Chapter 13
Ethics of Mindfulness in Organizations

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The chapters in this section examine the ethics of bringing mindfulness-based programs (MBPs) into secular settings that do not necessarily embody the ethics typically associated with Buddhism or with Buddhist practice. This has been seen as particularly problematic when the Buddhist practice of mindfulness is introduced into organizational settings (Ronald Purser, 2015; Ronald Purser & Milillo, 2015). The intent of my chapter is to acknowledge their contributions and examine two other ethical issues that require deeper examination.

The first ethical concern I address is the potential for MBPs to result in significantly distressing emotions or experiences. This is usually not what participants expect and thus can be more troubling because it is unexpected. I examine the consequences of negative effects of mindfulness practice through the lens of a duty to care and the process of ensuring safety through appropriate consent to be taught mindfulness practices. The second ethical concern is rooted in the different expectations and impact an MBP has on the employee attending the program and the organization sponsoring the program. This difference in expectations can arise as the participants become more aware of any conflict between sustaining their well-being and meeting the organization's demands; that is, while meeting an individual's needs an MBP may not meet the organizational client's expectations. Issues such as the format of an MBP, clarity of outcomes, and managing the possible divergent expectations of employee and employer are examined.

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L.M. Monteiro et al. (eds.), *Practitioner's Guide to Ethics and Mindfulness-Based Interventions*, Mindfulness in Behavioral Health,
DOI 10.1007/978-3-319-64924-5_13

Mindfulness Extracted from Its Historical Social Context

In considering why care should be taken in translating a spiritual practice into a secular, organizational context, we can refer to the expectations of practice and the safeguards that were likely inherent in the historical social context where the Buddha shared his teachings. When we contrast those expectations with the expectations modern organizations as well as mindfulness trainers have of their MBPs, two areas emerge where differences between historical and modern social contexts suggest the need for care. The first is the potential risks for modern day participants enrolled in mindfulness programs in organizations that have cultures that are radically different from the historical culture from which the Buddha's practice of mindfulness emerged.

The second is the potential differences between the expectations of mindfulness practices in organizations and the expectations of the followers of the Buddha who were practicing meditation in his sangha.

McMahan (2008) reminds us that the Buddha said he only taught two things, suffering and the end of suffering. The intent of practice was solely to attain the end of suffering by ending the cycle of dependent origination which… "denotes in early Buddhist literature the chain of causes and conditions that give rise to all phenomenal existence in the world of impermanence, birth, death, and rebirth (samsara)" (p. 153). In modern times, the Buddha's idea of dependent origination has come to be a model, for modern Buddhists and others, of an interconnected world. It has become a source of inspiration for the ecology movement as well as a source of inspiration for those of us who see the beauty and wonder in the interconnectedness of all things (McMahan, 2008). Thus, it is important to recognize that Buddhism itself has changed over the centuries so that, at least in the West, it has become oriented more toward reducing the suffering in and of this world than toward following a path of practice that ultimately would allow those who followed his path to escape forever the suffering that was inevitably the consequence of birth.

In the next section, I highlight aspects of the social history of early Buddhism that shaped the intent and expectation of practice at the time. The intent and expectation of practice for those early Buddhists was radically different from the intent and expectation of modern secular mindfulness practice, particularly in organizations. Those differences form the core of our understanding of why there is a need to take care for participants in our MBPs and a need to manage the expectations of organizational clients and program participants.

Much of the next section is based on the work of the historian Richard Gombrich (2006, 2009) who has written extensively on the social history of the Buddha's time. He suggests that the Buddha probably was the son of a leader of a large village that likely did not have a caste system but used other means to rank individuals. According to Gombrich (2006), this is the model the Buddha likely used for his sangha.

While he grew up in a village, he taught in what was likely the beginning of an urban center (Gombrich, 2006). The beginnings of urbanization likely resulted from

an agricultural surplus that allowed some people to remove themselves from the land. Some would have been absentee landlords while others would have had a livelihood that was not "derived directly from agriculture" (p. 39).

Gombrich (2006) notes that during the time of the Buddha there was already a counter-culture of individuals who were renouncing the norms of the time. Thus, when he left his own home he stepped into a life that already existed. It is also likely that these renouncers were able to exist also because householders, the heads of families, had the surplus available to support them. Gombrich suggests that the Buddha's message may have resonated with this particular group because, despite their relative material prosperity, they still were subject to the realities that life was often brutal and short. Gombrich (2006) citing McNeill (1998) speculates that the Ganges basin where the Buddha shared his teachings was an ideal environment for producing an agricultural surplus. But because it was warm and damp, it was also a fertile breeding ground for deadly diseases. It was this contrast between the comfort associated with relative wealth and the constant threat of painful illness and death that provided a receptive audience for his teachings.

The Buddha welcomed all into his sangha. As well, his sangha was organized in the manner of his village with no caste system. However, Gombrich's examination of the suttas leads him to conclude that most of the members of the sangha were from the class of householders. There are three aspects of the social history of the Buddha's time that resonated with his teachings and with his decision to create a sangha that was based on his village life. These same three are ones that may not translate well into how mindfulness is presented in secular organizational settings.

The first is the peoples of the time accepted as a reality that life was inherently unsatisfactory. Thus, those who became part of the Buddha's sangha were not expecting to find a way to make life more satisfying but rather to enter a path that would eventually end their cycle of rebirth. This is a very different perspective from that of the modern mindfulness meditator in an organization who expects the meditation to be relaxing and to help manage stress.

Second, the monastic members of the Buddha's sangha viewed meditation as a means to apprehend the wisdom of the Four Noble Truths. That wisdom emerged from a moral life that provided the clarity necessary for the meditator to embody that wisdom. In contrast to secular mindfulness taught in organizations, moral behavior present in a monastic community is not typically taught nor is there the intent that mindfulness practice will lead to wisdom as defined in the Four Noble Truths. However, the participant who begins the practice of meditation may still experience an incongruence between the demands of organizational life and develop an emerging sense of how the demands of their work contrast with their values.

Third, it was likely that only the members of the monastic community who had stepped away from the complexities of living in the world could practice meditation as a means toward the ultimate goal of achieving awakening. There was likely an inherent emotional safety associated with being in the Buddha's sangha removed from many of the stresses that characterized life outside the sangha. It is not clear how a monastic with a pre-existing disorder might have fared in sangha, but it can possibly be presumed that, at least, in some instances the order inherent in sangha

life and the Buddha's supportive community would have been therapeutic. The expectations of that historical time included hearing voices, having visions, and so on (Armstrong, 2006). Thus, it is possible to speculate that the sangha would have been accepting of behavior that in modern times would be diagnosed as severe mental illness.

These distinctions between the Buddha's intention for mindfulness practice are a frame against which we can examine the current critiques of mindfulness set in organizational environments.

Critiques and Concerns of Organizational Mindfulness Programs

As MBPs expand in their application into organizations such as corporations and the military, concerns have been voiced that such venues do not necessarily have the commitment to the ethical practices that are at the core of Buddhist practice (Purser & Loy, 2013). The criticisms that have been voiced of secular mindfulness in general and of these specific applications, in particular, are that such secularized, de-ethnicized applications create a risk of causing harm.

The Economist (Schumpeter, 2013) raised a similar concern and added the perspective that perhaps corporate mindfulness programs were really no more useful than, and maybe not even as useful as, a walk in the woods. That suggestion was also addressed in an extensive review by Good and colleagues (Good et al., 2016). While it appears that emerging research suggests there can be benefits from introducing mindfulness into organizations, the research is sparse and the specific nature of those benefits is not yet clear. These observations echo the responses (Choi & Tobias, 2015; Connolly, Stuhlmacher, & Cellar, 2015; Hülsheger, 2015) to a focal article by Hyland, Lee, and Mills (2015).

Monteiro, Musten, and Compson (2015) explored the complexities of bringing mindfulness, a spiritually based practice, into secular settings. A sample of the responses to their article (Baer, 2015; Purser, 2015; Van Gordon, Shonin, Lomas, & Griffiths, 2016) echoed the concern expressed in the Economist (Schumpeter, 2013) and by Choi and Tobias (2015) and Hülsheger (2015). However, these responses from both the secular mindfulness and Buddhist communities also offered an array of possible paths toward addressing those concerns.

Shalini Bahl and Sean Bruyea, authors of chapters in this section, reiterate the concern that MBPs in organizations risk ignoring the ethical intentions that were historically meant to guide mindful practice. Bahl suggests that two ethical paradoxes challenge the trainer who wants to bring mindfulness into organizations. The first is that organizations may be introducing mindfulness practices so that their employees can manage work stress more effectively. However, they may not be altering the working conditions that are the primary source of the stress. The second paradox proposes that corporate cultures, in general, do not embody the same ethic that is integral to the intention of mindfulness practice (Kabat-Zinn, 2011).

Bahl provides a balanced discussion of these paradoxes, focusing on how the mindfulness trainer can navigate them. She refers to "circles of influence" that bring mindful inquiry first into the trainer's personal development, then into the relationship the trainer has with the network of people, potential and actual, who are associated with the trainer's MBP. She suggests that this network be diverse and can include other mindfulness teachers, Buddhist teachers, and the clients themselves. Her final circle includes the processes associated with providing the program.

A detailed description of how to bring mindful inquiry into each of these circles provides a path the mindfulness trainer can follow as they navigate through the ethical challenges associated with bringing mindfulness into organizations. Finally, she introduces the need to bring wisdom and ethical practices into the training processes, engaging the root causes of the problem, and thereby avoiding a myopic approach to mindfulness training.

Bruyea in his chapter describes the complex challenges of bringing mindfulness into a military organization. He chooses to structure his discussion of the ethics of bringing mindfulness into military organizations by first discussing ethics as they are understood by mindfulness trainers. He then gives us a detailed look at the complex nature of the discussion of ethics in the military followed by an insightful look at military culture. Finally, he brings his arguments together into a nuanced discussion of the ethical issues associated with bringing ethics into the military and veteran populations. Bruyea notes that many military tasks require the training in intention and attention that are familiar to mindfulness trainers. Thus, from that perspective mindfulness would not be unfamiliar to military members and thus might facilitate the use of mindfulness as an effective intervention with soldiers and veterans. He discusses the ethical and practical barriers to introducing mindfulness either as resilience training or as a clinical intervention. But he notes that the military culture itself may also pose the most difficult challenge. His discussion of the military culture is insightful. He makes the point clearly that the service-before-self culture of the military and veteran communities may not fit well with the individual approach to practice and awareness that is at the core of many mindfulness programs. He clearly articulates a number of concerns about how mindfulness might be used by the military. However, he also notes that with appropriate cultural awareness, mindfulness trainers can play an important role in helping military members as they are transitioning into civilian life.

Bahl and Bruyea have provided balanced discussions of the ethical challenges associated with extracting a practice like mindfulness from its spiritual context, and specifically from its complex ethical framework. In addition, Bruyea raises the idea that mindfulness trainers may have to recognize there are also cultural challenges they will have to address as they begin to introduce mindfulness as a clinical intervention in military and veteran populations. While his focus is on one population, his insights remind us that all organizations have unique cultures that must be taken into account when mindfulness trainers are considering how they are going to deliver their interventions.

Both authors have clearly laid out a range of ethical challenges we face when we consider bringing mindfulness into organizations. And they have suggested

approaches we can take to mitigate against violating the ethical intent of mindfulness as we introduce the practice into organizations. In this chapter, I would like to expand on two areas they touched on. The first, raised by Bahl, is, simply, how can we be assured that our intervention is doing what we say it is doing? The second, raised by Bruyea, is how do we take care of those in the room when we often know very little about who is in the room. That is, we often know very little about the acute and chronic psychological challenges individual participants may be bringing into the MBP sessions. These issues form the first ethical concern that I now address as a duty to care.

The Duty to Care

Bruyea, in his chapter on the ethics of bringing mindfulness into the military, raised the challenges associated with introducing an individually based practice like mindfulness into a culture that puts service before self. His discussion explored the responsibility trainers, who bring mindfulness into organizations, have to know who is in the room. It is possible to generalize from his discussion and acknowledge that all mindfulness trainers have a responsibility not only to know who is in the room. They also have a duty to provide care for those in the room for whom mindfulness is not necessarily a benign intervention. In clinical settings, the question of who is in the room is usually managed through pre-screenings (Dobkin, Irving, & Amar, 2012). The issue of the duty to provide appropriate care for those in the room is addressed in the ethical standards proscribed by the clinician's professional code of ethics.

However, in many organizational settings, codes of conduct, awareness of scope of practice, and ethical guidelines may vary considerably depending on the trainer's own professional training. This level of variation can impact how the iatrogenic effects of mindfulness practice are managed. Evidence is just beginning to emerge that some participants in these programs can experience levels of distress that, at times, can be intense (Creswell, 2017; Lindahl et al., 2017; Lomas, Cartwright, Edginton, & Ridge, 2015; Russ & Elliot, 2017). In part, some distress is a normal consequence of bringing open awareness to the reality of one's life (Coffey et al., 2010); it is a result of the goal of mindfulness training. That distress may not moderate in the early sessions of the program but begins to moderate as mindfulness skills are acquired (Baer, Carmody, & Hunsinger, 2012).

However, some participants may have stronger reactions that may not moderate, or they may experience more serious mental health events during a class. The evidence for these more severe occurrences is often found in anecdotal examples of what has come to be termed "dark night" experiences (Creswell, 2017). There is stronger evidence of significant distress emerging during longer meditation experiences (Lomas et al., 2015; Russ & Elliott, 2017; Yorston, 2001). However, the possibility of a significant distressing experience is acknowledged by the common practice of screening for disorders that are likely to be adversely impacted by mind-

fulness training (Dobkin et al., 2012). My own experience is that these incidents do occur both in the mindfulness-based programs that are offered generally and in the shorter programs offered in organizations. A model for how these incidents might be managed is offered in a later section.

For the moment, it is important to recognize that most trainers offering these programs in organizations may not be clinicians or may not be experienced in dealing with the distress that could arise in a mindfulness program. Further many trainers may feel that since they are not teaching the program as a clinical intervention, they would not expect anyone to experience significant distress. However, epidemiological studies of the incidence of serious psychiatric disorders within the general population regularly report non-trivial incidence of these disorders (Ahola et al., 2011; Baumeister & Härter, 2007; Norris & Slone, 2014), suggesting there is always a likelihood of someone in the room who is at risk for or experiencing a mental health disorder.

As well, it has been my experience that organizations often have a circumscribed idea of mindfulness as something that will help their employees better manage the stress that seems to be permeating everyone's life and is independent of their overall psychological status (Duxbury, 2008; Duxbury, Stevenson, & Higgins, 2017; Higgins, Duxbury, & Lyons, 2010; Pines, Neal, Hammer, & Icekson, 2011; Toker & Biron, 2012). Thus, both organizations and participants in an organization-sponsored MBP may not have an expectation that distress can emerge as a consequence of participating in a program.

As part of an evaluation of the programs that my colleagues and I at the Ottawa Mindfulness Clinic regularly conduct with organizational clients, we ask participants to complete the Maslach Burnout Inventory, a standard measure of work burnout (Maslach, Jackson, & Leiter, 1997) before they begin the program. It is not uncommon for about half the participants to report levels of emotional exhaustion consistent with burnout. Given the research generally reports high levels of stress in the modern work force, we do not expect other trainers would experience their participants as different from those in our programs. Thus trainers can expect that someone in the room may be experiencing significant psychological distress simply because of the incidence of mental disorders in the general population (Baumeister & Härter, 2007). And, they can also expect that some of their participants will be experiencing significant levels of burnout as a result of their work stress as well as from challenges to work–life balance (Dewa, Lin, Kooehoorn, & Goldner, 2007; Diestel & Schmidt, 2011; Higgins et al., 2010; Watts & Robertson, 2011).

Although there is evidence that mindfulness interventions can mitigate against becoming burned out (Geller, Krasner, & Korones, 2010; Grégoire & Lachance, 2015; Halpern & Maunder, 2011; Hülsheger, Alberts, Feinholdt, & Lang, 2013; Krasner et al., 2009; Wolever et al., 2012), it does not mean everyone in the room will benefit equally or that no one will be distressed by the intervention. Thus, there remains the duty to care for those individuals whose pre-existing distress may be exacerbated by attending a mindfulness program, as well as for those who may experience significant distress as a direct result of attending a mindfulness program.

The potential for unexpected mental health distress related to mindfulness practices means our duty to care begins with informed consent. In clinical settings, it is standard practice to obtain informed consent from participants acknowledging that they are aware of the possibility that the program may include negative experiences or potential exacerbation of present symptoms. Participants also are aware of the support available to them should they feel the need to connect with a trainer who is also usually a clinician. Finally, because participants are regularly screened for pre-existing conditions the trainers typically know who is in the room.

Those same safeguards are not usually available, even for clinicians, offering mindfulness programs in organizational settings. Thus, honoring the duty to care in organizational settings is a common problem for all trainers regardless of their backgrounds. Organizations and participants typically expect mindfulness to help and would not likely understand the need for informed consent. Nor would they likely be particularly comfortable asking their employees to submit to a pre-screening process before signing up for what they believe is a course that will help enhance their sense of well-being. Recognizing those challenges, we have developed a process that we refer to as Affirmed Assent. What I mean by Affirmed Assent is that participants are introduced to both the benefits of mindfulness as well as the challenges that can emerge during practice, typically before enrolling in a program. Thus, when they do enroll they have an idea of what to expect and by signing up they are affirming their assent to take part. In early sessions, the idea that the practice can be difficult and can also be distressing is normalized. And, the program is also offered as one way to increase personal well-being not the only way and for some, not the best way. Thus, the space is left open for a participant to choose another approach at any time during the MBP. This concept may not meet some stringent and rigid perspectives of informed consent, but it does provide a reasonable approach to duty to care that would be acceptable in most organizational settings. (The details of how we introduce Affirmed Consent into our programs, as well as, specific aspects of the inquiry that support Affirmed Consent are discussed in a later section on bringing MBPs into the marketplace.) Having established the need for a duty to care in this section, I address the second ethical concern which is related to issues of evaluating and clarifying outcomes of MBPs.

Outcomes and Expectations

Outcome Evidence

Implicit in the duty to care is the confidence we place in evidence-based outcomes. However, organizational MBPs have yet to produce consistent patterns of effectiveness. Choi and Tobias (2015) noted that there is a lack of longitudinal research confirming that participants who have completed a program actually retain the benefits of mindfulness over the long term. These authors also note there is an absence

of controlled studies providing clear support that mindfulness factors rather than, for example, a placebo effect are a likely reason for any observed changes. Hulsheger (2015) suggests there is evidence that mindfulness creates increased awareness. However, he notes that creating increased awareness does not necessarily mean that once an employee is more aware they will therefore be a better employee from the organization's perspective.

Although recent reviews suggest there is significant potential benefit both for individuals and organizations by bringing mindfulness into the workplace (Good et al., 2016; Hülsheger et al., 2013; Hyland et al., 2015; Roche, Haar, & Luthans, 2014), much also remains unknown (Choi & Tobias, 2015; Connolly et al., 2015; Hülsheger, 2015). Thus, it is important for trainers who are developing MBPs in organizational settings to develop clear intentions for their programs that include providing expectations consistent with the current literature. In general, the wise practitioner would be best served by being cautious about the benefits claimed for their MBP.

My colleagues and I have addressed some of these concerns in a program developed to introduce mindfulness as one means of increasing well-being in a public service organization. Recent studies have shown a relationship between mindfulness and well-being mediated by a number of constructs (Bajaj, Gupta, & Pande, 2016; Bajaj & Pande, 2016; Galante, Galante, Bekkers, & Gallacher, 2014; Roche et al., 2014) including Psychological Capital (Roche et al., 2014), a validated measure that has been related to well-being in organizations (Luthans, Avolio, Avey, & Norman, 2007; Luthans, Youssef, & Avolio, 2007; Luthans, Youssef-Morgan, & Avolio, 2015; Roche et al., 2014; Youssef & Luthans, 2012). Based on current research, we felt it was appropriate to assume increased well-being in an organizational setting was a reasonable expected outcome of an MBP. Other researchers (Biron, 2014; Burke, 2009; Singh, Burke, & Boekhorst, 2016) have shown that fostering well-being in organizations has a practical, beneficial impact on organizational functioning. Thus, there also seemed to be good reason to expect that connecting mindfulness to organizational effectiveness is likely when the intent of an MBP is to foster employee well-being. As studies are becoming more complex and are including more elegant controls, we are beginning to see that mindfulness remains an effective intervention. However, the degree to which mindfulness is effective depends on many factors (Buchholz, 2015; Good et al., 2016). For example, in clinical settings, where much of the research has been done, it seems that more traditional approaches are as effective (Kuyken et al., 2015; Moon, 2017) and, at times, perhaps more effective (Garland et al., 2014) than a mindfulness intervention.

It becomes more challenging in organizational environments where the challenges of interpreting research findings are compounded by the demands of designing organizational MBPs that suit the organization's infrastructure. Availability of personnel, physical space, participants' schedules—especially in travel-intense companies—often require modifications of standard protocols of MBPs. My own experience is that protocols also are in a constant state of fluidity to meet these organizational realities.

Typical concerns for issues such as time for formal practice can become the least of a trainer's concern. If we take MBSR-informed (Kabat-Zinn, 1990) programs as a model, trainers may be required to decrease the number of sessions from the standard eight-session protocol. Organizational requirements may mean that sessions will have to be shorter than the recommended two and a half hours. That also applies to the length of the meditations themselves which may have to be shortened because of many factors, both organizational and individual. Bahl noted that there is little research that provides direction for knowing if and how protocols can be modified and still be seen as providing the same training. These issues may have a significant impact on the research findings.

As our understanding matures of how mindfulness works, it becomes increasingly important to have a clear expectation of an outcome for a proposed MBP. This problem is not unique to trainers who offer MBPs in organizations, however we will discuss later in this chapter how trainers can provide evidence that their MBP is doing what it is intended to do. Fortunately for our purposes a model, practice-based evidence (Barkham, Stiles, Lambert, & Mello-Clark, 2010; Green, 2012; Jensen et al., 2012), has been developed in response to a similar need among practicing therapists. Much like trainers who structure their MBPs to meet organizational requirements, therapists have the same need to be assured that therapeutic protocols developed in ideal research settings are still valid when translated into the complex interchanges with clients in their real-world offices. I will describe the use of practice-based evidence in an organizational setting below.

Bringing Caring and Efficacy into the Marketplace

The trainer walks a fine line between recognizing that there can be some risk of harm associated with an MBP and not, at the same time, presenting mindfulness as being more harmful than it might be. Coffey, Hartman and Fredrickson (2010) reported a positive though paradoxical relationship between attention and psychological distress. They interpreted this positive relationship as the possible result of paying attention to psychological distress which may make it more salient in the short run but also provide data for better management of those symptoms in the long run. Consistent with these findings and interpretations, some participants in our programs have reported increases in their experience of distress or that, early in the program, the practice does not appear to help them manage their distress. Those expectations are almost always managed through an inquiry process that has the participant beginning to understand mindfulness as a practice of "paying attention to" rather than "getting rid of" one's experience. However, discernment is also required because, in a few instances, we have had participants experience significant emotional distress that increased over the course of sessions. In these cases, it was and is recommended, after an individual session with the participant, that they discontinue in the group in favor of other options.

The trainer can walk a more established line when they make an effort to determine that the MBP they are offering is achieving what it is expected to achieve. In other words, it is an evidence-based practice. Organization representatives, whether they are referring health care providers, disability insurers, or managers want to be assured that the program they are supporting with their referrals or inviting into their organization is a good investment in time and money.

It is often useful to refer back to what the research shows. However, as is the case with psychotherapy (Barkham, Stiles, et al., 2010; Green, 2012; Jensen et al., 2012) most programs evolve to meet the needs of the participants. In many if not most cases, the specific MBP will not completely adhere to the program evaluated in the research study. It thus becomes important to develop an evaluation protocol that can demonstrate that a specific program a trainer has designed achieves the expected results. Clinicians in psychological practice, as well as in health care generally, are beginning to use the evidence they collect from their practice as a means for ensuring that their interventions are achieving what they are meant to achieve. We have adopted this Practice Based Evidence approach to evaluate the efficacy of the programs we offer and have also included Practice Based Evidence in our organizational programs.

In the next two sections, I describe a model for Affirmed Assent as a practical approach for honoring a trainer's duty to care. Following that discussion, an evaluation protocol based on the Practice Based Evidence model is described.

A Two-Stage Approach to Affirmed Assent

The process of Affirmed Assent is a model for honoring the duty to care when the trainer cannot know who is in the room. The two stages include an information session where participants are introduced to the potential challenges they may encounter as they are cultivating a mindfulness practice. The second stage encompasses the first and second sessions of a multiple week program where the inquiry opens the space for those participants who may be having challenges to voice those challenges. There also is an overarching commitment by trainers in the program to ensure that there is an opportunity for those individuals who may feel the need for support or have questions and concerns to have access to the trainers.

Stage One Information sessions are typically offered a week before a program begins. In the information session, in addition to explaining what mindfulness is and how it might be beneficial to participants, we also introduce participants to some of the challenges associated with mindfulness using three experiential exercises. In the first exercise participants are led through a guided meditation where they are asked to intentionally and gently bring their attention first to the objects of their awareness, seeing if it is possible to just know that the objects are present without needing to explore them, then shifting their attention to the breath, and finally bringing awareness to the body.

In the inquiry that follows, some participants will usually share the difficulties they experienced maintaining their attention on the object of their attention; sometimes indicating that they could not turn their mind off. This becomes an opportunity to normalize their experience and to note that the practice, although it sounds simple, is hard, and it is best if they are gentle with themselves. It is also a time to note that the intent is not to change what is happening but to notice what is happening. Often, we then ask participants to offer a single word or a couple of words (popcorn style) that describes why they think it would be important to notice what is going on. In this way, we are beginning to orient participants toward seeing the practice as a way of noticing and then connecting the noticing to taking intentional steps toward the intent of the program which is to foster well-being.

In the second experiential exercise, we introduce participants to the conditions at work that are likely to increase stress at work. Traditionally those have been High Demand, Low Control, and Lack of Support (Karasek & Theorell, 1990; Luchman & González-Morales, 2013; Regehr & Millar, 2007; Shirom, Toker, Alkaly, Jacobson, & Balicer, 2011; Tucker et al., 2008). In the experiential exercise, participants are asked to settle into their breathing, bringing attention just to the breath itself, and then bringing to mind the demands they have in their work and personal life; noticing the physical sensations, emotions, and thoughts that come up. This template is followed for the other two factors related to work stress.

Once the exercise has been completed they are asked to popcorn out a word or two that describes what they noticed when they brought the demands of their work and personal life to mind. This template is repeated for each of the factors associated with work stress.

Participants' responses usually include feeling overwhelmed, exhausted, anxious, and so on. These responses give the trainers an opportunity to note that mindfulness opens up space to see where you are; some time is spent reminding participants that the present moment is not always a pleasant moment. In the last experiential exercise, the three factors that define burnout (Leiter, 2015; Maslach, Schaufeli, & Leiter, 2001), Emotional Exhaustion, Cynicism or Depersonalization, and Loss of a Sense of Personal Efficacy are introduced and explored using the same template. Taken together, these two exercises introduce participants to the reality that what one experiences in a mindfulness course can be distressing. Participants typically only register for a program after the Information Session.

Stage Two In the first and second classes, we open the space for individuals who may be having difficulty sharing their experiences. It can sometimes be challenging as there is a tendency for those who initially share to be ones who have had a pleasant experience with the exercises. Thus, it is sometimes necessary to offer space for other experiences by saying, "That's good. I am sure that not everybody's experience was that pleasant. Could someone share a less pleasant experience they had with the exercise"? That usually opens the space for difficult experiences to emerge and an opportunity to note that too is mindfulness and remind participants that mindfulness is about noticing, not about having a good experience.

Beginning with the first class, we also note in a general way that if anyone is having difficulty understanding the home practice, is struggling with a concept, or is having difficulty with an exercise to contact one of the trainers either by email or by arranging to chat with a trainer either before or after class. Thus, the idea that the experience may not be pleasant is normalized as one of the possible challenges that a participant might encounter.

In summary, starting with the information session participants have an opportunity to explore the ranges of experiences that can arise in meditation. The program is also presented as one, but not necessarily the only, way to foster well-being. Affirmed Assent is a process whereby trainers open the space for potential participants to make an informed decision to enroll in the program and also to continue in the program once they have enrolled.

Are We Doing What We Say We Are Doing?

Most of our programs are offered in public service organizations committed to the well-being of managers and staff. They are also conscious of the public purse and want to ensure that they are getting value for money spent. In one department that was science-based, it was expected that there would be some form of program evaluation that would allow the executive who had championed the program to show the department's senior executives that the program had merit.

There were restrictions that limited the content of the evaluation. First, the program was expected to contribute to employees' well-being with an emphasis on well-being at work. The program was offered in a public service department that required all materials were in English and French. The evaluation had to be brief because there was limited time in the program to administer pre- and post-evaluations.

The evaluation included both standardized assessment instruments that could be scored numerically and thus would provide quantitative measures of pre–post changes. It also included a structured qualitative assessment instrument that examined the processes underlying the changes (Barkham, Hardy, & Mellor-Clark, 2010a). Two primary quantitative measures were chosen, the Maslach Burnout Inventory (MBI) (Maslach et al., 1997) and the Psychological Capital Questionnaire (PsyCap) (Luthans, Avolio, et al., 2007). The MBI scores on Emotional Exhaustion, the factor most often associated with burnout, were used to assess the level of stress experienced by participants pre- and post-program, Scores across the four factors of Hope, Efficacy, Resilience, and Optimism that make up the construct of Psychological Capital (Luthans, Avolio, et al., 2007; Youssef & Luthans, 2012) were used to assess well-being. The qualitative results contributed insight into how individual practitioners were bringing the practices into their work and personal lives. Together these data allowed us to begin to construct a model of how mindfulness was impacting on the participants in this MBP. This model then allowed us to conceptualize how we may want to improve the quality of our interventions.

The evaluation process is important for many reasons. First, it provides evidence that a program is doing what it is intended to do. It provides the data needed to assure the client that the cost of the program was money well spent. The qualitative data provide insight into processes that contributed to the changes in well-being and guide our iterative changes that can improve program effectiveness. Taken together these data allow us to better understand our program and to potentially contribute in a meaningful way to the emerging science around the usefulness of bringing mindfulness into organizations.

Conclusions

My discussion of the trainer's duty to care, as well their need to confirm expectations with outcome evidence, along with the two papers in this section serve as a reminder that much remains to be done before we have a clear picture of how mindfulness impacts organizational life. Shalini Bahl has articulated ethical concerns associated with bringing mindfulness into for-profit organizations. She also notes that trainers are, at times, asked to bring mindfulness into organizations whose practices are not congruent with Buddhist ethics and that mindfulness trainers working in these organization are challenged to maintain their own integrity and the integrity of the teachings.

Sean Bruyea introduces us to the complex field of military ethics. He relates the current discussion of ethics on MBP to the ethical challenges associated with bringing mindfulness into the military particularly when it is intended to improve resilience in hostile environments. Because the organizational culture is not likely to change, the ethics of bringing mindfulness into the military will continue to challenge trainers.

Both authors expand our awareness of the ethical challenges associated with providing MBPs in organizations. However, they do not suggest that trainers not take up those challenges. Instead, they suggest that trainers have an understanding of those ethical challenges. By acknowledging those challenges, they can take the steps that are possible to encourage the practice of wisdom and compassion in program participants.

It is possible for the reader to conclude that, given many, if not most, organizations are not inclined to make structural changes to foster well-being, teaching participants mindfulness to foster individual well-being may be a fruitless or even an inappropriate intervention. However, it is always important to keep in mind that the Buddha accepted the reality of the world he lived in, while he continued to teach the end of suffering (Batchelor, 1998; Gombrich, 2006). In order to facilitate MBPs skillfully, I have outlined how trainers need to be aware of the ethical challenges associated with bringing a practice that was developed in a specific historical sociocultural context into a modern context that is radically different. I suggest that safeguards that were likely present in the historical context are not likely to present in the modern organization where MBPs are now regularly being offered.

Organizations are not the only settings where Buddhist practices are being taught in contexts that are radically different from the historical contexts where the Buddha shared his teachings. As McMahan (McMahan, 2008) has argued, the intent and practice of Buddhism in modern times is radically different from the intent and practice of monastics in the historic Buddhist sangha.

Our model of Affirmed Assent follows from our increasing awareness that mindfulness is not necessarily a benign intervention, and that it is the responsibility of all mindfulness trainers to include protocols in their interventions that honor the common duty to care for participants in our programs.

The need, not only to care for the participants in our MBPs but also to ensure that our programs are doing what we say they are doing, is also not unique to providing intervention in organizations. A protocol referred to as Practice-Based Evidence (Barkham, Hardy, & Mellor-Clark, 2010b; Green, 2012) has been developed to assist practitioners in private practice in insuring that their therapeutic outcomes are consistent with expected outcomes of a specific intervention. The need for this assurance comes from the common experience among therapists and other health care professionals that the clinical research conditions where interventions are developed do not typically reflect the real life clinical conditions under which the treatment is offered. Practice-Based Evidence provides the clinical practitioner with an assurance that the intervention is effective in their own particular real world context.

The divide between expectations and research validation of outcomes is an even bigger concern in organizations where expectations of outcomes may not be supported by available research (Choi & Tobias, 2015; Connolly et al., 2015; Good et al., 2016). Practice-Based Evidence is not intended as a substitute for Evidence-Based Practice with its requirement for randomized assignment to treatment and control groups. However, it does focus the mindfulness trainer in organizations on being able to articulate to a client the potential outcomes expected from an intervention and being able to demonstrate that the intervention had (or potentially did not have) the desired impact on participants completing the MBP.

The chapters in this section remind us how far we have to go to be as confident as we would like that our programs are having the desired impact on individual participants and on organizations. However, the chapters in this section and book also provide the needed direction if we want, finally, to be able to respond to the challenges posed in the Economist article (Schumpeter, 2013): to be more aware of the real impact of what we are doing.

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