

Chapter X

Beyond Deficit Reduction: Exploring the Positive Potentials of Mindfulness

Tim Lomas & Itai Ivtzan

Tim Lomas ✉: AE.3.29, Department of Psychology, Stratford Campus, Water Lane,
University of East London, London, E15 4LZ, t.lomas@uel.ac.uk

Itai Ivtzan: AE.3.23, Department of Psychology, Stratford Campus, Water Lane, University
of East London, London, E15 4LZ, i.ivtzan@uel.ac.uk

E. Y. Shonin, W. Van Gordon and M. D. Griffiths (eds.), *Mindfulness and other Buddhist-Derived Approaches in Mental Health and Addiction*, Advances in Mental Health and Addiction Series. DOI:

Abstract (to be included only in the e-Book version)

The past few decades have seen an extraordinary explosion of interest in mindfulness, both in academia and in Western society more broadly. Central to this burgeoning enthusiasm has been the development of mindfulness-based interventions, which have had great success in treating physical and psychological health issues across diverse patient groups. However, for all their merits, these interventions have mostly been formulated in the context of clinical practice, and as such have tended to endorse a ‘deficit’ model of the person (which conceptualises humans as inherently dysfunctional or deficient, and views the role of therapeutic disciplines as being limited to the correction of such defects). Thus, nearly all mindfulness-based interventions are concerned with treating dysfunction or illness, from stress and depression to pain and discomfort. As necessary as such interventions are, this has meant that mindfulness has been largely de-contextualised from its original purpose within Buddhism as a means for radical personal transformation. However, in recent years, the emergent field of positive psychology has been at the forefront of efforts to create mindfulness-based interventions that capture more of the missing spirit of the original Buddhist teachings. These new interventions will hopefully augment existing interventions, helping us to collectively further explore and appreciate the exciting promise of mindfulness.

Keywords: Buddhism, mindfulness, positive psychology, interventions, wellbeing.

Introduction

Mindfulness has travelled a long distance, in all kinds of ways. In historical terms, as we peer back through the mists of time from our current vantage point at the dawn of the 21st Century, we can discern its origins in antiquity, over two and a half millennia ago. Geographically, as we sit in England writing this chapter, we can appreciate how, from its initial roots on the Indian subcontinent, mindfulness has slowly migrated across the world, finally reaching the West towards the close of the 19th Century. Finally, in conceptual terms, it is fascinating to trace the way in which the idea of mindfulness has shifted and developed as it has journeyed through time and space, often changing shape to suit the needs, values and worldviews of the various cultures that have embraced it. And so it is the case with the way mindfulness has been taken up in the West today. As this chapter will show, its main route of transmission has been through therapeutic interventions that were developed in a clinical context, most notably Jon Kabat-Zinn's (1982) seminal Mindfulness-Based Stress Reduction (MBSR) programme. Given their formative and influential role, these interventions have rightly been celebrated as making a hugely important contribution in bringing mindfulness to new Western audiences. However, at the same time, one can recognise that the type of clinical psychological context in which these interventions were formulated has had a definite influence on the way in which mindfulness has so far been appraised, understood, and utilised.

Unfortunately, it could be argued that, by being filtered through this clinical context, the great potential for mindfulness to facilitate psychological wellbeing and development has been somewhat limited. Of course, that is not to denigrate the pioneering interventions noted above; these have been revolutionary in their impact, improving people's wellbeing in myriad ways. However, these interventions have been constrained by one crucial factor: this clinical context is fundamentally based on a 'deficit' model of human psychology. In their various ways, all these interventions are concerned with treating or alleviating dysfunction or illness

– from stress and depression to pain and discomfort. Needless to say, such aims are laudable and necessary. That said, they do not exhaust the vast potential of mindfulness; for example, in its original Buddhist context, mindfulness was the vehicle for radical psycho-spiritual development and the gateway to transcendent states of great import. Sadly, if mindfulness is conceived of narrowly according to a deficit model of wellbeing, such potentials are neglected if not overlooked entirely. This is not an issue that is confined to mindfulness; arguably, much of Western psychology has been founded upon and driven by this deficit model, focussing predominantly on disease, disorder and dysfunction. Thus, one might argue that mainstream academia generally has failed to appreciate the great potential of people to develop, flourish and find fulfilment.

However, in recent years, a new branch of psychology has emerged focusing specifically on concepts such as wellbeing and flourishing, namely, positive psychology (PP). It is of course recognised that such phenomena have been studied and analysed for decades, if not centuries. That said, the formulation of an academic field devoted specifically to such ‘positive’ topics has been valuable in providing a common forum and discursive space where these can be brought together and investigated collectively. And, to return to the topic at hand, PP has brought a fresh perspective to bear on mindfulness, developing interventions that are not focussed on alleviating dysfunction, but on actively promoting positive outcomes, from meaning in life to psychological development. As such, this chapter aims to introduce the contribution that PP has made to our understanding and utilisation of mindfulness in contemporary psychology. It will do so over the course of three parts. Part 1 takes a historical view, exploring the long migration of mindfulness, from its distant Asian roots far back in the Axial age, to its transmission to the West over recent centuries. Part 2 then considers the way mindfulness has been embraced by Western psychology, and how this was shaped by the clinical context in which early mindfulness-based therapeutic interventions were developed,

as noted above. Part 3 then introduces the emergent field of PP, and highlights a number of new interventions being developed within the field – including the Positive Mindfulness Programme, created by Dr Ivtzan – which opens up new possibilities for the way in which we might harness mindfulness to promote health and wellbeing.

Transmission of Mindfulness to the West

This first part traces the long journey of mindfulness, from its origins on the Indian subcontinent over 2,500 years ago to its current embrace by Western psychology. The practice of mindfulness dates back to Siddhartha Gautama, better known by the honorific *Buddha*, meaning ‘Enlightened one.’ Although the dates and location of his birth are contested, there is some consensus that he was born in Lumbini in present-day Nepal (Thomas, 2000) and lived from around 480 to 400 BC (Cousins, 1996). The cultural context in which the Buddha was born and lived was suffused by Hinduism, which developed the earliest examples of meditation (excavations of the Indus Valley have uncovered pottery depicting people sitting in the lotus posture, dating back to 3000 BC; Varenne, 1977). Hinduism features a comprehensive system of physical, mental and spiritual disciplines, referred to collectively as yoga (a Sanskrit term derived from the verb *yug*, meaning to bind or to yoke together; thus yoga is interpreted as meaning to ‘unite the mind and body in a way that promotes health (Wren et al., 2011, p.477)). It was in this context that the Buddha developed his own teachings. Having been raised in relative luxury, a series of encounters with illness and mortality aged 19 led to an ‘existential crisis,’ prompting him to pursue a religious existence dedicated to exploring the human condition (Kumar, 2002). However, after spending five years engaging in austere yogic practices, he determined that such self-mortification was unhelpful, and decided to pursue his own path – leading to the formulation of a unique body of teachings and practices which we now refer to as Buddhism.

Buddhism is a tradition of astonishing depth and breadth, and it is far beyond the scope of the present chapter to provide even a cursory summary of its insights. As such, we can merely hope here to introduce its teachings that pertain to mindfulness (and even then only briefly). That said, mindfulness occupies a central place in the Buddha's teachings, playing a pivotal role in his message of the possibility of psychological development and ultimately of liberation. Arguably, the key teaching of Buddhism is the Four Noble Truths, which acknowledges the ubiquity and universality of suffering, but which also proposes a remedy in the form of a medical diagnosis for its alleviation: suffering is universal; it has a cause; cessation is possible; achieved by following the Noble Eightfold Path (Thrangu, 1993). Building on this central insight, much of Buddhism is devoted to elucidating this path, a prescription for 'right living', which involves meditation and other moral recommendations, including: right vision, thought, speech, conduct, livelihood, effort, mindfulness, and concentration. As such, in its original context, mindfulness was an integral component of an extensive programme of psycho-spiritual development, which had the radical aim of ending suffering and allowing people to achieve 'enlightenment.' While terms such as enlightenment are hard to operationalise within the ontological and epistemological context of Western psychology, we might view it as the ultimate state of happiness, equanimity and freedom that a human being is capable of experiencing. Unfortunately, just as the notion of enlightenment is difficult to appreciate within the context of Western science, as mindfulness has been transmitted to the West and conceptualised within psychology, its original potential as a component of psycho-spiritual transformation has to some extent been lost (Van Gordon et al., 2014).

So, how did mindfulness reach the West in the form that it did? Buddhism was known to Western cultures as early as the 13th century through the accounts of Marco Polo (Abeydeera, 2000). However, it was only in the late 19th century that it achieved any degree

of cultural prominence, as translations of scriptures became available, and religious figures from Asia began to travel abroad. Foremost among the scholars engaged in the exegesis and translation of original Buddhist texts was T. W. Rhys Davids (1881, 1910) who was pivotal in introducing mindfulness to the West. Indeed, it was Rhys Davids who coined the term ‘mindfulness’ itself, selecting this as a translation of the Pali term *sati* (Gethin, 2011). The notion of *sati* is the basis for *the* foundational teaching on mindfulness in the Buddhist canon, the *satipaṭṭhāna sutta* (the ‘Discourse on the Establishment of Mindfulness’), in which the Buddha first sets out practical instructions for how to cultivate the desired mental state of *sati*. Now, what is *sati*? Within the Brahmanical tradition of ancient India – the context in which the Buddha lived and taught – the word had connotations of ‘remembrance’ and ‘recollection’ (Peacock, 2014, p.5). However, as used by the Buddha, it does not refer to historical or chronological memory per se, but to a state in which one ‘recalls’ the activity that ‘one is engaged in, in the present moment’ (p.6). This meaning of *sati* is evident in the pre-eminent contemporary definition of mindfulness, proposed by Kabat-Zinn (2003, p.145) – who explicitly cited *sati* as the origin of his formulation – namely, “*the awareness that arises through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment.*”

And, it is this particular notion of *sati* – translated and conceptualised by Rhys Davids, and subsequently operationalised and defined by Kabat-Zinn – that has fundamentally shaped the way in which mindfulness has been embraced and understood in the West today (alongside the teachings of other influential contemporary masters, such as Thich Nhat Hanh). As we explore in part 2, this harnessing of mindfulness has led to a proliferation of interventions that have helped improve mental health and wellbeing in diverse populations, which is of course hugely welcome. However, this enthusiasm for mindfulness, based on a particular translation of *sati*, has come at a price. There are various

issues. Firstly, of all the concepts and practices in Buddhism that could be relevant to wellbeing, *sati* has been emphasised above all others. This means that other potentially equally valuable notions have been overlooked. For example, there are at least two other Buddhist terms which also pertain to awareness (as *sati* does) – and thus which could also be translated as mindfulness – but which possess additional layers of meaning that are largely absent in *sati* (Lomas & Jnanavaca, 2015). These include *appamada*, which can be understood as referring to awareness infused with an ethos of ethical care, and *sampajañña*, which may be thought of as awareness suffused with a sense of spiritual progress. Thus, one consequence of basing our current conception of mindfulness on *sati*, as opposed to *appamada* or *sampajañña*, is that mindfulness has become detached from considerations around ethics and spirituality that were present in the original teachings.

This latter point brings us to the second issue with the construction of mindfulness in contemporary psychology: it has become largely ‘de-contextualised’ from the Buddhist teachings in which it was originally formulated. That is, mindfulness has tended to be presented in a secular way, without reference to Buddhism (Shapiro, 1994), conceptualised and operationalised using cognitive theories of attention and awareness (Bishop et al., 2004). Now, it is not necessarily the case that constructs such as attention are discordant with the original Buddhist teachings. Moreover, it is likely that this de-contextualisation was ‘necessary’ in order for mindfulness to find a receptive audience in secular Western societies (King, 1999). However, viewing mindfulness as ‘just’ a form of attention training is somewhat limiting. For example, as noted above, in Buddhist teachings, mindfulness is inextricably linked to ethics, with the ethical quality of one’s actions seen as shaping the subjective content of mindfulness itself. Thus, the risk with the current enthusiasm for mindfulness (as a translation of *sati*) is that the precious insights of the original teachings may be overlooked. This danger is recognised by Kabat-Zinn himself, who suggests that “*the*

rush to define mindfulness within Western psychology may wind up denaturing it in fundamental ways,” and thus there is *“the potential for something priceless to be lost”* (Williams & Kabat-Zinn, 2011, p.4).

Indeed, as one analyses the transmission of mindfulness to the West, one can clearly see that the way it has been received and interpreted has been shaped and filtered by the values and epistemological contours of Western science. As such, it has been suggested that we are seeing the emergence of a new form of ‘Western Buddhism’, referred to by sociologists as ‘Scientific Buddhism’ (McMahan, 2004) or ‘Therapised Buddhism’ (Obadia, 2008). By way of explanation, critical sociologists have argued that as people in the West have engaged with Buddhism, this engagement has unfolded in three main ways (Lomas, Cartwright, Edginton, & Ridge, 2014): Westerners becoming ‘Easternized,’ Eastern practices being ‘Westernized,’ and the ‘inter-mingling’ of East and West. With the first development, Buddhism in the West is seen as retaining its original ‘Eastern’ form, and is valued just for that reason. Here we see Western Buddhists espousing discourses which Said (1995) identified as being ‘Orientalist,’ featuring the construction of an otherworldly ‘mystic East.’ For example, Phillips and Aarons (2005) found that Buddhists in a group in Australia had experienced disenchantment with Western society, and had consequently sought escape in Eastern ideas and practices.

Conversely, a second movement has seen Buddhism becoming ‘Westernized,’ diverging from traditional forms, eschewing ‘ritualized forms and traditional religious affiliations,’ and being reconstructed to suit secular ‘Western sensibilities’ (King, 1999, p.156).’ From this perspective, even people who meditate in a secular way – as most do (Shapiro, 1994) – might be regarded as ‘engaged’ with Buddhism, albeit in a form which dis-identifies with its antecedent roots. Finally, a third current has seen the emergence of ‘New Religious Movements’ which ‘intermingle’ discourses and practices from various spiritual

and therapeutic sources, both East and West, promoting a ‘flexible and diffuse version of spiritual identity’ (Phillips & Aarons, 2005, p.217). Here, the practitioner is viewed as a consumer in a ‘spiritual marketplace,’ selecting from interchangeable beliefs and practices – of which Eastern spiritualities are just some of many – to suit their individual needs (Roof, 2001). So, according to the above analysis, clinical and academic engagement with mindfulness can be seen as an example of the second current, ‘Eastern’ practices becoming ‘Westernised.’ Such Westernisation is thus reflected in the emergent forms of ‘Scientific Buddhism’ (McMahan, 2004) or ‘Therapised Buddhism’ (Obadia, 2008), of which a clinical interventions such as MBSR is just one example, as we explore in part 2.

Clinical and Academic Engagement with Mindfulness

In this second section, we examine the way in which mindfulness has been embraced by clinical practitioners and researchers in the West. Moreover, we consider the way such engagement has led to the emergence of new ‘Western’ forms of Buddhism, in particular, ‘Scientific Buddhism’ (McMahan, 2004) and ‘Therapised Buddhism’ (Obadia, 2008). The story here begins over 30 years ago, with Kabat-Zinn’s (1982) pioneering Mindfulness-Based Stress Reduction (MBSR) intervention, which played such a pivotal role in introducing mindfulness to the West. Since then, the past few decades have seen an astonishing ‘explosion’ of interest in mindfulness, in academia and beyond (Brown et al., 2007). This interest encompasses an extensive programme of research across a diverse range of methodological paradigms, from cognitive neuroscience to sociology, as well as a panoply of emergent mindfulness-based interventions aimed at various (mostly clinical) populations. Moreover, this enthusiasm for mindfulness continues to grow, and even appears to be accelerating, with over 500 studies published on it in 2012 alone (Shonin et al., 2013). Thus, it can truly be said that mindfulness has entered mainstream academia and clinical practice.

As Fortney and Taylor (2010, p.81) conclude in their review of the use of mindfulness in medical practice, rather than being a ‘fringe or marginal concept,’ it is now widely known and accepted as a beneficial mind-body practice by the general public and the scientific community.’

However, strikingly, as this programme of research and clinical practice has unfolded, it has tended to eschew any overt connection to Buddhism, and especially to any explicit spiritual or religious ideas or practices (King, 1999). Instead, mindfulness has been filtered through a contemporary scientific understanding, resulting in a number of distinct characteristics. First, as McMahan (2004) has identified, this has produced a form of ‘Scientific Buddhism.’ This means, for one thing, that mindfulness has generally been ‘conceptualized as a nonreligious concept suitable for scientific study,’ as Baer and Sauer (2009, p.324) put it, using cognitive theories of attention and awareness, rather than with the terminology and discourses of Buddhism (Bishop et al., 2004). However, Scientific Buddhism does not just refer to the overarching conceptual approach with which mindfulness has been appraised, but also to the type of developments that practitioners themselves are seen as experiencing. That is, rather than emphasising spiritual or ethical progression, for example, research has tended to focus on the development of cognitive skills, such that the practitioner themselves might be seen as cultivating a more ‘scientific’ mode of thinking and approach to life. This includes the idea that mindfulness enhances emotional intelligence (Lomas, Edginton, Cartwright, & Ridge, 2014), rationality (Lee, 2005), attentional control (Moore et al., 2012), brain connectivity (Kilpatrick et al., 2011), and so on.

Perhaps even more significant and dominant than this type of Scientific Buddhism has been the phenomenal development of what Obadia (2008) calls ‘Therapised Buddhism.’ This encompasses the panoply of mindfulness-based interventions that have emerged over recent decades. Now, as noted above, most such interventions present mindfulness in a secular way,

without reference to Buddhism. However, this is exactly Obadia's point – these reflect the way in which mindfulness, and Buddhism more generally, has been 'Westernised' within academia and clinical practice, co-opted into and filtered according to a dominant secular scientific worldview. This worldview places restrictions on the types of outcomes that are considered valid objects of enquiry, and more specifically, tends to denigrate or overlook more nebulous and less quantifiable phenomena, such as spiritual experience and development. Moreover, as highlighted in the introduction, the dominant scientific worldview – evident in contemporary disciplines from psychology to medicine – tends to endorse a somewhat negative 'deficit' model of the person. Generally speaking, this means that humans are regarded as inherently flawed or dysfunctional; as such, any role that therapeutic disciplines such as clinical psychology might play is limited to correcting or ameliorating such deficits, as reflected in Freud's (1895, p.351) infamous remark (to a hypothetical patient) that psychotherapy could aim no higher than hoping to transform the misery of neurosis into 'common unhappiness.' Of course, there are exceptions, such as humanistic psychology, from Jung's (1939) concept of individuation, to Rogers' (1961) notion of self-actualisation. Nevertheless, on the whole, a deficit model of human functioning has definitely held sway within psychology and medicine.

And, it was into this context that mindfulness was received and developed. As we shall see, almost without exception, mindfulness-based approaches have been underpinned by this deficit-based approach, seeking to alleviate or correct disease or dysfunction, both mental and physical. It is crucial to emphasise here that this is 'not' a critique of these interventions; these have all played extremely valuable roles in treating the very real issues that people suffer with, from depression and anxiety to pain and discomfort. The pioneer in this regard, as noted above, was Kabat-Zinn's (1982) MBSR intervention. This was designed and intended initially as a treatment for chronic pain, and had considerable success in this regard,

with half of participants reporting a decrease in perceived pain of 50%. In the MBSR protocol, an 8-10 week course for groups of between 10 and 40, participants undertake weekly sessions to learn and practice mindfulness, as well as homework activities designed to promote it in everyday life. In essence, these varied activities encourage participants 'to become more aware of, and relate differently to thoughts, feelings and bodily sensations' (Shapiro et al., 2005, p.165). This process includes teaching participants to 'decentre' from negative qualia, that is, cultivating the 'ability to observe one's thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true' (Fresco et al., 2007, p.234). Thus, in the case of chronic pain, rather than resisting or seeking to escape the pain, as patients might normally do, people are encouraged to decentre from it, which helps to lessen its physical and psychological impact.

As the efficacy of MBSR continued to be demonstrated (e.g., Miller et al., 1995), clinicians began exploring its use with other patient populations. Soon, an impressive body of work was accumulating showing that, in clinical trials, MBSR could reduce psychological problems (e.g., anxiety, depression) and even physical issues (e.g., symptomology, pain) across diverse illness groups. These included people with cancer (Ledesma & Kumano, 2009), HIV (Creswell et al., 2009), migraine (Schmidt et al., 2010), sleep disturbance (Shapiro et al., 2003), fibromyalgia (Schmidt et al., 2011), irritable Bowel Syndrome (Kearney et al., 2010), rheumatoid arthritis (Pradhan et al., 2007), and coronary disease/cardiac risk symptoms (Olivio et al., 2009). MBSR was also used successfully with various other groups of people, united by a common deficit or issue, including adolescent psychiatric outpatients (Biegel et al., 2009), adolescents with substance abuse problems (Bootzin & Stevens, 2005), transplant patients (Gross et al., 2009), parents/caregivers of children with developmental disabilities (Bazzano et al., 2010), workers in high stress jobs (Walach et al., 2007), and various groups of health-care professionals (e.g., to prevent stress-

related burnout; see Irving et al. (2009) for a review). In all these cases, mindfulness was harnessed – very valuably and usefully – to reduce deficits and ameliorate issues, whether psychological (e.g., anxiety) or physical (e.g., pain).

Following the success of the MBSR, clinicians and researchers began to develop other mindfulness-based interventions, targeting different clinical issues and populations. Foremost among these was Mindfulness-Based Cognitive Therapy (MBCT), designed to prevent relapse or recurrence of major depression (Segal, Williams & Teasdale, 2002). Teasdale's (1988) 'differential activation hypothesis' holds that previously depressed individuals are susceptible to relapse because even mildly dysphoric states can reactivate 'depressogenic' thinking patterns (e.g. rumination) associated with previous episodes of depression. Thus, Teasdale, Segal & Williams, (1995) proposed that the attentional training involved in MBSR could be harnessed to prevent such relapse, and so MBCT was developed from the MBSR protocol. Just as MBSR taught patients to decentre from subjective pain, MBCT aimed to help "*recovered recurrently depressed individuals to disengage from dysphoria-activated depressogenic thinking that may meditate/recurrence*" (Teasdale, Segal & Williams, 2000, p.615). Corroborating this hypothesis, MBCT was found to significantly reduce relapse rates for people with three or more previous major depressive episodes (Ma & Teasdale, 2004), and as such was included in the National Institute for Health and Care Excellence's (2004) guidelines for prevention of recurrent depression. Subsequent to this success, the MBCT protocol was then used with other patient populations, including people with bipolar disorder (Williams et al., 2008), insomnia (Heidenreich et al., 2006), generalised anxiety disorder (Craigie et al., 2008), traumatic brain injury (Bedard et al., 2008), panic disorder (Kim et al., 2010), hypochondria (Lovas & Barsky, 2010), and cancer (Foley et al., 2010).

With MBSR and MBCT leading the way in the treatment of psychological and physical issues, clinicians and researchers began to develop new mindfulness-based

interventions targeted at a wide range of further conditions and problems, designed specifically to meet the needs of that particular disorder. These include interventions for bipolar disorder (Weber et al., 2010), epilepsy (Thompson et al., 2010), chronic-heart failure (Sullivan et al., 2009), age-related cognitive deficits (McHugh et al., 2010), multiple sclerosis (Mills & Allen, 2000), irritable bowel syndrome (Ljótsson et al., 2010), maladaptive behaviours in adults with learning disabilities and mental illness (Adkins et al., 2010), physical aggression in offenders with learning disabilities (Singh et al., 2008), pain management (Cusens et al., 2010), post-traumatic stress disorder (Nakamura et al., 2011), obsessive-compulsive disorder (Patel et al., 2007), obesity (Dalen et al., 2010), substance abuse (Bowen et al., 2006), smoking (Bowen & Marlatt, 2009), weight loss (Tapper et al., 2009), and alcohol-dependency relapse (Zgierska et al., 2008). Further unique mindfulness-related interventions – focussed on deficit reduction (e.g., reducing anxiety) – have also been developed for use in a wide variety of clinical and non-clinical groups, including bone-marrow transplant patients (Horton-Deutsch et al., 2007), people with diabetes (Rungreangkulkij et al., 2011), US marines prior to deployment (Stanley et al., 2011), and care-givers of children with developmental disabilities (Singh et al., 2007), as well as for use in therapeutic settings such as couples therapy (Carson et al., 2004) and life-coaching (Collard & Walsh, 2008).

As the previous few paragraphs have demonstrated, there is a burgeoning arsenal of emergent mindfulness-based interventions that is truly extraordinary; the studies featured above – which by no means exhaust the literature in this area – represent a fantastic collective effort among clinicians and researchers to bring mindfulness to people suffering from a wide range of ailments and issues. And, to reiterate a point repeatedly made above, all of these interventions are valuable and to be welcomed. Nevertheless, reading through the list above, and the literature generally, it is striking the extent to which almost all the work here takes a

deficit-based approach to mindfulness. Almost without exception, all current mindfulness-based interventions are concerned with remedying or ameliorating a deficit of some kind, whether depression (Teasdale et al., 2000), anxiety (Craigie et al., 2008), insomnia (Heidenreich et al., 2006), aggression (Singh et al., 2008), pain (Cusens et al., 2010), substance abuse (Bowen et al., 2006), and so on. As such, there is an almost total absence of interventions, and research more generally, exploring the great ‘positive’ potential of mindfulness – i.e., not simply as a prophylactic or remedy for dysfunction, but as a tool to help people soar and strive for the peaks of human experience and development. However, over the course of the last few years, there has been an effort to augment the deficit-based therapies above with an exploration of the radical positive possibilities offered by mindfulness. At the forefront of this effort has been the emergent field of positive psychology, as the final part explores.

Mindfulness in Positive Psychology

So, we suggested above that most contemporary clinical and academic disciplines have tended to adopt a ‘deficit-based’ model of the person, focusing on dysfunction and disorder, which has influenced the way mindfulness has been adopted and adapted by these fields. However, in recent years, a new discipline has emerged which has avowedly sought to focus on the assets, capabilities and potentials of human beings, namely, positive psychology (PP). The field came into being in 1998, when Martin Seligman used his ascension to the presidency of the American Psychological Association to inaugurate this new branch of psychology. His broad intention was to provide a corrective balance to ‘psychology as usual’ – i.e., to conventional psychology – redressing its ‘negative bias’ by accentuating the positive (Seligman & Csikszentmihalyi, 2000). That is, in contrast to the deficit-model of the person outlined above, PP aimed to focus on all that is ‘good’ about human beings, their values, strengths, and skills. Above all, PP was concerned with the issue of what makes life worth

living; as such, it took a particular interest in valued ends such as meaning and happiness. Of course, prior to the emergence of PP, most of these topics had been studied empirically for years. However, this newly created field offered a conceptual space where all these diverse topics – all of which share the ‘family resemblance’ (Wittgenstein, 1953) of pertaining to wellbeing in some way – could be analysed collectively. Thus, as a novel branch of academia focussed ‘specifically’ and entirely on ‘the science and practice of improving wellbeing’ (Lomas, Hefferon, & Ivtzan, 2014, p.ix), PP was indeed a useful new addition to the broader field of psychology.

Crucially, from the perspective of this chapter’s central message – that mindfulness has become detached and decontextualised from its Buddhist origins, to its detriment – PP is aligned in various ways with the spirit of Buddhism. For instance, Buddhist teachings contain various prescriptions and exhortations, advising practitioners to cultivate particular qualities as a route towards fulfilment (Keown, 2009). In the Theravadan tradition, there is an emphasis on the four *brahmaviharas* (divine abidings): *metta* (loving-kindness), *karuṇā* (compassion), *muditā* (sympathetic joy), and *upekkha* (equanimity). Similarly, the Mahayana tradition elucidates six *pāramitās* (perfections): *dāna* (generosity), *sīla* (morality), *khanti* (patience), *virīya* (perseverance), *samādhi* (concentration), and *paññā* (insight). PP not only likewise emphasises many of these qualities as being conducive to wellbeing, but has been at the forefront of developing interventions to help people ‘cultivate’ such qualities. That is, one of the most important components of PP is the area of ‘applied’ PP, which is in the business of developing positive psychology interventions (PPIs). As will be outlined further below, PPIs are often modelled on the type of clinical interventions discussed above, but instead of aiming at deficit reduction (e.g., reducing anxiety), they are explicitly focused on promoting some positive quality or outcome (e.g., increasing compassion). And indeed, there is an emergent body of PPIs which aim to engender the types of qualities encouraged by

Buddhism, including interventions based around *metta* (e.g., loving-kindness meditation; Fredrickson et al., 2008), *karuṇā* (e.g., mindful self-compassion; Neff & Germer, 2013), and *dāna* (e.g., charitable giving; Surana & Lomas, 2014).

Such PPIs are quite different in spirit and nature to the type of deficit-based therapies featured above, and as such are valuable additions to the corpus of interventions currently used within psychological and clinical practice. This difference is highlighted in definitions of PPIs provided by scholars within the field. For example, Sin et al. (2011, p.469) suggest that a PPI is ‘an intervention, therapy, or activity, primarily aimed at increasing positive feelings, positive behaviors, or positive cognitions, as opposed to ameliorating pathology or fixing negative thoughts or maladaptive behavior patterns.’ Likewise, Parks and Biswas-Diener (2014) outline a number of rigorous inclusion and exclusion parameters for the classification of PPIs, beginning with the need for the intervention's goal to build a positive variable(s). Now, it is worth stating that, within the field, it is recognised that the concept of ‘positive’ can be somewhat problematic (Lomas et al., 2014). Theorists of a critical persuasion have pointed out that qualities or states that might be deemed ‘positive’ can be detrimental to wellbeing under certain circumstances, while ostensibly ‘negative’ ones may conversely promote flourishing (Wong, 2011; Ivtzan, Lomas, Hefferon, & Worth, 2015). For example, optimism can be harmful if it becomes unrealistic or ‘excessive’ (e.g., leading to misperception of risk, and subsequently to health risk behaviours; Weinstein et al., 2005); likewise, pessimism can be adaptive in certain cases (e.g., if it prompts pre-emptory fault-finding and problem solving; Norem, 2001). Nevertheless, even while remaining cognizant of such critical caveats, the field has begun to develop an emergent body of PPIs which aim to help individuals flourish.

Crucially – and this is where PP can really be seen as augmenting extant deficit-based therapeutic fields such as clinical psychology – flourishing is not the same as an absence of

mental disorder or pathology (Ryff & Singer, 1998). An often used metaphor here is that of a continuum (Ryff et al., 2006), involving a (somewhat arbitrary) scale stretching from minus five (mental illness) through zero (absence of mental illness) and up to plus five (mental health). By eliminating deficits such as anxiety or depression, as interventions such as MBSR and MBCT aim to do, this could be seen as bringing a person from minus five up to zero. However, doing so does not necessarily then mean that a person is thriving and fulfilling their potential, which is represented in this metaphor by the positive integers on the continuum. Thus, PP aims to help people progress beyond zero to reach towards plus five. Thus, in a sense, PP could be seen as complementing fields such as clinical psychology, picking up where they leave off (i.e., once therapies have brought people up to zero, PP can help take them further). It is worth saying that there are issues with this metaphor (Keyes, 2002): mental life is far more multidimensional than implied by a single continuum, and people may have deficits in some aspects of their functioning (and thus be in minus territory) and be flourishing in others (thus being in positive territory). Moreover, recent studies (e.g., Sin & Lyubomirsky, 2009) show that PPIs may also be able to help people while they are still in ‘negative territory’ – i.e., suffering from mental health issues – as discussed further below. Nevertheless, the metaphor is still a valid way of appreciating the contribution that PP may be able to make in the context of applied psychology (i.e., in terms of where PPIs sit within psychology’s diverse array of interventions aimed at improving mental health and wellbeing).

And so, to return to the central topic of this chapter, PP has brought new dimensions to our appreciation of mindfulness by seeking to develop PPIs that harness its ‘positive’ potential. That is, beyond the deficit reduction of the mindfulness-based interventions highlighted above, these PPIs aim to help people thrive and move towards mental health (which, to reiterate the point above, is not the same as an absence of mental illness). Before we introduce some of these new PPIs, it is worth stating another caveat: despite being

ostensibly deficit-focused, clinical interventions such as the ones detailed above have led to incidental improvements in positive variables, such as positive affect (Geschwind et al., 2011), positive reappraisal of thoughts (Hanley & Garland, 2014), interpersonal interactions (Allen et al., 2009), and quality of life (Godfrin & Van Heeringen, 2010). However, as valuable as such outcomes are, they are not the primary goal of the intervention, rather emerging as beneficial side-effects. The central point about PPIs is that there may be much more to be gained if interventions seek to explicitly promote and facilitate such positive outcomes. As outlined below, by specifically designing activities to target such outcomes, it is possible to enhance the efficacy with which these can be facilitated.

Moreover, in a broader sense, having an overarching ‘positive’ intention for engaging in the intervention – i.e., promoting flourishing, rather than correcting deficits – has an impact on the types of outcomes people can experience. Shapiro et al. (2006) suggest that mindfulness comprises three central components: attention (‘observing the operations of one’s moment-to-moment, internal and external experience’; p.376), attitude (‘a sense of open-hearted, friendly presence and interest’; Kabat-Zinn, 2003, p.145), and intention (reasons for practising). Shapiro et al. (2006, p.375) contend that the latter component is often neglected in discussions around mindfulness, which they attribute to the fact that Western psychology has generally sought to ‘extract the essence of mindfulness practice from its original religious/cultural roots,’ a point that is central to this chapter. However, one’s intention for practising mindfulness plays a key role in shaping the kinds of outcomes one may experience. As Kabat-Zinn (1990, p.32) puts it, “*Your intentions set the stage for what is possible. They remind you from moment to moment of why you are practicing in the first place.*” The importance of intention is underlined in Shapiro’s (1992) study, which showed that the majority of meditators attained effects which were congruent with their original intentions. For example, if they aimed for self-regulation (control over self), they were more

likely to achieve greater self-regulation, whereas an intention of self-exploration (knowledge of self) meant that they were more likely to increase self-exploration. Such findings suggest that the intentions of a mindfulness programme – both the stated aim of the intervention itself (whether reducing deficits such as anxiety, or promoting flourishing), and the intentions of the practitioner undertaking it – will affect its outcomes.

Given the above considerations, it is encouraging that interventions are being developed within PP which aim to augment existing deficit-based interventions by harnessing some of the positive possibilities offered by mindfulness. Two such PPIs are Mindfulness-Based Strengths Practice (Niemiec et al., 2012), which combines strengths-based approaches with mindfulness, and the Mindful Self-compassion programme (Neff & Germer, 2013), which aims to increase self-compassion and kindness. Both of these have successfully integrated mindfulness and PP variables to good effect. However, these programmes only focus on one quality promoted within PP, i.e., strengths and self-compassion respectively. As such, a potentially more comprehensive intervention is the Positive Mindfulness Programme (PMP), created by Dr Ivtzan, which is currently being validated in a number of independent research studies (e.g., Ivtzan et al., 2015). The PMP is an online, eight-week programme, which combines mindfulness training with a variety of PPIs and theory. Aimed at the general population, the programme is designed to increase wellbeing by targeting nine positive variables: positive emotions, self-compassion, wellbeing (happiness), autonomy, mindfulness, self-efficacy (strengths), meaning, compassion, and engagement (savouring).

These variables are designed to facilitate different facets of wellbeing; that is, in PP, a distinction is made between ‘hedonic’ wellbeing (i.e., pleasure, satisfaction) and ‘eudaimonic’ wellbeing (i.e., fulfilment, psychological development) (Peterson et al., 2005). Between them, the nine variables were selected to cover both ‘types’ of wellbeing. For example, engagement and gratitude both increase positive emotions (Adler & Fagley, 2005;

McCullough et al., 2002), and as such facilitate hedonic wellbeing (Deci & Ryan, 2008). The remaining seven variables all promote eudaimonic wellbeing, as based on Ryff's (1989) model of 'Psychological Wellbeing,' which comprises six dimensions, five of which are targeted in the PMP: self-acceptance (self-compassion), autonomy, environmental mastery (self-efficacy), purpose in life (meaning), and positive relations with others. Finally, mindfulness has been linked to both hedonic and eudaimonic wellbeing (Brown et al., 2007). Early findings from the programme have been promising. For instance, Ivtzan et al. (2015) offered it to 455 participants in a randomised controlled trial (reduced to 168 in the final analysis due to attrition). Relative to a control group, the experimental group enjoyed significant self-reported post-intervention improvements in all nine positive variables, as well as reductions in depression and stress. Moreover, these gains were also maintained at the one-month follow-up. Thus, the programme shows good promise as an intervention that harnesses the positive potential of mindfulness, taking it beyond a tool for deficit reduction and helping to actively promote flourishing.

Intriguingly, findings from Ivtzan et al.'s (2015) study suggest that PPIs such as the PMP may not only be suitable for people who are 'free' of mental health issues, but can potentially help people who are currently experiencing such problems. That is, participants who had mild to moderate levels of depression at the beginning of the programme experienced greater benefits – on measures of mindfulness, gratitude, depression, and stress – than those with no depression at baseline. Likewise, participants with lower baseline levels of wellbeing gained more, relative to those with higher baseline levels, in eight variables: mindfulness, wellbeing, depression, stress, gratitude, self-efficacy, and meaning. The researchers suggest that such findings may be due in part to the fact that such participants were in greater initial need of the programme, and therefore utilised its tools and benefits more fully. These results are in line with a meta-analysis conducted by Sin and

Lyubomirsky's (2009), featuring 25 separate studies examining the impact of PPIs on depression, which found that depressed participants gained more from PPIs than non-depressed participants. Such findings suggest that the potential role for PP may be greater than that implied by the continuum metaphor above: rather than PPIs simply assisting people without disorders (i.e., above 'zero') to flourish, they may have a role too in helping treat such disorders. However, such PPIs arguably remain distinct from conventional therapeutic offerings, such as MBSR, as they are still focussed on accentuating positive qualities, rather than reducing deficits.

It is important to recognise that PP is still very much a new and emerging field, and likewise that PPIs such as the PMP are in the very early stages of development. Nevertheless, hopefully the promise of such interventions is evident. By harnessing the positive potentials of mindfulness, these PPIs may help us further deepen our appreciation of its practice; moreover, they might enable us to capture some of the spirit of the original Buddhist teachings that have to an extent been lost with the deficit-based mindfulness interventions. Indeed, our engagement in the West with mindfulness, and with Buddhism more broadly, is only just beginning. In the context of its long history of evolution and migration, spanning over two and a half millennia, Buddhism has only just begun to make its immense presence felt in the West. Even then, its impact has been remarkable, especially over the past few decades. Thus Western psychology, and academia and society more broadly, has an exciting future ahead exploring the great riches and insights offered by this ancient – and yet still breathtakingly relevant – tradition of wisdom and spiritual practice. To this end, the present chapter, and this book more generally, will hopefully play a useful role in our unfolding appreciation and utilisation of mindfulness, and ideally of Buddhism more broadly too.

References

- Abeydeera, A. (2000). The travels of Marco Polo in the land of Buddhism. In V. Elisseeff (Ed.), *The Silk Road: Highways of Culture and Commerce* (pp. 69-80). Paris: UNESCO.
- Adkins, A. D., Singh, A. N., Winton, A. S., McKeegan, G. F., & Singh, J. (2010). Using a mindfulness-based procedure in the community: Translating research to practice. *Journal of Child and Family Studies, 19*(2), 175-183.
- Adler, M. G., & Fagley, N. S. (2005). Appreciation: Individual differences in finding value and meaning as a unique predictor of subjective well-being. *Journal of Personality, 73*(1), 79-114.
- Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: "it changed me in just about every way possible". *Behavioural and Cognitive Psychotherapy, 37*(04), 413-430.
- Baer, R. A., & Sauer, S. (2009). Mindfulness and cognitive behavioral therapy: A commentary on Harrington and Pickles. *Journal of Cognitive Psychotherapy, 23*(4), 324-332.
- Bazzano, A., Wolfe, C., Zylowska, L., Wang, S., Schuster, E., Barrett, C., & Lehrer, D. (2010). Stress-reduction and improved well-being following a pilot community-based participatory mindfulness-based stress-reduction (MBSR) program for parents/caregivers of children with developmental disabilities. *Disability and Health Journal, 3*(2), e6-e7.
- Bedard, M., Felteau, M., Marshall, S., Dubois, S., Weaver, B., & Gibbons, C. (2008). Mindfulness-based cognitive therapy reduces depression symptoms in people with a traumatic brain injury: Results from a pilot study. *European Psychiatry, 23*(2), S243-S243.

- Biegel, G. M., Brown, K. W., Shapiro, S. L., & Schubert, C. M. (2009). Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 77*(5), 855-866.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., . . . Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice, 11*(3), 230-241.
- Bootzin, R. R., & Stevens, S. J. (2005). Adolescents, substance abuse, and the treatment of insomnia and daytime sleepiness. *Clinical Psychology Review, 25*(5), 629-644.
- Bowen, S., & Marlatt, A. (2009). Surfing the urge: Brief mindfulness-based intervention for college student smokers. *Psychology of Addictive Behaviors, 23*(4), 666-671.
- Bowen, S., Witkiewitz, K., Dillworth, T. M., Chawla, N., Simpson, T. L., Ostafin, B. D., . . . Marlatt, G. A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors, 20*(3), 343-347.
- Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18*(4), 211-237.
- Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy, 35*(3), 471-494.
- Collard, P., & Walsh, J. (2008). Sensory awareness mindfulness training in coaching: Accepting life's challenges. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 26*(1), 30-37.
- Cousins, L. S. (1996). The dating of the historical Buddha: A review article. *Journal of the Royal Asiatic Society (Third Series), 6*(1), 57-63.
- Craigie, M. A., Rees, C. S., Marsh, A., & Nathan, P. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder: A preliminary evaluation. *Behavioural and Cognitive Psychotherapy, 36*, 553-568.

- Creswell, J. D., Myers, H. F., Cole, S. W., & Irwin, M. R. (2009). Mindfulness meditation training effects on CD4+ T lymphocytes in HIV-1 infected adults: A small randomized controlled trial. *Brain, Behavior, and Immunity*, 23(2), 184-188.
- Cusens, B., Duggan, G. B., Thorne, K., & Burch, V. (2010). Evaluation of the breathworks mindfulness-based pain management programme: effects on well-being and multiple measures of mindfulness. *Clinical Psychology & Psychotherapy*, 17(1), 63-78.
- Dalen, J., Smith, B. W., Shelley, B. M., Sloan, A. L., Leahigh, L., & Begay, D. (2010). Pilot study: Mindful Eating and Living (MEAL): Weight, eating behavior, and psychological outcomes associated with a mindfulness-based intervention for people with obesity. *Complementary Therapies in Medicine*, 18(6), 260-264.
- Deci, E., & Ryan, R. (2008). Hedonia, eudaimonia, and well-being: An introduction. *Journal of Happiness Studies*, 9(1), 1-11.
- Foley, E., Baillie, A., Huxter, M., Price, M., & Sinclair, E. (2010). Mindfulness-based cognitive therapy for individuals whose lives have been affected by cancer: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 78(1), 72-79.
- Fortney, L., & Taylor, M. (2010). Meditation in medical practice: A review of the evidence and practice. *Primary Care: Clinics in Office Practice*, 37(1), 81-90.
- Fredrickson, B. L., Cohn, M. A., Coffey, K. A., Pek, J., & Finkel, S. M. (2008). Open hearts build lives: Positive emotions, induced through loving-kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology*, 95(5), 1045-1062.
- Fresco, D. M., Moore, M. T., van Dulmen, M. H. M., Segal, Z. V., Ma, S. H., Teasdale, J. D., & Williams, J. M. G. (2007). Initial psychometric properties of the experiences

- questionnaire: Validation of a self-report measure of decentering. *Behavior Therapy*, 38(3), 234-246.
- Freud, S., & Breuer, J. (1895). *Studies on hysteria, S.E., 2*. London: Hogarth.
- Geschwind, N., Peeters, F., Drukker, M., van Os, J., & Wichers, M. (2011). Mindfulness training increases momentary positive emotions and reward experience in adults vulnerable to depression: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 79(5), 618-628.
- Gethin, R. (2011). On some definitions of mindfulness. *Contemporary Buddhism*, 12(01), 263-279.
- Godfrin, K., & Van Heeringen, C. (2010). The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. *Behaviour Research and Therapy*, 48(8), 738-746.
- Gross, C., Cramer-Bornemann, M., Frazier, P., Ibrahim, H., Kreitzer, M. J., Nyman, J., . . . Thomas, W. (2009). Results of a double-controlled trial of mindfulness-based stress reduction to reduce symptoms in transplant patients. *Explore: The Journal of Science and Healing*, 5(3), 156-156.
- Hanley, A. W., & Garland, E. L. (2014). Dispositional mindfulness co-varies with self-reported positive reappraisal. *Personality and Individual Differences*, 66, 146-152.
- Heidenreich, T., Tuin, I., Pflug, B., Michal, M., & Michalak, J. (2006). Mindfulness-based cognitive therapy for persistent insomnia: A pilot study. *Psychotherapy and Psychosomatics*, 75(3), 188-189.
- Horton-Deutsch, S., O'Haver Day, P., Haight, R., & Babin-Nelson, M. (2007). Enhancing mental health services to bone marrow transplant recipients through a mindfulness-based therapeutic intervention. *Complementary Therapies in Clinical Practice*, 13(2), 110-115.

- Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary Therapies in Clinical Practice, 15*(2), 61-66.
- Ivtzan, I., Lomas, T., Hefferon, K., & Worth, P. (2015). *Challenging Positive Psychology: Embracing the Dark Side of Life*. London: Routledge.
- Ivtzan, I., Young, T. K., Jeffrey, A. D., Martman, J. L., Hart, R., & Eiroa-Orosa, F. J. (2015). Integrating Mindfulness in Positive Psychology: A Randomised Controlled Trial of an 8-week Positive Mindfulness Programme (PMP). *Manuscript submitted for publication*.
- Jung, C. G. (1939/1963). *The Integration of the Personality* (S. Dell, Trans.). London: Routledge & Kegan Paul.
- Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4*(1), 33-47.
- Kabat-Zinn, J. (1990). *Full Catastrophe Living: Using the Wisdom of your Body and Mind to face Stress, Pain and Illness*. New York: Delacorte.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144-156.
- Kearney, D. J., McDermott, K., Martinez, M., & Simpson, T. (2010). Mindfulness-based stress reduction for irritable bowel syndrome. *Gastroenterology Clinics of North America, 138*(5), S-710.
- Keown, D. (2009). *Buddhism: A Brief Insight*. New York: Sterling Publishing.
- Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior, 43*(2), 207-222.

- Kilpatrick, L. A., Suyenobu, B. Y., Smith, S. R., Bueller, J. A., Goodman, T., Creswell, J. D., . . . Naliboff, B. D. (2011). Impact of mindfulness-based stress reduction training on intrinsic brain connectivity. *Neuroimage*, *56*(1), 290-298.
- Kim, B., Lee, S.-H., Kim, Y. W., Choi, T. K., Yook, K., Suh, S. Y., . . . Yook, K.-H. (2010). Effectiveness of a mindfulness-based cognitive therapy program as an adjunct to pharmacotherapy in patients with panic disorder. *Journal of Anxiety Disorders*, *24*(6), 590-595.
- King, R. (1999). *Orientalism and Religion: Post-Colonial Theory, India and "The Mystic East"*. London: Routledge.
- Kumar, S. M. (2002). An introduction to Buddhism for the cognitive-behavioral therapist. *Cognitive and Behavioral Practice*, *9*(1), 40-43.
- Ledesma, D., & Kumano, H. (2009). Mindfulness-based stress reduction and cancer: A meta-analysis. *Psycho-Oncology*, *18*(6), 571-579.
- Lee, E.-J. (2005). When placebic information differs from real information cognitive and motivational bases of mindful reactions to informational social influence. *Communication Research*, *32*(5), 615-645.
- Ljótsson, B., Andréewitch, S., Hedman, E., Rück, C., Andersson, G., & Lindefors, N. (2010). Exposure and mindfulness based therapy for irritable bowel syndrome – An open pilot study. *Journal of Behavior Therapy and Experimental Psychiatry*, *41*(3), 185-190.
- Lomas, T., Cartwright, T., Edginton, T., & Ridge, D. (2014). A religion of wellbeing?: The appeal of Buddhism to men in London, UK. *Psychology of Religion and Spirituality*, *6*(3), 198-207.
- Lomas, T., Edginton, T., Cartwright, T., & Ridge, D. (2014). Men developing emotional intelligence through meditation? Combining narrative, cognitive, and

- electroencephalography (EEG) evidence. *Psychology of Men and Masculinity*, 15(2), 213-224.
- Lomas, T., Hefferon, K., & Ivtzan, I. (2014). *Applied Positive Psychology: Integrated Positive Practice*. London: Sage.
- Lomas, T., & Jnanavaca. (2015). Weaving the threads: Types of mindfulness, orders of conditionality, and stages of the spiritual path. In E. Shonin, W. van Gordon & N. N. Singh (Eds.), *Buddhist Foundations of Mindfulness*. London: Springer.
- Lovas, D. A., & Barsky, A. J. (2010). Mindfulness-based cognitive therapy for hypochondriasis, or severe health anxiety: a pilot study. *Journal of Anxiety Disorders*, 24(8), 931-935.
- Ma, S. H., & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology*, 72(1), 31-40.
- McCullough, M. E., Emmons, R. A., & Tsang, J.-A. (2002). The grateful disposition: A conceptual and empirical topography. *Journal of Personality and Social Psychology*, 82, 112-127.
- McHugh, L., Simpson, A., & Reed, P. (2010). Mindfulness as a potential intervention for stimulus over-selectivity in older adults. *Research in Developmental Disabilities*, 31(1), 178-184.
- McMahan, D. L. (2004). Modernity and the early discourse of scientific buddhism. *Journal of the American Academy of Religion*, 72(4), 897-933.
- Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry*, 17(3), 192-200.

- Mills, N., & Allen, J. (2000). Mindfulness of movement as a coping strategy in multiple sclerosis: A pilot study. *General Hospital Psychiatry, 22*(6), 425-431.
- Moore, A., Gruber, T., Derosé, J., & Malinowski, P. (2012). Regular, brief mindfulness meditation practice improves electrophysiological markers of attentional control. *Front Hum Neurosci, 6*, 18.
- Nakamura, Y., Lipschitz, D. L., Landward, R., Kuhn, R., & West, G. (2011). Two sessions of sleep-focused mind-body bridging improve self-reported symptoms of sleep and PTSD in veterans: A pilot randomized controlled trial. *Journal of Psychosomatic Research, 70*(4), 335-345.
- National Institute for Health and Care Excellence (2004). Depression: Management of Depression in Primary and Secondary Care *Clinical guideline 23*.
- Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28-44.
- Niemiec, R. M., Rashid, T., & Spinella, M. (2012). Strong mindfulness: Integrating mindfulness and character strengths. *Journal of Mental Health Counseling, 34*(3), 240-253.
- Norem, J. K. (2001). *The Positive Power of Negative Thinking*. New York: Basic Books.
- Obadia, L. (2008). The economies of health in Western Buddhism: A case study of a Tibetan Buddhist group in France. In D. C. Wood (Ed.), *The Economics of Health and Wellness: Anthropological Perspectives* (pp. 227-259). Oxford: JAI Press.
- Olivio, E., Dodson-Lavelle, B., Wren, A., Fang, Y., & Oz, M. (2009). Feasibility and effectiveness of a brief meditation-based stress management intervention for patients diagnosed with or at risk for coronary artery disease: A pilot study. *Psychology, Health & Medicine, 14*(5), 513-523.

- Parks, A. C., & Biswas-Diener, R. (2014). Positive interventions: Past, present and future. In T. Kashdan & J. Ciarrochi (Eds.), *Mindfulness, Acceptance, and Positive Psychology: The Seven Foundations of Well-Being* (pp. 140-165). Oakland, CA: New Harbinger.
- Patel, S. R., Carmody, J., & Simpson, H. B. (2007). Adapting mindfulness-based stress reduction for the treatment of obsessive-compulsive disorder: A case report. *Cognitive and Behavioral Practice, 14*(4), 375-380.
- Peacock, J. (2014). Sati or mindfulness? Bridging the divide. In M. Mazzano (Ed.), *After Mindfulness: New Perspectives on Psychology and Meditation* (pp. 3-22). Basingstoke: Palgrave Macmillan.
- Peterson, C., Park, N., & Seligman, M. P. (2005). Orientations to happiness and life satisfaction: The full life versus the empty life. *Journal of Happiness Studies, 6*(1), 25-41.
- Phillips, T., & Aarons, H. (2005). Choosing Buddhism in Australia: Towards a traditional style of reflexive spiritual engagement¹. *The British Journal of Sociology, 56*(2), 215-232.
- Pradhan, E. K., Baumgarten, M., Langenberg, P., Handwerker, B., Gilpin, A. K., Magyari, T., . . . Berman, B. M. (2007). Effect of mindfulness-based stress reduction in rheumatoid arthritis patients. *Arthritis Care & Research, 57*(7), 1134-1142.
- Rhys Davids, T. W. (1881). *Buddhist Suttas*. Oxford: Clarendon Press.
- Rhys Davids, T. W. (1910). *Dialogues of the Buddha* (Vol. 2). London: Henry Frowde.
- Rogers, C. R. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. New York: Houghton Mifflin.
- Roof, W. (2001). *Spiritual Marketplace*. Princeton, NJ: Princeton University Press.

- Rungreangkulkij, S., Wongtakee, W., & Thongyot, S. (2011). Buddhist group therapy for diabetes patients with depressive symptoms. *Archives of Psychiatric Nursing, 25*(3), 195-205.
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069-1081.
- Ryff, C. D., Dienberg Love, G., Urry, H. L., Muller, D., Rosenkranz, M. A., Friedman, E. M., . . . Singer, B. (2006). Psychological well-being and ill-being: Do they have distinct or mirrored biological correlates? *Psychotherapy and Psychosomatics, 75*(2), 85-95.
- Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*(1), 1-28.
- Said, E. W. (1995). *Orientalism: Western Conceptions of the Orient*. London: Penguin.
- Schmidt, S., Grossman, P., Schwarzer, B., Jena, S., Naumann, J., & Walach, H. (2011). Treating fibromyalgia with mindfulness-based stress reduction: Results from a 3-armed randomized controlled trial. *Pain and Headache, 152*(2), 361-369.
- Schmidt, S., Simshäuser, K., Aickin, M., Lüking, M., Schultz, C., & Kaube, H. (2010). Mindfulness-based stress reduction is an effective intervention for patients suffering from migraine—Results from a controlled trial. *European Journal of Integrative Medicine, 2*(4), 196-196.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. New York: Guilford Press.
- Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5-14.

- Shapiro, D. H. (1992). A preliminary study of long term meditators: Goals, effects, religious orientation, cognitions. *Journal of Transpersonal Psychology, 24*(1), 23-39.
- Shapiro, D. H. (1994). Examining the content and context of meditation: A challenge for psychology in the areas of stress management, psychotherapy, and religion/values. *Journal of Humanistic Psychology, 34*(4), 101-135.
- Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management, 12*(2), 164-176.
- Shapiro, S. L., Bootzin, R. R., Figueredo, A. J., Lopez, A. M., & Schwartz, G. E. (2003). The efficacy of mindfulness-based stress reduction in the treatment of sleep disturbance in women with breast cancer: An exploratory study. *Journal of Psychosomatic Research, 54*(1), 85-91.
- Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. *Journal of Clinical Psychology, 62*(3), 373-386.
- Shonin, E., Van Gordon, W., & Griffiths, M. D. (2013). Mindfulness-based interventions: Towards mindful clinical integration. *Frontiers in Psychology, 4*(194). doi: 10.3389/fpsyg.2013.00194
- Sin, N. L., Della Porta, M. D., & Lyubomirsky, S. (2011). Tailoring positive psychology interventions to treat depressed individuals. In S. I. Donaldson, M. Csikszentmihalyi & J. Nakamura (Eds.), *Applied positive psychology: Improving everyday life, health, schools, work, and society* (pp. 79-96). New York: Routledge.
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology, 65*(5), 467-487.

- Singh, N. N., Lancioni, G. E., Winton, A. S., Singh, A. N., Adkins, A. D., & Singh, J. (2008). Clinical and benefit—cost outcomes of teaching a mindfulness-based procedure to adult offenders with intellectual disabilities. *Behavior Modification, 32*(5), 622-637.
- Singh, N. N., Lancioni, G. E., Winton, A. S., Singh, J., Curtis, W. J., Wahler, R. G., & McAleavey, K. M. (2007). Mindful parenting decreases aggression and increases social behavior in children with developmental disabilities. *Behavior Modification, 31*(6), 749-771.
- Stanley, E. A., Schaldach, J. M., Kiyonaga, A., & Jha, A. P. (2011). Mindfulness-based Mind Fitness Training: A case study of a high-stress predeployment military cohort. *Cognitive and Behavioral Practice, 18*(4), 566-576.
- Sullivan, M. J., Wood, L., Terry, J., Brantley, J., Charles, A., McGee, V., . . . Bosworth, H. B. (2009). The support, education, and research in chronic heart failure study (SEARCH): A mindfulness-based psychoeducational intervention improves depression and clinical symptoms in patients with chronic heart failure. *American Heart Journal, 157*(1), 84-90.
- Surana, P. K., & Lomas, T. (2014). The power of charity: Does giving away money improve the wellbeing of the donor? *Indian Journal of Positive Psychology, 5*(3), 223-230.
- Tapper, K., Shaw, C., Ilesley, J., Hill, A. J., Bond, F. W., & Moore, L. (2009). Exploratory randomised controlled trial of a mindfulness-based weight loss intervention for women. *Appetite, 52*(2), 396-404.
- Teasdale, J. D. (1988). Cognitive vulnerability to persistent depression. *Cognition & Emotion, 2*(3), 247-274.
- Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help? *Behaviour Research and Therapy, 33*(1), 25-39.

- Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology, 68*(4), 615-623.
- Thomas, E. J. (2000). *The Life of Buddha as Legend and History*. New York: Dover.
- Thompson, N. J., Walker, E. R., Obolensky, N., Winning, A., Barmon, C., DiIorio, C., & Compton, M. T. (2010). Distance delivery of mindfulness-based cognitive therapy for depression: Project UPLIFT. *Epilepsy & Behavior, 19*(3), 247-254.
- Thrangou, K. (1993). *The Practice of Tranquility and Insight: A Guide to Tibetan Buddhist Meditation* (R. Roberts, Trans.). Boston, MA: Shambhala Publishing.
- Varenne, J. (1977). *Yoga and the Hindu Tradition*. Chicago: University of Chicago Press.
- Walach, H., Nord, E., Zier, C., Dietz-Waschkowski, B., Kersig, S., & Schupbach, H. (2007). Mindfulness-based stress reduction as a method for personnel development: A pilot evaluation. *International Journal of Stress Management, 14*(2), 188-198.
- Van Gordon, W., Shonin, E., Griffiths, M. D., & Singh, N. N. (2014). There is only one mindfulness: Why science and Buddhism need to work together. *Mindfulness, 6*(1), 49-56.
- Weber, B., Jermann, F., Gex-Fabry, M., Nallet, A., Bondolfi, G., & Aubry, J.-M. (2010). Mindfulness-based cognitive therapy for bipolar disorder: A feasibility trial. *European Psychiatry, 25*(6), 334-337.
- Weinstein, N. D., Marcus, S. E., & Moser, R. P. (2005). Smokers' unrealistic optimism about their risk. *Tobacco Control, 14*(1), 55-59.
- Williams, J. M. G., Alatiq, Y., Crane, C., Barnhofer, T., Fennell, M., Duggan, D., . . . Goodwin, G. (2008). Mindfulness-based cognitive therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning. *Journal of Affective Disorders, 107*(1), 275-279.

- Williams, J. M. G., & Kabat-Zinn, J. (2011). Mindfulness: Diverse perspectives on its meaning, origins, and multiple applications at the intersection of science and dharma. *Contemporary Buddhism*, 12(01), 1-18.
- Wong, P. T. P. (2011). Positive psychology 2.0: Towards a balanced interactive model of the good life. *Canadian Psychology/Psychologie canadienne*, 52(2), 69-81.
- Wren, A. A., Wright, M. A., Carson, J. W., & Keefe, F. J. (2011). Yoga for persistent pain: New findings and directions for an ancient practice. *Pain*, 152(3), 477-480.
- Zgierska, A., Rabago, D., Zuelsdorff, M., Coe, C., Miller, M., & Fleming, M. (2008). Mindfulness meditation for alcohol relapse prevention: A feasibility pilot study. *Journal of Addiction Medicine*, 2(3), 165-173.