Chapter 8
Mindfulness-Based Symptom Management: Mindfulness as Applied Ethics

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Introduction

The principles of mindfulness-based stress reduction (MBSR; Kabat-Zinn, 2013) and mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2012) present a challenge to teleological, conceptual, and relational aspects of Western concepts of health care. The directional aim of health care was, and likely still is, predominantly about reversing or excising the causes of illness with wellness left to evolve as it may. Conceptually, the targets of interventions are categorized as physical (focused on the body) *or* psychological (focused on the mind) with the intent of reducing symptoms and the discomfort they produce. Not only are body and mind seen through a lens of dualism, the concepts of illness and wellness are dichotomized, with wellness defined as the absence of illness and illness as a circumscribed event ranging from acute to chronic. Relationally, traditional models of care are portrayed with the health care provider holding unique expertise and the patient as the recipient of that expertise. The relationship is hierarchical with primacy given to knowledge and its flow from the professional to the patient.

With the advent of MBSR and MBCT, three important shifts in the teleological, conceptual, and relational aspects of health care entered the mainstream. First, the idea of "fixing" the problem of illness is being accepted as unrealistic because of a more interconnected view of illness and well-being. This gave way to an understanding of the biopsychosocial system as subject to all manner of change that is only partially in our control. Second, reinhabiting the connection between mind and body has been introduced as the path to experiential awareness. Finally, the source

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of wisdom and healing has shifted to a relationship that is co-created between the individual who is suffering and the health care professional where wisdom arises from knowledge and insight. In addition, the means of addressing the individual's suffering is seen as lying in the relationship between their state of mind and the event they are experiencing.

Now, almost 40 years later, the efficacy of mindfulness-based interventions (MBIs) has become better researched (Baer, 2003; Brown & Ryan, 2003; Fjorback, Arendt, Ornbol, Fink, & Walach, 2011; Goyal, Singh, & Sibinga, 2014). The rapidity and sheer volume of research also has given rise to calls for caution against the overly positive tone of the studies and the uncritical swell of popularity (Eberth & Sedlmeier, 2012; Khoury et al., 2013); that in turn raises concerns of mindfulness becoming increasingly presented as a panacea (Hanley, Abell, Osborn, Roehrig, & Canto, 2016; Purser & Loy, 2013). However, MBIs have enjoyed a growing acceptance through work on defining the psychological nature of mindfulness (Brown, Creswell, & Ryan, 2015; Brown & Ryan, 2004; Coffey, Hartman, & Fredrickson, 2010), investigations into its mechanisms (Coffey et al., 2010; Grabovac, Lau, & Willett, 2011), and models of understanding efficacy studies (Dimidjian & Segal, 2015). Further, as the chapters in this book exemplify, MBIs have branched out from MBSR and MBCT in unique ways that offer a variety of approaches and serve many vulnerable populations, indicating the term "mindfulness-based programs" (MBPs) may better reflect their scope beyond the psychotherapeutic. The growth of these "second generation" mindfulness programs (Van Gordon, Shonin, & Griffiths, 2015) also offers an opportunity to address one of the key concerns raised about MBSR and MBCT: the multilayered ethics involved in translating mindfulness from Buddhism to a Western psychological and secular intervention (Monteiro, Musten, & Compson, 2015).

There are two important issues of ethics for health care professionals to consider in relation to the issue of ethics and mindfulness. The first is the ethics *of* mindfulness, which comprises the complexity and implications of migrating Eastern philosophical approaches into a secular Western framework. Specifically, it poses the following questions: What are the ethical implications of reconstructing a spiritual process as a secular intervention? How does this impact issues such as informed consent and sufficient training in the new interventions. An auxiliary concern relates to the question of who can or should be taught mindfulness; this raises questions about the potential for misguided or outright misuse of mindfulness practice, for subverting social justice by maintaining an unconscionable status quo for vulnerable populations, or by giving military and police members the capacity to suppress compassion and care in order to commit acts of violence and killing (Stanley, 2013).

The second issue is ethics *in* mindfulness and comprises how the content of MBIs embodies or conveys the practice and cultivation of morality and virtues. It prompts the following questions: Can a secular program hold to the same teleological path of mindfulness as described and practiced in Buddhism (Davis, 2015; Greenberg & Mitra, 2015; Lindahl, 2015); in fact, does it need to? Given morality and the cultivation of virtues is central to Buddhist teachings of mindfulness, how can this migrate to secular programs with sensitivity to multicultural perspectives of

how values are lived? Critics of secular mindfulness point out that the definition of mindfulness in secular terms is stripped down to bare essentials and loses the Buddhist intention for a wider and deeper practice of growth (Purser, 2015; Purser & Loy, 2013; Titmuss, 2013). In Buddhism, mindfulness is part of a tightly interwoven series of practices whose ultimate purpose is the cultivation of virtues with the intention of full liberation from the suffering generated by our misperceptions (Olendzki, 2008, 2011). Reduced to an eight-session protocol, can secularized mindfulness be effective as a highly truncated version of a key Buddhist practice or does it become symptom-focused? That in turn questions whether it is also individualistic and therefore inconsistent with the Buddhist intention of mindfulness as a wholistic process (Amaro, 2015), which McCown (2016) appropriately describes as a relational process. Moreover, McCown (2014) argues that the current focus on studying the individual responses to MBIs in service of establishing treatment efficacies has misdirected the practice away from its relational component.

These concerns foretell a common process and outcome: The secularized practice risks cultivating a form of awareness that is antithetical to Buddhist philosophy and therefore destined to do harm. In Buddhism, all practices have a moral arc of cultivating virtues that result in wisdom and therefore moral action, not only for self, but also for others and the world (Bodhi, 2011, 2013). The development of MBSM sought to find a path through this complex world of spiritual and secular principles and practices. In the sections that follow, we describe the issues that influenced both ethics *in* and in later sections we describe our approach to ethics *of* mindfulness in MBSM.

Roots of Mindfulness-Based Symptom Management

History

In developing Mindfulness-Based Symptom Management (MBSM), we were especially concerned about the issues of how to communicate Buddhist concepts clearly, ensuring the issues of ethics *in* and ethics *of* mindfulness were embodied in the co-created relationships and embedded in the program delivery, respectively. Although we held both aspects of ethics and mindfulness as equally important, how to convey the concept and practice of ethics in the curriculum and embody it in our role as teachers was our initial focus. We sought to translate the Buddhist model of alleviating suffering, seen as an arc of moral development, into a language that was accessible to participants while standing on a base of psychological models that supported mindfulness as a treatment protocol. Further, we viewed the intention of the intervention and the practice of mindfulness itself as an arc of (relational) moral development. Thus, we worked to keep the role of ethics as action-guides (Gombrich, 2009/2013; Harvey, 2013) and values-clarification front and center in our vision of a mindfulness program that offered more than alleviation of the distressing symptoms of depression, anxiety, and reactions to physical pain. In fact, we struggled

over naming the program, finally settling on "symptom management," which reflected the reality of our clinical population. In other words, we are always symptomatic of some aspect of suffering and its impact on our actions, thoughts, and values could only be managed through diligent and ardent practice of wise choices. Finally, if the intent in our programs was to facilitate symptom management rather than simply symptom reduction or symptom elimination, then it followed that the program had to cultivate an ongoing presence to the complete experience of well-being *and* suffering, the values we live well by *and* those we are distanced from.

Antonio Machado's poem "Campos de castilla" (Machado, 2002) is frequently quoted by mindfulness scholars and teachers; it stands as a guiding wisdom of what it means to practice mindfulness: *Wanderer, your footsteps are the road, and nothing more; wanderer, there is no road, the road is made by walking*. Developing mindfulness programs is a process of constantly revisiting and refining its intention. Dimidjian and Segal (2015) described a stage model developed by the National Institutes of Health (NIH) "from an interest in shaping the training of future generations of clinical scientists by providing a well-articulated view of the goals and process of clinical psychological science" (p. 593). Using the stages as defined by the NIH, Dimidjian and Segal (quoting Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014) describe Stage I as the process of creating a new intervention or the adaptation of an existing one (Stage IA); this definition would include most mindfulness-based programs that emerged immediately after MBSR/MBCT gained traction in the health care community. Feasibility and pilot studies were defined as Stage IB, which included the development of training and supervision. Stage II involves testing treatment protocols in research settings using research, and in Stage III, testing is conducted in community settings using community facilitators.

While the model clearly organizes a way forward and is important to the work of clinical psychological science, it is vague in its reference to "all activities related to the creation of a new intervention, or the modification, adaptation, or refinement of an existing intervention." With Stage I set as part of an empirical process or evidence-based model, the implication is that the development of a new intervention is de facto evidence-based. In fact, part of the development of a new or adapted intervention can include and benefits from practice-based evidence, an iterative approach that is relational with respect to the community and which inquires into the relevance of the protocols to the population treated (Barkham & Mellor-Clark, 2003; Holmqvist, Philips, & Barkham, 2015).

As clinical psychologists, informed by both our clinical training and the constant need to modify, adapt, or refine treatment protocols for our individual clients, we approached the development of MBSM with a close eye to our own development, how the inclusion of an explicit values-based approach served the real-life situations of the participants, and the adaptations that were made for different populations. As teachers of mindfulness protocols, this required an iterative process of being in conversation with participants in the program and refining what and how we delivered the teachings; it grew in parallel to the thematic structure of the program itself. It began with the struggle of integrating seemingly disparate ways of knowing in the Buddhist and Western approaches to awareness (essentially the early

stage participants encounter in an 8-week program). For example, our cognitive and behaviorist inclinations would seek to change thoughts and actions while observing for concomitant changes in emotions; the frame of mindfulness required a shift to an open and invitational stance to our experience and that of our participants. This different way of being in relationship with participants and working with the discomfort of uncertainty that is the mark of all relationships required attention to our own ways of being with our difficult and unwanted experiences. In turn, this highlighted the subtle values we were bringing into the room, the main one being a primacy of the thinking function.

With the inclusion of a values-based practice that explicitly addressed the ethics, MBSM stands in counterbalance to the tenet of MBSR that ethics remain implicit (Kabat-Zinn, 2011); thus we did not view MBSM as a modification or adaptation of MBSR/MBCT. Instead it was envisioned as what is now called a "second generation" mindfulness programs that directly addresses the issues of attention cultivation, spiritual roots, and ethics in the pedagogy (Van Gordon et al., 2015). Navigating the complex territory of ethics in general also presented challenges in differentiating ethics *of* mindfulness (transparency, informed consent) from ethics *in* mindfulness (inclusion of cultivating virtues in the curriculum). And finally, we were faced with making a deep discernment of how to take the program into the marketplace. Could we offer mindfulness to individuals and organizations whose vision and mission would be antithetical to cultivating compassion, the highest ethic of practice? Throughout this process, we were informed and inspired by Buddhist and psychological teachings in how to meet and be with our experience. These are explored in the next two sections followed by an examination of the complexity of ethics and mindfulness programs.

Buddhist Roots

Foundational Teachings Relevant to Secular Mindfulness The Buddha is said to have described what he taught as only a handful of leaves compared to all the leaves in the forest (Thanissaro, 1997b). However, the teachings are of sufficient depth to effect change. By focusing on the nature of suffering and its cessation, they are a self-administered treatment that eliminates the roots of suffering and cultivates an ethical, values-based life for the good of all beings (Thanissaro, 2012). Although one would argue that understanding and practicing with all the teachings is essential to liberation, much like any religious or philosophical system, some Buddhist teachings are more immediate in their helpfulness and more readily accessible to the everyday person (known as a householder in the Buddha's times). Space precludes examination of the many relevant teachings. However, Monteiro (2015) has explored the various teachings that inform secular mindfulness programs and Cayoun (2011) offered a detailed examination of Buddhist psychology as applied to secular mindfulness. For the purposes of this chapter, we will focus on three core Buddhist teachings that we incorporated into the MBSM curriculum: suffering, mindfulness, and ethics.

Suffering The first core teaching is the meaning of suffering or *dukkha*. The idea that we suffer is difficult to grasp because the conventional use of the term is typically in the context of profound tragedy, loss, or some life-rending event beyond the pale of our cultural experience (Batchelor, 2017; Epstein, 2013, 2014). In Buddhist terms, suffering or *dukkha* refers to the essential dissatisfaction we feel when we don't want what we have (objects, experiences), want what we don't have, or are generally confused about what we want or what our experience is (Bodhi, 2008; Gunaratana, 2001). These three stances to our experience are referred to as the three poisons: aversion (aversive type), clinging/grasping (greedy type), and delusion (misperceiving type). The presumptive idea in this teaching is that we cannot avoid things happening to us; we are, without exception, heir to illness, death, injury, and loss. Suffering then is defined as our stance to or how we meet these experiences. The Sallatha Sutta (Thanissaro, 1997a), one of the many teachings of the Buddha, uses the metaphor of being struck by two arrows showing suffering as both physical (the initial event) and mental (reactivity). For example, when we are injured, we feel the physical pain, which is then accompanied by a mental proliferation, or what it means to have been injured ("I'm never going to walk again!" "This is unfair." "How am I going to get to work?" or "I can't afford not to work."). In another Buddhist teaching, our resistance to treat our suffering is compared to a person struck by a poison arrow and who is refusing to remove it until they understand why and how it happened, by whose hand, and the meaningfulness of the act (Thanissaro, 1998).

Becoming aware of the vulnerability of our mind to aversion, greed, and delusion requires diligent practice. For most of us, "practice" carries a sense of working towards a specific outcome; it is something one does, driven by internal and external factors, with the intention of achieving a goal. Once the goal is achieved, the drive reduces or extinguishes and is typically replaced by another drive. This perspective is also consistent with the idea of attaining milestones developmentally. As adults in a hedonic culture, we check off most of the achievements: home, family, education, relationships, career, etc. The idea of practice without a driven quality to it and as something continuous is a personal paradigm shift. It also brings into high relief the suffering we create by our aversion, grasping, and delusion. The teachings of Zen master Thich Nhat Hanh (1999, 2007, 2009, 2011) are invaluable in understanding what it means to practice continuously; his talks, retreats, and books compassionately introduce the practice of non-attaining and mindfulness as a continuous engagement with every moment.

Mindfulness The second core teaching is the cultivation of mindfulness itself. Although efficiently defined by Kabat-Zinn (2003) as "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145), understanding the term "mindfulness" remains complex and discussion among mindfulness researchers and Buddhists of different traditions offers insight to that complexity (P. Grossman & Van Dam, 2011; Williams & Kabat-Zinn, 2013). Despite these differences in interpreting mindfulness, there is consensus that the teachings on

establishing mindfulness and the practice of breath awareness underlies and informs, implicitly or explicitly, secular mindfulness programs (e.g., MBSR training includes attending silent retreats that teach in the context of the four foundations of mindfulness). The formal process is described in the Satipaṭṭhāna (Four Foundations of Mindfulness) and Ānāpānasati (teaching on Awareness of Breathing) Suttas (Analayo, 2003, 2013; Goldstein, 2013); the practice cultivates sustained attention, awareness of experiential processes, and development of virtues necessary for liberation from suffering.

The Satipaṭṭhāna and Ānāpānasati Suttas work in unison with the former offering the framework for practice and the latter the meditative component that supports practice (Gunaratana, 2012; Hanh, 2006). The practitioner begins with stabilizing attention using the breath as an object of meditation. When attention is disciplined and steady, the focus shifts to awareness of the body, feeling tones (pleasant, unpleasant, and neutral), the mind, and the nature of all phenomena. Although the text implies a sequential process, it is far from sequential and progressive (Analayo, 2013). As with all practices that build capacity, meditation is an iterative process, returning repeatedly to the object of meditation (the breath) and approaching the experiences that arise with an observer's stance or without reactivity.

As attention and awareness develop, phenomena are experienced as impermanent; they are observed as rising, enduring, and dissipating over and over. With continuous practice, insight develops into seeing the nature of suffering as being clearly rooted in the three poisons, and how we have the tendency to misidentify with our experience. The cultivation of mindfulness continues with a systematic practice in the Eightfold Noble Path (right view, right thinking, right action, right livelihood, right speech, right mindfulness, right effort, and right concentration; Gethin, 1998; Harvey, 2013); with further practice the factors of awakening (mental states of mindfulness, investigation, energy, joy, tranquility, concentration, and equanimity) develop. Monteiro et al. (2015) discussed the depth to which these two specific components of the Satipaṭṭhāna extend into secular mindfulness programs, concluding that while the programs focus on attention and open awareness, they may fall short of fully cultivating the depth of wisdom possible through the wisdom aspects of practice. Arguably, it may be possible that the cultivation of attention, awareness, and initial insight into the nature of phenomena is sufficient for addressing acute experiences of the second arrow of suffering (our reactivity). However, this is also the equivalent of not completing the full course of treatment that can provide deeper resilience to the three poisons of anger, greed, and delusion.

Ethics The third core teaching is ethics or sīla, a critical aspect of practice often left unaddressed and therefore resulting in a major criticism of secular mindfulness programs (Senauke, 2013; Titmuss, 2013). Buddhist ethics or sīla are defined variously as an action-guide, a cultivation of virtues, or the taking up of vows; they form the fundamental rationale for practice (Aitken, 1991; Anderson, 2001; Harvey, 2000; Keown, 2001, 2005). The virtues of kindness, generosity, and wisdom comprise the antidotes to the three poisons of aversion, grasping, and delusion and are practiced through wise action, speech, and livelihood, the relational (interconnected) aspect

of the Eightfold Noble Path. Ethics is conveyed through a set of precepts, the number of which depends on the role of the individual whether they are householder or monastic. For the householder or non-monastic, there are typically five precepts of restraint: do not kill, do not take what is not given, do not engage in inappropriate sexual activities, do not engage in false speech, and do not use intoxicants. Zen teacher Robert Aitken (1984) describes the precepts as both restraint (the putting down of harmful thoughts, speech, and action) and enacted (the taking up of compassionate thoughts, speech, and action). Thich Nhat Hanh (1998, 2007) formulated the five precepts as action-guides called the Five Mindfulness Trainings: reverence for life, generosity, responsible sexual desire/conduct, mindful speech, and mindful consumption. Both Aitken and Thich Nhat Hanh extend the concept of each precept beyond the concrete definition of physically taking a life. For example, we can engage in "killing" speech, act in ways that "kill" a relationship, or hold thoughts that "kill" our compassion for others. Thich Nhat Hanh also extends mindful consumption beyond the physical act of ingesting food or substances. In his conceptualization, consumption includes messages we send out and take in from the media and in relationships. The Five Mindfulness Trainings ultimately relate to stewardship of communities and the environment. This particular formulation of vows or principles offers the opportunity to explore and engage, beyond the idea of restraint, through action-oriented ways of being. The Five Mindfulness Trainings also provide the opportunity to generate a set of actionable behaviors that reflect a values-based approach to practice grounded in the individual lived experience. Both Aitken and Thich Nhat Hanh's approach to the precepts are important because they present the concept of ethics as a balance between inhibition and activation, between an avoidance- and approach-based moral regulation (see Janoff-Bulman, Sheikh, & Hepp, 2009, for a discussion of proscriptive and prescriptive ethics and moral regulation).

Not Getting Lost in Translation The vastness of Buddhist philosophy and psychology is daunting even to scholars. Still, carving away sections for specific use in a culture and context that is very different from that in which the original teachings were delivered has been discouraged by Buddhist scholars and teachers (Amaro, 2015; Bodhi, 2011, 2013). And certainly, cannibalizing Buddhist practice is no more justifiable than excising Catholic spiritual practices such as praying the rosary or novenas and repackaging them as stand-alone psychological interventions. Like other religious communities, the practice of Buddhism is a slowly unfolding process that allows it to take hold and transformation to be more likely; further, growth and adherence to the process is individual. In that context, it is possible to see secular mindfulness as having a similar influence through a paced process with respect for individually determined trajectories (Compson & Monteiro, 2015). However, because our program is offered to people who typically are not Buddhists and who have a Western mind-set with regard to psychological interventions, we needed to ensure there was support in current psychological science mindfulness. The psychological concepts that influenced MBSM are explored in the next section.

Psychological Roots

Convergence of Concepts In developing MBSM, we were informed by three psychotherapeutic theories and approaches, some of which echoed Buddhist thought: Cognitive Behavioral Therapy (CBT) with its emphasis on examining and challenging negative mind states resonates philosophically with both Buddhism and the Greek Stoics (Tirch, Silberstein, & Kolts, 2016); somatic awareness therapies (Levine, 1997) invite cultivation of awareness of body-mind in tune with the Satipaṭṭhāna and Ānāpānasati suttas; and the Polyvagal Theory (Porges, 2007, 2011), as a physiological theory, contributes significantly to understanding the issues of emotional dysregulation and reactivity. A detailed exploration of each modality is beyond the scope of this chapter; thus, we take a conceptual approach below to the way psychological concepts have informed MBSM and indicate the overlap with Buddhist concepts.

Underlying the approaches from different psychological lineages is the interplay of three Western psychological concepts (Monteiro, 2015): identity, emotion regulation, and stress. In Western psychology, the concept of self contains a sense of agency and the presence of an agent, a doer of deeds, thinker of thoughts (Baumeister, 1999, 2011). In contrast, Buddhist thought differs and holds the view that there is no agent, no lasting, substantive "self," although Tuske (2013) notes this concept is not without its difficulties. Buddhist and Western psychology, however, share an overlapping idea of a constantly changing perception of who we are based on cultural, emotional, and situational influences, that is, an emergent and embodied self (Varela, Thompson, & Rosch, 2017). Cognitive theories and therapies (Beck, Rush, Shaw, & Emery, 1987; Riso, du Toit, Stein, & Young, 2007) view identity as schemas or aggregates of characteristics, relationships with others, and aspirations in the world. A schema can be challenged by lived experiences especially if the schema holds or is close to an aspect of self that is valued. Traditionally, psychological distress is viewed as our response to these challenges, typically framed as a response to a threat to self-constructs (R. S. Lazarus & Folkman, 1984).

Emotion regulation and the role of mindfulness training is perhaps the central focus of contemplative approaches in psychology and thus occupy a larger space for discussion here. Holzel et al. (2011) outlined a set of mechanisms that interact to produce self-regulation and Roeser et al. (2014) described the intricate research connecting emotion regulation and sensory perception in developing ethical action. Emotions, while not specified in the Buddhist view, are linked to sensations, ephemeral arisings from the process of contact with the world and one's interpretation of that experience. From the Western perspective, Ekman and Davidson (1994) conceptualized emotions as arising from a confluence of cognitive, behavioral, and physiological responses to an external or internal event. R. S. Lazarus and Folkman (1984) proposed that cognitive appraisal of an event activates the stress response system. A. Lazarus (1989, 2006) placed emotions (affect) as part of a multimodal determination of experience involving behavior, affect (emotion), sensations, imagery, and cognition (BASIC). Emotion regulation is central in Western psychological

theories of psychotherapy and is often one of the core intentions in psychotherapy. Thus, although emotions are not a specific concept in Buddhism, becoming dysregulated can be seen to arise from a fixed idea of who we are, which is itself a manifestation of the three poisons of aversion, clinging, and/or confusion.

Porges (2011) proposed in the polyvagal theory that the brain is a risk assessor, through an unconscious automatic process he refers to as neuroception. For most of us, our neuroceptors are activated periodically throughout the day. But once it has been determined that there is no threat, we settle back into what we had been doing. That process of resettling involves the vagus nerve, the primary nerve activating the parasympathetic system that, as part of the autonomic nervous system, lowers arousal and returns a complex set of physiological processes back to homeostasis. This change can be measured in terms of heart rate variability that is referred to as vagal tone and means that an individual can quickly return to resting heart rate, and equilibrium, after determining that an event was not a threat. However, because of historical or current experience with stress some individuals have poor vagal tone and are not able to reset to equilibrium.

Further, Porges (2011) relates the breath to vagal tone and specifically notes that the aspiration (out-breath) puts a cap on the heart rate. This relationship between breath and heart rate is taught as breathing exercises in, for example, the tactical breathing techniques taught to soldiers (G. Grossman, 2009). The meditation instructions in mindfulness programs invite participants to let the breath breathe itself. Through repeated practice the breath tends to fall into a natural rhythm of slower, deeper in-breaths and longer out-breaths effectively increasing vagal tone. Porges indicates that as vagal tone increases, there is less emotional dysregulation along with related greater cognitive capacity. Eisenberg and Eggum (2008) reported that good vagal tone is associated with improved prosocial behavior in children. Keltner (2009), as quoted in Narvaez (2014), has noted that good vagal tone was correlated with compassion and open heartedness towards others suggesting that good vagal tone also promotes moral behavior.

Finally, stress models have a favored position in the work of general psychology and mindfulness interventions. Endocrinologist Hans Selye (1974) was among the first to investigate and define stress (he later noted it was better referred to as "strain") as the physiological response regardless of the positive or negative nature of the stimulus and that pathological outcomes occur when the stress is unremitting. Later models include Bruce McEwen's model of allostatic load which more closely aligns with the idea that strain on an existing biological system results in its eventual breakdown (McEwen, 2002). As discussed above, Porges' polyvagal theory posits a complex model of neural regulation of the autonomic system (Porges, 2011). According to Porges (2007), external events and intentionality in social contexts are appraised via neuroception and discerned for their threat value, which activates the appropriate response, defense, or engagement. Evolved to be adaptive to both low and high threat environments, the neural system is staged to appraise the degree of safety in a hierarchical manner with the higher cognitive functions able to override lower "primitive" systems in responses to threat. Under prolonged stress, the lower appraisal system is reinforced to be highly active and the feedback provides what

can be seen as misperceived levels of threat. Under such conditions, moral decision-making may be biased towards individual survival. Thus, regulation of the nervous system, when under stress or threat while activating the downregulation to reestablish homeostasis, relies on a well-functioning feedback system and plays an important role in developing ethical actions.

Our intent is not to claim there is nothing new under the sun, rather an interweaving of several strands of psychological and spiritual lineages. Baer (2015) and Harrington and Dunne (2015) both describe how psychological science and the interweaving of psychology with Buddhist practices, respectively, have contributed to an understanding of contemplative practices. In our perspective, there is a constantly emerging wisdom that has always been in the service of meeting and transforming suffering so that one could flourish as a human being. By grounding MBSM in current psychological science, we sought a manner of communicating mindfulness that is authentic in the current culture and language, which becomes important when communicating the concepts of mindfulness to a clinical population. Humanist approaches and psychotherapies such as those developed by Carl Rogers (Rogers, 2003; Rogers & Kramer, 1995) and the concepts of human potential developed by Maslow (2014) laid down the path to what became Positive Psychology, an approach focused on developing conditions for flourishing. Defined by Seligman's Wellness Theory as comprised of positive emotions, engagement, positive relationships, meaning, and accomplishment (PERMA; Seligman, 2012), it includes the development of virtues, which Seligman defines as a core characteristic that is universally valued. The six virtues are wisdom, courage, humanity, justice, temperance, and transcendence. Its contribution to the integration of ethics, values, and secular mindfulness is Seligman's view that seeking personal happiness independent of relationships and meaning makes a poor moral guide for caring behavior. We now examine what constitutes a moral guide or moral decision-making.

Moral Development and the Ethic of Care Because we conceptualized mindfulness practice as a process of moral development consistent with Buddhist views of mindfulness as cultivation of virtues through ethical actions, it was important to explore how moral decisions are made and what is important in guiding those decisions. S.L. Shapiro, Jazaieri, and Goldin (2012) reported that there are few studies linking mindfulness with moral reasoning and that moral reasoning in their study was not impacted by MBSR post-intervention, although it did improve at a 2-month follow-up. Shapiro and her colleagues posited that moral reasoning like mindfulness might require time to coalesce and strengthen. It is however important to note that the measure used in this study was a traditional format of posing a moral dilemma requiring a selection of a single response from participants. Moral reasoning and its investigation are complex and may require a different approach, one that is more relational and exploratory of the individual's own process of making moral decisions.

The study of moral development began with Kohlberg (1976) and a turning point in the study of the complex nature of moral guides, or how we make moral decisions, occurred with the work of Carol Gilligan (1993). Her book, *In a Different*

Voice (Gilligan, 1993), broke ground for a deeper understanding of moral decision-making; choices in real life are not just made as means of securing justice but as an expression of care. Flanagan (1993) explored the important differences between Kohlberg's and Gilligan's concepts of moral development and others have discussed the contrasting models and issues in justice and care (Giammarco, 2016; Larabee, 1993). In subsequent work extending the understanding of her model (Gilligan & Attanucci, 1988) and recent exploration of a "human voice" that arises from moral injury (Gilligan, 2014), she refined the theoretical concepts of justice and care orientations. The relevance of Gilligan's work to mindfulness lies in her conceptualization of morality as care and responsibility in the context of relationships. Blum (1993) describes it as "genuinely distinct from impartiality" (p. 50) and consisting of "attention to, understanding of, and emotional responsiveness toward the individuals with whom one stands in these relationships" (p. 50). He is also careful to point out that care is not a replacement of impartiality or a theory of everything in moral development; instead it offers a broader landscape within which moral decisions are made, specifically one that includes the role of personal integrity.

The concept of an ethic of care, mentioned in a reflection on key ideas in her body of work (Gilligan, 2011), draws from Tronto (1993) who challenged the association of care with "women's morality." The expanse of the discourse of the ethics of care is beyond the scope of this chapter; however, the potential for secular mindfulness to benefit from Tronto's arguments is compelling (see B. Fisher & Tronto, 1990; van Nistelrooij, Schaafsma, & Tronto, 2014, for details of Tronto's perspectives of an ethic of care). Not only does she challenge the feminist localizing of care in the domain of being female, but also, quoting Walker (2007), she argues instead for "an ethics of responsibility," which "as a normative moral view would try to put people and responsibilities in the right places with respect to each other" (in van Nistelrooij et al., 2014). Care, therefore, is a moral activity that is both contextual and relational; it is embedded in a negotiated relationship among equals but does not presume a commonality of cultural or psychological experiences. It is embodied in practitioners and located in the world. These tenets fall close to the intentions of MBIs, which are to cultivate values that result in care, or responsibility, for self, and others. In other words, the resting place of mindfulness is compassion for self and others. Whereas it is hoped that including ethics explicitly in MBSM can cultivate an ethic of care in the individual for themselves and their relationships, there are challenges, which are explored in the next section.

The Ethos of Ethics in MBIs

In the Thick and Thin of Ethics The contentious nature of ethics in MBIs may not be easily resolved in the context of a debate about whether and what ethics should be implicit or explicit in a program because, in any relational process, both processes exist. In MBIs, ethics *in* mindfulness emerges through the teacher's professional conduct and is embodied in the relational aspects of delivering the teaching

points while interacting with the participants. While the former bridges into ethics *of* mindfulness, that is, the procedural aspects of an MBI, both address a deep exploration of the intangible aspects of an MBI such as teacher and participant characteristics, their intentions, and the meaning they give to the relational and pedagogical process. However, McCown (2013) discovered that an online search of "the terms 'mindfulness' and 'ethics' was actually the concept of 'ethical mindfulness': a vital awareness of the ethical implications of a situation" (p. 40). In other words, the online search tapped into what we are calling the "ethics *of* mindfulness," which is related to the procedural aspects and asks questions about the "right" and "wrong" of MBIs. What remains to be explored are "ethics *in* mindfulness" that asks about the process of connecting and being in relationship.

In ethnographic terms, procedural issues are called a "thin description," an evaluative statement (Kurchin, 2013) which is related to culture and interpretation (Geertz, 1973). Gilligan's work discussed above, for example, constitutes a "thick description" of moral development (Blum, 1993). An example of a thick description is distinguishing among a variety of possible deeper descriptions for someone who winks. A thin description is to say that there was a wink. A thick description is to explore not just the contraction of an eyelid but also the ways it was done and the reasons for it being done (Geertz, 1973; Kurchin, 2013). In the context of mindfulness, thin descriptions arise when we ask whether ethics should be implicit or explicit in MBIs. This classification leads to a description of procedural ethics and while important, belies the more complex issue of ethics in mindfulness, which requires "thick descriptions." That is, thick descriptions allow for an exploration of the cultural and deeper aspects of relational components and of the development of virtues that underlie the more evaluative terms of ethics being right/wrong or good/bad.

In what might be read as a call for thick descriptions of ethics in mindfulness, McCown (2013, 2016) asks, "How are teachers and participants to be together ethically?" A transection of this question exposes several layers of relational components that run through an MBI. For example, as a thick concept in the framework of ethics in mindfulness, we would want to know what implicit and explicit values teachers and participants bring to the room that will influence the relationship. In the sections that follow, we explore the debate around implicit/explicit ethics, resistance to including explicit ethics in MBIs, the issue of presumed values-neutrality, and the complex relational processes in an MBI.

Implicit and/or Explicit Ethics The issue of ethics and MBIs remains a central and often contentious topic in Buddhist and secular mindfulness circles. Buddhist teachers and scholars argue that the absence or high opacity of ethics in secular mindfulness renders the programs inauthentic and likely to do harm (Purser & Loy, 2013; Rosenbaum & Magrid, 2016; Titmuss, 2013). Recent responses from Buddhist and secular mindfulness teachers to Monteiro et al. (2015) explored the complexities of integrating Buddhist ethics as action-guides into contemporary mindfulness programs including the issue of explicit versus implicit ethics (Amaro, 2015; Baer, 2015; Greenberg & Mitra, 2015; P. Grossman, 2015; Lindahl, 2015; Mikulas, 2015).

Critics of implicit ethics (sometimes confounded with the assumption of an absence of ethics) suggest that the exclusion of explicit teachings of Buddhist ethics uncouples the core elements of mindfulness from its roots. Amaro (2015) noted that Kabat-Zinn's (2011) rationale for such an approach is "vague" and lends itself to a "dubious principle upon which to structure a pedagogical approach" (p. 67). Monteiro et al. (2015) indicated that regardless of the intention not to impose extraneous values, the very act of teaching a philosophy derived from an Eastern spiritually oriented practice has led into that arena. That is, the challenge is not simply what and how to teach in a curriculum but to address higher-order ethical issues (see also Chap. 3—Dr. Gunther Brown) such as the value-infused therapeutic relationship and the complex container of the teacher, teachings, and who is taught. These three categories are examined in the sections below.

Secular practitioners argue that making ethics explicit would itself result in ethical difficulties. Cullen (2011) noted that the implicit form is consistent with the Buddha's pedagogy of discovering for oneself how unethical actions lead to suffering; the implication being the inclusion of explicit ethics would alter the intent of the Buddha's teachings. Kabat-Zinn (2011) stated that ethics are implicit and embodied in the presence of the teachers of MBIs through their personal practice and the guidelines of their professional ethics. In other words, ethics are best expressed in MBSR by its embodiment by teachers without turning it into an "ideal" or carry it as a "burden" (p. 295). Cullen (2011) suggested that ethics and mindfulness support each other and that an insight arising from personal experience of the connection between unethical action and one's suffering could be more transformative than "imposed edicts." In both cases, while not explicitly stated as such, the argument for implicit ethics is set up as a desire to avoid proscriptive ethics, which are restraining and avoids the negative, and incline to prescriptive ethics, which are action-based and engages in the positive (see Janoff-Bulman et al., 2009, for a discussion on the need for balance between these two modes of moral regulation).

Taking a vastly different stance, McCown (2013) argues for making ethics explicit in MBIs by which he means the qualities or virtues that are developed relationally between participant and teacher. According to McCown, ethics lies in the pedagogy and emerges out of community where qualities of corporeality, contingency, friendliness, and cosmopolitanism or openness to possibility inform the participant's experience. Experiencing the curriculum creates the ethical space without imposition through interpretation or ascribing meaning on the participant's experience.

Values-Neutrality in Psychotherapy From the Buddhist perspective, mindfulness and ethics are inseparable; they are embedded in the teachings and embodied in practice. It is possible that the resistance to make ethics explicit in secular mindfulness is a holdover of an historical idea that therapeutic interventions must be values-neutral (Monteiro, 2016). The assumption that therapies and interventions are or should be values-neutral represents an historical division in psychology away from a study of character and towards an objective, actuarial science with a focus on measures of personality. This view of values-neutrality may continue in subtle ways

despite evidence that the clinician and client bring their unique patterns of values into the therapeutic space (Jackson, Hansen, & Cook-Ly, 2013; Patterson, 1959). In fact, there is sufficient evidence currently that no therapeutic approach is values-neutral (Hathaway, 2011).

Alan Tjeltveit (1999) suggests that the adherence to values-neutrality arose from viewing therapy as a scientific endeavor. He also presents strong arguments that psychologists' resistance to philosophical reflection (as opposed to relying on scientific findings) has been a primary obstacle to understanding ethics and values in psychotherapy. Tjeltveit organizes the examination of ethics into six intertwined dimensions of professional ethics, theoretical ethics, virtue ethics, social ethics, clinical ethics, and cultural ethics.

Typically, in debates around the need to include ethics in MBIs, the dimensions of professional and clinical ethics are appealed to as proof that the ethical component does not need to be explicit in the teachings because they are implicit in those values. For example, Kabat-Zinn (2011) claims the Hippocratic oath is sufficient for ensuring ethics are upheld in MBSR because all teachers adhere to this oath. While this may be necessary to galvanize a commitment to do no harm, it is certainly not sufficient; this is more so where mindfulness is offered by persons or organizations with no training or conduct oversight from regulatory and disciplinary associations. It also does not ensure that individual or organizational values will not influence and shift the application of ethics, changing what it means to do no harm.

Teacher, Teachings, and Who Is Taught The abovementioned implications of implicit/explicit values conveyed in therapy are not the sole bête noir of MBIs. Amaro (2015) noted that it is equally important to investigate the "subtle influences that are already with us, in the Judeo-Christian conditioning of the West, particularly in relation to such issues as the concepts of right and wrong as well as the broader topic of ethics" (p. 64). These points are consistent with the explorations of the fallacy of values-neutrality in therapy and the implicit ethics and values embodied by the therapist and therapeutic models (Burns, Goodman, & Orman, 2013; Hamilton, 2013).

As mentioned above, it appears that much of the debate about explicit or implicit ethics in MBIs is rooted in the historic aim of medicine and psychology to be objective and scientific. If therapies are viewed as moral encounters (Burns et al., 2013), the process of treatment lies in the client's examination of disconnection between ideal and actual values, a state that leads to distress (J. W. Fisher, 2011; Jackson et al., 2013; Leiter, Jackson, & Shaughnessy, 2009). Influenced by the assumption of values-neutrality as a form of respect for the client's own values, therapies have adopted a putative stance of objectivity and neutrality to avoid unduly influencing or detracting from these values. It is understandable, therefore, that the desire to avoid an overt ethical framework in MBIs arises from this historic paradigm of therapy as being values-neutral of necessity to not interfere with or negate the participants' own values.

Nevertheless, having noted the fallacy of values-neutrality, it is important to examine the role of ethics and values in mindfulness-based programs. These are

present in three dimensions (Monteiro et al., 2015). First, ethics is contained, explicitly or implicitly, in the content of a mindfulness program. While Buddhists precepts may not be formally referenced in an MBI, the theme of restraint by not doing harm to self and others, found in many traditions, is implicit in the process of cultivating awareness of one's actions and their consequences (Mikulas, 2015). Recent debates have focused on the consequences of implicitly conveying ethics in MBIs and, given the commonality of ethics among faith traditions, whether it is appropriate to assume Buddhist ethics are the only ones conveyed in an MBI (Amaro, 2015; Davis, 2015; Lindahl, 2015).

Second, ethics is modeled or embodied in the person of the MBI teacher (Evans et al., 2014; P. Grossman, 2015; McCown, 2013; van Aalderen, Breukers, Reuzel, & Speckens, 2014). There are many MBI training programs and they typically require pre-existing meditation practice, attendance at (usually Buddhist) retreats, and an ongoing personal contemplative practice (Crane, Kuyken, Hastings, Rothwell, & Williams, 2010; Crane et al., 2011). The primary aim in teacher training is to cultivate an embodiment of the principles, including ethics (P. Grossman, 2015) that support the cultivation of character, or what is called in Buddhism, the "Noble Person" (Harvey, 2000, 2013). Health care professionals such as physicians, psychologists, social workers, and nurses who train as MBI teachers would carry these principles along with the additional, though not contradictory, set of ethical guidelines of their specific professional practice.

The third dimension is related to those who are taught, who seek out a mindfulness program. One of the major concerns of Buddhist practitioners and scholars of contemporary mindfulness applications is that it may be misappropriated by agencies such as police and military institutions as well as profit-focused business corporations whose mission-related ethics may be questionable (Senauke, 2013; Titmuss, 2013). In this regard, the issue of ethics is a crucial one, not only as it relates to the teacher's own ethics, but the intention of the program and oversight of its eventual use. However, it is important to remember that even in an 8-week program the participants present with their own system of desires and intentions that can lead to misunderstanding and misuse of mindfulness practices (see Thanissaro, 2004, for a simile that addresses the potential consequences of misunderstanding or misusing teachings).

Each of these dimensions—teachings, teacher, and who is taught—is fertile ground for the cultivation of what Amaro (2015) called a holistic mindfulness. McCown (2013) describes this as a co-created ethical space, within which transformation arises; he acknowledges that ethics in MBIs are implicit but also important that they are made explicit. Present in that ethical space are the values brought by the teacher and the participant; the personal preferences, perspectives of well-being, and the subtle influences of the values of the teacher are entwined immediately in the delivery of the curriculum. It is a rarely considered reality, but crucial nevertheless; each participant and teacher comes to mindfulness with their own set of ethics, values, and perspectives of well-being. Neither arrives *tabula rasa*; their ethics and values enter the space in the first session, if not in the moment they decided to seek out the potential of mindfulness.

While the analysis of secularized mindfulness has focused on the content of MBIs (i.e., the debate around implicit and explicit ethics as a dichotomy), a far more complicated picture emerges when teachings, teacher, and who is taught are taken as a three-fold interaction of already existing implicitly and explicitly expressed values and ethics. Perhaps the allure of claiming that implicit ethics are best practice is simply an historic artifact of the fallacy of values-neutral therapy; it may even be a misguided effort to maintain respect for the client by inadvertently shifting from client to protocol. However, actual respect for the client's values and ethics lies not in the red herring of values-neutrality, but rather in the more challenging process of how to cultivate well-being as an aspect of character. That is, the roots of the intervention, its spiritual framework, and the teacher's values as informed by those roots all must be transparent in relationship. To do less is to circle back, negate the non-hierarchical relationship in healing, sustain the fallacy of a values-neutral system, and maintain the split between personality factors and character. In our terms, the ethics *in* mindfulness and the ethics *of* mindfulness serve and support each other through the relationship of the teacher and the participants of an MBI.

Viewed through the lens of cultivating character, mindfulness is consistent with the Buddhist intention of mindfulness practice as the cultivation of the Noble Person (Harvey, 2013). In Western psychology, for researchers and clinicians the dominant paradigm of best practice is supported by scientific psychology and an actuarial measure of personality, which has eclipsed the development of character as a goal in therapy. Therefore, if MBIs are to contribute to the well-being of its participants, it is important to acknowledge the ways in which ethics and values unfold in MBIs.

The Arc of Moral Development If an MBI is viewed as an arc of moral development, then flourishing as the cultivation of the Noble Person is consistent with the Buddhist paradigm. Participants begin in the clutches of their delusion, craving, and anger; as the program progresses, they and the teachers are faced with choice point after choice point to turn towards and transform suffering or to continue to simmer in the anger, greed, and ignorance. As their practice grows in the relational container of the program, and their capacity to meet difficult and unwanted experiences strengthens, they begin to take cognitive and experiential responsibility for their well-being and to trust in their capacity for insight in how their ethics and values guide them. In fact, Kabat-Zinn's paradigm shift towards the wholeness of the person points to the process of growth as both *intra-* and inter-relational. McCown (2013) suggests the relationship that is co-created between teacher and participant (actually both are participants and a more appropriate term may need to evolve) is both necessary for transformation and the heart of ethics in mindfulness. Mindfulness practice as an intrapersonal cultivation of well-being is intricately bound with the cultivation of character through values awareness and clarification. While there is concern that introducing character invites historic beliefs that connect illness to moral weakness, the holistic view of the individual and relationships mitigates that fear by creating an environment where strengths and weaknesses become the source materials to develop insight. It is also important to note that, in Buddhist practice, insight arises through mindfulness by calling to mind past actions and their

consequences, and to foster skillfulness (Goldstein, 2013). In other words, insight arises through an awareness of incongruence between one's values and actions, with the precepts offering an opportunity to clarify and reset. Finally, because values and the desire to live well are in and of the world, the practice of mindfulness offers a larger vision than changing individual suffering. It can be seen as cultivating the character of the Noble Person whose interest is the welfare of all beings, that is, clarifying what it means to "live well" in the world. Secular mindfulness therefore cannot be limited to symptomatic relief and must encompass the welfare of society by also healing the conceptual and structural divisions within it.

Walking the Path Continuously

Mindfulness-Based Symptom Management

Communicating Mindfulness The primary issue of ethics *of* mindfulness is being transparent and striving for informed consent to take part in MBSM. In 2003, when the program was first offered, a significant amount of time was spent individually meeting with participants and creating space for questions about the roots of mindfulness. Questions tended to focus on the concerns that this would be a religious inculcation or that some type of conversion to Buddhism would be attempted. With the rapid increase of mindfulness in the media and the scientific literature, these questions have taken a different slant. Participants are more concerned with not having meditation experience or even a concern that the practices in the program may interfere with their current meditation practice. Nevertheless, effort is made to be clear that the program is derived from a spiritual tradition, is a secular translation, and that it includes a practice of clarifying and cultivating one's values so that actions foster well-being.

Infrastructure MBSM was designed through an iterative process of delivering the curriculum and recalibrating it after feedback from participants. It is an 8-week program held once a week for 2 to 2 ½ h with a 5-h. session ("all-day") held about halfway through the program. The all-day session is ideally set after the fourth session but no earlier than the third or later than the fifth sessions. The rationale for the timing of the all-day is important as it relies on practice in the meditations having been sufficiently strengthened by this point in the program. It also serves as a check-in and is often a pivotal point for the participants' felt experience and realization of the impact of continuous practice. The program is delivered in small-group format (8–14 participants) and typically led by two teachers trained in the MBSM curriculum. Contact with the teachers is made available throughout the program either via email, telephone, or individual meetings if necessary. Halfway through the week, a summary called "Session Essentials" is emailed to the participants; these summarize the core practices of the session, repeat links to the meditation for that week, and give a brief description of any specific topic that was part of the session (practice

obstacles, expectations, frustration, helpful insights). Specific sharings from the group process are not included in the "essentials." Each session begins with the meditation (Body Scan, awareness of breath, BEST, compassion/loving-kindness, or silence) appropriate to the session (see Monteiro & Musten, 2013, for practice details).

Session Themes and Formal Practices The eight sessions unfold as building blocks with each session adding to or extending the previous session. The core structure of MBSM includes meditation practices such as the Body Scan, awareness of breath, BEST (a guided meditation exploring body, emotions, sensations, and thoughts), loving-kindness or compassion meditation, and a silent meditation at the last session. Thematically, session one introduces the concept of mindfulness practice and session two explores the challenges of folding practice into a busy and harried life. Sessions three to six explore the various ways of reconnecting body and mind. Session seven introduces compassion and session eight prepares for the "ninth session," the rest of our life.

The overarching template for the MBSM protocol draws from S.L Shapiro, Carlson, Astin, and Freedman (2009) who describe the mechanisms of mindfulness as Intention, Attention and Attitude (IAA model). Each class is structured so that these three components are embedded in the class exercises, in the didactic material covered in class, and in the formal and informal practices (see below) throughout the week. The core practices of MBSM sessions, like most 8-week MBIs, are derived from the original mindfulness-based stress reduction (MBSR) program designed by Kabat-Zinn (2013). Thus, for example, in the first class, participants are introduced to the now-iconic Raisin Exercise as their first practice of IAA. They are asked to *intentionally* use one sensory system at a time—vision, touch, etc.—to observe the raisin. They are then asked to find one word that describes what they noticed when they *attended* to the raisin using, for instance, the vision sense. Typically, some participants will find themselves slipping away from the intention of the exercise into stories about the raisin (e.g., "It reminds me of my mother's raisin pie," "I always had raisins in my lunch box at school and I hated them"). When that happens, the participant is invited through the inquiry (see Monteiro in this book and Crane, 2009) to adopt an *attitude* of curiosity, noticing the mind's natural tendency to create stories that take us away from the actual experience. Participants are encouraged to take this attitudinal stance into their everyday life events, noticing the multidimensional nature of their experience as well as the quality of mind they bring to the experience.

Similarly, the meditations cultivate the intention to pay attention to the object of attention associated with the particular meditation. The Body Scan, the first meditation in the program, asks participants to intentionally bring their attention of a specific part of the body as they are progressively led from the tips of the toes to the top of the head. Participants again are invited to be curious about their experience, notice the mind's propensity to prefer one experience over another and remember that the practice **is** in the noticing. This basic practice protocol unfolds across the eight sessions and provides participants with a constant framework they can use as they confirm their mindfulness skills in the classroom.

Informal Practices Beginning with the first class, participants are introduced to practices called Mindful Bells and Brief Ordinary Tasks. Mindful Bells are ambient events in a participant's day-to-day environment that signal for a pause, take three or four conscious breaths, and intentionally bring attention to what is unfolding in that moment. This cultivates awareness of attitudinal stances as they engage with events in brief practices (informal practices) intended to promote a mindful way of being in everyday life. Thus, for instance, a participant reported that she used her telephone ringing at work as a "Mindful Bell" reminding her to take a conscious breath or two as she created an intention to turn away from her computer. She then intentionally shifted her attention to the telephone, noticing from call display that it was her boss calling and also noticing that she was holding her breath. Without spinning off into a story about why, she brought her awareness back to her breath, returning her attention to answering the phone while letting go of expectations of what the call is about. In Shapiro and Carlson's terms (2009), this may be viewed as an attitude of openness or beginner's mind. It may also, in a Buddhist teacher's terms, be viewed as skillful means. Thus, when session eight begins with a silent meditation, participants can more easily and intentionally bring their attention to the breath, becoming aware of the changing nature of experience, and adopting an attitude of nonjudgmental awareness of their experience while letting the experience be what it is. Brief Ordinary Tasks are ones that participants can chose to make an intentional focus of their attention. Brushing teeth, drinking a cup of tea or coffee, washing dishes, etc. are opportunities to intentionally attend to a mundane part of life and observe with an attitude of curiosity how hard it can be to hold one's attention on brief, simple tasks. These two tasks are regular weekly practices over the 8 weeks. Other home practices include Pleasant Event (Week 2) and Unpleasant Event (Week 3) logs (Kabat-Zinn, 2013).

Curriculum MBSM is unique in its building-block approach to teaching themes and specific practices that frame and encourage the experiential connection of body-mind and to clarify and cultivate the values important to the participants. Although it shares the infrastructure of MBSR, its curriculum has been developed as a progression in cultivating intention, attention, and an awareness of mental states, as well as a behavioral-focused practice of values awareness and clarification. These are the BEST model and the Five Skillful Habits described below.

Body, Emotions, Sensations, Thinking (BEST) The curriculum of MBSM was adapted from the core teachings of the Satipaṭṭhāna, which is taught as mindfulness of the body, feelings (pleasant, unpleasant, neutral), mind, and all phenomena (Analayo, 2003; Goldstein, 2013; Hanh, 2006). Because the majority of participants who attend are not versed in Buddhist terminology or teachings, the four ways to establish mindfulness were adapted as mindfulness of the body, emotions, sensations, and thoughts (BEST) to reflect a set of themes that would resonate with them.

From the first session onwards, participants practice noticing how their storylines hijack them and lead to emotional distress and painful, often ruminative, thought patterns; the metaphor of heedlessly getting on a train resonates with participants. Being taken away from our intended practice is likened to standing at a

train station intending to get on a particular train but, because of lack of attention, automatically getting on the wrong (typically negative) train that is often bound for a dark neighborhood. It offers an image that is very likely to have happened to most of them (e.g., getting off on the wrong floor of their office, taking the wrong exit on the highway, getting on the wrong bus). The working principle in the metaphor is not about never getting on these trains; we are all born with tickets and will keep getting on trains. The practice is to notice as soon as we can that we are not headed in a direction we intended (emotionally or in our thinking patterns) and, without analyzing what is happening, getting off the train. The exercise has a cognitive overlay of noticing, disrupting the forward momentum of unintended practice, and by doing so, slowing down its unintended consequences. The impact of the practice is to connect with the internal reactivity, creating a space between stimulus and the string of reactions. In that pause, changing the trajectory of the experience becomes more possible.

Starting with the third session, awareness of BEST (Body, Emotions, Sensations, Thoughts) is introduced with their accompanying practices. Mindfulness of the body resonated with the clinical population because they tended to present with physical health issues such as cancer, diabetes, and injuries. They also report stress-related illnesses such as tension and physical symptoms of insomnia, hypervigilance, and agitation. Their stance to their body is typically one of benign or deliberate neglect; in cases of trauma or injury their reaction is woven with shame and deep fear. In general, their stance is that the body had failed them and they felt betrayed, let down, fearing the future, and angry because of the limitations imposed by what they perceived as a mechanical breakdown. To be invited into intimate connection with the body in these circumstances proves a challenge and necessitates slow, deliberate steps. Returning to awareness of the body while lying down, sitting, moving when walking, or engaged in daily activities typically resulted in a capacity to befriend themselves.

Nuttall (2009) examined the effect of participating in an MBSM program on the number of symptoms endorsed (positive symptom total, PTS) and the degree of distress associated with the symptoms (positive symptom distress index, PSDI) using the Symptom Checklist (SCL-90-R; Derogatis, 1994). The impact of psychological symptoms on daily functioning (effects on daily functioning, EDF) was measured using an in-house psychometric scale developed for assessing personal injury history and daily functioning (Self-Administered Psychosocial Survey, SELAPS; Musten, Monteiro, & Hollands, 2007). The results indicated gender differences and the data were presented separately by gender. Both genders reported reduced number of symptoms (Cohen's *d*: Female, 0.53; Male, 0.34) and lower distress about the symptoms (Cohen's *d*: Female, 0.94; Male, 0.55); the former result was contrary to the hypothesis which proposed that mindfulness would shift the attitude or mental distress about symptoms and therefore not impact the actual number of symptoms themselves. However, it is likely that with increased awareness of sensations, participants were more discerning between acute and chronic symptoms. Daily functioning improved for both genders with lower impact of symptoms reported post-intervention (Cohen's *d*: Female, 0.57; Male, 0.55).

Mindfulness of feelings (tones) was expanded to include emotions for obvious reasons. The dominant language in clinical settings is of the emotional states and, perhaps because they feel disconnected from the body, most difficulties are presented through the language of emotions. Participants speak of feeling angry, frustrated, shame or shamed, depressed, anxious, and afraid. This shift to conventional psychological concepts and language gave a space for deeply felt experiences that often could not be voiced elsewhere. Awareness of emotions exposes difficult and unwanted emotions that have been silenced or suppressed, needs that have not been met, and comfort that has not been received. The result is typically a resurgence of emotion avoidance strategies because of the often-intense states of feeling dysregulated (see Holzel et al., 2011, for discussion of emotion regulation). However, practice provides the opportunity to calm the reactivity and create space in which the arising, presence, and dissipation of the emotional state can be observed. Practice then leads to an awareness of emotions as aggregate terms, labels, or schema (e.g., I am an angry person) along with the feeling tone (pleasant, unpleasant, neutral) and sensations (e.g., tension in the gut, tightness in the shoulders) that coalesce as the emotion label.

Mindfulness of sensations extends the previous practice of feelings (emotion, tone, schema) and is informed by somatic experiencing approaches (see Levine, 1997, for description of somatic experiencing therapy related to trauma). This section takes a deconstructive stance to experience, investigating the underlying sensations of experience, noticing both the emotion label and the narrative that arises along with the experience. How labels are applied to experiences is explained as dependent on personal and cultural history of classifying aggregates of sensations. One example, inspired by an historic study by Schachter and Singer (1962) and the two-factor theory of emotions, is to imagine standing at the top of a mountain on skis, feeling sensations of shakiness, shortness of breath, knot in the stomach, etc. Someone exposed to skiing down mountains would label that as exhilaration whereas another might label it as terror. The central teaching point is that labels we provide for our experiences are multifactorial, arising from many causes and conditions, most of which may never be fully known.

Mindfulness of thoughts draws from cognitive behavior therapy. It explores the way thoughts can color mind states and how that impacts the body as well. Consistent with Buddhist teachings, this session also explores how we construct our reality through our assumptions and perceptions. The session includes a dedicated didactic section on the stress model and how trauma is registered in the body, and is also the first time in the 8 weeks that the participants are "allowed into the frontal lobe." That is, up to this session all interactions through their descriptions of weekly practice, events they experience, and emotions they felt have been gently guided back to their experience while noticing the story about the experience. Their language of sensations and feeling tones has developed over the previous sessions and the reliance on stories to validate their inner experience has uncovered the subtle ways of the mind. More than that, the supremacy we give to our thinking function has been challenged, and trust in the subtler ways the body speaks to the mind has developed. What also develops is the beginning of an ability to track physical sensations as the

first markers of states of being that may lead to heightened emotions and consequent catastrophic thinking.

Session seven is unique in the challenges it presents and benefits from a specific description. It introduces compassion for self and others and the session begins with a loving-kindness practice as the meditation. Where the first six sessions were focused primarily on developing an inner steadiness in the face of physical and emotional challenges, the exploration of the responses to the meditation in session seven brings out the challenges of self-compassion (Germer, 2009; Neff, 2011), the aversion it evokes (selfish, not deserving, being criticized or diminished), and the fear that it will dull the edge of competitiveness participants feel is necessary to survive in their lives. The brahmaviharas or the four limitless contemplations (Gilbert & Choden, 2014) are introduced as four ways to engage in loving relationship: loving-kindness, resonant joy, compassion, and equanimity. The first two are described as practices we engage in to nourish and sustain relationships; the second two are necessary to meet and transform moments and periods of suffering. We liken these to prophylactic and curative measures, respectively. Both are necessary for a balanced stance in the constantly changing flow of being in relationship with others, the world, and ourselves.

Shaw (2012) studied the relationship of participating in MBSM and its impact on factors of burnout (MBI, Maslach Burnout Inventory; Maslach & Jackson, 1981) and self-compassion (SCS, Self-Compassion Scale; Neff, 2003). Results for the MBI indicated a significant reduction in only one subscale, Emotional Exhaustion ($p < 0.001$; Cohen's d: 0.46). The SCS obtained significant increases in all three subscales of Self-kindness ($p < 0.001$; Cohen's d: 0.66), Common Humanity ($p < 0.001$; Cohen's d: 0.53), and Mindfulness ($p < 0.001$; Cohen's d: 0.53). The counterparts to these subscales (Self-judgment, Isolation, and Over-identification) decreased significantly ($p < 0.001$; Cohen's d: 0.83, 0.44 & 0.59, respectively). At follow-up 3 months later, most gains measured by the MBI and SCS had been maintained; however, the MBI subscale of Cynicism had decreased further. Self-judgment increased reversing towards the pre-intervention levels. Informal practices of the 3-min breathing exercise and walking meditation were associated with maintaining post-intervention positive gains in self-kindness. In an interesting process, thought awareness practice and time spent in informal practices were related to decreases in self-judgment; recalling that self-judgment had increased at post-intervention, it appeared the informal practices had the effect of "slowing down" the reversal to preconditions. These results supported our approach to mindfulness as inherently a practice of self-compassion and continued to set the tone for conversation around perceived failure as well as cultivating trust in personal experience and in empathy with others.

This session also integrates the Five Skillful Habits as a central practice of compassion and highlights its application across the four platforms of mindfulness practiced in the previous weeks. The next section explores the Five Skillful Habits specifically.

Five Skillful Habits (5SH) The arc of MBSM is the cultivation of skillfulness in living; that skillfulness is comprised of making wise decisions based on a clear

understanding and connection with the values that underpin thought, speech, and action. Embodying the spirit of creating the path by walking, the 5SH are the framework of practice that breathes life into the abstraction of values and the virtues they represent. Its intersection with BEST is introduced in the third session.

Derived from Thich Nhat Hanh's Five Mindfulness Trainings, they are respect for mortality, generosity, respect for boundaries, compassionate speech, and mindful consumption (Hanh, 2007). We introduce them as daily practices early in MBSM because we believe there is a need for intentional practices; these practices also honor the idea that moral effort was a necessary condition for meditative practices to be effective (Whitehill, 2000). S.L. Shapiro and Carlson (2009) make a similar point when they suggest that, consistent with both Buddhist and Western approaches to moral psychology and philosophy, the Buddhist concepts of "right" or "wholesome" intentions are descriptive of a way of living that is intended to relieve suffering. And, importantly, they "believe that explicit teachings of these guidelines are critically important to mindfulness practice" (p. 10).

It was also apparent in our discussions with participants that the incongruence between their ideal state and actual lived state was experienced as the root of their suffering; that is, living with authenticity was important to them. Kernis and Goldman (2006) investigated the relationship between authenticity and mindfulness, noting "that an open and trusting stance toward one's self-aspects goes hand-in-hand with tendencies to observe internal and external stimuli, competence in describing one's internal states, ability to focus one's attention on the task at hand, and a nonjudgmental stance in general" (p. 312). Further, Smallenbroek, Zelenski, and Whelan (2017) reported that acting in congruence in one's values was related to state and trait authenticity, which they define as "generally understood as acting in accordance with core aspects of the self" (p.197).

Exploring whether participants attending MBSM presented with such incongruences of values, Monteiro (2012) examined the relationship between burnout factors (MBI, Maslach Burnout Inventory; Maslach, Jackson, & Leiter, 1996) and incongruence in spiritual values (SWBQ, Spiritual Well Being Questionnaire; J. W. Fisher, 2010) in a group of MBSM participants at pre-intervention. Significant differences were obtained between the ideal and actual scores of the SWBQ (used as a measure of incongruence) with ideal scores higher than actual scores. Personal incongruence was significantly different from the other three SWBQ factors (communal, environmental, and transcendental) suggesting participants entered the MBSM program with a sense of not feeling aligned with their ideal personal values. Correlations with the burnout factors and personal incongruence scores were significant for exhaustion ($p < 0.05$), cynicism ($p < 0.05$), and personal effectiveness ($p < 0.01$). Analysis of the effect of emotional exhaustion scores on personal incongruence indicated that, compared to those in the high emotional exhaustion group, participants in the low emotional exhaustion group reported lower incongruence on the personal values factor ($p = 0.016$; Cohen's d: 0.65). Participants with high personal effectiveness scores reported low personal incongruence ($p < 0.01$; Cohen's d: 0.72) compared to those in the group with low personal effectiveness scores. These results suggested participants present with an experience of incongruence in their

personal values and indicated a connection between their burnout symptoms and the incongruence they experience.

In this context, the 5SH are viewed as guideposts that provide the framework for participants to develop an embodied ethical relationship to their lived lives. They provide the framework that first affords participants the opportunity to look at how they are living their lives and second provides the frame for them to introduce healthier, more compassionate ways of being with themselves. In the words of Thich Nhat Hanh, mindfulness is always mindfulness of something, be it the breath, speech, thought, or action. In other words, because we are always practicing something, it may as well be something congruent with our values.

Although mindfulness is usually taught as present-moment awareness, it is also a recollection of actions and their consequences, a nodal point at which a different choice is possible, and a recalling of what supports practice (Goldstein, 2013). In order to see the need for and to support choices that have a different outcome, action-guides are necessary. Held up against the template of who we wish to be (ideal) and the question of who we are in the moment (lived experience), the 5SH provide a way of directing or experimenting with change. These habits, in the service of well-being, are intended to cultivate behaviors that: (1) attend to physical health to reduce risks related to higher mortality; (2) develop appropriate generosity; (3) increase awareness of physical and emotional boundaries; (4) cultivate compassionate speech, and (5) increase discernment in consumption of physical and emotional nourishment, including use of necessary medication treatments. Table 8.1 shows interconnection of the four methods of establishing mindfulness (body, emotions, sensations, thinking) and the 5SH with examples of possible actions or attitudes to cultivate.

Making the Five Mindfulness Trainings congruent with Western approaches to cultivating wholesome living required sensitivity to intent and language. The intentions of the first, second, fourth, and fifth of Thich Nhat Hanh's Five Mindfulness Trainings with an emphasis on cultivating values-congruent behaviors fit well with Western values as noted by our participants. The third mindfulness training, however, presented unique issues because it was a prohibition against excessive sensual indulgence (Hanh, 2007) and refers specifically to sexual relations. This focus on sexuality was considered too narrow and perhaps likely to trigger feelings of being judged or being "sinful." We sought a broader and more applicable concept of sensual attachment that would connect with participants who felt challenged in knowing when their physical and emotional pain threshold had been exceeded. They described pushing themselves physically and emotionally beyond limits because of messages to "get through" or "breakthrough" their unpleasant experiences of depression, injuries, grief, and so on. Despite their vulnerable state, they often practiced a "no pain, no gain" philosophy which only served to exacerbate their condition or deplete their resources. Pushing the boundaries of physical and emotional tolerance was a form of overindulgence in physical or emotional sensations and a misguided attempt at symptom management. Given these parameters, it seemed appropriate to modify the third mindfulness training to reflect respect for physical and emotional boundaries.

Each week participants in the program are invited to focus on one aspect of their experience in the context of body, emotions, sensations, and thinking. We also are

Table 8.1 Examples of possible behaviors to cultivate in each domain of mindfulness

Five Skillful Habits	Behavioral examples
Respect for mortality (the life we have)	Body: Exercise, attend to treatment plans (medication, etc.).
	Emotions: Note how positive and negative experiences are connected to physical sensations.
	Sensations: Notice the sensation of your heart beat, muscles relaxing or aching, joint pain, heaviness, lightness, etc.
	Thoughts: Note positive and negative thoughts and connection to physical experiences.
Generosity	Body: Rest, sleep in, take frequent breaks.
	Emotions: Allow yourself to feel the range of emotions guilt, anger, happiness, etc.
	Sensations: Practice deep diaphragmatic breathing when you notice uncomfortable sensations. Incline towards experiences with kindness and compassion.
	Thoughts: Allow thoughts to come and go (allow yourself to hop off trains).
Respect of limits	Body: Note when fatigued, appropriate pain monitoring, say "No," manage expectations.
	Emotions: Note unpleasant emotions and be present to them as long as is comfortable for you. Note pleasant emotions and savor them.
	Sensations: Stay with sensations as long as is comfortable for you—play with that edge. Notice the arising, presence, and dissolving of sensations.
	Thoughts: Notice when your thoughts are dictating your limits rather than what your body really feels (e.g., I can't do this).
Compassionate speech	Body: Bring a flavor of kindness to whatever physical experience you are having.
	Emotions: Approach arising of emotions with an attitude of curiosity.
	Sensations: Notice when judging about sensations arises.
	Thoughts: See the thoughts as they are, just thoughts
Mindful consumption	Body: Take time for lunch, notice effect of media messages about body image
	Emotions: Note the sensation/emotional effects of what you are watching on television
	Sensations: Note sensations of satiation
	Thoughts: Note thoughts while eating: tone, language, etc. Also note how interactions are "consumed": joyful, kind, angry, tense, etc.

clear that experience is not categorical or orderly and the four frames of experience tend to flow together. Participants are invited to adopt an approach of holding one in the foreground while holding the others lightly in the background. Folded into these four ways to establish mindfulness, the 5SH form an intentional behavioral focus for the home practice and each week a different way to establish mindfulness is chosen until the four ways are integrated in the penultimate class on compassion and loving-kindness. At the end of each session, as part of the home practice discussion, participants are invited to identify specific behaviors, based on the 5SH themes, to which they can commit as their practice for the week; occasionally someone declines and this is typically because they wish to think further on the value or behavior that is salient for them. Table 8.2 summarizes responses by program

Table 8.2 Examples of behaviors selected by participants to practice in each method of establishing mindfulness

	Body	Emotions	Sensations	Thoughts
Respect for Life	Health-related (e.g., while eating, paying attention to body)	Attend to emotional suffering Established a formal gratitude practice	Observe ("tune in") Try not to avoid pain	Attend to underlying pain when thinking "violent" thoughts
Generosity	Exercise Rest	Nonviolent communication (speech/thoughts) to identify responsibility Charitable donations	Listening Eating slowly	Compassion, self-empathy, focusing Tapas acupressure technique
Boundaries	Saying "no" Taking time for self and others Taking breaks, not over-exerting self	Expressing emotions in ways not be harmful to self or others	Reduce and deal with negative events/ emotions	Expressing gratitude Noticing good in life
Speech	Being nonjudgmental about health-related choices	Express and allow emotions to exist Express self in non-harmful ways (choose words carefully and aware of intentions behind words)	Listening	Let go of negative thoughts Welcome thoughts but let them pass Watch "train" (thoughts) pass and refocus on now More sensitive to others, less critical
Consumption	Not eating foods that are hard to digest (healthy choices)	(no participants provided examples here)	Eating slowly	More relaxed More positive Accepting "this is me"

graduates on the behaviors chosen and insights that emerged when using the 5SH (Monteiro, Nuttall, & Musten, 2010; Nuttall, 2009).

In summary, MBSM, and the 5SH specifically, are an exploration of well-being as it is experienced by each participant personally; inevitably the inquiry and awareness that develop lead to understanding how they value their relationships with others and the world. The behavior participants chose to action their understanding of each 5SH represents what they value as a path to personal well-being. Respect for mortality (the life we have) investigates ways of living that undermine or enhance well-being in terms of body, emotions, sensations, and thinking. Generosity explores ways to give and receive so that there is a constant process of replenishing. Respect for limits experiments with the hard and soft edges of emotional and physical limits that signal the need for attention and recalibration. Compassionate speech brings awareness to the impact of the inner critic and an opportunity to become more skillful in how to encourage kindness. Mindful consumption cultivates awareness of the intake and "digestion" of all forms of toxic material from food to media messages. What each participant chooses to practice is individually determined; however, the intent is not to replace one behavior for another. Practice offers the opportunity to bring awareness of the dance between ideal and lived states; it is an inquiry into what is valued (the preciousness of life, kindness, etc.) and how that is lived, and to develop awareness of how it can be lived more skillfully. The richness of this practice is in the way participants discover the futility of perfectionistic approaches and the many simple ways their values can be upheld.

Conclusions

In this chapter, we have explored the development of a mindfulness-based intervention which we hoped would address the gaps we experienced in the seed programs of early mindfulness interventions. The process was challenging at professional and personal levels. We were constantly faced with the complex intersection of religion, spirituality, ethics, values, mental health issues, and our own concerns about the now-apparent iatrogenic effects of meditation. Along the way, we also had to examine issues of earning a living through the use of religious/spiritual practices, what in Buddhism is right livelihood, one of the three components of cultivating the moral aspect of a life well lived. The other two are right speech and right action, practices that became our touchstone as we struggled to ensure that what we offered respected the professional, spiritual, and local communities around us.

MBSM, we hoped and continue to hope, represents an easeful integration of what the Buddha intended in his teachings of 2600 years ago with our knowledge of how people in this century meet and manage their experiences of distress, joy, love, and care. Our concerns that mindfulness could become a mechanical technique or a topical application for quick relief have substance when we listen to our participants initially ask for a "quick fix" or "magic bullet." This desire is very understandable because the pain of change is hard to accept and the suffering that arises from being

averse to, clinging to alternatives, or feeling doubt about managing feels overwhelming. Nevertheless, while MBSM offers that initial relief in the form of relaxation or calm, we aimed for a design that dug into the roots of our dissatisfaction—or at the very least offers an idea that such action was possible. And for us those roots are the values by which we try to live and from which we often felt disconnected.

However, MBSM is far from—and likely never will become—an intervention that is fixed and manualized. The essential truth is that nothing is permanent and everything is in constant state of change; it is both a spiritual claim of Buddhism and of physical science. But there is also a more immediate reason for the constant state of change: every program we offer is new simply because all those who come together are doing so for the very first time. In the space that each program is conducted, everything is happening for the first time. Even as teachers who have walked into that room hundreds of times over the years, we too are new because the relationship with everyone there creates us anew.

What we aspire to then is that the core values which drew us together in the first place—that value for a life lived well—become our North Star and together we learn again how to use our moral compass to navigate the waters we are in together.

References

Aitken, R. (1984). *The mind of clover: Essays in Zen Buddhist ethics*. New York: North Point Press.

Aitken, R. (1991). *The gateless barrier: The Wu-Men Kuan*. Berkeley, CA: North Point Press.

Amaro, A. (2015). A holistic mindfulness. *Mindfulness*, *6*(1), 63–73. https://doi.org/10.1007/s12671-014-0382-3

Analayo. (2003). *Satipatthana: The direct path to realization*. Birmingham, AB: Windhorse Publications.

Analayo. (2013). *Perspectives on satipatthana*. Cambridge: Windhorse Publications.

Anderson, R. (2001). *Being upright: Zen meditation and the bodhisattva precepts*. Berkeley, CA: Rodmell Press.

Baer, R. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, *10*, 125–143.

Baer, R. (2015). Ethics, values, virtues, and character strengths in mindfulness-based interventions: A psychological science perspective. *Mindfulness*, *6*(4), 956–969. https://doi.org/10.1007/s12671-015-0419-2

Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology and Psychotherapy*, *10*, 319–327. https://doi.org/10.1002/cpp.379

Batchelor, S. (2017). *After Buddhism: Rethinking the dharma for a secular age*. New Haven, CT: Yale University Press.

Baumeister, R. F. (1999). The nature and structure of the self: An overview. In R. F. Baumeister (Ed.), *Self in social psychology: Key readings*. Philadelphia, PA: Psychology Press.

Baumeister, R. F. (2011). Self and identity: A brief overview of what they are, what they do, and how they work. *Annals of the New York Academy of Sciences*, *1234*(1), 48–55. https://doi.org/10.1111/j.1749-6632.2011.06224.x

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1987). *Cognitive therapy of depresison*. New York: The Guilford Press.

Blum, L. A. (1993). Gilligan and Kohlberg: Implications for moral theory. In M. J. Larabee (Ed.), *An ethic of care*. New York: Routledge.
Bodhi, B. (2008). *The Noble Eightfold Path: The way to end suffering*. Onalaska, WA: BPS Pariyatti Editions.
Bodhi, B. (2011). What does mindfulness really mean? A canonical perspective. *Contemporary Buddhism*, *12*(1), 19–39.
Bodhi, B. (2013). Nourishing the roots: Essays on Buddhist ethics. *Access to insight*. Retrieved from Access to Insight http://www.accesstoinsight.org/lib/bodhi/wheel259.html
Brown, K. W., Creswell, J. D., & Ryan, R. M. (Eds.). (2015). *Handbook of mindfulness: Theory, research, and practice*. New York: The Guilford Press.
Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, *84*, 822–848.
Brown, K. W., & Ryan, R. M. (2004). Peril and promise in defining and measuring mindfulness: Observations from experience. *Clinical Psychology: Science and Practice*, *11*, 242–248.
Burns, J. P., Goodman, D. M., & Orman, A. J. (2013). Psychotherapy as moral encounter: A crisis of modern conscience. *Pastoral Psychology*, *62*, 1–12.
Cayoun, B. A. (2011). *Mindfulness-integrated CBT: Principles and practice*. Chicester: Wiley-Blackwell.
Coffey, K. A., Hartman, M., & Fredrickson, B. L. (2010). Deconstructing mindfulness and constructing mental health: Understanding mindfulness and its mechanisms of action. *Mindfulness*, *1*, 235–253.
Compson, J., & Monteiro, L. (2015). Still exploring the middle path: A response to commentaries. *Mindfulness*, *7*(2), 548–564. https://doi.org/10.1007/s12671-015-0447-y
Crane, R. S. (2009). *Mindfulness-based cognitive therapy: Distinctive features*. New York: Routledge.
Crane, R. S., Kuyken, W., Hastings, R. P., Rothwell, N., & Williams, J. M. G. (2010). Training teachers to deliver mindfulness-based interventions: Learning from the UK experience. *Mindfulness*, *1*(2), 74–86. https://doi.org/10.1007/s12671-010-0010-9
Crane, R. S., Kuyken, W., Williams, M. J. G., Hastings, R. P., Cooper, L., & Fennell, M. J. V. (2011). Competence in teaching mindfulness-based courses: Concepts, development and assessment. *Mindfulness*. https://doi.org/10.1007/s12671-011-0073-2
Cullen, M. (2011). Mindfulness-based interventions: An emerging phenomenon. *Mindfulness*, *2*, 186–193.
Davis, J. H. (2015). Facing up to the question of ethics in mindfulness-based interventions. *Mindfulness*, *6*(1), 46–48. https://doi.org/10.1007/s12671-014-0374-3
Derogatis, L. R. (1994). *Symptom Checklist-90-R: Administration, scoring, and procedure manual*. Minneapolis: National Computer Systems.
Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist*, *70*(7), 593–620. https://doi.org/10.1037/a0039589
Eberth, J., & Sedlmeier, P. (2012). The effects of mindfulness meditation: A meta-analysis. *Mindfulness*, *3*, 174–189.
Eisenberg, N., & Eggum, N. D. (2008). Empathic responding: Sympathy and personal distress. In B. Sullivan, S. Snyder, & J. Sullivan (Eds.), *Cooperation: The political psychology of effective human interaction* (pp. 71–83). Malden, MA: Blackwell Publishing.
Ekman, P., & Davidson, R. J. (Eds.). (1994). *The nature of emotion: Fundamental questions*. New York: Oxford University Press.
Epstein, M. (2013). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective* (Revised ed.). New York: Basic Books.
Epstein, M. (2014). *The trauma of everyday life*. New York: Penguin Books.
Evans, A., Crane, R. S., Cooper, L., Mardula, J., Wilks, J., Surawy, C., … Kuyken, W. (2014). A framework for supervision for mindfulness-based teachers: A space for embodied mutual inquiry. *Mindfulness*, *6*(3), 572–581. https://doi.org/10.1007/s12671-014-0292-4

Fisher, B., & Tronto, J. C. (1990). Toward a feminist theory of caring. In E. Abel & M. Nelson (Eds.), *Circles of care*. Albany, NY: SUNY Press.
Fisher, J. W. (2010). Development and application of a spiritual well-being questionnaire called SHALOM. *Religions*, *1*, 105–112.
Fisher, J. W. (2011). The four domains model: Connecting spirituality, health and well-being. *Religions*, *2*, 17–28.
Fjorback, L. O., Arendt, M., Ornbol, E., Fink, P., & Walach, H. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy – A systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica*, *124*, 102–119.
Flanagan, O. (1993). *Varieties of moral pesonality*. Cambridge, MA: Harvard University Press.
Geertz, C. (1973). *Thick description: Towards an interpretive theory of culture*. New York: Basic Books.
Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York: The Guilford Press.
Gethin, R. (1998). *The foundations of Buddhism*. Oxford: Oxford University Press.
Giammarco, E. A. (2016). The measurement of individual differences inmorality. *Personality and Individual Differences*, *88*, 26–34.
Gilbert, P., & Choden. (2014). *Mindful compassion*. Oakland, CA: New Harbinger.
Gilligan, C. (1993). *In a different voice: Psychological theory and women's development* (revised ed.). Cambridge, MA: Harvard University Press.
Gilligan, C. (2011). *Joining the resistance*. Cambridge: Ploity Press.
Gilligan, C. (2014). Moral injury and the ethic of care: Reframing the conversation about differences. *Journal of Social Philosophy*, *45*(1), 89–106.
Gilligan, C., & Attanucci, J. (1988). Two moral orientations. In C. Gilligan, J. V. Ward, & J. Taylor (Eds.), *Mapping the moral domain*. Cambridge, MA: Harvard University Press.
Goldstein, J. (2013). *Mindfulness: A practical guide to awakening*. Louisville, CO: Sounds True.
Gombrich, R. (2009/2013). *What the Buddha thought*. Bristol, CT: Equinox Publishers.
Goyal, M., Singh, S., Sibinga, E. S., Gould, N. F., Rowland-Seymour, A., Sharma, R., … Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine*, *174*(3), 357–368. https://doi.org/10.1001/jamainternmed.2013.13018
Grabovac, A., Lau, M., & Willett, B. (2011). Mechanisms of mindfulness: A Buddhist psychological model. *Mindfulness*, *2*(3), 154–166. https://doi.org/10.1007/s12671-011-0054-5
Greenberg, M., & Mitra, J. (2015). From mindfulness to right mindfulness: the intersection of awareness and ethics. *Mindfulness*, *6*(1), 74–78. https://doi.org/10.1007/s12671-014-0384-1
Grossman, G. (2009). *On killing: The psychological cost of learning to kill in war and society*. New York: Back Bay Books.
Grossman, P. (2015). Mindfulness: Awareness informed by an embodied ethic. *Mindfulness*, *6*(1), 17–22. https://doi.org/10.1007/s12671-014-0372-5
Grossman, P., & Van Dam, N. (2011). Mindfulness, by any other name …: trials and tribulations of sati in western psychology and science. *Contemporary Buddhism*, *12*(1), 219–239.
Gunaratana, B. (2001). *Eight mindful steps to happiness: Walking the Buddha's path*. Somerville, MA: Wisdom Press.
Gunaratana, B. (2012). *The four foundations of mindfulness in plain English*. Boston, MA: Wisdom Publishers.
Hamilton, R. (2013). The frustrations of virtue: The myth of moral neutrality in psychotherapy. *Journal of Evaluation in Clinical Practice*, *19*, 485–492.
Hanh, T. N. (1998). *Interbeing: Fourteen guidelines for engaged Buddhism*. Berkeley, CA: Parallax Press.
Hanh, T. N. (1999). *The miracle of mindfulness: An introduction to the practice of meditation*. Boston: Beacon Press.
Hanh, T. N. (2006). *Transformation and healing: The sutra on the four foundations of mindfulness*. Berkeley CA: Parallax Press.

Hanh, T. N. (2007). *For a future to be possible: Buddhist ethics for everyday life*. Berkeley, CA: Parallax Press.
Hanh, T. N. (2009). *Breathe, You Are Alive! Sutra on the full awareness of breathing*. Berkeley, CA: Parallax Press.
Hanh, T. N. (2011). *Our appointment with life: Sutra on knowing the better way to live alone*. Berkley, CA: Parallax Press.
Hanley, A. W., Abell, N., Osborn, D. S., Roehrig, A. D., & Canto, A. I. (2016). Mind the Gaps: Are conclusions about mindfulness entirely conclusive? *Journal of Counseling & Development*, *94*, 103–113. https://doi.org/10.1002/jcad.12066
Harrington, A., & Dunne, J. (2015). When mindfulness is therapy: Ethical qualms, historical perspectives. *American Psychologist*, *70*(7), 621–631. https://doi.org/10.1037/a0039460
Harvey, P. (2000). *An introduction to Buddhist ethics*. Cambridge: Cambridge University Press.
Harvey, P. (2013). *An introduction to Buddhism: Teachings, history and practices* (2nd ed.). Cambridge: Cambridge University Press.
Hathaway, W. L. (2011). Ethical guidelines for using spiritually oriented interventions. In J. D. Aten, M. R. McMinn, & E. L. Worthington Jr. (Eds.), *Spiritually oriented interventions for counseling and psychotherapy* (pp. 65–81). Washington, DC: Ameerican Psychological Association.
Holmqvist, R., Philips, B., & Barkham, M. (2015). Developing practice-based evidence: Benefits, challenges, and tensions. *Psychotherapy Research*, *25*, 20–31. https://doi.org/10.1080/10503307.2013.861093
Holzel, B. K., Lazar, S. W., Gard, T., Schuman-Olivier, Z., Vago, D. R., & Ott, U. (2011). How does mindfulness meditation work? Proposing mechanisms of action from a conceptual and neural perspective. *Perspectives on Psychological Science*, *6*(6), 537–559.
Jackson, A. P., Hansen, J., & Cook-Ly, J. M. (2013). Value conflicts in psychotherapy. *Issues in Religion and Psychotherapy*, *35*, 6–15.
Janoff-Bulman, R., Sheikh, S., & Hepp, S. (2009). Proscriptive versus prescriptive morality: Two faces of moral regulation. *Journal of Personality and Social Psychology*, *96*(3), 521–537.
Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present and future. *Clinical Psychology: Science and Practice*, *10*, 144–156.
Kabat-Zinn, J. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism*, *12*(1), 281–306.
Kabat-Zinn, J. (2013). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Bantam.
Keltner, D. (2009). *Born to be good: The science of a meaningful life*. New York: W.W. Norton.
Keown, D. (2001). *The nature of Buddhist ethics*. New York: Palgrave.
Keown, D. (2005). *Buddhist ethics: A very short introduction*. Oxford: Oxford University Press.
Kernis, M. H., & Goldman, B. M. (2006). A multicomponent conceptualization of authenticity: Theory and research. *Advances in experimental social psychology*, *38*, 283–357. https://doi.org/10.1016/S0065-2601(06)38006-9
Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., Bouchard, V., … Hofmann, S. G. (2013). Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review*, *33*, 763–771.
Kohlberg, L. (Ed.). (1976). *Moral stages and moralization: The cognitive developmental approach*. New York: Holt, Rinehart, & Winston.
Kurchin, S. (2013). Thick concepts and thick descriptions. In S. Kurchin (Ed.), *Thick concepts* (pp. 60–77). Oxford: Oxford University Press.
Larabee, M. J. (Ed.). (1993). *An ethic of care*. New York: Routledge.
Lazarus, A. (1989). *The practice of multimodal therapy: Systematic, comprehensive and effective psychotherapy*. Baltimore, MD: Johns Hopkins University Press.
Lazarus, A. (2006). Multimodal therapy: A seven-point integration. In G. Stricker & J. Gold (Eds.), *A casebook of psychotherapy integration* (pp. 17–28). Washington, DC: American Psychological Association.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
Leiter, M. P., Jackson, N. J., & Shaughnessy, K. (2009). Contrasting burnout, turnover intention, control, value congruence and knowledge sharing between Baby Boomers and Generation X. *Journal of Nursing Management*, *17*(1), 100–109. https://doi.org/10.1111/j.1365-2834.2008.00884.x
Levine, P. (1997). *Waking the Tiger*. Berkeley: North Atlantic Books.
Lindahl, J. (2015). Why right mindfulness might not be right for mindfulness. *Mindfulness*, *6*(1), 57–62. https://doi.org/10.1007/s12671-014-0380-5
Machado, A. (2002). *Campos de Castilla y Soledades – Fields of Castille and Solitude*. London: Duckworth Publishers.
Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach burnout inventory manual* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.
Maslow, A. (2014). *Toward a psychology of being*. Floyd, VA: Sublime Books.
McCown, D. (2013). *The ethical space of mindfulness in clinical practice: An exploratory essay*. Philadelphia, PA: Jessica Kingsley Publishers.
McCown, D. (2014). *Mindfulness: Fulfilling the promise at last, with a relational view.* Paper presented at the Beyond the Therapeutic State: Collaborative Practices for Individual and Social Change, Drammen, Norway.
McCown, D. (2016). Being is relational: Considerations for using mindfulness in clinician-patient settings. In E. Shonin, W. van Gordon, & M. D. Griffiths (Eds.), *Mindfulness and Buddhist-derived approaches in mental health and addiction* (pp. 29–60). Switzerland: Springer.
McEwen, B. S. (2002). *The end of stress as we know it*. Washington, DC: Joseph Henry Press.
Mikulas, W. L. (2015). Ethics in Buddhist training. *Mindfulness*, *6*(1), 14–16. https://doi.org/10.1007/s12671-014-0371-6
Monteiro, L. (2012). *Burnout and spiritual incongruence: An evidence-based counselling model for Buddhist chaplains*. Santa Fe, NM: Upaya Zen Institute.
Monteiro, L. (2015). Dharma and distress: Buddhist teachings that support psychological principles in a mindfulness program. In E. Shonin, W. Van Gordon, & N. N. Singh (Eds.), *Buddhist Foundations of Mindfulness* (pp. 181–215). New York: Springer.
Monteiro, L. (2016). Implicit ethics and mindfulness: Subtle assumptions that MBIs are values-neutral. *International Journal of Psychotherapy*, *20*, 210–224.
Monteiro, L., & Musten, R. F. (2013). *Mindfulness starts here: An 8-week guide to skillful living*. Victoria, BC: Friesen Press.
Monteiro, L., Musten, R. F., & Compson, J. (2015). Traditional and contemporary mindfulness: Finding the middle path in the tangle of concerns. *Mindfulness*, *6*(1), 1–13.
Monteiro, L., Nuttall, S., & Musten, R. F. (2010). Five skillful habits: An ethics-based mindfulness intervention. *Counselling and Spirituality*, *29*(1), 91–103.
Musten, R. F., Monteiro, L., & Hollands, R. (2007). Self-administered psychosocial survey.
Narvaez, D. (2014). *Neurobiology and the development of human morality*. New York: W.W. Norton.
Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250.
Neff, K. D. (2011). *Self-compassion: Stop beating yourself up and leave insecurity behind*. New York: William Morrow.
Nuttall, S. (2009). *Mindfulness-based symptom management: A naturalistic study of a new mindfulness-based intervention.* (B.A.), University of Ottawa.
Olendzki, A. (2008). The real practice of mindfulness. *Buddhadharma*, *7*, 8.
Olendzki, A. (2011). The construction of mindfulness. *Contemporary Buddhism*, *12*(1), 55–70.
Onken, L. S., Carroll, K. M., Shoham, V., Cuthbert, B. N., & Riddle, M. (2014). Reenvisioning clinical science: Unifying the discipline to improve the public health. *Clinical Psychological Science*, *2*, 22–34. https://doi.org/10.1177/2167702613497932
Patterson, C. H. (1959). *Counseling and psychotherapy*. New York: Harper & Row.
Porges, S. (2007). The Polyvagal perspective. *Biological Psychology*, *74*(2), 116–143.

Porges, S. (2011). *The Polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: W.W. Norton.
Purser, R. (2015). Clearing the muddles path of traditional and contemporary mindfulness: A response to Monteiro, Musten, and Compson. *Mindfulness*, *6*(23–45).
Purser, R., & Loy, D. (2013). Beyond McMindfulness. *Huffington Post*. Retrieved from http://www.huffingtonpost.com/ron-purser/beyond-mcmindfulness_b_3519289.html website: http://www.huffingtonpost.com/
Riso, L. P., du Toit, P. L., Stein, D. J., & Young, J. E. (2007). *Cognitive schemas and core beliefs in psychological problems*. Washington, DC: American Psychological Association.
Roeser, R. W., Vago, D., Pinela, C., Morris, L. S., Taylor, C., & Harrison, J. (2014). Contemplative education: Cultivating ethical development through mindfulness training. In L. NUcci, D. Narvaez, & T. Krettenauer (Eds.), *Handbook of moral and character educaiton*. New York: Routledge, Taylor & Francis Group.
Rogers, C. (2003). *Client-centered therapy: Its current practice, implications and theory*. London: Constable Publisher.
Rogers, C., & Kramer, P. D. (1995). *On becoming a person: A therapist's view of psychotherapy* (2nd ed.). New York: Mariner Books.
Rosenbaum, R. M., & Magrid, B. (Eds.). (2016). *What's wrong with mindfulness (and what isn't)*. Somerville, MA: Wisdom Books.
Schachter, S., & Singer, J. (1962). Cognitive, social, and physiological determinants of emotional state. *Psychological Review*, *69*, 379–399. https://doi.org/10.1037/h0046234
Segal, Z. V., Williams, J. M., & Teasdale, J. D. (2012). *Mindfulness based cognitive therapy for the prevention of depression relapse* (2nd ed.). New York: The Guilford Press.
Seligman, M. (2012). *Flourish: A visionary new understanding of happiness and well-being*. New York: Free Press.
Senauke, A. (2013). Wrong Mindfulness: An interview with Hozan Alan Senauke. Retrieved from http://www.tricycle.com/blog/wrong-mindfulness website: http://www.tricycle.com/blog/wrong-mindfulness
Selye, H. (1974). *Stress without distress*. Toronto: HarperCollins.
Shapiro, S. L., & Carlson, L. E. (2009). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions*. Washington, DC: American Psychological Association.
Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2009). Mechanisms of mindfulness. *Journal of Clinical Psychology*, *62*(3), 373–386. https://doi.org/10.1002/jclp.20237
Shapiro, S. L., Jazaieri, H., & Goldin, P. R. (2012). Mindfulness-based stress reduction effects on moral reasoning and decision making. *The Journal of Positive Psychology*, *7*(6), 504–515.
Shaw, C. (2012). *Mindfulness-based symptom management and the treatment of burnout* (M.A. Research, Carleton University, Ottawa, ON).
Smallenbroek, O., Zelenski, J. M., & Whelan, D. (2017). Authenticity as a eudaimonic construct: The relationships among authenticity, values, and valence. *The Journal of Positive Psychology*, *12*(2), 197–209.
Stanley, S. (2013). 'Things said or done long ago are recalled and remembered': The ethics of mindfulness in early Buddhism, psychotherapy and clinical psychology. *European Journal of Psychotherapy and Counselling*, *15*(2), 151–162.
Thanissaro, B. (1997a). Sallatha Sutta: The arrow. *Samyutta Nikaya*. Retrieved from http://www.accesstoinsight.org/tipitaka/sn/sn36/sn36.006.than.html
Thanissaro, B. (1997b). Simsapa Sutta: The Simsapa Leaves SN 56.31. *Samyutta Nikaya*. Retrieved from http://www.accesstoinsight.org/tipitaka/sn/sn56/sn56.031.than.html
Thanissaro, B. (1998). Cula-Malunkyovada Sutta: The shorter instructions to Malunkya. Retrieved from http://www.accesstoinsight.org/tipitaka/mn/mn.063.than.html
Thanissaro, B. (2004). Alagaddupama Sutta: The Water-Snake Simile. Retrieved from http://www.accesstoinsight.org/tipitaka/mn/mn.022.than.html
Thanissaro, B. (2012). *Right mindfulness: Memory and ardency on the Buddhist path.*

Tirch, D., Silberstein, L., & Kolts, R. (2016). *Buddhist psychology and cognitive-behavioral therapy: A clinician's guide*. New York: The Guilford Press.

Titmuss, C. (2013). The Buddha of mindfulness. The politics of mindfulness. http://christophertitmuss.org/blog/?p=1454. Retrieved from http://www.christophertitmuss.org/

Tjeltveit, A. C. (1999). *Ethics and values in psychotherapy*. London: Routledge.

Tronto, J. C. (1993). *Moral Boundaries: A political argument for an ethic of care*. New York: Routledge.

Tuske, J. (2013). The non-self theory and problems in philosophy of mind. In S. M. Emmanuel (Ed.), *A companion to Buddhist philosophy*. Chicehester, West Sussex: Wiley.

van Aalderen, J. R., Breukers, W. J., Reuzel, R. P. B., & Speckens, A. E. M. (2014). The role of the teacher in mindfulness-based approaches: A qualitative study. *Mindfulness*, *5*, 170–178.

Van Gordon, W., Shonin, E., & Griffiths, M. (2015). Towards a second generation of mindfulness-based interventions. *Australian & New Zealand Joyrnal of Psychiatry*, *49*(7), 591–592. https://doi.org/10.1177/0004867415577437

van Nistelrooij, I., Schaafsma, P., & Tronto, J. C. (2014). Ricoeur and the ethics of care. *Medical Health Care and Philosophy*, *17*, 485–491.

Varela, F., Thompson, E., & Rosch, E. (2017). *The embodied mind: Cognitive science and human experience* (2nd ed.). Cambridge MA: MIT Press.

Walker, M. U. (2007). *Moral understandings: A feminist study in ethics*. New York: Oxford University Press.

Whitehill, J. (2000). Buddhism and the Virtues. In D. Keown (Ed.), *Contemporary Buddhist Ethics*. London: Routledge Curzon.

Williams, J. M., & Kabat-Zinn, J. (2013). *Mindfulness: Diverse perspectives on its meaning, origins and applications*. New York: Routledge.