CONTENTS

INTRODUCTION

If Mindfulness is the Answer, What is the Question?

MINDFULNESS IS EVERYWHERE. Advertisements encourage consumers to 'Breathe in for as long as it takes to read this line. Breathe out for as long as it takes to read this line.' Magazines at supermarket checkouts list meditation in features offering advice on '10 tips for a happier life'. Radio DJs and talk-show hosts interview monks and mindfulness teachers, and books on meditation, psychology and the brain sciences sell in their millions, while tens of thousands of news stories wax lyrical about mindfulness's benefits for stress management in workaday lives (Van Dam et al. 2018, 68). It is now so normal for people to practise mindfulness (or think that they ought to) that if you have an iPhone, you have an inbuilt mindfulness section in your health data app that tells you that 'taking some time to quiet your mind, be in the moment, can make you less stressed and improve your health overall'. In short, learning to 'be present in the moment' is having its moment.

The timing of this meteoric public ascent is noteworthy. Mindfulness is being championed as a prophylactic psychological support at a time of intense public concern about mental health and psychological vulnerability. Depression is the number one cause of disability worldwide (Kousoulis 2019, 2), and the burden of mental health is on the rise (WHO 2020). In the United States, one in four Americans is reported to have a mental or substance use disorder (McCane-Katz 2020) and the National Center for Health Statistics reported a suicide-rate increase of 35 per cent between 1999 and 2018 (Hedegaard, Curtin and Warner 2020). In the UK, it is estimated that up to 10 per cent of the adult population will experience symptoms of depression in any given week and depressive relapse rates are high: following one episode of depression 50 per cent will go on to have a second episode, and 80 per cent of these will

go on to have three or more episodes (Singleton et al. 2003). Since 2009 the number of sick days lost to stress, depression and anxiety has increased by 24 per cent and the number lost to serious mental illness has doubled (Mehta, Murphy and Lillford-Wildman 2014). And this rise in mental health challenges is not limited to adult populations. The number of fifteen- to sixteen-year-olds with depression nearly doubled between the 1980s and the 2000s (Nuffield Foundation 2013), and over half of those who experience mental illness in childhood suffer it again as adults (Kim-Cohen et al. 2003; Kessler, Berglund et al. 2005).

Interest in mental health is not limited to clinical conditions. Researchers focusing on positive mental health conceptualise mental health as a spectrum encompassing mental disorder, 'languishing' and 'flourishing' (see Huppert 2009; Keyes 2002a; 2002b; also Huppert 2005);[1] and primary prevention is a central focus of public mental health campaigns that seek to stop mental health problems before they arise. As the Mental Health Foundation states on its website (MHF 2022), '[w]e all have mental health, just as we all have physical health'. Researchers characterise positive mental health, or 'flourishing', as the presence of psychological and social well-being, a categorisation that extends far beyond the absence of mental illness. And they suggest that many of us may be occupying the suboptimal space of 'languishing' most of the time.

By the time I began the fieldwork for this book, a body of research was growing that linked mindfulness to the prevention of mental disorder and the cultivation of positive mental health. Thousands of articles in scientific journals explored the therapeutic potential of mindfulness, examining everything from brain waves to irritability.[2] Evidence was being compiled that suggested that Mindfulness-Based Cognitive Therapy (MBCT) might help large numbers of people experiencing depressive affect and patterns of recurring depression (Baer 2003; Coelho, Canter and Ernst 2007) and three randomised-controlled trials had found that MBCT significantly reduced the risk of depressive relapse (Kuyken et al. 2008; Ma and Teasdale 2004; Teasdale, Segal et al 2000).[3] Clinical studies were investigating the benefits of meditation, motivated by the possibility of reducing stress, increasing productivity, addressing psychological disorders and supporting 'flourishing'. Bolstered by an increasingly healthy evidence base, advocates and practitioners had introduced mindfulness into schools and universities, prisons, the probation service, healthcare institutions and workplaces (public, private and third sector). It is an extraordinary phenomenon that a Buddhist awareness training practice is now being framed as a solution to societal challenges as wide-ranging as

criminal recidivism, academic attainment, depressive relapse and workplace absenteeism.

In this book I ask, if mindfulness is the answer, what is the question? What is it that unites the workplace and the prison cell? How are the classroom and the hospital understood, such that they are connected by an awareness practice? And how have mindfulness practitioners come to think of cultivating a kindly relationship with their own minds as a constituent aspect of the 'good life'? How has it happened that mindfulness has become an appropriate support for such a range and variety of different societal challenges? What has changed to lead to this framing? And how have these changes affected how people relate to themselves and to others? To put it another way: if mindfulness is an appropriate practice in every area, from the clinic to the classroom, and for diverse people, from people who are leading healthy, happy lives to those struggling with their mental health in circumstances that are stacked against them, what does this tell us about the questions people are asking about the mind and how they understand themselves in relation to their minds?

Mindfulness provides a window onto a particular moment in which the mind has become a preeminent focus (see McMahan 2008, 201–2). The category of mental health has progressively altered in recent years, shifting from an either/or categorisation of those who do or do not suffer from mental ill-health, to one of an affliction affecting one in four people, to one of a fluctuating condition of all human life. Sometimes described as a shifting landscape, sometimes as a scale, location on which changes, mental ill-health is often now thought of as something that affects all people to a greater or lesser extent at different points in their lives. The expansion of the category of mental health swells the populations for whom it is a concern and transforms responses to address it. 'Mental health' is no longer only relevant for those who would qualify for a mental health diagnosis; in this new categorisation, all people are more or less well at different points in their lives. And emphasis shifts from illness to health: the prevention of illness is met and supported by the active cultivation of positive mental health in order to 'live well'. In this book, I interrogate the consequences of these transformations, examining how people think of themselves, what they think they should do, the values with which mental health is invested, the policies that are created around it and the ways in which the goals of those policies are achieved. Mental health has become a transversal feature of life and one that can be actively supported through dedicated practices. Through my focus on mindfulness, I show how

mental health is incorporated into people's relationships with themselves, therapeutic interventions, structures of governance and political campaigns.

An Anthropology of Metacognition

Mindfulness is often thought of as a solitary activity (people sitting still with their eyes shut, perhaps), and is commonly described as an acultural, universal, timeless or ancient practice. But recent anthropological and social scientific work has challenged these assumptions, revealing the historical and cultural processes that inform mindfulness and meditation in diverse contexts. Kirmayer (2015a) has rightly highlighted that adapting techniques like mindfulness from the social contexts in which they originate changes the meaning, nature and effect of their practice; and, as Gajaweera emphasizes (2016) in her work with ethnic and racial minority meditators in Los Angeles, origin traditions do not themselves stay still, and are perpetually subject to proximate and foreign influences. Historians and religious scholars have provided excellent considerations of the development of mindfulness and its relationship to wider religious and secular contexts (see Braun 2022; Husgafvel 2018; McMahan 2008; Nathoo 2019; Wilson 2014; 2017). And anthropologists have demonstrated that mindfulness is informed by normative registers that influence the self-knowledge generated through practice (see Cassaniti 2018; Hedegaard 2020; Mautner 2020; McKay 2019; Myers, Lewis and Dutton 2015; Pagis 2009; 2010; 2019; Vogel 2017; Wheater 2017), providing descriptive accounts of the ways in which interior experiences are socially enabled. Anthropologists have shown, that is, that far from being timeless and universal, mindfulness is fundamentally informed by the cultures and the contexts in which it is ensconced.

Mindfulness, as it is now found in institutions around the world, originated in Buddhist meditation, and the term itself is often taken to be a translation of the Pali word *sati* (see Cassaniti 2018; Gethin 2011 for sustained discussions of this). Beginning in the 1950s in south-east Asia, reformist monks developed, reinvigorated and propagated a form of meditation, *vipassanā*, based on a Buddhist text, *The Mahāsatipatthāna Sutta* (see Braun 2013; Cook 2010a; Jordt 2007). Reformers understood *sati* as an ethically positive perspectival awareness, which could be cultivated through meditative discipline, requiring morality, concentration and wisdom. Therapeutic mindfulness-based interventions are described by their originators as 'marriages' between a conceptual framework from cognitive psychology and quite intensive training in mediation, a 'confluence of two powerful and potentially synergistic epistemologies'

(Williams and Kabat-Zinn 2011, 1). But while the Buddhist roots of mindfulness may be fleetingly referenced in mindfulness courses, mindfulness is most commonly interpreted as a universal human capacity that can be cultivated by practitioners in order to alleviate mental, physical and emotional suffering. Thus, while mindfulness is understood to have originated in Buddhism, it is commonly conceptualised as modern, scientific and secular. And it is framed as a universal and acultural psychological skill that can support the reduction of suffering and the cultivation of mental health.

While there are some disagreements about how mindfulness should be defined (see Mikulas 2011), it is most commonly understood as an awareness-training practice that enables people to '[pay] attention in a particular way, on purpose, in the present moment and non-judgementally' (Segal, Williams and Teasdale 2002, 121). Through daily practice, mindfulness practitioners learn to 'pay attention'; that is, to develop awareness of the patterns of their thoughts, emotions and bodily experiences. This is done 'on purpose' as practitioners intentionally change the focus and style of their attention, by 'non-judgementally' focusing on what they experience in the 'present moment', making emotional experience and the fluctuations of cognition the object of self-conscious reflection without trying to alter that experience. Through this ongoing cultivation of awareness, people intend to relate differently to their experiences and, as a result, to live healthier lives.

Mindfulness gained legitimacy as a secular and therapeutic practice following the development of Mindfulness-Based Stress Reduction (MBSR), an intervention designed by Jon Kabat-Zinn in America in the 1970s to treat chronic disease and pain, though it was only with the development of Mindfulness-Based Cognitive Therapy (MBCT) by Mark Williams, Zindel Segal and John Teasdale in 1991 that mindfulness-based interventions began to influence mental healthcare significantly in the UK (see chapter 1). MBCT is a psychosocial group-based intervention for people who have had three or more depressive episodes but who are currently well. The course is a practice-based training to support participants to identify early signs of depression in order to prevent relapse and to actively maintain their mental health. It encourages participants to develop awareness of small fluctuations in mood, thoughts or bodily experiences, and they learn that developing awareness in this way while they are well has the potential to prevent them relapsing into depression. Practitioners and promotors of mindfulness describe this meta-cognitive ability as a universal human capacity that can be cultivated,[4] and they learn to relate to the mind as a mind, to think about thinking in a peculiarly

committed way, by recognising thoughts as 'objects in the mind' and relating to them with kindliness.

Anthropologists have highlighted that attentional and metacognitive skills vary across cultures (see Proust and Fortier 2018) and that how people think about thinking has effects on the strategies that they employ in relation to thought, and on the habits and skills that they seek to cultivate in order to influence the direction or quality of their attention (see Cassaniti and Luhrmann 2014; Hirschkind 2001; 2006; Luhrmann 2012, xxi; Mair 2018). They have shown that people have clear ideas about the nature of thought and how they ought to relate to it, and that these ideas are embedded in particular relationships and practices. Anthropological accounts reveal the effortful practice that people make to attend to attention in particular ways; that people wilfully and actively cultivate attentional skills in order to effect change in their lives. The pan-human capacity for metacognition is invested with specific cultural and attitudinal values through the practice of mindfulness. And it is the particular way in which people relate to their minds (and not just the fact that they do so) that is central to mindfulness. The mindfulness practitioners who are the focus of this book intentionally cultivate forms of awareness and attentional focus through mindfulness training. They learn that they *can* have a relationship with their own minds, and they learn techniques for developing a particular form of effortful attention to the mind that involve repetitive practice, requiring ongoing training in metacognitive awareness. They think that cultivating metacognitive ability, or learning to 'make friends' with one's own mind through self-reflective practice, is of benefit to all people in the maintenance of mental health, whether or not they have ever received a mental health diagnosis. For them, living well is characterised by metacognitive skill, attentional training and the cultivation of a kindly relationship with one's own objectified mind. In chapters 2 and 3 I delineate the particular attitudinal dispositions that characterise the metacognitive skill that mindfulness practitioners cultivate. In mindfulness as a therapeutic intervention and as a daily practice, the attitudinal quality of kindliness imbues metacognitive ability and is central to the objectification of the mind.

Psychological Governance and the Ethical Turn

In the 1950s, depression was so rare that pharmaceutical companies saw no benefit in investing money in its treatment (Healy 1997). And yet, by the 1990s, the second most prescribed drug in the United States was the antidepressant

Prozac (Elliott 2018). While statistics about the projected costs, prevalence and severity of depression all point to an emerging public health crisis and provide grounds for immediate action, such as funding, research and intervention to support individuals and communities, anthropologists have argued that cause and effect work the other way: that depression is 'socially constructed' through changes to diagnostic criteria, increased awareness, and the medicalisation and commercialisation of mental states (see Hirschbein 2014; Kitanaka 2011). Social scientists have characterised shifting dynamics of mental health classification and presentation as a diagnostic (rather than a psychological or biological) epidemic, finding in escalating mental health statistics a 'contagion of representation' (Mattingly 2017; see also Grinker 2007). Such social constructionist accounts provide illuminating insights into the cultural and historical conditions that inform the way that categories of representation such as 'mental health', 'depression' or 'anxiety', are constructed, charting the new forms of biosociality established around changes in diagnostic criteria as scientific research is targeted, rights and services are expanded and people come together in activist movements and self-help groups organised around a particular illness or disability (Rabinow 1996; Rose and Rabinow 2006).

Important studies of the cultural history of psychology have highlighted how truth discourses about human character are taken up by different authorities, informing strategies for intervention and the ways in which individuals work on themselves in support of individual or collective health (see Cushman 1995; Danziger 1990; Rose 1985; 1996b). Psychological terms, diagnoses, explanations, values and judgements thus get entangled with a more general contemporary 'regime of the self' as the prudent yet enterprising individual actively shapes his or her life course through acts of choice (see Novas and Rose 2000). As psychological thinking expands, it informs the habits, values and obligations of the self-sufficient, 'responsibilised' citizen who is able to withstand the uncertainties of modern life (Brown 2003; Cruikshank 1996; Rose 1996a, 1996b). In such a reading, it is people's *freedom* that enables them to become objects of governance, because it binds them 'to a subjection that is more profound because it *appears* to emanate from our autonomous quest for ourselves, it *appears* as a matter of freedom' (Rose 1990, 256, emphasis added). The intensified attention to the inner life of psychological subjectivity is, as Rose revealed in his seminal work, intimately connected to the marriage between political agendas and 'the personal projects of individuals to live a good life' (ibid., 10; see also Kleinman et al. 2011). Such approaches afford us

the opportunity to examine one form of relationship between self-governance and social forces: the influence of psychological knowledge and technologies for the identification and management of populations, and the influence of expert knowledge in the creation of psychological subjectivity. Psychological knowledge doesn't just describe experience; it also creates and shapes subjects, informing what people think they know about themselves and what it is to be human; and this influences the ways in which they relate to themselves and others.

Where I differ from such approaches is in placing the emphasis of my analysis on first-person experiences of mental health in order to reflect on the categories and structures of governance to which they are constitutively related. In what follows I show that the micro-level efforts that people make to support their mental health, to engage in intentional projects of cognitive and emotional discipline in order to prevent mental ill-health and to promote psychological well-being and flourishing are intimately related to macro-level projects of governance and social structure. Transformations in social services, institutional structures and governmental agendas reflect and contribute to the everyday efforts that people make to attend to their psychological selves. In what follows, I examine how transformations in the category of mental health are central to the reimagining of psychological subjects, the reshaping of techniques of governance and the refashioning of the relationship between parliamentarians and citizen-subjects. And yet, I am in no way arguing that people are *determined* by the social or material forces in which they are ensconced. In fact, this book may be read as a critique of the 'neoliberalism made 'em do it' arguments that circulate around psychological subjectivity and self-governance. Rather, I examine the social processes by which mental health is lived, the normative values that inform it and the practices of self-cultivation by which it is addressed. That is, I extend my analysis beyond the Althusserian 'interpellation' of changing social categories and expert practices to examine the values and efforts with which people navigate the world, and the ethical complexity and cultural particularity of so doing (see also Cook 2023). For example, in the transformations in the category of depression from an acute to a relapsing or recurring condition, or the shift in the category of mental health from relevant for certain at-risk populations to a constituent aspect of life for everyone, how do people's relationships with themselves and others change, what values inform their efforts to live well, and what is the lived experience of these?

In this approach, this book takes inspiration from the recent ethical turn in anthropology (Faubion 2001a; Laidlaw 2002; Lambek 2000a). The

development of the anthropology of ethics is seen by some as a move away from earlier culturalist claims that people think or behave in certain ways because of the society, culture or ideology in which they find themselves (Heywood 2017; Laidlaw 2002).[5] A foundational claim of the anthropology of ethics is not that ethics or morality have a universal content or are constituted by any particular configuration of values. Rather, it claims that people are evaluative: that they hold themselves to different understandings about what is right and wrong, and that they reflect and deliberate on these things (Laidlaw 2014, 3). People exercise this reflective capacity in their considerations about best courses of action, their choices between possible goods, and as a way of accounting for risk, responsibility and consequences. They think about how they ought to live, and this deliberation influences the ways in which they relate to themselves, the practices they undertake, their interactions with others and the choices that they make.

Drawing inspiration from this, I consider psychological subjectivity from the perspective of its 'potentialities as well as its repressive normativities' (Mattingly 2014b, 203). I ask, 'Are there ways of interrogating the moral universalisms of modernity, or technologies of governance, without completely discounting optimism, self-reflection and aspiration?' That is, as Mattingly puts it (2014b, 203),

> Without a strong theory of the human subject as a complex moral agent capable of *acting upon history* (even within a history that also makes her) as well as an agent compelled to *respond* to history, including the small histories that comprise ordinary life, then we, as scholars, miss a great deal about how social life takes shape, what morally matters to people, and even how social change might occur.

My starting point, therefore, is not to take the will of the individual and her capacity to reflect on how she might wish to live and work towards that aim as symptoms of broader knowledge practices or social forces. Instead, I examine the ways in which people negotiate their lives and the ethical potential of the worlds in which they find themselves. That is, I propose that efforts to realise the good life in how people relate to themselves may be explored from the ground up, as well as the top down. Transformations in mental health, the obligations that these entail and the possibilities that they offer involve not only changes in categories, but changes in values, norms and ethical practices. In taking this approach, I seek to account for those aspects of self-cultivation practices and engagement with psychological knowledge that lie beyond

formal institutional structures and are motivated by optimistic, hopeful or even utopian ideas about the human condition. And I examine the ways in which people might work to bring something new into being, as much in their relationships with themselves as in political campaigns, and the reasons they might have for so doing.

The Ethics and Instrumentalism of Mental Health

As I have pointed out above, the popularity of mindfulness is bolstered by an increasing evidence base that suggests that mindfulness-based interventions are effective in a range of areas. It is fair to say that, without randomised controlled trials and advanced statistical analyses reporting the 'efficacy' of meditation practice, mindfulness-based initiatives would not have received endorsement from the National Institute for Health and Care Excellence (NICE), would not have been mandated on the UK National Health Service (NHS) and would not be being discussed in the UK parliament as an appropriate response to policy challenges in civil society. But this pragmatic and instrumentalist framing of mindfulness is only part of the picture. At the same time as mindfulness is being witnessed as a targeted intervention for specific populations, it is also being described as a practice for living well, flourishing and 'waking up' to life that is appropriate for everyone. Awareness and attention characterise both the prognosis of and the cure for the challenges of modernity (see Cook 2018; Pedersen, Albris and Seaver 2021): stressed-out lives are hampered by the unhealthy encounter between innate cognitive weakness and radical transformations in the structure of social life, leading to anxiety, emotional numbness and the reactivity of cognitive bias. 'Coming to our senses' through mindfulness, as Jon Kabat-Zinn's celebrated book (2005) is titled, means reconnecting with immediate phenomena, reinhabiting one's direct experiences by cultivating awareness of bodily sensations. One is supposed to cook mindfully, wash the dishes mindfully or wait for the bus mindfully. This emphasis on mindful awareness in daily life far exceeds the short-term management of illness. Rather, the prevention of illness and the promotion of health rest on a fundamental shift in the relationship that a practitioner has with herself and her routine experiences.

As people engage with practices like mindfulness, they invest them with their own values, shaping the taken-for-granted nature of ongoing transformations in the category of mental health. For the people discussed in this book, mindfulness is not transcendent, but ameliorative, a 'this-worldly' means for

living well that they think of as both pragmatic and ethical: a means for improving capacities and a capacity in its own right. They think that mindfulness extends from formal practices into daily life and that a mindful relationship with oneself is informed by virtuous dispositions of friendliness, patience and compassion. They also think that, properly supported by evidence, costed and communicated, mindfulness has the potential to help large numbers of people. In a mental health landscape increasingly characterised by an emphasis on preventative healthcare, cultivating a healthy relationship with one's own mind is described as both an evidence-based 'technique' and an ethical practice: Mindfulness is simultaneously promoted as a pragmatic and targeted intervention to address the high levels of stress and anxiety found in diverse populations and it is engaged with as a way to 'wake up' to life.

The coexistence of these two languages, of utility and ethics, seems counterintuitive: one represents the 'bottom line' of a highly rationalised, impersonal and measurable modern world. The other points to subjective experience and inner orientation, often promoted as a supportive response to the alienation and disenchantment resulting from the harshness of that same modernity (see Nolan 1998, 285). I argue that, in the logic of preventative healthcare, instrumental questions about 'fixing' are blended with Socratic questions about the good life. In combining the psychological/medical question, 'How can mental ill-health be prevented/alleviated?' and the ethical questions, 'How can I live well?' and 'What is flourishing?', instrumental concerns about alleviation of suffering and deliberation about the good life are merged. Mental health is simultaneously framed as an epidemic that requires action and as 'something we all have', and mindfulness is engaged with as both a preventative intervention for those most at risk of mental ill-health and as a practice that enables people to live more 'fully', one that is as personally relevant for cognitive psychologists as it is for patients. In such a reframing of mental health, it is unsurprising that people in diverse areas of life take up mindfulness to address seemingly different challenges, as questions particular to a given issue (criminal recidivism, worker presenteeism, etc.) become interwoven with ethical questions about the 'good life'.

Combined, the logics of these developments have had a profound impact on the ways in which mental health is understood and addressed. It is no longer something that can be 'fixed': we all have mental health, all of the time; it is not a disease that can be removed, but rather, something to be tended to and maintained in order to prevent a slide into mental ill-health and to support a flourishing and happy life. Two correlated effects result from this shift. First,

not all mental health is to be treated medically. While acute depressive episodes can be treated with antidepressant medication, an emphasis on the cultivation of positive mental health is not limited to a strictly medical domain. Most therapeutic work escapes the domain of psychiatrists, even though they may endorse it or undertake some of it themselves. And second, the category of mental health is expanded to encompass both the suffering of mental illness and the ups and downs experienced by all people in daily life. We all now have mental health, and we can all do things actively to support it. This expansion of the category of mental health makes it a transversal issue, affecting patients, psychologists and politicians alike, as preventative supports for positive mental health neutralise or sidestep the antimonies of medicalisation: between health and illness, between normal life and pathology, between living well and preventing symptoms and between ethical practice and instrumentalism.

The interaction between incommensurate ethical and economic values extends from personal practices of self-cultivation into contemporary governmental interest in mental health much more broadly. In the second half of this book, I focus on two recent changes in policy development in the UK that exemplify this. First, in an era of evidence-based policy-making, political deliberation increasingly draws on academic research in its commitment to 'what works'. Governmental policy on mental health is informed by evidence from the psychological, social and economic sciences as policy makers seek to develop costed, evidence-based and effective policies. Second, in response to charges of technocratic governance, evidence-based policy deliberation occurs through structures of participatory governance, based on the orchestration of governmental, third sector, academic, lay and professional collaboration. The recategorisation of mental health as a transversal concern informs this emphasis on evidence-based participatory governance: Civil servants and politicians understand themselves to be as vulnerable to mental health issues as other citizens and the evidence from the psychological sciences is deliberated in participatory fora as transversally relevant. The rationalism of evidence-based psychological services for the prevention and treatment of illness and the Romanticism of the potential of self-work for living more fully coalesce in the expanded category of mental health as a transversal issue, and in the popularity of mindfulness as an evidence-based ethical practice. Mindfulness is *both* an instrumentalised intervention *and* an ethical practice; a pragmatic support for mental health and a 'way of being' that infuses everyday life. Furthermore, as

I will show, it is important to the people discussed in this book that mindfulness maintains this multiplicity of values as this 'both/and' characterisation of mindfulness extends from personal practice into policy discussion and political deliberation.

Researching Cultures of Mindfulness

I first encountered mindfulness while I was finishing my book on Buddhist meditation (Cook 2010a). I had spent years researching how monks and nuns in a monastery in northern Thailand cultivate insight into the Buddhist truths of impermanence, suffering and non-self. Through intensive meditation practice, monastics intentionally cut attachment to a delusional sense of self, and progress towards enlightenment. Writing the book had been a labour of love over a number of years, during which time I participated in a regular meditation group in Cambridge, UK. Once a week, six or seven of us would meet to meditate, listen to a *dhamma* talk and eat cake. It was here that I first heard about MBCT, and I was struck by the fact that this therapeutic intervention shared direct links with the soteriological discipline of the Thai monastery (see chapter 1). While the ink was drying on my book about Thai renunciation and meditative discipline, people across the UK were engaging with meditation as a scientifically verifiable support for living well in a stressful world. And the meditative practices that were central to ascetic discipline and enlightenment in the monastery were being used by my companions to support their mental health and to navigate the daily ups and downs of romantic relationships, work stresses and family responsibilities.

As in America, in Britain mindfulness was the focus of scientific research and media interest at the time. But while mindfulness grew in popularity in the US over the same period (see Wilson 2014; 2017), it is possible to make a case for Britain as the epitome of the 'mindful nation'. Unlike in the US, mindfulness in Britain receives public funding, and its uptake has been facilitated by centralised deployment through the NHS and the country's relatively smaller size. Mindfulness-Based Cognitive Therapy (MBCT) is available on the NHS as a preventative intervention for recurrent depression and is now taught as a master's degree for healthcare professionals at British universities. In 2013 mindfulness courses were established in Westminster for parliamentarians and parliamentary staff and, at the time of writing, over 250 parliamentarians and 450 staff have completed an eight-week course. In 2014, parliamentarians and

advocates set up an All-Party Parliamentary Group (APPG) in Westminster to investigate the policy potential for mindfulness in the criminal justice system, education, healthcare and the workplace.

The fieldwork upon which this book is based spanned each of these sites: mindfulness courses for people suffering from recurrent depression and anxiety; postgraduate courses for mindfulness-based therapists; parliamentarians' mindfulness practice; and political advocacy for mindfulness in public policy. In 2013 I began participant observation with two cohorts on a two-year mindfulness therapist training programme at a university in the UK. Over the course of three years, fieldwork involved engaging with the full pedagogy of the programme as I sought to embed myself in training: personal practice, participation in the eight-week MBCT course, regular practice periods, silent retreats, guided reading, lectures and workshops, peer presentations, tutorials, supervised practice, reflective diaries, essays, peer observation and out-of-school activities. The two cohorts of students with whom I worked were made up of healthcare professionals from a range of different backgrounds, including therapists, nurses, GPs (general practitioners), carers and psychologists. They were enthusiastic and excited about my research. With their consent, I sought to understand the struggles that they faced in training, and subsequently in practice, and to make sense of the ways in which mindfulness informed their personal and professional practice over the course of years (see Cook 2017; 2020). During this time I also conducted participant observation on eight-week MBCT courses with people who had been referred by healthcare professionals, usually to address issues of recurrent depression and anxiety. In the UK, people who wish to participate in an MBCT course on the NHS must be referred via the Depression and Anxiety services, their GP or local Mental Health Assessment Teams (see Cook 2015). In order to research it as a structured learning process for both therapists and participants, experiential knowledge of mindfulness was of paramount importance, and fieldwork involved a methodological commitment to practice-based research, a focus that shares interesting parallels with the place of practice in mindfulness-based interventions themselves (see Cook 2020).

The other focus of my research was the British parliament. From May 2014 I worked with the group of parliamentarians and volunteer advocates who established the Mindfulness All-Party Parliamentary Group (APPG), beginning an eighteen-month inquiry into the benefits of mindfulness in the areas of health, education, criminal justice and the workplace (see Cook 2016). Following this period, volunteer advocates drafted a report, *Mindful Nation UK*,

gathering evidence for mindfulness-based interventions across diverse sectors of civil society in the UK. Over the course of the fieldwork I made dozens of trips to Westminster either to meet advocates and parliamentarians or to attend the meetings and events to which I had been invited, and much of the work in parliament was organised around scheduled meetings and interviews. Each time, the 'imponderabilia' of life—the catch-up in the café before a meeting, the conversation in the halls afterwards—provided important insights into people's engagement with mindfulness. But Westminster is not a place where one can just 'show up' and 'hang out'; one needs a good reason to be there. Entering through the Cromwell Green entrance on the other side of the building from the river Thames, visitors are asked by a police officer or a visitor assistant what they are there for or whom they are there to meet before being allowed to move through security. On busy days, this can take up to an hour, and requires patience. Each person is given a visitor security pass before putting all bags and coats through the airport-style X-ray machines and stepping through a metal detector. Once on the other side of security, one comes to Westminster Hall, the oldest building on the parliamentary estate. Here, one sees the business of Westminster unfolding—tours of schoolchildren being shown around, groups of constituents waiting for meetings, businessmen and military personnel, interns and politicians, all under a magnificent hammer-beam roof and on flagstones literally marked by the events of history. Strikingly, and importantly for my argument in this book, the practice-based fieldwork methods that were central to my work with therapists and MBCT participants were vital for fieldwork in Westminster as well, and one of the most unanticipated experiences of fieldwork was meditating in Westminster Palace with MPs (members of the House of Commons), peers (members of the House of Lords) and special advisors. Every meeting of the APPG was prefaced with a mindfulness practice, as advocates, parliamentarians and parliamentary staff joined invited experts and stakeholders in mindfulness practice, their doing so informed by their ongoing personal practice.

The most intensive periods of fieldwork were the three years on the therapist training programme when I was participating in training and retreats, the period of the inquiry process in parliament when I was attending hearings and the subsequent work with advocates as they drafted the *Mindful Nation* report. During this period, from 2013 to 2015, I spent part of each week with participants on courses, therapists in training, advocates and parliamentarians. On most occasions, I joined the people I was working with in meditation. I had had significant experience of various meditative practices prior to beginning

this research, and my earlier work on Thai monasticism had involved ongoing practice in intensive Burmese *vipassanā* (insight) (see Cook 2010a, 19; 2010b). But while mindfulness in Britain shares historical roots with the meditative discipline of the Thai monastery where I worked (see chapter 1), I was surprised by how far the two differed. Whereas in the monastery, meditation was characterised by renunciation through meditative discipline, mindfulness in this research was focused on kindliness towards oneself and, over the course of fieldwork, this emphasis on 'softening' profoundly influenced my personal practice. My own meditative experience is not the focus of this book, but it was a key part of my methodology and I spent hundreds of hours meditating with research participants in each of the field sites.

Over the course of the research, I conducted seventy-three recorded interviews, collected formal and informal histories and attended regular and ad hoc meetings. While employing formal research methods in each of the four areas (mindfulness courses, therapist training, appointments in Westminster and advocacy meetings) was important, such methods are, by and large, in addition the anthropologist's methodological bread-and-butter: participant observation. The less accountable activity of myriad 'small moments' was vital for the research. These included 'hanging out' on lunch breaks, dinners, social events, picnics, walks by the river, sober raves, sitting together waiting for a meeting to begin or debriefing afterwards. This anthropological hanging out involved both the formal research methods of life histories and interviews, and participation in shared practices such as meditation training, group therapy or (countless) meetings. But it also involved innumerable 'small moments', noting what comes up in the in-between spaces, when I was meeting others not to conduct an interview, but simply to spend time together.

Through long-term ethnographic research, I sought to understand how the people with whom I work engage with mindfulness. I have pseudonymised everyone who appears in this book, except for those cases in which their statements are a matter of public record. Most of the relationships that inform what follows were intimate and ongoing, and I have attempted to represent the values and practices of the people with whom I work as faithfully as I am able to. For many of the people featured in this book, mindfulness is a practical activity, a way of becoming familiar and friendly with the patterns of the mind, and emotional and somatic responses. They engage with mindfulness as a support for their mental health and as a way of cultivating a skilful engagement with life, and they believe that they are healthier and happier as a result of their practice. They think that mindfulness reduces psychological suffering and

changes the relationship they have with themselves, and they are committed to practising mindfulness themselves, to teaching other people to practise it and to promoting it in society. Practitioners across society promote mindfulness, from the grass-roots to the government, as both a targeted and pragmatic antidote to the more terrible effects of anxiety and depression and as a form of awareness training associated with well-being and flourishing, broadly conceived.

In chapter 1 I develop a history of mindfulness in the UK, tracing contemporary framings of mindfulness through the ongoing dialogue between Buddhism and psychology over the last century and a half. I show that contemporary mindfulness developed as a scientifically verifiable method for living more 'fully', steeped in the tensions between rationalist calls for empirical certainty and Romantic calls for meaning and experience, and I argue that the threads of Romanticism and rationalism are woven through preventative mental healthcare more broadly. In chapter 2 I examine the recent reframing of depression from being an acute to a relapsing or recurring condition, and the development of Mindfulness-Based Cognitive Therapy (MBCT), a long-term psychosocial intervention for those most vulnerable to relapse. Focusing on the structured learning process of the eight-week MBCT course, I examine how participants learn to relate differently to their experience and to depression. Participants learn that there is a cognitive component to depressive relapse, they cultivate reflexive awareness of their own thoughts, feelings and bodily sensations, and they work to develop a relationship with themselves and their experiences that is kind.

The emphasis on preventative mental healthcare in MBCT reflects broader changes in the category of mental health in Britain, as concern about mental health extends beyond the purview of therapy into the activities of daily life. In chapter 3 I focus on the ways in which mindfulness-based therapists integrate mindfulness into their daily lives simultaneously to prevent mental ill-health, to navigate the ups and downs of life and, as they say, to 'live fully'. Mindfulness practitioners learn metacognitive theories and strategies (what people think about thinking, and what they think they should do about it), and these inform their efforts to cultivate habits of awareness that will transform the ways in which they experience ordinary life. I extend this argument in chapter 4, focusing on the development of mindfulness classes for parliamentarians in the British parliament and the influence of popular psychology books. I show that politicians, peers and government advisors recognise their own experiences of stress, depression and anxiety in popular psychological

representations of mental health. Through their mindfulness practice, parliamentarians seek to live well in a highly stressful professional world by cultivating a metacognitive relationship with their own experience.

In chapter 5, I argue that the transversal relevance of mental health links practices of psychological self-cultivation, such as mindfulness, with macro-level state agendas and governmental techniques. Focusing on the Mindfulness APPG, I interrogate the wider governmental trends of evidence-based policy-making and participatory governance, showing that, in the APPG, experts and parliamentarians took on a participant's as well as an observer's point of view as they related mindfulness and mental health to themselves and their own actions. Throughout, mindfulness was presented as simultaneously rational and ethical, as an evidence-based intervention that 'works', and a personally transformative practice. The APPG inquiry process culminated in the launch of the *Mindful Nation* report. In chapter 6, I focus on the drafting of *Mindful Nation* by a group of volunteer advocates who had no previous experience of political advocacy. I examine the relationship between the ethical value that mindfulness held for volunteers and the economic values that underpinned the governmental technologies with which they engaged, and I argue that the political case for mindfulness was produced through the ongoing relationship between personal ethics, normative imperatives and new technologies of governance, in a non-linear process informed by ethical, epistemological and economic agendas.

Making a Mindful Nation is an ethnographic study of what happens when mental health becomes a site for self-conscious work. I argue that the popularity of mindfulness is, in part, a result of broader transformations in ideas about the self, mental health and human flourishing. In the UK, people across society have increasingly come to think of mental health as 'something we all have' and something that can be actively supported through cultivating a kindly relationship with their own minds: they think that they can effect positive change on themselves, their habits, their impulses and their reactions by learning to relate differently to their minds. It is a culturally new phenomenon to think of the cultivation of attention and awareness, learning to develop a metacognitive relationship with one's own mind, as a central constituent of the good life. I demonstrate that mental health has become a transversal issue, impacting politicians as much as the populations that they serve: learning to relate to the mind in a kindly way is thought to be of benefit to all people in the maintenance of mental health, whether or not they have ever received a mental health diagnosis. I show that the ways in which people represent

mental health, the distinctions that they make, and the solutions that those distinctions lead to, have changed; and I examine how the logics of preventative mental healthcare are incorporated into people's relationships with themselves, therapeutic interventions, structures of governance and political campaigns. The popularity of mindfulness is testimony to its relationship to these larger transformations in the category of mental health, including a remarkable upswing in public and political interest in the mind as an object of governance, by both the self and others.

INDEX

Note: Page numbers in italic type indicate illustrations.