

Chapter 2

Beginning with the Context: The Mind–Body Conundrum

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In fact ‘connection’ understates the case: in the yoga tradition [and Āyurveda] the mind is said to be the most subtle aspect of the body, and body the most tangible aspect of mind. They exist on a continuum

Wallis (2016).

Understanding what is meant by the term “mind” is dependent on who you ask and during which period in history. In current times, Siegel (2007) speaks of the mind in terms of “an embodied and relational process that regulates the flow of energy and information” (p. 5). As an interpersonal neurologist, he views the mind as encompassing more than what the brain does. What we think of as that the mind cannot be separated from the body despite our Cartesian heritage. “Mindfulness is a process of self-inquiry directed at what is happening in the moment, often focused on how the body feels, on how we *embody* this moment...without inner commentary, judgment, or storytelling” (Kozak 2009, p. 2). Conceptualizing mindfulness as a whole body experience rejoins the mind and the body in a way that the western world has historically had difficulty reconciling and operationalizing. The current medical, economic, and political environment reflects that mis-attunement. Too often our pattern in America has been that of segregated health care:

In a hospital, the body is divided into departments. One department for the ear, nose and throat, one for the eyes, one for the stomach and the intestines, one for the sexual organs, one for heart and blood vessels, and one for the soul, which is treated in the psychiatric wards (Knausgaard 2014).

However, research has shown that the tendency to separate the mind and body leads to missing vital information which then leads to “poorer outcomes and higher costs in the care of patients” (Pettersson et al. 2008, p. 1). In order to better understand the relevance of mindfulness for clinical practice, it is important to first consider the context of health and mental health care in the United States today.

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Clinical social workers, physicians, and healers in many if not all cultures recognize that our bodies can be understood as conduits or carriers of messages if we listen carefully. However, this holistic approach to health has not been consistently understood or appreciated. Harrington (2008) proposes that the relationship between mind and body in medicine represents a complex myriad of stories woven together across time. Such narratives are formed, edited, and influenced by scientific and humanistic disciplines, as well as economic, political, religious, secular, and historical factors. Consequently, we must look at results of empirical study and the narratives surrounding the study of both mind and body to gain a more complete understanding of how to best intervene clinically.

Gay (2010) suggests in his analysis of the contrasts between progress in science versus progress in the humanities that science has advanced by examining objects under study with greater and greater magnification.¹ In contrast, understanding advances in the humanities requires an examination of individuals and the contexts in which they lived, which cannot be made more meaningful by simple magnification of the object under study.² In a similar way, to better understand mindfulness and how it can be used with clients in western culture at this point in time, we should examine some of the narratives that have shaped our scientific and humanistic advances and not just elucidate the steps to becoming more mindful. As with progress in the field of humanities, we are in essence trying to understand the “intellectual ecology” shaping our study of the mind and body by looking at the persuasive narratives surrounding health and mental health (Gay 2010).

What then have been some of the more predominant narratives influencing our current understanding of mind and body? Harrington (2008) suggests six important narratives beginning around what was known in Europe as the Renaissance period: the Power of Suggestion; the Body that Speaks; the Power of Positive Thinking; Broken by Modern Life; Healing Ties; and Eastward Journeys. She resists confining these narratives to particular dates and times because with any narrative there is not a strict beginning and end for when the stories are true (White 2007). In epigenetic fashion, each narrative builds on the prior, continuing to exert influence even as new narratives take shape and dominate. As the protagonist in Bernhard Schlink’s novel *The Reader* states, “the tectonic layers of our lives rest so tightly one on top of the other that we always come up against earlier events in later ones, not as matter that has been fully formed and pushed aside, but absolutely present and alive” (Schlink 1995, p. 217). There cannot be a linear exposition of narratives as they cycle forward and backwards in ever widening circles. It is also important to emphasize that covering a few of the historical narratives relevant to mind–body medicine, inevitably leaves out innumerable other narratives and influences. The authors and significant figures and events mentioned in this chapter are a

¹e.g., the discovery of cells under a microscope advancing to examination of these same cells under greater magnification for the presence of DNA and even genetic markers.

²e.g., poems or paintings lose their beauty and value if appreciation and understanding is restricted to a dissection of each word or brush stroke.

microcosm of the many important contributions to the ongoing narratives that have impacted each of us in how we conceptualize good health. A biographer, reports Oates (1987), often feels a “tapping on the shoulder” leading him or her to choose a particular subject (Hart 2014, p. 787). While not writing a biographical narrative, I did find particular scholars more compelling perhaps based on a curiosity about why I had not heard them mentioned before in many historical accountings of mental health. In an effort to change what has unfortunately been a “white man’s history” so common in the medical and psychological fields, I have tried to include voices not often heard, which of course reflects my own personal narrative. There cannot be one scientific reality or an equitable balance or fair representation of the impact of each historical event, professional discipline, scholarly researcher or theoretician. However, I have tried to include some of the more obvious influences as well as voices that have been perhaps marginalized in usual discussions of mind and body medicine. We begin where Harrington does, with **The Power of Suggestion**.

The impact of religious and political environments is evident in the first narrative of **The Power of Suggestion** (Harrington 2008). Mental illness was viewed as representing demonic possession requiring a form of exorcism by a special person consecrated by God. That legacy of the importance of someone other than ourselves as necessary to facilitate healing of another continues today. Centuries ago this “essential other” was only able to heal the other when appropriately endowed with religious or spiritual powers. This paradigm of the Power of Suggestion dominated many developed countries at least as far back as the 1600s when Pope Paul V affirmed the existence of demons and laid out the process for exorcism of these demons.³ All through centuries in the United States, many religious beliefs and practices have immigrated to form a powerful rubric that influences how we understood any form of dysfunction—physical or psychological. These dysfunctions in the 1600–1700s were not yet viewed as having a sociological source. Rather, they were believed to stem from an external force inhabiting the person against their will, requiring another person to force the possession to leave the patient. An “other” could assess and determine whether someone was ill, why they became ill, and how and if they could be cured.

By the 1700s, a general skepticism about the likelihood of possession took hold with some recognition that perhaps there was an investment by ruling parties in supporting the power of the “healers”. The political philosopher Thomas Hobbes living in a time of economic, political, military, and religious turmoil in England, questioned what he saw as the inappropriateness of blending religion and public policy (Williams, n.d.). Hobbes was grappling with the dominance of civil conflict and trying to figure out how human beings can live together peacefully. While Descartes is credited (or blamed) with the Cartesian dualism of separating mind and

³The procedures for exorcism by priests “remained on the books” until 1999 when the “rules for the millennium” were changed as part of the liturgical reform (Harrington 2008, p. 37, and endnote on p. 260).

body, it is Hobbes who promulgated the mechanistic view of the human body as an alternative to the view in which mind and body were able to be influenced by those in power at the time. Hobbes' influence on the separation of the material world from the spiritual world relied on his belief that human judgment was inherently flawed and should not be trusted as authority. Science needed to have a much more powerful role in decisions affecting the public domain in his view, to separate civil discourse from emotional and passionate ideology that interfered with peaceful coexistence. He believed men were "vehemently in love with their own new opinions...and obstinately bent to maintain them" (*Leviathan*, vii. 4). The emerging scientific method challenged the belief in the ability of another human being to exorcize demons and the apparent magical ability of one person to cure another. In contrast to Foucault's twentieth century views on the use of scientific knowledge as a form of social control (Chambon et al. 2009), Hobbes ushered in what he saw as the need for scientific knowledge to combat the power of the ruling class to use their religious knowledge to control public and private behavior. The social world, influenced by Hobbes, was no longer willing to accept changes in the human body by faith alone. As historian Ellenberger eloquently states, "It is not enough to cure the sick; you have to cure them with methods accepted by the community" (1970, p. 57 as cited in Harrington 2008). The "power of suggestion" narrative was ushered out by skepticism of the power of religious confessional rituals and replaced by a narrative of **The Body That Speaks** (Harrington 2008).

Darwin's research supporting natural selection (that species evolved in order to adapt to the environments around them) and the theory of evolution reinforced how helpful science could be in explaining human behavior. Guided by the need to be considered scientific and therefore valid, Freud, as well as other European psychosomatic scientists examining the effects of WWI (and subsequently WWII), viewed the mind as having depth warranting excavation and exploration. There was an attempt to examine the body as a scientific object—one capable of being understood by magnification, as Gay (2010) would suggest. As a detective is confronted with a mystery, the body became the subject to investigate to decipher the message being conveyed through symptoms. Healing was believed possible when messages the body sends were decoded. The mind-body narrative shifted to **The Body that Speaks** as a result. It was believed, if we could find a way to listen appropriately, we could find a more effective way to intervene therapeutically.

Freud and other European scientists were dominant influences during this time period. Many texts and websites have recounted and analyzed that history.⁴ However, we need to look further than just European Freudians, to understand what was happening in the United States. For example, social work became a part of the mental hygiene movement in America during the early twentieth century, as the profession combined efforts on casework stemming from work in the settlement

⁴(e.g., Freud's texts, Jones 1955; Mitchell and Black 1996; Berzoff et al. 2016; Heller and Gitterman 2011; <http://www.dualdiagnosis.org/mental-health-and-addiction/history>; <http://www.mentalhealthamerica.net/our-history>, etc.).

houses with the scientific method attempted by psychoanalysis. Mary Jarrett was a welfare worker in the Children’s Aid Society and was trained in the casework method. She was hired by Dr. E.E. Southard at Boston Psychiatric Hospital to help engineer the clinical approach that became the hallmark of psychiatric social work. In 1918, they began what would become one of the earliest schools for social work, Smith College School for Social Work to address the growing needs of World War I veterans suffering from shell shock. They thought soldiers’ reactions to stress were parallel to civilian’s response to high stress situations. Their emphasis was on trying to understand the relationship between emotions and symptoms as psychiatry shifted focus from a moral to a physiological one (Rubin 2009).

A female voice not often referred to in mental health literature is that of Helen Flanders Dunbar. She notably tried to bridge the mind, body, and spirit and was an important advocate of physicians and clergy cooperating in their efforts to care for the sick. Dunbar received degrees in mathematics, psychology, theology, philosophy, and medicine. The founder of the American Psychosomatic Society and its professional journal *Psychosomatic Medicine*, she explicitly focused on the mind–body connection during her short life (1902–1959). Influenced by philosophers such as Alfred North Whitehead, William James and the American School of Psychiatry, Dunbar and her colleagues “saw patients first as human beings who were dynamically involved in an environment in which they were formed and transformed.... And her concern with seeing patients and disease in terms of a patterned, organic whole anticipates what came to be formally called by the 1960s the ‘biopsychosocial model’” (Hart 2014, p. 784). The patient began to be viewed as a combination of the psych and soma, body and soul. Dunbar was also interested in trying to link certain diseases with certain personality types related to her observation of 1300 patients and seeing their varying inhibitions or unregulated expression of emotion.⁵

Franz Alexander, a Hungarian psychoanalyst arriving in the United States in the 1920s, emphasized Freudian theories about the physiology of emotions. Similar to Dunbar, Alexander also believed that repressed emotional conflicts led to certain diseases by “chronically stimulating or activating different specific vegetative organs in one’s body...until they finally begin to malfunction” (Harrington 2008, p. 91). The implication that the body held secrets that could make us ill had important ramifications: who then knew what the secrets were and what they meant?

Feminists became concerned about men in positions of power assuming the role of telling women what their bodies needed. While women were struggling to ratify the 19th amendment in 1920 to allow their right to vote, it took almost 50 more years before women used their voice to reclaim the right to know their own bodies. It was not until the late 1960s that a women’s health movement in Boston attempted to

⁵Dunbar foreshadowed current work on emotional regulation as being one of the cornerstones in understanding personality syndromes considered for DSM5 and further research (e.g., Bradley et al. 2011; Carpenter and Trull 2013; Cole et al. 1994; Hoermann et al. 2013; etc.).

dispel the mysteries popularized by the paradigm of the body speaking, by organizing to publish *Our Bodies, Ourselves* (Boston Women's Health Book Collective and Norsigian 2011; *Our Bodies, Ourselves* (2016). Women wanted to take ownership over their own bodies and to prevent being at the mercy of a significant other, medical or personal, usually male, who claimed to know what was best for them. They decided to put their knowledge into an accessible format that could be shared and would serve as a model for women who want to learn about themselves, communicate their findings with doctors, and challenge the medical establishment to change and improve the care that women receive. Scientific gains were filtered with the sociological and psychological ramifications of those discoveries.

It was not only that the body had secrets or communicated via its symptoms that was important. With Darwin's understanding of the human body adapting to the needs of the environment over generations, we began to recognize that the body has self-righting, evolutionary guidelines that react to external traumatic events. Walter Cannon believed the body could, would, and should experience a severe reaction when confronted with danger. In 1923, he published his empirical findings related to how trauma impacted the body. Traumatic shock was caused by blood being drained into the dilated capillary region, a phenomenon for which he coined the term *exemia*. The treatment of shock, he argued, should concentrate on reinstating normal circulation. His observations also convinced him that the living body always strives toward a harmonious equilibrium—a state which Cannon called “homeostasis” in his book, *Wisdom of the Body* (Harrington 2008). Cannon is also responsible for the term “flight or fight” to represent how the body responds to fear and anxiety (Massey 2015). One of his investigations as early as the 1930s showed that when cats were upset by the presence of an enemy (a barking dog), their peristaltic activity was inhibited. Excitation and fear were producing an increase in blood pressure, blood sugar, pupil dilations, and piloerection (hair standing on end) (Harrington 2008, p. 146). We now had scientific proof that the body was directly impacted by the immediate physical environment in ways that would be evident in physiological measures. The physiological impact became even more critical to understand when trying to discover methodology of appropriate treatment. *What interventions could be introduced to patients experiencing the effects of trauma that would cause their bodies to recalibrate and return to normal functioning?*

Traumatic experiences increased with the impacts of both WWI and WWII. America experienced two world wars that stimulated an essential positive sense of unity and pride in the country. The victory with WWII brought a new optimism, which in turn impacted the mind–body narrative as it evolved into “**The Power of Positive Thinking**” (Harrington 2008). Norman Vincent Peale's (1952) positivism was popular with the majority white middle class as evidenced by subscription rates to his popular *Guideposts* religious magazine exceeding 4.5 million (Harrington 2008). As veterans reestablished themselves in their “victorious” homeland, there was a great emphasis on the belief in the ability to achieve the American Dream of economic success and prosperity. It was believed we could do anything we set our minds to. However, with men returning from war, they returned to jobs that women held during their absence. It was considered patriotic for women to leave their

positions for the men and return to care for the home and children. The economy flourished after years in postdepression stagnation. Veterans had access to the GI bill for their respected service to the country to help train and educate them for the new frontier of the business and technological world, with less emphasis on manual labor. However, minorities had limited voice and power in setting public policy, consequently a robust economy was seen as a result of the hard work of the majority, not as a combination with optimal privileges setting the stage for optimal development.

Despite the scientific “proof” that the body can be ill for a variety of reasons, the mind was viewed as very powerful and capable of overruling any symptoms or difficulties. This was a popular American message of the Christian gospel as well; healing could occur with the appropriate level and kind of faith. As William James predicted in his philosophical text *The Varieties of Religious Experience*, “the greatest discovery of my generation is that man (sic) can alter his life simply by altering his attitude of mind” (Harrington 2008, p. 117; James 1905, p. 95). Research caught up to ideology espoused by earlier philosophers by proving the power of placebos in effecting change, which translated into the power of the mind to cure. The double-edged sword of the scientific research supporting the ability of placebos to effect positive change was that if the mind could heal, then it could also make us sick.

Ehrenreich’s (2009) timely book *Bright-Sided: How Positive Thinking is Undermining America* challenged the scientific argument for cheerfulness during her personal experience of breast cancer. The predominant message she received was that a positive attitude could reduce the risk of cancer or its return. During the 1980s Bernie Siegel published his book *Love, Medicine and Miracles* which proposed that a healthy, vigorous, immune system could overcome cancer. In addition to Siegel’s work, many other physicians, psychiatrists, and life coaches began to emphasize that not only could a positive attitude facilitate better health, but that sickness was a gift that could help realign someone’s priorities. Ehrenreich challenged the extremism evident in some of these simplistic conclusions when she described the content of many motivational speakers and her response:

If you want to improve your life – both materially and subjectively – you need to upgrade your attitude, revise your emotional responses, and focus your mind. One could think of other possible means of self-improvement – through education, for example, to acquire new “hard” skills or by working for social changes that would benefit all. But in the world of positive thinking, the challenges are all interior and easily overcome through an effort of the will (Ehrenreich 2009, p. 51).

In Ehrenreich’s experience and in emerging scientific results, the pressure to be positive was proving to be exhausting and not delivering physical cures or stress relief. As one example, sociologist Hochschild (1983) published results of her study with flight attendants who were exhausted by the work requirement of cheerfulness to passengers at all times. At its extreme, the push for optimism resulted in the imperative to get rid of not only negative thoughts and emotions, but also the negative people in our lives.

Another major impact of the power of positive thinking narrative is the belief that you can manipulate external reality through your thoughts and feelings. Visualization of what you wanted could bring it to you via positive energy. If you do not receive what you are wanting then it is because of your faulty vision. “External conditions such as failure and unemployment were projections of one’s inner sense of well-being” (Ehrenreich 2008, p. 61). A paradoxical result of that kind of mentality was the Calvinistic need to work harder to be happy. Overwork became a virtue and an admirable trait. Workplaces became “reprogrammed” into new age motivational environments that needed to overcome negativity. Positive thinking had become an obligation and the mind shifted to be a focus of observation. If we could just train our minds, we could also have the power to change our circumstances.

Despite the positivity movement, there were still large economic and demographic changes brought about by war such as the population increase with baby boomers. However, all was not positive; research on the negative impact of military experience on bomber pilots continued. Hans Selye, an endocrinologist contemporary of Cannon, had continued to study how negative emotions impacted body chemistry. While popular writers and speakers such as Norman Vincent Peale in the 1950s and physician Norman Cousins in the 1970s focused on positive emotions, there was still simultaneous research continuing on the impact of “stress entering our bodies not as a disease, but as a human experience” (Harrington 2008, p. 145). Unfortunately at that time, pilots who experienced negative reactions to their experiences in war were viewed as having preexisting character weaknesses. Selye and other colleagues were able to convince military researchers that their study of stress had some bearing on military personnel which helped to reduce the moral bias against stressed based reactions. However, that moral bias still exists in the public as many mental health and health difficulties are still viewed as being the personal failure of the politician, sports figure, entertainer, or neighbor next door (Drexler 2016; Sundararaman 2009).

Health problems escalated despite the discoveries and emphasis on the power of the mind to heal. Cancers and other illnesses defied attempts to be cured by positive thinking. At this point, “stress” developed as a separate focus and we moved into the narrative of **Broken by Modern Life**, according to Harrington (2008). Stress as a concept or entity for study helped us make sense of postwar anxieties and what appeared to be the cost of prosperity. Heart disease was on the increase and the Type A personality emerged—a tragic yet admired figure evident in Western culture. The dialectic of admiration and yet concern led to the uniquely American individualistic approach of biofeedback which asked how can we systematically and individually cope with the consequences of modern life. We cycled back to listening to the body to determine the slightest physiological response in brainwaves, heart rate and pain perception utilizing our new technological advances. The goal was to harness the mind to change thoughts, emotions, and behavior in order to improve health (Association for Applied Psychophysiology and Biofeedback 2011).

The 1950s also saw the rise and plateau of behaviorism. According to Miller (2003), Pavlov and B.F. Skinner argued that mental events were not observable and

consequently not sufficiently scientific. Using behaviorism as the gold standard, psychology attempted to become an objective science.⁶ Fortunately, a first revolution of cognitive theorists and researchers realized that there were problems with a strict behaviorist approach:

Behaviorism was an exciting adventure for experimental psychology but by the mid-1950s it had become apparent that it could not succeed. As Chomsky remarked, defining psychology as the science of behavior was like defining physics as the science of meter reading. If scientific psychology were to succeed, mentalistic concepts would have to integrate and explain the behavioral data. We were still reluctant to use such terms as ‘mentalism’ to describe what was needed, so we talked about cognition instead. Whatever we called it, the cognitive counter-revolution (against behaviorism) in psychology brought the mind back into experimental psychology (Miller 2003, p. 142).⁷

The fields of psychology, anthropology and linguistics began to connect with the emerging fields of artificial intelligence, computer science, and neuroscience. American theorists drew strength and ideas from psychologists in other countries, namely Piaget in Switzerland (cognitions in children), Luria in the Soviet Union (connections between brain and mind), and Bartlett in the United Kingdom (memory and thinking) (Miller 2003). The work of Albert Ellis and Aaron T. Beck focused on irrational and automatic thoughts, respectively. Many publications have documented the history of the movement and the empirical results supporting the premise that modifying thoughts could alter behavior.⁸ By the 1970s, Beck’s work with colleagues was demonstrating that cognitive therapy was effective in treating depression in randomized controlled studies by helping patients solve problems, become behaviorally activated, and “identify, evaluate, and respond to their depressed thinking, especially to negative thoughts about themselves, their worlds, and their future” (Beck 2011, p. 6).⁹ Therapeutic work on anxiety followed with shifting the focus to assessing risk, evaluating internal and external resources, and testing negative predictions via behavioral exercises (Beck 1976).

Modern life also included numerous traumas, whether it was the lingering effects of war or the increasing visibility of physical and sexual traumas. Herman (1992) became known for her distinctive contributions to the understanding of trauma and its survivors. She was able to shed light on the impact of single-incident traumas and complex or repeated traumas such as Complex Post-Traumatic Stress Disorder. Bessel A. van der Kolk M.D., another clinician, researcher and teacher in the area

⁶Alfred North Whitehead challenged Skinner to “account for utterances that allude to stimuli conspicuously absent from the environment of the speaker and that therefore appear to require conceptual tools unavailable to the behaviorists” (Palmer 2006, p. 253). Ultimately Skinner wrote *Verbal Persuasion* (1957) to try to demonstrate that all verbal and nonverbal behavior could be explained by the conceptual tools of behaviorism.

⁷For a full discussion of Chomsky’s critique of behaviorism, see Palmer (2006).

⁸(See Beck 1976; Messer and Gurman 2011; Turner 2011; Northcut et al. 2016; etc.).

⁹However, Jacobson et al. (1996) provide a critique of the theory of change proposed by Beck and associates by breaking down the treatment into its specific components (i.e., behavioral activation, modifying automatic thoughts, or the full cognitive therapy treatment protocol).

of posttraumatic stress and its effects, worked (and continues) to work to integrate developmental, biological, psychodynamic, and interpersonal aspects of the impact of trauma and its treatment (van der Kolk 1984, 1987, 2014). The quest was to find a way to reunite mind and body based on the results of research in a variety of disciplines studying trauma.

While depression and anxiety may have resulted from the stresses of everyday living postindustrial society, the AIDS epidemic exposed the power and vulnerability of the immune system. The nervous system could lead to more illness if stress taxed the immune systems of vulnerable individuals. Focus then turned to how resistance and resilience could be built within our immune systems and what kind of stressors tax the body. Minority groups, LGBTQ in particular, began to speak out about the effects of being marginalized by society as they had been pre- and post AIDS epidemic. The western bias of individualism at all costs, even down to our own individual cognitive distortions, began to also consider how groups might serve as a form of social protection and treatment for what ails us and isolates us.

Consequently, a narrative of **Healing Ties** ushered in nostalgia for an ideal of life before modernity which had a greater sense of community and intimacy (Harrington 2008). Post World War II also led the psychiatric profession to transform care from asylum-based mental health care to community-oriented therapeutic approaches. Despite the attempts of the mental hygiene movement to visualize a whole community as the patient (Bertolote 2008), it had not been effective in achieving great strides with the care and prevention of mental illness. The deinstitutionalization movement focused on social integration of the mentally ill and emphasized prevention and rehabilitation (Novella 2010). Massive funding supported studies that showed how social support could alleviate the symptoms or behaviors considered unhealthy or pathological. One of the consequences of our technological advances had been the creation of social isolation, and rather than abandon those advances, technology was utilized to address an ironic sense of disconnection. Social media advanced rapidly and created the means for contact that could transcend geographic and time limitations.

The baby boomer generation produced children that were considered “digital natives” or at the very least able to possess “digital wisdom” (Prensky 2001, 2012). The first social networks and blogs surfaced by the turn of the millennium making it possible to communicate in real time around the world (Palfrey and Gasser 2008). Platforms such as Facebook still in use by “digital immigrants” (parents of digital natives) (Prensky 2001), made way for ephemeral social media that displays shared content for a limited period of time such as Snapchat and Instant Messaging (Bayer et al. 2015). While concerns about the effects of social media on intimacy and brain wiring continue, there is preliminary evidence that with our new ways of relating and gathering information, we are less likely to feel intimacy despite extensive self-disclosures on Facebook, or less likely to think in deep and contemplative ways as a result of endless surfing with short message bytes (Carr 2010; Dakin 2014). Interestingly enough, teens seem to have moved away from Facebook in favor of the newer apps such as Snapchat or Instagram in order to feel a closer connection with a more limited number of closer friends. However, Snapchat interactions do

not necessarily correlate with higher rates of social support. In contrast, Snapchat is associated with lower social support, albeit with higher positive affect (Bayer et al. 2015). Heavy social media users report higher levels of anxiety because of what is called FOMO—Fear of Missing Out. Despite feeling that their heavy social media use has “brought stronger relationships, more effective goal setting, ability to seek help through social media as well as feeling part of a global community” (Bayer et al. 2015, p. 1), teens report fears their friends are having more fun and rewarding experiences than they are, which is leading to greater anxiety (Fuller 2015).

While the rapid growth of social media has produced increased communication around the world, it has not necessarily reduced the stress associated with modern life. If anything, modern life, with its greater technological advances, has brought its own set of stressors associated with always being available electronically 24 hours a day, 7 days a week. In addition, we are immersed in a positive psychology movement, an outgrowth of the positive thinking paradigm despite efforts of that movement to distance them from pop psychology.

Martin Seligman is generally credited with being the founder of the positive psychology movement with the goal of leading a good life. A life is considered good if we use our unique strengths every day to produce happiness and gratification (Seligman 2002, 2009). The Positive Psychology Institute’s website suggests:

Positive Psychology is grounded in the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within them, and to enhance their experiences of love, work, and play...The field is intended to complement, not to replace traditional psychology. It does not seek to deny the importance of studying how things go wrong, but rather to emphasize the importance of using the scientific method to determine how things go right (Positive Psychology Institute 2012).

While the attempt to balance a mind–body narrative that has become too focused on pathology and dysfunction has been critical, it has raised a number of problems as identified by Held (1995, 2001, 2002; Held and Bohart 2002) and other humanist psychologists. For example, Aspinwall and Staudinger (2003) stated:

...a call for the scientific study of...positive states...should not be misunderstood as a call to ignore negative aspects of human experience. That is, a psychology of human strengths should not be the study of how negative experience may be avoided or ignored, but rather how positive and negative experience may be interrelated....Indeed, some philosophical perspectives suggest that the positive and negative are by definition dependent on each other, that is, human existence seems to be constituted by basic dialectics (Aspinwall and Staudinger 2003, pp. 14–15; Held 2004, p. 13).

A balance or integration of good and bad or positive and negative feelings and thoughts has been the focus of theories of human behavior for decades although more common in the eastern religions.¹⁰ **Healing Ties** segued into another important narrative **Eastward Journeys** (Harrington 2008). This evolving narrative

¹⁰For example, Zen focuses on the need to move beyond or not to be confined by the basic dialectics.

epitomized the western fantasy that other societies had a better way to heal than through just developing or expanding social communities. This exoticism approach focused on ancient Eastern cultures that have not traditionally had a strong influence in this country. There has been a longstanding orientalist (Said 1978) tendency in western culture to consider the East as a foil to our own Western values and lifestyles—generally to the West’s advantage. We were superior because we had moved from the scientific revolution to a social world that emphasized efficiency, rationality, and self-control. However we were victims of our own success. We could draw on the wisdom of the other to learn from, but not forsake any of our progress. The American perspective of “West is Best” had to make way to appreciate that the East had lessons to teach us about morality and medicine.

This process of changing the narrative was built on several other historical phenomena as well. Novelists and poets of the Beat generation in the 1950s paved the way for musicians and actors to search for wisdom in Buddhism in the 1960s. Drug use and anti-Vietnam sentiment brought about a countercultural movement. Maharishi and Transcendental Meditation (TM) took the country by storm during the 60s and 70s with the emphasis on mantras and spiritual regeneration (fees not included). Celebrities proved fickle in their interest, however, scientists began to debate the relationship between Eastern mysticism and quantum physics. Fortunately, Robert Keith Wallace studied the physiological effects of meditating college students in Los Angeles and found not only changes in oxygen consumption, heart rate, and skin resistance, but also the occurrence of newly identified brain activity: an altered consciousness. It was not until Harvard psychologist Herbert Benson attempted to determine the connection between stress and heart disease that a potential opportunity presented itself to incorporate the effects of transcendental meditation into medical research. Benson used operant conditioning and biofeedback to alter the blood pressure in monkeys and human subjects. Young TM practitioners offered to be guinea pigs simply by allowing Benson to study the effects on them during routine meditation practice. Even though he was nervous about admitting to the world that he was combining medicine and TM, once Benson learned of Wallace’s work, collaboration began. By 1972 they were clear: regardless of the original purpose, “TM and all the other ancient meditative techniques central to faith traditions around the world also acted as technologies for turning off the stress response” (Harrington 2008, p. 217). Though Benson renamed the use of meditation as relaxation and published the New York Times bestseller *The Relaxation Response*, he “domesticated and medicalized meditation” in the 1970s (Harrington 2008, p. 219). Benson articulated its universal appeal in this way: “Even though it (the relaxation response) has been evoked in the religions of both East and West for most of recorded history, you don’t have to engage in any rites or esoteric practices to bring it forth” (Benson 1975, p. 117).

Meanwhile in China, efforts to reduce economic and ideological dependence on the Soviet Union contributed to Mao Tse-Tung’s celebration of traditional Chinese medicine as the socialist wave of the future. In addition, the United States reopened diplomatic relations with China in the 1970s under the Nixon administration. Acupuncture was publicized as helpful in overcoming postoperative complications.

The reopening of diplomatic relations encouraged more cultural exchange including the Chinese practice of qigong:

Qigong is an ancient Chinese health care system that integrates physical postures, breathing techniques and focused intention. The word Qigong (Chi Kung) is made up of two Chinese words. Qi is pronounced *chee* and is usually translated to mean the life force or vital-energy that flows through all things in the universe. The second word, Gong, pronounced *gung*, means accomplishment, or skill that is cultivated through steady practice. Together, Qigong (Chi Kung) means cultivating energy, it is a system practiced for health maintenance, healing and increasing vitality (NQA 2016).

In 1990, Jon Kabat Zinn published the renowned book *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness*, based on his work from the previous ten years. He had a degree from MIT in molecular biology and taught Buddhist meditation and yoga. With the support of the University of Massachusetts Medical Center in Worcester, he designed and implemented a program to help patients utilize mindfulness in order to cope with chronic pain and suffering. The course itself was not stress-free; it was a demanding, intense eight-week course. But by couching the terminology as stress reduction, Kabat-Zinn had successfully introduced a nonthreatening way for the medical establishment and the public to try a consistent, meditative practice and document the results. Mindfulness-based stress reduction (MBSR) proved to be successful and began to be replicated around the country (Kabat-Zinn 2013).

The twenty-first century brought even more scientific research focused on the health benefits of Buddhism.¹¹ However, what is sometimes forgotten is the fact that meditation was not designed to alleviate stress. Rather it was a spiritual technology that had an ethical and moral imperative about how we live with and treat each other. The Dalai Lama's investment in the results of scientific research into the relationship between the spiritual practices of his Tibetan community and physiology was based in part on his political concerns. Traditionally, a Buddhist religious leader would not expose his followers to any kind of study or potential interference. However, out of concern about the Chinese occupation of Tibet, Dalai Lama agreed to afford the opportunity of access to Harvard researcher Herbert Benson (Harrington 2008). Although part of the proliferation of mindfulness practices in a variety of disciplines and settings stems from its positive results, the nonsectarian nature makes it easier and user-friendly for reluctant participants to engage in.

While research in this country may have begun studying meditation from a place of trying to obtain relief from stress, achieve health benefits, or even reach a state of higher consciousness, there remains several related pragmatic questions. Hobbes was asking how we can live together and negotiate civil conflict when he pushed for reliance on the scientific method to inform public policy. Theoreticians, researchers, and practitioners since then have tried to use science to prove what treatment methods improve individual functioning. Our lingering narrative about utilizing an

¹¹This research will be discussed in subsequent chapters when relevant.

“other” to persuade our bodies to cooperate into health, has led us to look to other cultures and charismatic figures to provide answers. We do know the body expresses many experiences, positive and negative, and seeks to restore itself to cope with the demands our current environment places upon it. The challenge currently is how to find a way to reintegrate the mind and body in a manner that allows us to “knit together domains of experience that we struggle otherwise to relate: the medical and the moral, the biological and the biographical, the natural and the cultural” (Harrington 2008, p. 255). The need for greater integration in mind and body reflects our historical conundrum about how to do so. It appears we have reached a point in health and mental health care when we can perhaps balance the many narratives we have in order to appreciate that mind and body are not separate, have never been, and philosophically and pragmatically exist on a continuum. “This happy marriage of objective science and subjective patient experiences may be the aspect of modern medicine that allows for a deeper understanding of the mind-body connection, and ultimately creates a culture of medicine that reserves a space for the soul” (Mokrycke and Li 2015, p. 21). The inclusion of mindfulness in clinical social work is one attempt to do so.

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