



The normal is pathological: semi-conscious brains, mindless habits, and the paradoxical science of mindfulness

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Abstract

The article investigates the recent attempts to create a medical technique and a scientific object of knowledge out of ‘mindfulness’, paying particular attention to the paradoxical implications of these attempts for biosocial theorizing. The author compares the scholarly and non-scholarly works of mindfulness therapists to understand how they introduce their practice to the medical/scientific community and their clients. This comparison reveals that ‘mindfulness’ is translated differently in these two realms, as a bio-neurological process in the former and an ethical practice in the latter. Mindfulness therapy is made possible by the linking together of these different translations, which results in a paradoxical relationship to modern medicine and biosocial disciplines. Whereas in most contemporary biosocial theories, ‘mindless’ (automated) processes are considered as being essential to the ‘normal’ functioning of both biologic and social life, in mindfulness therapy ‘mindlessness’ and socially induced habits are viewed as obstacles to one’s wellbeing. Thus, mindfulness therapy challenges some of the fundamental assumptions of biosocial sciences about ‘normality’, while seeking recognition in the world of those very sciences by adopting their methodology. Ultimately, this paradoxical attitude gives mindfulness therapy a capacity to both serve and resist the biopolitical interests underlying modern therapeutic culture.

Keywords Mindfulness therapy · Medicalization · Neurotechnologies · Technologies of the self · Sociology of translation · Habits

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Introduction

The contemporary psychotherapeutic approaches usually referred to as ‘mindfulness therapy’ employ attention training techniques for the treatment of relatively mild psychological and somatic ailments. In very general terms, this recent development can be seen as a medical innovation attempt partly because mindfulness therapists often utilize meditative exercises that were, and continue to be, used for non-medical purposes in many cultures.¹ This has given way to lively discussions about the relationship between Buddhism and modern mindfulness practices (e.g., Anālayo 2018; Gethin 2011; Levman 2017; McMahan 2008), the potential of mindfulness therapy to introduce ‘religious’ elements into modern medicine (Braun 2017; Brown 2016; Kucinkas 2019; Wilson 2014), as well as the spiritual, ethical and philosophical foundations of mindfulness therapy in general (Ng 2016; Purser et al. 2016; Stanley et al. 2018; Stingl and Weiss 2014). Yet, so far, there have been few inquiries about *how exactly – i.e., through the involvement of which actors, concerns and technologies – this new field of therapy is constituted and what kind of implications this novel therapeutic approach might have for the prevalent modes of thinking in modern medicine and other biosocial disciplines*. These two questions are the main focus of this study.

There is, of course, already a considerable social research literature that provides a background to this inquiry. In recent years, several scholars have paid close attention to the articulations between contemporary psychotherapy practices and various economic, political and ‘ideological’ interests (Illouz 2008; Madsen 2014; Rose 1998). Although mindfulness therapy is not examined in these studies, the theoretical frameworks used in them are often employed in research on mindfulness practices as well. Currently, in addition to those studies that focus on popular uses of mindfulness in Western societies from diverse angles (e.g., Goto-Jones 2013; Leggett 2021; Purser et al. 2016; Purser 2019; Wilson 2014; Žižek 2001), there is also growing research on mindfulness-based therapy programs. Most of these studies approach mindfulness therapy critically, depicting it as serving neo-liberal ideals (Arthington 2016); leading to the medicalization of daily life (Barker 2014); promoting an ideology of “brain management” (Eklöf 2017); operating as a self-surveillance device (Stanley and Longden 2016); carrying religious elements into mainstream medicine (Brown 2016) or medicalizing mindfulness, in the sense of stripping it of its religious elements (Goto-Jones 2013), or both (Wilson, 2014). It is also important to note that almost all of these publications gather their data predominantly from non-scholarly sources, such as books written for the lay public by therapists or online texts on various mindfulness therapy programs.²

¹ There are, however, also theories of mindfulness that do not rely on Buddhist teachings (Langer 1989, 2014).

² There are however some important exceptions such as Smolka’s (2022) praxiographic research on clinical trials, Stanley and Kortelainen’s (2019) study of a training session and Stanley and Longden’s (2016) interactional analysis.



The present inquiry differs from these highly insightful studies in several respects. One important gap I wish to fill here concerns the lack of a detailed analysis of *scholarly* publications, which are essential for understanding the attempts of mindfulness therapists to gain credibility in the scientific/medical community.³ Thus, for example, although there are ample references to “medicalization of mindfulness” in the literature, the *actual procedures and conceptual elaborations used in translating mindfulness into a medical notion* have received little attention. In fact, the problem here is not just the lack of attention to scholarly research literature but also to *the links and contrasts between academic and non-academic sources*. This study, therefore, investigates the endeavors of mindfulness therapists to introduce their practice to the medical/scientific community *and* to potential clients, by *comparing* their *scholarly and non-scholarly publications*. The findings indicate that, mindfulness therapists face different challenges in these two realms, which they tackle by developing different ‘translations’ (Callon 1984; Law 2006) of mindfulness and by linking different conceptions, actors and concerns together. One fruitful way of studying the emergence of mindfulness therapy, therefore, is to view it as an assemblage of heterogeneous elements, which is beginning to be used as a key methodological tool in recent studies of psychotherapeutic practices (Salmenniemi et al. 2019; Stanley and Kortelainen 2019). Such an approach has been particularly useful for bringing to light the tensions and dilemmas inherent in mindfulness therapy and in uncovering its paradoxical relation to modern medicine and other biosocial disciplines.

This paradox has its roots in mindfulness therapists’ attribution of a *therapeutic* role to escaping automated forms of thinking and the ‘mindless habits’ that permeate our ordinary social activities (Kabat-Zinn 1990, 1994; Langer 1989). In current medical and biosocial literature, however, ‘not being mindful’ is not recognized as a *disease*. On the contrary, automated information processing is understood as a basic characteristic of biologic and neural systems (Hart, et al. 2013; Kahneman, 2011; Raichle, 2015). In this respect, mindfulness therapy is at odds with prevalent conceptions about ‘normality’ and ‘health’ in biosocial disciplines. Yet, it is by adopting the same methodological tools—particularly ‘population thinking’—used by these disciplines that it attempts to justify its scientific/medical status.

This paradox has a direct bearing on several sociologically significant questions. To begin with, in the current literature, the sociological relevance of scientification of mindfulness is often sought in its ‘non-scientific’ effects, such as legitimizing a religious/cultural movement. The findings of this study, however, suggest that mindfulness therapy has a far too paradoxical nature to produce such unambiguous effects. In fact, beyond its articulation to various cultural movements, the most sociologically significant question about mindfulness therapy—as a practice that partly deviates from the prevalent methods of therapeutic guidance in modern medicine—might be whether it can constitute an alternative to biopolitical technologies

³ The authors of the many scholarly publications cited here include researchers (particularly neuroscientists) who are not engaged in therapeutic work. The involvement of these researchers in mindfulness studies, however, does not mean that they are always supportive of the therapeutic uses of mindfulness (Komjathy 2018).



of self-formation. As we shall see, here too, the paradoxical nature of mindfulness therapy complicates the answer.

Conceptual framework and methodological remarks

The methodological perspective adopted in this study refrains from treating ‘mindfulness’ as an abstract, a-historical experience. Rather than trying to portray mindfulness therapy as a continuation or distortion of an ‘original’ tradition, it takes its starting point in the idea that there exist many historical practices of mindfulness, which differ from each other in terms of *how, for what aims, and in conjunction with what other elements mindfulness is deployed* in these practices. Such a methodological approach can also help us to reconsider the widespread argument that mindfulness therapy results from a process of *medicalization* of mindfulness. It may be true that, historically, mindfulness exercises are used to gain access to a kind of sublime experience and/or to give a new ‘character’ to one’s existence—two objectives that largely correspond to what Foucault (1999, 2005) describes as spiritual and ethical endeavors, respectively (see also: Carrette and King 2005; Flanagan and Jupp 2007; Gethin 2011; Hadot 1995; Karakayali 2015; Levman 2017; Ng 2016; Stingl and Weiss 2014). The use of mindfulness techniques *primarily* for medical purposes seems to be quite unique to mindfulness therapy. We cannot, however, assume that medicalization of mindfulness is a smooth process where ethical-spiritual functions are simply taken over by medical ones. Nor is it enough to portray mindfulness therapy as a more or less problematic encounter between religious and secular orientations. The crucial question is *how exactly the ethical-spiritual and therapeutic elements are assembled and distributed in mindfulness therapy?*

From this perspective, the constitution of mindfulness therapy as a new medical field can be viewed as the assembling together of heterogeneous actors/concerns (Law 1992). We can frame it as a process of *translation*, where mindfulness practices gain a new sense. Here, the use of the concept of translation is inspired by ‘sociology of translation’—especially by a number of principles outlined by Law (2006, pp. 47–53): “translation implies both similarity and difference”; all translation processes entail “betrayals”; and, wherever there is translation, new relations are created (see also: Latour 2005). This methodological tool, however, does not have to be construed as a fixed procedure like, for example, Callon’s (1984) five-stage process. It makes much more sense to translate the concept of translation differently in each distinct project. In the present case, for example, understanding the strategies of mindfulness therapists and their research collaborators in ‘demonstrating’ the scientific status of their practice is of paramount importance. Finally, sociology of translation is inseparable from the idea of sociology *as* translation (Latour 2005). Thus, the below depiction of the introduction of mindfulness to the medical world as a ‘three-step’ process should not be read as a historiographic account of the ‘development’ of mindfulness therapy but rather as the sociologist’s way of bringing intelligibility to the ‘assembling’ of mindfulness therapy.

In a somewhat different but parallel context, Kucinskas (2019) also used the concept of ‘translation’ in studying the strategies of what she characterizes as the



leaders of a quasi-religious social movement (“the contemplatives”) to promote Buddhism-inspired values and meditative practices in various secular groups and institutions. She argues that, to gain legitimacy in such circles, including war veterans, the business world and the educational system, the ‘contemplatives’ “translated Buddhism into local professional vernacular languages” (p. 83). Kucinskas (2019) uses the same framework of ‘translation’ in her analysis of the introduction of mindfulness to the medical field, a process that also received attention in Braun (2017) and Wilson (2014). These works, however, do not include an in-depth analysis of scholarly research literature. Kucinskas (2019, pp. 79–80), for example, states that, in trying to gain access to the academic world, the proponents of the contemplative movement, “(1) ... use ... a scientific epistemological framework, (2) ... publish ... in ... peer-reviewed journals, (3) ... associate with other esteemed professionals, and (4) ... distance themselves from ... New Age believers.” These are, however, rather general points. Questions such as how exactly one can use a ‘scientific epistemological framework’ in studying mindfulness, how do other scientists respond to it, what kind of actors and technologies are mobilized to achieve this, etc. remain untouched in Kucinskas’ study.

Scholarly publications of mindfulness therapists constitute the first data source of the study, which are used to explore the relationship of therapists to their colleagues and, more generally, to the medical/scientific community. This is not to suggest that mindfulness therapy is simply a textual construct but rather that these publications are *the major sites* where the attempt to construct mindfulness therapy as a scientifically acceptable method literally *takes place*. There are some forty sources cited in this article, published between 1995 and 2022. Due to space considerations, I selected only those texts that most explicitly involve the attempts of mindfulness therapists and researchers to define, operationalize, and bring intelligibility to their practice vis-à-vis the scientific community.

The second major data source of the study are two non-scholarly books on mindfulness therapy: Kabat-Zinn’s *Full Catastrophe Living* (1990) and Langer’s *Mindfulness* (1989). In selecting these two texts, several methodological criteria were used. First, these two books *specifically* address mindfulness-based therapy and interventions *by scholars who are directly involved* in such practices. There are, of course, numerous other non-scholarly sources on mindfulness therapy (Eklöf 2017). Since, however, this study is based on a *comparison of academic and non-academic works of scholars who are engaged in mindfulness therapy*, including this latter type of texts in the comparison would amount to comparing rather incompatible types of data. Secondly, these two books are selected because their authors are considered as the founders of the two major ‘schools’ of mindfulness therapy (Hart et al. 2013; Carmody 2014). This is particularly important because in the existing sociological literature mindfulness practices are almost exclusively associated with Buddhism and, therefore, the focus is usually on Kabat-Zinn’s non-scholarly texts. Including Langer’s work in this study, which does not seem to be inspired by a Buddhist viewpoint, was crucial in avoiding this one-sided approach. Finally, these books were published some 30 years ago, when most of the research literature cited in this article were not yet written. As the broader historical context changed in these three decades, the attitudes of the authors considered here were also modified (see:



Harrington 2008). This, however, does not mean that these books are ‘outdated’. Their re-editions are published with little or no changes and continue being read widely. Most works in the subsequent literature still refer to these works. As such, they can be considered as ‘classics’ of mindfulness therapy.

Mindfulness therapy in theory and in practice

Although mindfulness therapists do not constitute a homogeneous group, they share at least two common objectives: first, to justify their techniques to other psychotherapists and doctors and, second, to convince existing or potential patients to follow their therapeutic instructions. As these two relationships constitute the ‘social core’ of mindfulness therapy, they are a natural starting point for this inquiry.

Translating mindfulness for psychotherapists and scientists: mindfulness as a technique

Let us begin by noting that when mindfulness therapists offer a general definition of mindfulness, many of them state that their definitions are essentially simplified versions of traditional Buddhist conceptions. That includes the most widely-cited definition in the literature: “Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn 1994, p. 4).

While this definition and many other similar ones (see: Ie et al. 2014, p. 1) might have commonalities with one or another tradition in Buddhism (Anālayo 2018; Gethin 2011), it would not be accurate to describe them as succinct reformulations of some kind of an ‘ur-idea’. Rather, the very notion of mindfulness as assumed by these definitions seems to have been made possible as a result of several selective translations over time. Levman (2017) and Gethin (2011) trace the beginning of this usage to the end of the nineteenth century when mindfulness becomes the standard rendering of the ancient term *sati* in English, at the expense of several other possible translations. Thus, some of the previous renderings of *sati*—most notably *remembrance*—becomes undermined in texts discussing mindfulness in the West (Gethin 2011; Levman 2017).

There is some disagreement in the scholarly literature about whether the ‘original’ sense of *sati* implied a more encompassing and stronger connection to memory than just remembering to pay attention to the given moment (Anālayo 2018; Levman 2017). We do not, however, have to view them within an essentialist framework, as if they are mutually exclusive options—and, more generally, as if the question is whether mindfulness therapy is a genuine or distorted version of Buddhism (Grossman and van Dam 2011). As some scholars suggest, acknowledging the multifaceted relationships between mindfulness and memory should not deter us from recognizing that there is also a ‘practice’ side to mindfulness (Anālayo 2018). In this latter sense, as Anālayo (2018, p. 5) puts it, we do not have to consider mindfulness as “something inherently Buddhist.” Anālayo’s (2018, p. 5) point, of course, is not to exclude Buddhism from the picture but



rather to note that “it is not mindfulness as such, but rather its practice [in a particular form] ... that should be considered a distinctly Buddhist contribution.”

In fact, if we want to understand what is unique about the particular form in which mindfulness is deployed in current mindfulness therapy, it is essential to note that a multifaceted association between mindfulness and remembrance existed in historical practices. As Gethin (2011, p. 270) puts it, for example, in many Buddhist practices, the basic, ‘technical’ remembrance involved in mindfulness is considered as the beginning of a long chain of other remembrances:

in remembering that one should remember the breath, one is remembering that one should be doing a meditation practice; in remembering that one should be doing a meditation practice, one is remembering that one is a Buddhist monk; in remembering that one is a Buddhist monk, one is remembering that one should be trying to root out greed, hatred and delusion.

In other words, mindfulness is not simply remembrance but remembrance is what ties it to an ‘obligation’, to a socio-cultural identity, and, ultimately, to a way of living, an ethics. In addition to Buddhistic traditions, we also find similar configurations, for example, in the “arts of existence” taught in ancient philosophy schools (Hadot 1995) and in the practices of diverse Sufi traditions (e.g., Toussulis 2011).

The crucial point is that, in the definitions offered in the literature, mindfulness becomes reconceptualized primarily as a technique or exercise of ‘paying attention’ and ‘remembering to attend to the present moment’ is detached from the other remembrances. This detachment is vividly expressed by Bishop et al. (2004), who separate what they consider to be the “central” feature of mindfulness (i.e., “self-regulation of attention”) from peripheral “correlates” (e.g., patience, trust, nonre-activity, wisdom, and compassion). It is not difficult to see here that these so-called “correlates” are often very essential aims of ethical traditions in which attention regulation is practiced.

The representation of mindfulness as a technique of attention regulation, then, can be seen as the first step in the translation of the concept from an ethical to a medicinal notion. When we look at the scholarly literature closely, such a definition, rather than being based on some kind of philosophical deliberation, seems to be associated with the practical concerns of modern therapists, for whom, as several observers point out, clinical and operational needs often dictate the conceptualizations used in research (Grossman and van Dam 2011, p. 221; Gethin 2011, p. 263; see also, Grossman 2008). To put it bluntly, *as a technique* mindfulness appears as a practice that can be clinically applied and tested. Moreover, this is a highly familiar notion for modern psychologists in the West, where control of attention has been a topic of interest in philosophy and science for two millennia (Hatfield 1998; Neumann 1996). Thus, for example, the authors of a widely-cited article state that their conceptualization of mindfulness “draws heavily on self-regulation models of cognition and mood ... and contemporary cognitive models of psychopathology” (Bishop et al. 2004, p. 236). Not surprisingly, therefore, there is also a ‘home-grown’ version of mindfulness therapy, which does not seem to draw on non-western traditions (Langer 1989; Hart et al. 2013; Carmody 2014).



Operationalizing mindfulness: how to observe a solipsistic experience

Although defining mindfulness primarily as a ‘technique’ might be a good start, for mindfulness to be accepted by the scientific community as a meaningful concept, its proponents should find convincing methods to observe and measure it. This is not some kind of a formal methodological requirement, even though distinguishing mindfulness from other concepts such as self-control or self-regulation (see: Hart et al. 2013, p. 456), self-observation (Bishop et al. 2004, p. 236), or “attentional control” (Quaglia et al. 2015) are deemed as important issues. Rather, there is a vital *practical* concern here since such observations/measurements are meant to serve the *clinical evaluation* of mindfulness therapy. And, therein lies a series of challenges.

As is well-known, the standard procedure used in clinical trials involves the comparison of a user group and a control group. This method was initially invented for the testing of drug treatments and continues to be used extensively for this purpose, even though it is not without problems (Lilienfeld 1982; Smolka 2022; Timmermans and Berg 2003). The dynamics of mindfulness therapy, as well as other behavioral therapy methods, however, differ significantly from drug treatments.

To begin with, mindfulness therapy techniques are not standardized—at least not in a way comparable to standardized drug treatments. It is highly questionable whether such a standardization will ever occur—or whether it is even a desired objective—since there exist several ‘schools’ of mindfulness therapy that considerably differ in their approaches (Carmody 2014; Hart et al. 2013). Another notable difference is that, while drugs are either prescribed or directly administered by doctors to patients, mindfulness therapy requires the *self-application* of the techniques by the patients. I shall return to some of the crucial consequences of this characteristic later. But one obvious implication of this is that it becomes quite difficult to ascertain, for instance, whether two patients who report meditating 30 min per day are going through the same ‘treatment’. In a recent pioneering study, Smolka (2022) has shown in detail the full scope of such complications, to which there is little to add. Here, however, I would like to focus on one fundamental problem that underlies most of the methodological challenges that mindfulness researchers face.

This fundamental complication relates to the fact that mindfulness is essentially a solitary experience. Thus, the challenge of observing and measuring an event that, by definition, happens in a ‘mind’ has been bothering mindfulness researchers all from the beginning. It seems that, so far, most researchers have been trying to overcome, if not bypass, this question by various strategies. As one strategy, participating in a mindfulness training program and/or engaging in a meditative activity are used as the key measures of mindfulness (for overviews, see: Kabat-Zinn 2003, p. 151; Tang et al. 2015). The most notable weakness of this method is that involvement in such activities is *not* the same thing as leading a mindful existence. Indeed, there are conflicting findings about whether engaging in mindfulness meditation is always positively correlated with other measures of mindfulness (e.g., Fox et al. 2012; Khalsa et al. 2008; MacKillop and Anderson 2007). A second, more widespread, way of operationalizing mindfulness has been to treat it as a perceived ‘state’ or ‘trait’ that can be measured through questionnaires. Currently, there are at least ten different ‘mindfulness scales’, which exclusively use *self-reported data*



(for overviews, see: Bergomi et al. 2013; Hart et al. 2013; Quaglia et al. 2015). This operationalization attempt, however, has also received much criticism because of its reliance on self-reports (Grossman 2011; Grossman and van Dam 2011), which is an issue that arises in the operationalization stage of many other concepts in the human sciences. Ultimately, many researchers underline that “[t]he inherently subjective nature of mindfulness makes it unlikely ... [to] be reduced to behavioral assessment alone,” even though they also remain hopeful that non-subjective indicators can be developed for “corroboration” of data based on self-reports (Quaglia et al. 2015, p. 165). But how?

Mindfulness as a bioneural process

Regarding the last question above, the most promising answer seems to come from the neurological studies that use ‘brain data’—mainly fMRI scans and brain-wave measurements—in conjunction with the two ‘measures of mindfulness’ considered earlier. Thus, for example, some of these studies look at brain scans of people with different scores in mindfulness scales and others compare brain activities of people with varying degrees of meditative experience, often also including a control group with no such experience. Tang et al. (2015) have provided an extensive overview and methodological critique of these studies, which I shall not repeat here (see also: Chiesa and Serretti 2010; Smith 2004).

What should be stressed here, however, is that the results of these studies cannot simply be posited as ‘hard facts’ that can be used for corroborating (or explicating) ‘subjectively based’ measurements. Mindfulness therapy, of course, is not the only field where brain scans have been used to ‘tap into’ the minds of people, initiating a whole new way of speaking about personality, emotions, mental problems, and so on (Dumit 2021), which has given way to a range of criticisms (Choudhury and Slaby 2012; Rose and Abi-Rached 2012). More specifically, the theoretical problems involved in establishing such links between conscious experience and neurological processes are also discussed in many studies (e.g., Chalmers 1995; Lutz and Thompson 2003; van de Werff 2018; Varela 1996). I cannot delve into the details of these discussions here but three key issues underlined by Lutz and Thompson (2003) regarding the problematic nature of linking first-person experiences with neural activities are particularly noteworthy for our concerns in this article.

First of all, neurological information can not be dissociated from self-reports of subjects because fMRI scans and brain-wave recordings provide data about *the brain of a person who* (says s/he) has a *particular experience* (e.g., “I’m meditating now,” “My mind is wandering now,” etc.). That means, the use of neurological data cannot simply eliminate the problems associated with first person reports (Varela 1996). Second, “the process of generating first-person reports about an experience can modify that experience” (Lutz 2003, p. 31), which is particularly relevant here since the lab environment might not be very conducive for meditative experiences. Finally, and most importantly, neurological findings themselves require interpretation at multiple levels. Which brain region does what? What does it mean when regions a and b are activated at the same time? How does it all relate to the experience of the



subjects? Although in recent years a number of hypotheses regarding the neural processes corresponding to mindfulness experiences have been proposed by researchers (Tang et al. 2015), there is still, as Lutz and Thompson (2003, p. 31) put it, “an ‘explanatory gap’ in our understanding of how to relate first-person, phenomenological data to third-person, biobehavioural data.”

Nevertheless, neurological studies about mindfulness constitute probably the most promising route for mindfulness therapists and their research collaborators to gain credibility in the scientific community, supplemented by the “images of Buddhist monks wired up with electrodes or emerging from fMRI machines” (Olendzki 2014, p. 70). Scans of meditators’ brains open up new ways of talking about mindfulness, which might sound more meaningful to the medical community than other discourses on the same topic. It is here that we can see the beginnings of a *science of mindfulness*, which, ironically enough, is made possible by the translation of the ‘mind’ into a ‘brain’.

Now, what makes this new science possible is the coming together of two very different kinds of objects, MRI machines and mindfulness techniques. There is a mutual transformation here. MRI devices begin to function—almost—like “neurotechnologies of the self” (Brenninkmeijer 2016) as if holding a mirror to, say, a ‘meditating self’, or a ‘mind-wandering self’, and so on, though, clearly, they cannot be put to use by individuals on their own.⁴ Conversely, as the ‘effects’ of mindfulness can be observed on a computer screen, its depiction as a technique/exercise is reinforced. *What is mindfulness? It is a technique – a particular mode of paying attention – by which one can turn on and off, and connect or disconnect various circuits in one’s brain.* As such, mindfulness training begins to look like a mainstream medical technique—something like a surgical method or a drug with measurable effects. And, that is certainly a vital step in the translation of mindfulness into a medical notion.

Explaining the therapeutic effects of mindfulness

But there is at least one more important task left. Namely, since the science of mindfulness is intertwined with clinical concerns, the methods and techniques discussed above are frequently used in the service of assessing the potential of mindfulness therapy in the alleviation of a long list of non-communicable ailments and symptoms. This list includes *chronic pain, sleep disorders, high blood pressure, fatigue, depression, anxiety, ADHD, fibromyalgia, irritable bowel syndrome, psoriasis, female sexual dysfunction and so on* (for a more extensive list, see: Hart et al. 2013).⁵

⁴ Although in recent years various new media technologies have been put to use for self-modification purposes in everyday life contexts (Karakayali and Alpertan 2021), the heavy hardware of MRI machines forbids such a use.

⁵ The number of studies investigating the therapeutic effects of mindfulness training/intervention is too vast to be cited here.



This is, however, not a painless process, not the least because these studies unfold in an ontological field where a body-mind distinction persists, often leading to a strong suspicion about the existence of “any good clinical evidence that psychological and social interventions can directly change the course of serious organic disease” (Relman and Angell 2002, p. 558; see also: Freedland et al. 2006; Moloney 2016). But even if one finds enough evidence to convince the scientific community that mindfulness therapy can alleviate certain symptoms, one still has to bring intelligibility to this outcome. Thus, for several decades now, mindfulness researchers have been proposing various theories suggesting, very roughly, that mindfulness exercises trigger certain *mediating* processes (e.g., self-control, self-regulation of attention, decentering, stress-reduction, creativity and so on), which happen to have salutary effects. Currently, this multiplicity of ‘mindfulness theories’ continue to be critically investigated, providing nourishment for the ‘science of mindfulness’ (e.g., Depraz et al. 2003; Hart et al. 2013; Shapiro et al. 2006).

An overview of these theories is beyond our scope. But one commonly shared idea in this literature is worth dwelling on. This idea is best exemplified by psychological ‘stress’, which is widely acknowledged as a contributing factor in many ailments, and which has so far turned out to be a highly useful concept for bringing intelligibility to the effects of mindfulness (Pascoe et al. 2017). In the mindfulness therapy literature, it is noted that stress is often triggered either by bodily disorders or by events in the social environment of an individual, over which s/he has no control. Clearly, we cannot expect from mindfulness exercises to act upon either of these sources directly. So, the well-known argument here, which might also be used in the case of many other cognitive behavioral therapy methods, is that mindfulness therapy can have healing effects by acting upon the *repercussions* of environmental effects in the ‘inner’ world of the individuals. And, this is the third step in the translation process.

To sum up, if the first step in the translation of mindfulness is its reformulation as an ‘attention-regulation technique’, and the second is the hooking up of this technique with fMRI machines and re-conceptualizing it as a kind of switch that can turn on and off neural circuits, the final step is the establishment of the idea that, by the effects it generates in the brain, mindfulness induces changes in the way the individual experiences the world, such that, for example, events that tend to induce stress are no longer experienced as stressful. This does not mean, however, that these steps form a linear sequence. Rather, the ‘three-step’ process here should be understood as an assembling together of events with diverse origins.

The crucial point, however, is that as a result of the coming together of these three translational steps, mindfulness therapy emerges, in effect, as a medical technology not so different from, say, stress-reducing drugs or, perhaps, a vaccine. This is where we arrive at the climax of translating mindfulness into an almost purely medicinal technique based on a science of mindfulness.

But this is perhaps also an anti-climax. A closer look at the writings of the proponents of mindfulness therapy can tell us that, their aspiration for acceptance in the scientific community notwithstanding, their ideals were rather different than devising a technique that would function like a drug. Kabat-Zinn (1990, p. 260), for example, was highly critical about the fact that “[w]e are a drug-ingesting culture”



and Langer (1989, p. 193) was hoping that through mindfulness interventions, “we should be able to ‘take’ a placebo instead of a pill.” In fact, the relationship of mindfulness therapy to the medical field is more *tense* than it might seem, which shows itself in the form of various ‘glitches’ in the translation process.

One of those glitches, for example, concerns the *space* of mindfulness therapy. We have seen that the therapeutization of mindfulness practices presupposes their removal from environments like schools or temples, and their redeployment in a setting sterilized from social remembrances and rituals. That setting is *the clinic*, which Foucault (1973) described as an impersonal space, where the patient is put under the objectivizing gaze of the doctor. Yet, many mindfulness therapists criticize this hierarchical system underlying the clinic: “Our philosophy is that you are the world expert on your life, your body, and your mind” (Kabat-Zinn 1990, p. 260). They also consider *self-healing* as a key value, lamenting the fact that “people who self heal are missing from the medical database ... we are discouraged from trying to self heal” (Langer, 2014, p. 13). Kabat-Zinn (1994) suggests that one can practice mindfulness almost anywhere. So, the fact that most mindfulness therapists continue to appeal to the principles of *clinical testing* indicates that the translation of mindfulness into a medicinal device is not without dilemmas. I shall take up some of the broader implications of these dilemmas later.

Mindfulness in practice: translating mindfulness for the patients

Let us now turn to the other side of the core network; i.e., to the relationship between mindfulness therapists and their patients. Numerous researchers underline that psychotherapist-patient relationship is a multifaceted reality, influenced by many non-medical interests (Illouz 2008; Madsen 2014; Purser 2019; Rose 1998; Wilson 2014). Here, however, I shall basically focus on this relationship as a therapeutic practice and mainly in reference to the concerns of the therapists voiced through their non-scholarly texts.

This, of course, does not mean that a ‘therapeutic’ relation is devoid of a power dimension, which I shall discuss in detail later. At this point, however, let us focus on a more practical issue. In practice, there are two major channels available to the therapists to influence their clients. The first is, of course, training sessions, which, due to the bodily presence of the therapist and the participants as well as the possibility of dialogue, involve a significant affective dimension (Stanley and Kortelainen 2019). But there is also a second channel of communication; namely, non-academic texts. This communication channel, where therapists can afford to use a far more ‘lay’ language than in their academic works, is quite important for the patients to continue their work in the absence of the therapist as well as for potential clients to develop a sense of the practice. Here, I shall particularly focus on the books of two leading figures in the field; namely, Kabat-Zinn’s *Full Catastrophe Living* (1990) and Langer’s *Mindfulness* (1989).

At first sight, the books seem to present mindfulness, as in academic publications, as an attention-regulation technique, which therefore “can be learned and practiced ... without appealing to Oriental culture or Buddhist authority to enrich



it or authenticate it” (Kabat-Zinn 1990, p. 12). Typically, almost all non-scholarly sources on mindfulness therapy provide some information about techniques (Eklöf 2017). That is, however, not the only purpose of the books considered here. They also have several other aims.⁶

Motivating the patients: mindfulness as an aesthetic and empowering experience

Numerous passages in these books are devoted to *motivating* the readers to continue their work despite challenges: “it takes a good deal of energy and effort to regulate your attention and to remain genuinely calm and nonreactive” (Kabat-Zinn 1990, p. 23). And, while Langer (1989, p. 116) thinks that mindfulness can be “relatively effortless,” many of the interventions she presents in her book require significant labor. The point here seems to be partly in conformity with the proposition of some neurobiologists that active regulation of attention requires more energy than ‘mindless’, automated forms of information processing, which seems to be the default mode of our neural system (Raichle 2015; see also: Baumeister et al. 1998; Hart et al. 2013; Kahneman 2011). This implies an attempt to overcome certain ‘natural’ limitations—hence the parallels drawn between mindfulness therapy and muscle training (Falk 2014). In fact, Kabat-Zinn (1990, p. 41) asks of his patients a “commitment ... similar to that required in athletic training.”

This *athleticism* is worth dwelling on. We can understand that an athlete, at least partly, is motivated by the possibility of winning a competition. Similarly, one can imagine that people who participate in mindfulness therapy might be motivated by the possibility of overcoming their ailments. But it is not only such rewards that are emphasized by Kabat-Zinn. His conception of athleticism directs our attention to something else: “The athlete trains regularly, every day, rain or shine, whether she feels good or not, whether the goal seems worth it or not ...” (Kabat-Zinn 1990, p. 41). In other words, mindfulness is not simply a means to an end; it is almost like a way of life.

Although the ‘science of mindfulness’, by highlighting the curative effects of mindfulness, might provide some justification for carrying on with this practice, this does not always seem to be sufficient for the patients. It is here we begin to see the emergence of a new layer of translation, involving a new ‘justification’. Or, more precisely, it is suggested that mindfulness does not need an external justification. It is desirable in itself: “the effort itself is its own end” (Kabat-Zinn 1990, p.29). One commits to it because it is enjoyable, like Simmel’s (1971) “sociable gathering,” which is sought for nothing other than itself. So, what we find in Kabat-Zinn’s book is not so much a functional reasoning, “do it and it’ll heal you,” but an *aesthetic promise*: “do it and you’ll like it.” This is also the idea that Langer (1989, p. 135) tries to convey when she characterizes mindfulness as “exhilarating.” Thus, as we move from the realm of medical science to the therapist-patient relationship, mindfulness seems to go through various re-translations: from having a causal

⁶ These aims are also mentioned in articles that provide practical advice to other therapists (e.g., Kabat-Zinn 2003).



justification to an aesthetic one; and, from being an object of knowledge towards an object of love.⁷ Mindfulness is no longer just a medical technology with veritable curative effects; it is *also* like a window that allows us to see “what is most beautiful and meaningful in our lives” and “perceive things as they actually are”; it can make a person feel “more joyful and ... more in control” (Kabat-Zinn 1990, pp. 25–26 and 5; see also: Langer 1989, p. 199).

Neither Langer, nor Kabat-Zinn, however, seem to pay attention to the possible connections between these two effects. While an in-depth analysis of the relationship between aesthetic joy and power is beyond the scope of this paper, two distinct possibilities are worth mentioning. An aesthetic relation to the world might be at odds with instrumental attempts to exert power on our surroundings, which is so essential to modern economic systems. At the same time, however, one might also conjecture that aesthetic joy can serve as ‘human capital’, providing a sense of well-being and confidence to an entrepreneurial subject. Here, we get a first glimpse of the fact that mindfulness therapy can concomitantly have opposite sociological effects.

Escaping the mindless habits of social life: mindfulness as an ethical practice

We cannot, however, grasp the full implications of the translation of mindfulness for the lay readers in the non-scholarly publications of Kabat-Zinn and Langer, unless we note that, for mindfulness therapists, ‘mindless’ behavior does not only have a neurobiological but also a sociological basis. Indeed, many contributors to the mindfulness literature echo Weber’s (1978, p. 21) century-old comment that most human activities in society are carried out “in a state of inarticulate half-consciousness” and are mainly “governed by impulse or habit.” Semi-conscious, habitual behaviors are not only ubiquitous in our social lives but, as countless social theorists, from Garfinkel (1967) to Bourdieu (1977), have emphasized, they are also *necessary* for the stabilization of social relations—a point Langer (1989, p. 36) also seems to acknowledge when she writes that mindless repetition of received ideas “brings stability.”

Mindfulness, then, is not just a neurological problem. It cannot be achieved only by training our ‘brain muscles’, but also requires leaving behind certain socially induced habits that render us ‘mindless’ and developing alternative attitudes: *stop preoccupying yourself with judging things; be patient; let things “unfold in their own time”; try to see things as if you are looking at them for the first time; stop striving; and, accept things and yourself as they are* (Kabat-Zinn 1990, pp. 34–38); *care for the process (rather than the results); be open (to new information and perspectives); try to see things from the point of view of the others; and so on* (Langer 1989, pp. 63–80). These principles largely overlap with what is presented as ‘dimensions’ of mindfulness in various mindfulness scales (Bergomi et al. 2013; Hart et al.

⁷ This aesthetic orientation, of course, is not a unique invention of mindfulness therapy. It would not be difficult to show that in many ancient as well as contemporary spiritual traditions, mindfulness practices are embedded in an aesthetic aura. What is, however, unprecedented in mindfulness therapy is the assembling together of this aestheticization with, among other things, ‘neurologizing’ and medicalizing translations.



2013; Quaglia et al. 2015). However, here, they are not presented in these terms but rather as, to use Kabat-Zinn's (1990, p. 31) words, the "attitudinal soil" in which mindfulness can grow. At a closer look, we can see that they have both an ethical and technical nature. They are ethical in the sense that they involve cultivation of certain attitudes towards life.⁸ But when cultivated, these attitudes are expected to help the pursuit of mindfulness by, for example, overcoming the interruptions to meditative processes from tendencies such as 'striving' and 'judging'.

The problem, however, is that tendencies such as striving, competing, judging, acting fast and being result-oriented are essential requirements of many of our ordinary activities in contemporary societies. These are very *useful* for functioning 'normally' in our social environment. So, leaving behind such habits would mean, to use Langer's (1989, p. 116) words, "escaping the heavy, single-minded striving of most ordinary life"—which clearly entails escaping our ordinary relationships, practices and routines.⁹

But how? About this truly challenging task, mindfulness therapists have very few suggestions. The following passage about Kabat-Zinn's own 'escape' is a good example:

It feels very good to be up and have nothing to do except to dwell in the present, being with things as they are, my mind open and aware. I know the phone won't ring. I know the rest of my family is asleep, so the meditation is not taking time away from them. Most of the time my children stay asleep ... There were periods when I had to push my meditation time back as far as 4:00 A.M. to be sure to get some uninterrupted time ... (Kabat-Zinn 1990, p. 44).

Not only the demands and strivings of ordinary life render us 'mindless', but also, even living in the same house with our family can distract us from the experience of mindfulness. The solution Kabat-Zinn proposes is to find times and spaces protected from the distractions of everyday activities. Needless to say, however, most 'distractions' in social life cannot be avoided by just getting up early. Here, one can also cite the recent attempts to induce mindful versions of various mundane activities such as walking, cooking, or eating (Schröder et al. 2022; Burton and Smith 2020).

⁸ The works covered in this study are published over a period of some thirty years. During this period, the ideas of some of the proponents of mindfulness therapy have gone through changes. No doubt, a detailed historiography of mindfulness therapy might reveal nuances missing from the analysis provided here. Braun's (2017) and Kucinkas (2019) analyses of Kabat-Zinn's texts, for example, implies that he became more concerned with ethical and social implications of mindfulness therapy over time. This, however, does not mean that ethical concerns were lacking from earlier books written by mindfulness therapists. As we can see from the above discussion, they were already there in the very first editions of both Kabat-Zinn's and Langer's books.

⁹ While this invitation to escape society is quite unique to non-academic publications, there are some vaguely noticeable allusions to this idea in academic publications as well. The widespread use of *monks* in neuroscientific mindfulness research is noteworthy in this respect (for overviews, see: Khalsa, et al. 2008; Lutz, et al. 2008; Tang, et al. 2015). This implies that monks are viewed as ideal representatives of a mindful existence. But who are 'monks'? They are not just subjects who happen to participate in mindfulness therapy; they are people who often detach themselves from society in pursuit of a mindful existence in all respects of their lives.



Interestingly enough, however, most of these activities can be carried out individually or in small groups and, therefore, already presuppose a certain detachment from society at large. Indeed, the problem is not only the absence of comprehensive instructions about ‘how to escape society’. There is also a profound dilemma here since mindfulness therapy is expected to cure people so that they *can continue with their ordinary social lives*. I shall pay closer attention to the implications of this dilemma below.

Conclusion

The above findings indicate that as we move from the academic publications to texts addressed to potential or actual clients, mindfulness begins to be translated in different terms. In addition to being described as a therapeutic technique with observable effects on neural circuits, it is now also presented as an enjoyable and empowering, albeit demanding, practice that requires a critical engagement with one’s habits and social life. This further entails that the ‘target’ of mindfulness therapy is no longer only a ‘patient’ but also a ‘subject’ who is expected to transform his/her way of living. These two translations, of course, are not meant to exist in isolation from each other since the relationship of therapists to the medical/scientific community and to their patients cannot be separated (Table 1). Rather, they are connected together in a single formula, which can be seen as the motto of mindfulness therapy: *to achieve bodily and psychological well-being, one needs to practice mindfulness and, to carry out this practice properly, one needs to change one’s habits and attitudes towards life*. Constructing such connections, however, is not an easy feat. As we have seen, it presupposes the co-operation of numerous actors, including psychotherapists and medical doctors, patients from all walks of life, neuroscientists, monks, MRI machines and brain-wave recorders. As such, mindfulness therapy incorporates very different—scientific, medical, neurotechnological, ethical, and even aesthetic and political—concerns. We have already observed some of the tensions and paradoxes that follow from the attempt to assemble together such diverse elements. In concluding, I shall focus more closely on the paradoxical relationship of mindfulness therapy to modern medicine and biosocial disciplines.

This paradoxical relationship can be traced back to a central proposition in the works of mindfulness therapists, which is already briefly hinted at in the preceding analysis. Namely, *escaping the basic, automated processes of our biologic, neural and social lives – our ‘semi-conscious brains and mindless habits’ – is a precondition for healing ourselves*. This is quite an unusual argument since, strictly speaking, in current biosocial research, ‘mindlessness’ is not recognized as a pathological state. Indeed, from a cognitive science perspective it is often argued to have important ‘benefits’. Thus, for example, building on Kahneman’s (2011) work, Hart et al. (2013, p. 458) note that, in comparison to mindfulness, a ‘mindless’ mode of information processing can be more “effortless, ... energy efficient, and ... faster” (see also: Baumeister et al. 1998; Raichle 2015). The proposition of mindfulness therapy, therefore, amounts to suggesting that what modern biosocial disciplines recognize as the ‘normal’ (or ‘default’) state of life can actually be a source of ailment. Of



Table 1 A map of the translations of 'mindfulness'

Core relations	Mindfulness therapists—other psychotherapists and scientists	Mindfulness therapists—patients/clients
Channel of communication Main translations of 'mindfulness'	Scholarly publications 'Mindfulness' as: <ul style="list-style-type: none"> ● An attention training technique ● A solipsistic experience ● A bioneural process ● A trigger for salutary mediators 	Non-scholarly publications 'Mindfulness' as: <ul style="list-style-type: none"> ● An aesthetic experience ● An empowering experience ● An ethical practice for escaping mindless habits



course, this is not simply a factual proposition. At least since Canguilhem (1991), we understand that the term ‘normal’, even if it is used only in the sense of ‘most widespread’, cannot be considered as an ‘objective’ notion. In effect, mindfulness therapists are suggesting that what is ‘most widespread’ is not something to be ‘valued’ or, to put it more bluntly, *the normal is pathological*. As such, the propositions of mindfulness therapists pose a challenge to *population-thinking*, which is often used in biosocial sciences to establish what is most widespread and acceptable in a society through the use of the ‘normal curve’—a key methodological tool in biosocial disciplines (Foucault 2007).

Yet, the aim of mindfulness therapy is to become a part of these very disciplines. In their attempt to establish a ‘science of mindfulness’, mindfulness researchers make full use of procedures such as random sampling, use of control groups, and statistical analysis, all of which presuppose the ‘normal curve’ (e.g., Fox et al. 2012; Khalsa et al. 2008; MacKillop and Anderson 2007; Pascoe et al. 2017; Smith 2004). In this sense, therefore, mindfulness therapists and their research collaborators fully embrace population-thinking. And, that is, no doubt, a striking paradox.

The extent of this paradox, however, goes farther than this because, for mindfulness therapists, the default inclinations of biologic and neural systems are not the only obstacles to the pursuit of mindfulness. As we have seen, they also view the ‘mindless habits’ that permeate social life in a similar light. More generally, one can argue that most habits/attitudes that mindfulness therapists advise their clients to develop as a supplement to their mindfulness exercises—such as patience, non-striving and being process-oriented (Kabat-Zinn 1990; Langer 1989)—implicitly involve a criticism of some aspect of modern social life. This ‘critical’ potential is often underlined by scholars who suggest that the spread of mindfulness practices can transform current social relations and institutions for the better (Leggett 2021; see also: Ng 2016; Stingl and Weiss 2014).¹⁰ One might even imagine that the modern socio-economic system would become seriously disrupted, if most people were to let things unfold in their time, stopped striving, and become process- rather than result-oriented.

Yet, we have no reason to assume that any such disruption is intended by mindfulness therapy. Here, it is also important to remember that most past traditions based on mindfulness practices take it for granted that one cannot lead a mindful existence without some detachment from society at large and, therefore, carry out their activities often, though certainly not always, in isolated spaces like temples, monasteries, Sufi lodges, ‘schools’, and so on (De Certeau 1992; Hadot 1995; Jonveaux et al. 2014; Toussulis 2011). Although mindfulness therapists also allude to the necessity of some form of ‘escape’ from ordinary social life, the readers are not given any guidelines about *how* exactly this can be realized. To what extent should the patients detach themselves from society? And, to what extent should they continue participating in ordinary social life? Clearly, these are not factual questions that mindfulness therapists can answer by the help of scientific or medical theories. In fact, leave aside providing an apparatus of escape as in other deployments of mindfulness in history, they encourage their clients to continue with their therapeutic

¹⁰ A viewpoint that is, of course, also shared by mindfulness therapists (Kabat-Zinn 2005).



exercises despite the “full catastrophe” (Kabat-Zinn 1990) unfolding in their social environment.

This is not, however, some kind of an avoidable ‘flaw’. Rather, it is an inevitable outcome of the allegiance of mindfulness therapy to the modern biomedical enterprise. Mindfulness therapy does not only adopt the population thinking of biosocial disciplines; it also embraces the idea of *therapy as rehabilitation*, the applications of which range from physical rehabilitation (Hardison and Roll 2016) to the rehabilitation of inmates of juvenile correction facilities (Milani et al. 2013). One might, therefore, argue that, in effect, mindfulness therapists are trying to help their patients to live as well-functioning individuals in what they have portrayed as a mindless world.

To sum up, then, creating a medical tool out of ‘mindfulness’ turns out to be a profoundly paradoxical project. Mindfulness therapists, of course, are aware of some of the contrasting tendencies in their work and try to tackle them by various strategies. This is particularly true for ‘secular’ versus ‘sacred’ connotations of their work (Braun 2017; Kucinkas 2019; Wilson 2014). However, the paradox resulting from the pathologization of what is considered as ‘normal’ aspects of life by biosocial sciences is not articulated in any explicit form by mindfulness therapists (or their critics). Nothing indicates that they have ever attempted to ‘resolve’ this particular paradox. In fact, it is highly questionable that it can ever be resolved by some clever strategy. To ‘resolve’ it would require either transforming the biomedical sciences so fundamentally that their whole definition of ‘normal life’ is shattered, or by making mindfulness therapy to give up treating mindfulness as a ‘healthier’ form of existence than mindlessness. As such, this paradox is the very *condition of possibility* of mindfulness therapy.

Perhaps not surprisingly, therefore, the societal effects of mindfulness therapy also tend to be quite paradoxical. One example here concerns the potential of mindfulness practices for serving capitalism (Žižek 2001) and neo-liberal ideals (Arthington 2016; Purser 2019).¹¹ It is not difficult to see that neoliberalism and mindfulness therapy can be connected on a *practical* basis. As briefly noted in the discussion of aesthetic and empowerment effects of mindfulness training, it is possible to view *mindfulness as a tool that can generate various forms of (human) capital* that are highly valued in a neoliberal society: health, efficiency, and perhaps even creativity. At the same time, however, some other types of capital that an entrepreneurial subject is supposed to strive for—above all material wealth and professional status—turn out to be ‘distractions’ for the pursuit of mindfulness. In other words, mindfulness techniques can provide much-needed tools for the entrepreneurial subject, but they might also require this subject to give up some of his/her desires that are essential for participating in a neoliberal competitive market economy.

Beyond such incongruous societal effects, however, the paradoxical nature of mindfulness therapy is particularly important for exploring its relationship to biopower. Drawing on Foucault, several authors have already been hinting at the potential of mindfulness techniques to facilitate self-surveillance and self-discipline

¹¹ The suggestion of one of the leading contributors to the field that mindfulness therapy can be highly useful for CEOs and people in the world of business (Langer 1989) lends support to these arguments.



(Barker 2014; Stanley and Longden 2016). To understand the power effects of mindfulness therapy fully, however, it is important to consider the broader context in which this potential is put to use. The self-surveillance involved here is not necessarily identical to those in panoptic systems (Foucault 1979), which targets the creation of ‘normal’ habits in the subjects. Rather, mindfulness training aims to induce in the patients *the habit of being mindful about their habits*. It is in the context of this somewhat unusual subjectivation process that mindfulness therapists *exercise power by providing guidance*. The ‘form’ of this guidance can give us important clues about the relationship of mindfulness therapy to biopower.

Here, it is important to remember that, in Foucault’s (1978) conceptualization, since biopower primarily targets the ‘life’ of a population, the guidance provided by professional *experts* such as doctors and psychiatrists is essential for its functioning. At first sight, as experts in various biosocial disciplines, mindfulness therapists and their collaborators fit this definition perfectly. Yet, as we have seen, mindfulness therapists do not want to adopt the objectifying gaze of the clinical expert. The neuroscientific objectification of a ‘mindful state’ notwithstanding, mindfulness is not some kind of a procedure that therapists apply to their patients but rather a practice that *they themselves* engage in. It is the *sharing of an experience*, rather than the administration of a cure by an expert, that constitutes the core of this relationship. In this respect, the therapist-patient relationship here might even be resembled to the master-disciple relationship assumed by ancient practices of ‘care of the self’ (Foucault 1990, 2005) as well as other spiritual traditions that adopt mindfulness practices. This resemblance, however, should not be exaggerated. In contradistinction to the ‘personalized’, life-long nature of master-disciple relations, mindfulness therapy operates through short-term interventions. Nor does it offer a niche environment, detached from society at large, where such companionships can unfold.

Strictly speaking, then, mindfulness therapists are neither spiritual companions, nor pastors. Nor can they be portrayed as participating in an expert-client relationship in the fullest sense of the term. Rather, they seem to inject some paradox into this relationship. In fact, it might be quite accurate to call mindfulness therapists as *paradoxical experts*, who use their expertise in biosocial disciplines to guide their clients into escaping the habits that these very disciplines consider as normal. It is too early to say whether this signals the beginning of a new type of guidance or whether mindfulness therapy will growingly integrate itself into the modern therapeutic culture as a new biopolitical technology.

But perhaps the only sociologically significant question here is not whether mindfulness therapy can serve biopower. An equally important—yet rarely raised—question is, *what would happen to biopower, if mindfulness therapy were to become assimilated into it?* This is not an improbable scenario since, if the health benefits of mindfulness techniques find support in biosocial research, then mindfulness therapy might be embraced by biopower like any other practice that can enhance the ‘life’ of a population. In the case of mindfulness therapy, however, such enhancement requires encouraging the *members* of a population to escape the routines and habits that sustain that very population. And, this strange requirement entails a sublime risk. For if these habitual practices disappear, what will there be left from ‘social life’ to enhance? What would remain of



a ‘population’—the very target of biopower—if its members begin to distance themselves from common norms and expectations? It seems that the translation of mindfulness techniques into biopolitical devices might involve quite serious ‘betrayals’.

Less dramatically, we can imagine that biopower would not only be adding a novel self-control technology to its inventory in this process but, sooner or later, it would also be confronted with a series of questions regarding its assumptions about biologic and social life. This is not necessarily an intended effect of mindfulness therapy, which was not invented to ‘confront’ biopower. But the twin themes of ‘pathologization of the normal’ and ‘escaping from habits’ are almost bound to generate questions regarding the *limits* of our current conceptions about biologic and social life. In fact, it seems to us that from a sociological viewpoint these questions might be the most significant, albeit unintended, products of mindfulness therapy. Or, to put it in slightly different terms, if mindfulness therapy could be translated into a sociological vernacular, these would possibly be the questions we would ultimately hear.

Could it be that our ‘normal’ bioneural tendencies and ways of living are the main sources of our ailments? And, if so, can we actually escape them? How exactly, and with what consequences?

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