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Mind the Gap: The History and Philosophy of Health Psychology and Mindfulness

Atenção aos Detalhes: A História e Filosofia da Psicologia da Saúde e Mindfulness

Ojo a los Detalles: Historia y Filosofía de la Psicología de la Salud y *Mindfulness*

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Abstract
The recent surge in popularity of the concept 'mindfulness' in academic, professional, and popular psychology has been remarkable. The ease with which mindfulness has gained traction in the health sciences and cultural imagination makes it apparent mindfulness is well-suited to our current social climate, appealing to both experts and laypeople. As a subdiscipline established relatively late in the twentieth century, health psychology has a unique relationship to mindfulness. This article elucidates the shared roots between health psychology and mindfulness as a psychological construct and field of research, providing a frame of reference for the ways in which health psychology and mindfulness share similar theoretical and methodological challenges that affect their integration into health, social systems, and services.
Keywords: mindfulness, history, philosophy

Resumo
O recente aumento na popularidade do conceito *mindfulness* (plena atenção) tem sido notado significativamente na área acadêmica e professional da psicologia. O termo tem se fortalecido nas ciências da saúde, além do imaginário cultural para expressar um contexto contemporâneo da sociedade, atraindo tanto especialistas quanto leigos. Sendo uma sub-área estabelecida relativamente tardia no final do século XX, a psicologia da saúde tem uma relação singular com o conceito. Este artigo elucida as raízes compartilhadas entre a psicologia da saúde e *mindfulness* como uma construção do campo de pesquisa e psicológica, fornecendo um quadro de referência para as maneiras em que a psicologia da saúde e *mindfulness* compartilham dos semelhantes desafios teóricos e metodológicos que afetam sua integração com a saúde, sistemas sociais e serviços.
Palavras-chave: *mindfulness*, história, filosofia

Resumen
El reciente aumento en la popularidad del concepto *mindfulness* (atención plena) ha sido notado significativamente en el área académica y profesional de la psicología. El término se ha fortalecido en las ciencias de la salud, extrapolando el imaginario cultural para expresar un contexto contemporáneo de la sociedad y, en consecuencia, ha atraído a especialistas y legos. Puesto que es una subárea establecida relativamente tarde, a finales del siglo XX, la psicología de la salud tiene una relación singular con el concepto. Este artículo elucida las raíces compartidas entre psicología de la salud y *mindfulness* como una construcción del campo de investigación psicológica, proporcionando un marco de referencia para las maneras como la psicología de la salud y *mindfulness* tienen desafíos teóricos y metodológicos similares que afectan su integración con la salud, los sistemas sociales y los servicios.
Palabras clave: *mindfulness*, historia,filosofía

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Mindfulness is omnipresent in the West today[2]. A highly malleable concept, mindfulness is currently understood as a process of focusing one's attention on experiences in the present moment, an ability individuals can enhance through various forms of training, including meditation. Such practices have been widely adopted by the health sciences, including health psychology. Mindfulness offers the promise of preventing or improving a variety of mental and physical health conditions. Because of its potential health benefits, mindfulness may seem to fit incontrovertibly in the terrain of health psychology, a field whose definition is wide enough to encompass any aspect of psychology that addresses health issues of any kind. However, health psychology and mindfulness research have developed largely in parallel over the same period of time, and proponents of both have had to work hard to establish legitimacy within psychology and medicine more broadly. As such, while the umbrella of health psychology can be understood to cover mindfulness as a behavioural treatment, the majority of research on and the application of mindfulness has been peripheral to health psychology proper, conducted instead within other psy-disciplines. Nevertheless, since they have developed over the same time frame and have been informed by many of the same contextual influences throughout, their histories are often intersecting and there is insight to be gained from investigating the similarities and differences in their progressions.

The ease with which mindfulness has gained traction in the health sciences and cultural imagination is the current pinnacle of a sustained societal emphasis on wellness. This surge in popularity makes it apparent that as a psychological concept, mindfulness is particularly well-suited to our current social climate, and it is appealing and accessible to both experts and laypeople. Thus, as one of the 'lifestyle' behavioural treatments that developed over the same time frame as disciplinary health psychology and one of the most pervasively adopted since the beginning of the new century, mindfulness serves as an exemplar of the success of behavioural and cognitive interventions in healthcare.

The health science applications provided by the health psychology and mindfulness discourse communities have similar intentions. As such, comparing and contrasting their respective relationships to the philosophical foundations of psychological and medical science can also prove fruitful. Historical metaphors and concepts about the human body and health can affect how health is understood in psychology and by proponents of mindfulness more widely. The Western philosophical legacy that frames humans as natural assemblages of components – traditionally traced through Cartesian dualism with the idea of body-as-machine (Rabinbach, 1992) – became influential in the twentieth century through the seemingly exponential advancement of technology and technologically-oriented modes of study (Harrington, 2008; Friedman & Adler, 2011). Additionally, because mindfulness as a psychological construct and method derives primarily from a variety of Buddhist traditions, it necessitates further consideration of the philosophical, epistemological, and sociopolitical dynamics at play when science studies or co-opts other approaches to knowledge production. For example, both psychological and Buddhist principles are often presumed to imply philosophical universalism – which is to say, that their beliefs, theories, and practices are generalizable to all humans at all times and places (Smith, Spillane, & Annus, 2006; Lopez, 2012; Dodson-Lavelle, 2015).

[2] Due to space limitations, the focus of this paper is mindfulness in the so-called West. The role of mindfulness in other contexts remains to be explored.

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One consequence of this presumption is a focus by health psychology and mindfulness research and application on individual control of experience and behaviour in an ahistorical manner, rather than on how individuals relate to their environmental, social, and cultural contexts. However, individual choice and actions are far from the only determinants of health and well-being. Any discipline or social system that aspires to provide health-oriented services to populations would be remiss not to address contextual factors, such as inequity in the allocation of social resources and services, which stand in the way of health for so many (DelVecchio Good, James, Good,& Becker, 2005; Kahn, Ilcisin, & Saxton, 2017). Thus, this emphasis on 'universalized individualism' has been a point of contention central to the establishment of critical health psychology (Gergen, 1973). It has also led to recent efforts within mindfulness work to clarify the definition and theoretical premises of Western mindfulness theories, in order to increase the rigour and accuracy of research, and to interrogate the sociopolitical ramifications of their application (Tang & Posner, 2013; Lutz, Jha, Dunne, & Saron, 2015). The spread of mindfulness practices undoubtedly has real and profound consequences for health services as structured around these notions of care and on the wellbeing of individuals enlisted in such practices. The parallel histories of mindfulness and health psychology, and the kind of naïve universalism prominent in these discourses, make evident the necessity of attending to the historically specific contexts in which health concerns are realized and the forms of address these contexts engender. Neither health psychology nor mindfulness as currently realized offer sufficient routes to health.

This article surveys the historical and philosophical contexts in the development of health psychology and mindfulness in North America over the past forty years, the geographical locale in which mindfulness has most thoroughly established itself and flourished. In doing so, we explore how health psychology and mindfulness have interrelated, and how each (and the relationship between them) have affected cultural understanding of health and the direction of health service provision in social systems, and markets.

Historical and Philosophical Contexts of Disciplinary Health Psychology

Health psychology coalesced as a field distinct from the other psy-disciplines during the latter half of the twentieth century due to growing interest in how environment, behaviour, and biology contribute to and impact both mental and physical health and illness (Engel, 1977; Wallston, 1997). Conceptualized as a cross-cutting area of research and application that would be of interest to a wide range of psychologists and other health professionals, opportunity in the field gathered momentum with the establishment of a division of the American Psychological Association in 1978 (Division 38) (Wallston, 1997). The definition penned by inaugural division president Joseph Matarazzo (1980) reflected an aggregated intention that through the particular educational, scientific, and professional contributions of psychology, health can be promoted and maintained, illness prevented and treated, etiologic and diagnostic correlates identified, and health policy and systems analysed and improved.

A recurrent theme throughout the history of health psychology is that of how medical philosophy has interacted with the rapid changes experienced by populations in the so-called 'Western' societies, including the growth of American individualism and the wide-ranging impacts of technological advancement. Reference texts on the formalization of health

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psychology relate it to theoretical and methodological trends in medicine, clinical psychology, epidemiology and public health, and the elucidation of biopsychosocial models for health and disease (Baum, Perry Jr., & Tarbell, 2004; Friedman & Adler, 2011; Pickren & Degni, 2011). More specifically, a century of rapidly changing causes of, and social responses to, illness, disability, and death contributed to the integration of psychology with the burgeoning multidisciplinary fields of behavioural medicine and behavioural health (which focus on the practice of collaborative health care and individual health needs and responsibilities, respectively) (Matarazzo, 1980). The eradication of previously pervasive contagious diseases, the extension of life expectancy, shifting international relations and the threat of nuclear attack, equalizing gender familial roles, and dissemination of scientific knowledge and authority contributed to the creation of new concepts about health that affect how people understand themselves and their actions, including: lifestyle, stress, diet, fitness, addiction, and mental health (Baum et al., 2004). As previously predominant realms of disease were addressed by contemporary medical industries, both federal and private research groups in the United States mandated multiple public heath reports to explore the ways in which individual behaviour was a major contributing factor to persisting illness, including the leading causes of death within developed populations (Pickren & Degni, 2011). This research led to late twentieth century public health initiatives targeting behaviours that influence chronic diseases, diabetes, and cancer. These kinds of endeavors focused on the interplay of public policy, communications, psychological-behavioural principles, and affirmed the value of medical theory that defines health at the intersection of biological, psychological, and social dynamics. Correspondingly, the reduction of expenditure within social and health service structures increased the need for cost-effective preventative behavioural interventions that can be clinically informed, but self-regulated by patients (Murray 2015; Davies, 2014). In the process, health psychology and behavioural medicine have been forwarded as correctives to the limitations of prominent biomedical theory that over-valorizes the roles of genetics and molecular biology on health outcomes (Kaplan, 2011).

A central question in much of the history of disciplinary psychology – and that is particularly relevant to the interrelation of health psychology and mindfulness – is whether the goal of the field is to establish universal laws that can apply equally to all humans at all times. The assumption of such universalism and ahistoricism in psychology has been predicated on positivistic philosophies in science which have been debated by anti-positivists for three centuries (seethe philosophical positions of Comte, Durkheim, Schlick, Vico, and Dilthey) (Chernilo, 2007). The mid twentieth century saw what has been dubbed the post-positivist turn in the philosophy of science (e.g., Karl Popper, Thomas Kuhn), and in psychology critics informed by this thinking questioned the long-standing dominance of operationalism and brought forth accusations of scientism and methodolatry (Bakan, 1967; Putnam, 1992). Central to such arguments is the assertion that positivist universalism invites ahistorical questions and explanations in psychology, which in turn limit the capacity to address social relations and structures and overemphasizes the role of the individual (Davies, 2014; Murray, 2012).

On the one hand, health psychology was envisioned as the psychological component of a holistic healthcare system that could also take account of social factors (Armstrong, 1987). On the other hand, the work of consolidating the boundaries of a new field of research, which aspired to integration with the medical field, required a degree of adherence to medicine's

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well-established biomedical orientation. The achievement of such integration with medicine depended on the field's simultaneous legitimization within psychology, which demanded a certain adherence to methods grounded in the values of natural scientific disciplines (Murray, 2014). Thus, the intention to create a theoretically eclectic field that would be able to provide the pluralistic explanatory frameworks then absent in contemporary medical practice was tempered by the need to engage in quantitative measurements, statistical analyses of variables, and to interpret those in a manner consistent with the dominant practices of both medical science and psychology (for a critique see Tafreshi, Slaney, &Neufeld, 2016); in other words, to construct knowledge based on averaged inferences that would apply to whole populations in a universalized manner. Professionalized in this way, qualitative methods and contextually-focused theories have been marginalized in health psychology, much as they have always been in psychology. Critics contend that this preoccupation with professionalization amounts to little more than a reinforcement of the status quo (Stam, 2015). Framing the prevention of illness and maintenance of health in terms of ahistorical universal principles that can be measured and analysed across populations prevents articulation of how experiences of sickness and health are historically and contextually bound.

As mentioned, an effect of this universalist approaches to research and application has been emphasis on individual behavioural causes and solutions to health issues. In social systems that are complicated by inequity and disparity at the intersections of wealth, race, gender, religion, sexuality, as well as physical and psychological ability, health care that focuses on how individuals manage their responses to circumstance, rather than addressing these circumstantial issues directly, can be considered victim-blaming (Stam, 2015). Functioning in this way, the field can account for the biological and psychological aspects of the biopsychosocial model, but the social remains beyond its purview. Consequently, in both health psychology and mindfulness individual choice, disassociated from surrounding social and cultural factors, is positioned as *the* determinant of health.

Historical and Philosophical Contexts of Mindfulness

This narrative of the emergence and development of health psychology also provides a context for the popularization of mindfulness as an individually-oriented behavioural construct and therapeutic intervention over the past four decades or so. Mindfulness is now generally understood by psychologists and medical doctors as a relaxation technique useful for the alleviation of anxiety and for emotional and affective regulation (Bishop et al., 2004). Its recent impact on academic, professional, and popular psychology has been remarkable. Publications about its neurocognitive and therapeutic effects have proliferated (see Goyal et al., 2014; Cavanaugh, Strauss, Forder, & Jones, 2014); training programs have been initiated in medical, clinical, educational, judicial, and business settings (Talbot-Zorn, & Edgette, 2016); mindfulness 'self-help' has inundated the popular press and blogs (Davis & Hayes, 2012; Cavanagh et al., 2014); and it has been commodified and capitalized on by a broad market of services and products, everything from cell phone applications to yoga gear (Davies, 2014).

Early legitimization of mindfulness as a secular concept was achieved by academics that came of age during the mid-century upheaval of colonial dominion and the reconfiguration of

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international relations according to neocolonial policies (McMahon, 2008; Murray, 2015). As part of this broader renegotiation of established authority, public and intellectual discourse communities began introducing alternatives to the biological framework of medical theory, including American proponents of meditation from Buddhist lineages who integrated their practices into medical and psychological research programs under the banner of mindfulness (see Goleman, 1971; Benson & Klipper, 1975; Engel, 1977; Shapiro, 1980; Langer, 1989; Kabat-Zinn, 1990). These foundations contributed to the production of a core of work on the subject during the 1980s and 1990s, setting the groundwork for the relative proliferation and popularization of mindfulness during the 2000s.

Given their similarly short and varied history, and the medical (and socio-political) relevance of mindfulness as a method for self-regulation, it is not surprising that there have been interactions between health psychology and mindfulness research since their beginnings. In fact, its broad scope of interest, and lack of narrow definition, has allowed health psychology to engage with the many different ways that mindfulness has been represented and interpreted in the Western psy-disciplines (as compared to other subfields of psychology which theoretically may only find one or two approaches to mindfulness relevant to their agendas).

One of the earliest, and perhaps the most well-known, mindfulness research institutes in the United States is a behavioural medicine program: The Mindfulness-Based Stress Reduction (MBSR) clinic at the University of Massachusetts Medical Center. Founded by Jon Kabat-Zinn in 1979, MBSR is not only one of the most successful mindfulness programs in terms of its contributions to the legitimization of the practice in secular contexts, but also one of the most explicitly health-oriented. The MBSR program is intended to address the experience (and cause) of stress and suffering through the development of innate capacities for self-healing via mindfulness (Kabat-Zinn, 1990; 2011; Dodson-Lavelle, 2015). The MBSR methods have been applied variously to suit specific needs that have arisen in relation to particular medical conditions as addressed within healthcare systems. The clinic's approach has been integrated as complementary medicine within oncology (see Will et al., 2015), modified specifically for addictions relapse prevention and disordered eating awareness (see Kabat-Zinn, 2011), and its effectiveness in addressing a multitude of other health-related issues, like insomnia and chronic pain, has been tested (see Hayes, Villatte, Levin, & Hildebrandt, 2011).

Clinical mindfulness modalities for mental health constitute the most substantive aspect of mindfulness research. While these are not central to health psychology per se, they are nevertheless relevant given their impact on clinical theory, methods, and culture. The value of creating therapeutic interventions and clinical measures garnered attention during the first two decades of mindfulness theorizing. Such efforts proliferated in the 2000s and include Mindfulness Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), Cognitive Based Compassion Training (Ozawa de Silva, & Lobsang, 2013), the Toronto Mindfulness Scale (Lau et al., 2006), the Mindful Attention Awareness Scale (Brown & Ryan, 2003), and the Cognitive and Affective Mindfulness Scale (Feldman,Hayes, Kumar, Greeson, & Laurenceau, 2007), among many others. As the establishment of Kabat-Zinn's MBSR within a medical research center attests, mindfulness functions well as a cognitive-behavioural component of medically organized healing. It has also opened the door for greater mobilization of knowledge between psychological and medical clinical contexts. Beyond this, because

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mindfulness-oriented interventions are aimed at understanding and increasing health and well-being in general, rather than only healing and preventing of illness, research has also investigated its usefulness to healthcare professionals (as well as those from a wide range of other industries) as a tool for stress alleviation and performance optimality (Davies, 2014; McCann, Marion, Davis, Crandall, & Hildebrandt, 2015).

Outside of clinical interventions, research into mindfulness has been dominated by investigations into the physiological veracity of claims about mindfulness's alleviation of forms of suffering like stress, anxiety, and depression, and its promise of nurturing forms of well-being like relaxation and increased capacity for attention (e.g. DeBerry, Davis, & Reinhard, 1989; Tlockzinski & Tantriella, 1998; Aftanas & Golocheikine, 2001; Tang et al., 2007; Lutz, Slagter, Dunne, & Davidson, 2008; McCann et al., 2015; Droit-Volet, Fanget, & Dambrun, 2015). As with their applied counterparts, these investigations also carry mindfulness into the domain of health psychology. Psychophysiologists and neuroscientists like Richard Davidson have done much to center discourse about individual health on the relationship between psychological states and processes with changes in the brain, nervous, and immune systems (Davidson et al., 2003). Contemporaneous with Kabat-Zinn, Davidson began his research on awareness and states of consciousness in the 1970s, founding the Center for Healthy Minds at the University of Wisconsin-Madison in 1984, and at the turn of the twenty-first century, his clinic was the first to conduct neuroimaging studies of meditators. Since Davidson's initial forays into the field a robust literature on the psych- and neuro-physiology of mindfulness has been produced, which has in turn been assessed in a variety of reviews and meta-analyses. These assessments of the accomplishments and limitations of the field thus far serve to increase the validity of mindfulness's clinical outcomes and further its status as a cutting-edge realm of scientific inquiry (Tang & Posner, 2013; Lutz et al., 2015).

In addition to these applications and research programs like Kabat-Zinn's and Davidson's, which partially derive from and engage with Buddhist teachings and practices, secular constructs of mindfulness and mindlessness were also developed during the 1970s. Social psychologist Ellen Langer, who differentiates her concepts from those derived from Eastern traditions, understands mindlessness and mindfulness as basic states of mind or being, including but not limited to: minimal and novel information processing, inflexible and flexible cognition, reduced attention and alert and lively awareness, reliance on previously drawn distinctions and categories, and the processes of drawing novel distinctions and the creation of new categories (Langer, 1989; 1997; Langer & Moldoveanu, 2000). She has identified health as one of the three areas of research, along with education and business, most engaged with her work (Langer & Moldoveanu, 2000). In the first of several of books on mindfulness (Langer, 1989), Langer elucidated the research on aging from which she derived her mindfulness theory during the 1970s, and how it related to health theory. This explanation emphasizes that cognitive focus on novelty, openness to new information, and the creation of new categories all serve to exchange unhealthy mindsets for healthy ones, and increase general mindfulness, which in turn creates more personal "control" (Langer, 1989, p. 195). Langer's findings have been part of the broader development of research on neural plasticity and the positive psychology movement.

This historical survey illustrates the unique manner in which mindfulness research relates to health psychology in contrast to its relationship with the other psy-disciplines.

Mindfulness has served as a particularly pervasive area of health interest that exemplifies how psychophysiological research and clinical methods can be applied within and informs the administration of medical and other healthcare settings. In fact, given their interrelation, it is perhaps surprising that health psychology has not done more to locate mindfulness within the boundaries of its disciplinary authority, especially when it could serve well as an ambassador for health psychology in the public sphere.

Philosophical Underpinnings of Mindfulness

Like psychology by psychologists, secularized mindfulness techniques are forwarded by most of their proponents as universal and ahistorical methods, of value to all humans. As a concept, mindfulness has remained undertheorized and oversimplified; however, it can also be argued that this general under-determination has contributed to its success, including ongoing liberal application in disparate settings, with at-times incommensurable intentions (Lutz et al., 2015; Dodson-Lavelle, 2015; Harrington & Dunne, 2015). The most widely disseminated and accepted definition within the literature is an operationalization that is simultaneously accessible and monolithic, by Kabat-Zinn. He explains mindfulness as follows: "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994, p. 4). This definition brings with it some assumptions (e.g., that mindfulness can describe both a soteriological way of life and a set of cognitive processes, see Lutz et al., 2015), but it is vague enough to be widely inclusive, encompassing methods that in practice have divergent aspects. Mindfulness is thus an 'umbrella' term that can be accommodated to fit many needs (Kabat-Zinn, 1994). Such ambivalence is appropriate within clinical contexts but is less functional within empirical research aimed at understanding the "underlying mechanisms" of such practices (Kabat-Zinn, 1994).

Attempts to define mindfulness are also often characterized as challenging or undesirable due to the complexities involved in secularizing a religious practice in a way that emphasizes its universality and commensurability with the scientific value of objectivity (Dodson-Lavelle, 2015). How such a task is approached has varied between advocates. Psychologists and neuroscientists such as Davidson, Francisco Varela, and Clifford Saron have championed partnerships with Buddhist contingencies who promote the compatibility between meditative methods and science (Davidson & Harrington, 2002). In contrast, Kabat-Zinn discusses the extent to which he strove, in the first couple of decades of his work on mindfulness, to prevent it from appearing beyond the scientific pale–he describes bending over backwards to ensure his research on meditation did not seem "New Agey," mystical or worse, flakey, while striving to present it as evidentiary, ordinary, and mainstream (Kabat-Zinn, 2011). Whether obscuring mindfulness's religious origins or emphasizing them for legitimacy, advocates like Kabat-Zinn and Davidson claim to access the heart of a Buddhist practice that reflects a universal human reality; a "lawfulness" that is not a characteristic of the religion specifically, but that is rather universally inherent and commonsensical (Kabat-Zinn, 2011). This interpretation asserts that the extraction of this crucial methodological component of Buddhist teachings is sufficient, and in fact necessary, to be the greatest benefit to the most people globally.

Disassociated from the Buddhist cosmological epistemology of human suffering and its relief, mindfulness has instead been fitted into Western ontological metaphors about the

body-as-machine and its corresponding explanation of health-as-machine-maintenance (Rabinbach, 1992). Within psychology this concept has been at play in theoretical and methodological trajectories from the beginning of the discipline's institution, and it can be traced through functionalism, behaviourism, and cognitivism. This philosophical legacy found a particularly strong foothold in mid-twentieth century psychological theories about the brain-as-computer, by way of ecology, systems theory, cybernetics and computer engineering (Bateson, 1979; Harrington, 2008; Friedman & Adler, 2011). The indeterminacy of what mindfulness means within psychology allows its purpose to be interpreted in diverse ways according to any number of theoretical priorities. For example, in positive psychology, mindfulness is said to produce a subject whose relaxation contributes to their strength in the face of adversity (e.g. Shapiro, Schwartz, & Santerre 2002); in cognitive behavioural therapy, a subject whose relaxations helps them affect how they think, feel, and behave (e.g. Koszycki, Benger, Shlik, & Bradwejn, 2007); and in neuroscience, a subject whose relaxation can be detected physically, measured, and established as a 'real' occurrence in their body (e.g. Vestergaard-Poulsen et al., 2009; Raffone, & Srinivasan, 2010).

In terms similar to health psychology's adherence to predominant approaches in medical scholarship and industry in an effort to establish its value, mindfulness has also gained legitimacy through commensurability. The fact that the meaning of mindfulness is ambiguous has allowed it to remain complementary to many psy-disciplines; its philosophical consistency with the theoretical trends in science and Western thought more broadly has provided the opportunity for 'verification' through scholarly methods and professional application and has thus garnered epistemological authority. In this context, whatever parts of the meditation modalities from which mindfulness has been partially extracted that are incongruent with the predominant philosophical presumptions already at play in the culture will continue to be precluded, obscured, or prevailed upon. At the same time, those aspects that happen to correspond to current cultural ideals will continue to be emphasized.

As it stands, mindfulness is comprehended only to the extent that it fits into psychological and medical premises and is used in ways that reaffirm the well-established humanistic[3] concepts of a universalized ontological individualism (Grogan, 2012; Davies, 2014). Those forms of mindfulness that do not successfully fit into this framework evade apprehension when divorced from their epistemological bearings.

Conclusion

The parallel successes of health psychology and mindfulness are also what incite critique. Many of these critiques fall along similar lines. Health psychology's coherence as a field has been achieved primarily through its usefulness in applied clinical cognitive and behavioural interventions and research, rather than theoretical rigour or advancement (Stam, 2015). Critical psychologists contend that while this approach has helped it integrate into medical systems, it has also stymied the transformative aspirations from which it originally arose (Murray, 2012). From this perspective, the influence of ahistorical universalism has prevented reflexive consideration of how health is defined and experienced historically,

[3] And Abrahamic concepts, but a comparison of Monotheistic and Buddhist conceptions of subjectivity requires an analysis of its own.

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contextually, and interelationally–as such, the health services it can provide cannot address issues of inequity, and its healing potential is inherently limited. Nevertheless, what with the strength of its applications, health psychology has largely remained unconcerned about such criticism. Current recommendations within health psychology suggest further integration with the medical field, rather than divergence, and emphasize the strength and resources associated with locating itself as an integral component of such services (Kaplan, 2009). They also acknowledge an attendant vulnerability to the same philosophical, practical, and sociopolitical issues as the rest of medicine (Lawrence & Barker, 2016). The disciplinary perks of inclusion in the medical sphere have, however, trumped such considerations.

In contrast, as an 'importation' of an order beyond Western disciplines, and as a burgeoning construct requiring validation through novel research instrumentation, the spread of queries into the soundness of mindfulness has elicited a different response from its researchers. Concerns have been expressed from a variety of angles: from a religious perspective, the secular 'dilution' of Buddhist forms of meditation as mindfulness has been framed by some to be misappropriation (Wilks, 2014; Gooch, 2014); moralistic stances have that theoretical instability or philosophical 'fence sitting' has led to inappropriate commodification within social systems and markets, as well as ethically dubious application in contexts like military training (Barker, 2014; Davies, 2014; Davis, 2015); and scholarly or scientific concern has often focused on issues of theoretical and methodological superficiality (Tang, Hölzel, & Posner, 2015; Davidson & Kaszniak, 2015). Some mindfulness discourse communities have actively sought to address these criticisms through engaged conversations about the intended future of their subfield, as well as explicit efforts towards philosophical clarification and analytic development (Dimidjian & Segal, 2015; Harrington & Dunne, 2015; Tang & Posner, 2013; Lutz et al., 2015).

An underlying tension in critiques of both health psychology and mindfulness research is the difficulty of criticizing work that aspires to – and by many metrics does – benefit psychological and physical health. Under the ideological banner of positivist universalism mindfulness practices have been promoted by health disciplines as panaceas for all manner of challenges in the modern world. Adopted within a variety of diverse contexts, mindfulness promises not only to resolve what ails you, be it physical or psychological, but also to improve your well-being more generally. Promoted as a democratic, self-directed practice that can benefit everyone, mindfulness has captured the imagination of health professionals, scientists, and the public at large. As a consequence of this wide-ranging support, any critique of mindfulness all-too-easily appears to be a critique of this very aspiration for health and wellness. In this article, however, we have documented how attention to the historical and epistemological underpinnings of health psychology and mindfulness reveals a fundamental failure of these fields to address the sociohistorical conditions of health issues. As currently conceptualized, health psychology and mindfulness are unable to account for the many determinants of health beyond individual choice and action (Chang & Fraser, 2017; DelVecchio et al., 2005; Kahn et al., 2017). Bridging the gap between health psychology and mindfulness necessitates not only integration of the latter into the former, but broader acknowledgement of and efforts to redress, the current inability of such initiatives to account for, and address social and health inequities at systemic levels.

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