International Journal of Whole Person Care* 4(1), 13–31.

Epstein, M. (2007). *Psychotherapy without the self: A Buddhist perspective*. New Haven, CT: Yale University Press.

Mental Illness through the Lens of Mindfulness

- Frances, A. (2016). A report card on the utility of psychiatric diagnosis. *World Psychiatry* 15(1), 32–33.
- Fulton, P. R. (2009). Mindfulness-based intervention in an individual clinical setting: What difference mindfulness makes behind closed doors. In F. Didonna (Ed.), *Clinical handbook of mindfulness* (pp. 407–416). New York: Springer.
- Grossman P. (2010). Mindfulness for psychologists: Paying kind attention to the perceptible. *Mindfulness* 1(2), 87–97.
- Hale, L., Strauss, C., & Taylor, B. L. (2013). The effectiveness and acceptability of mindfulness-based therapy for OCD: A review of the literature. *Mindfulness* 4, 375–382.
- Hassed, C. S. (2000). Depression: Dispirited or spiritually deprived? *Medical Journal of Australia* 173(10), 545.
- Hertenstein, E., Rose, N., Voderholzer, U., Nissen, C., Thiel, N., Herbst, N., & Külz, A. K. (2012). Mindfulness-Based Cognitive Therapy in obsessive-compulsive disorder: A qualitative study on patients' experiences. *BMC Psychiatry* 12, 1–10. <https://doi.org/10.1186/1471-244X-12-185>
- Jureidini, J. (2012). Explanations and unexplanations: Restoring meaning to psychiatry. *Australian & New Zealand Journal of Psychiatry* 46(3), 188–191. <https://doi.org/10.1177/0004867412437347>
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice* 10(2), 144–56.
- Kabat-Zinn, J. (2015). Two ways to think about meditation: The instrumental and the non-instrumental. *Mindfulness* 6, 396–397.
- Kearns, N. P., Shawyer, F., Brooker, J. E. et al. (2016). Does rumination mediate the relationship between mindfulness and depressive relapse? *Psych and Psychotherapy Theory, Research and Practice* 89, 33–49.
- Kelly, B. (2008). Buddhist psychology, psychotherapy and the brain: A critical introduction. *Transcultural Psychiatry* 45(1), 5–30. <https://doi.org/10.1177/1363461507087996>
- Kelly, B. (2016). Compassion, cognition and the illusion of self: Buddhist notes towards more skillful engagement with diagnostic classification systems in psychiatry. In E. Shonin et al. (Eds.), *Mindfulness and Buddhist-derived approaches in mental health and addiction* (pp. 9–28). Cham, Switzerland: Springer International Publishing
- Keown, D. (2013). *Contemporary Buddhist ethics*. London: Routledge.
- Kinderman, P. (2014). *A prescription for psychiatry: Why we need a whole new approach to mental health and wellbeing*. London: Palgrave and Macmillan

Mental Illness through the Lens of Mindfulness

- Kuyken, W., Hayes, R., Barrett, B., et al. (2015). Effectiveness and cost-effectiveness of MBCT compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (the PREVENT study): A RCT. *Lancet* 386, 63–73.
- Lakeman, R., & Cutcliffe, J. (2016). Diagnostic sedition: Re-considering the ascension and hegemony of contemporary psychiatric diagnosis. *Issues in Mental Health Nursing* 37, 125–130. <https://doi.org/10.3109/01612840.2015.1103341>
- Langer, A. I., Carmona-Torres, J. A., van Gordon, W., & Shonin, E. (2016). Mindfulness for the treatment of psychosis: Start of the art and future developments. In E. Shonin et al. (Eds.), *Mindfulness and Buddhist-derived approaches to mental health and addiction* (pp. 211–224). Cham: Springer International Publishing. https://doi.org/10.1007/978-3-319-22255-4_10
- Lemmens, H. J. M., Müller, V., Arntz, A., & Huibers, M. (2016). Mechanisms of change in psychotherapy for depression: An empirical update and evaluation of research aimed at identifying the psychological mediators. *Clinical Psychology Review* 50, 95–107.
- Lindahl, J. R., Fisher, N. E., Cooper, D. J., Rosen, R. K., & Britton, W. B. (2017). The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in Western Buddhists. *PLoS One* 12(5), e0176239.
- Lysaker, P. H., Glynn, S. M., Wilkniss, S. M., & Silverstein, S. M. (2010). Psychotherapy and recovery from schizophrenia: A review of potential applications and need for future study. *Psychological Services* 7(2), 75.
- Magid, B. (2002). *Ordinary mind: Exploring the common ground of Zen and psychotherapy*. Boston: Wisdom Publications.
- Marchand, W. R. (2016). Mindfulness in the treatment of depression. In E. Shonin et al. (Eds.), *Mindfulness and Buddhist-derived approaches in mental health and addiction* (pp. 139–164). Cham, Switzerland: Springer International Publishing.
- Meadows, G. (2003). Buddhism and psychiatry: Confluence and conflict. *Australasian Psychiatry* 11, 16–20.
- Mount, B. (2006). The 10 commandments of healing. *Journal of Cancer Education* 21(1), 50–51.
- Ñāṇamoli, Bhikkhu, & Bodhi, Bhikkhu. (1995). *The middle-length discourses of the Buddha: A translation of the Majjhima Nikāya*. Boston: Wisdom.
- National Center for Health Statistics. (2016). *International Statistical Classification of Diseases and Related Health Problems* (10th rev.). Retrieved from <http://apps.who.int/classifications/icd10/browse/2016/en>

Mental Illness through the Lens of Mindfulness

- Neitzke, A. B. (2016). An illness of power: Gender and the social causes of depression. *Culture, Medicine and Psychiatry* 40, 59–73. <https://doi.org/10.1007/s11013-015-9466-3>
- Nhat Hanh, Thich. (1999). *The heart of the Buddha's teachings*. Berkeley, CA: Parallax.
- Nhat Hanh, Thich. (2009). *Happiness: Essential mindfulness practices*. Berkeley, CA: Parallax.
- Norman, K. R. (2003). The Four Noble Truths. In *Collected Papers II* (pp. 210–223). Oxford: Pali Text Society.
- Osborne, T. R., & Bhugra, D. (2003). Spiritual thoughts in psychiatry. *Indian Journal of Psychiatry* 45, 142–146.
- Plante, T. G. (2008). What do the spiritual and religious traditions offer the practicing psychologist? *Pastoral Psychology* 56(4), 429–444.
- Ricard, M. (2007). *Happiness: A guide to developing life's most important skill*. New York: Little Brown.
- Röhricht, F. (2009). Body oriented psychotherapy. The state of the art in empirical research and evidence-based practice: A clinical perspective. *Body, Movement and Dance in Psychotherapy* 4(2), 135–156.
- Rosenbaum, R. (1999). *Zen and the heart of psychotherapy*. Philadelphia: Brunner/Mazel.
- Rothermundt, M., Arolt, V., Fenker, J., Gutbrodt, H., Peters, M., & Kirchner, H. (2001). Different immune patterns in melancholic and non-melancholic major depression. *European Archives of Psychiatry and Clinical Neuroscience* 251(2), 90–97.
- Schmidt, S. (2004). Mindfulness and healing intentions: Concepts, practice and research evaluation. *Journal of Alternative and Complementary Medicine* 10(1), S7–S14.
- Sguazzin, C. M. G., Key, B. L., Rowa, K., Bieling, P. J., & McCabe, R. E. (2017). Mindfulness-Based Cognitive Therapy for residual symptoms of obsessive-compulsive disorder: A qualitative analyses. *Mindfulness* 8(1):190–203.
- Tsou, J. Y. (2016). Natural kinds, psychiatric classification and the history of the DSM. *History of Psychiatry* 27(4), 406–424. <https://doi.org/10.1177/0957154X16656580>
- Van der Velden, A. M., Kuyken, W. K., Waar, U., et al. (2015). A systematic review of mechanisms of change in MBCT in the treatment of recurrent major depressive disorder. *Clinical Psychology Review* 37, 26–39.
- Vøllestad, J. (2016). Mindfulness and acceptance-based interventions in the treatment of anxiety disorders. In E. Shonin et al. (Eds.) *Mindfulness and Buddhist-derived approaches*

Mental Illness through the Lens of Mindfulness

to mental health and addiction (pp. 97–137). Cham, Switzerland: Springer International Publishing.

Notes:

(1.) Clinical vignettes represent actual patients treated by Kaveh Monshat or Patricia Lynn Dobkin. Names have been changed to preserve confidentiality.

Patricia Lynn Dobkin

Department of Medicine, McGill University

Kaveh Monshat

Consultant Psychiatrist, Psychotherapist and Mindfulness Teacher & Researcher