Chapter 4
Professional Ethics and Personal Values in Mindfulness-Based Programs: A Secular Psychological Perspective

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In Buddhist traditions, where most mindfulness practices have their roots, mindfulness training is accompanied by explicit instruction in ethical conduct (Monteiro, Musten, & Compson, 2015). In contemporary discussions of mindfulness, the most commonly cited of the Buddhist teachings on ethical conduct are the eightfold path and the five precepts. The former is described as a path to the cessation of suffering and includes eight elements: three representing ethical behavior (right speech, right action, and right livelihood), two representing wisdom (right view, right intention), and three representing mental or meditative development (right effort, right concentration, and right mindfulness). The term *right* signifies that each element of the path leads to reduced suffering for self and others (Amaro, 2015; Monteiro et al., 2015); for example, *right livelihood* means earning one's living in a way that is benevolent and causes no harm. Ethical behavior in the Buddhist traditions is further described in the five precepts: to refrain from killing, lying, stealing, sexual misconduct, and the misuse of intoxicants. These are sometimes expressed in more general terms (e.g., non-harmful speech) and are understood as methods of training that facilitate one's own awakening and the well-being of others, rather than as commandments from a higher authority (Amaro, 2015).

In developing the curricula for contemporary Western mindfulness-based programs (MBPs) in mainstream secular contexts, pioneers such as Jon Kabat-Zinn (1982) and Marsha Linehan (1993) adapted a variety of meditation practices from Buddhist traditions but did not include explicit instruction in the eightfold path, the five ethical precepts, or other Buddhist teachings. This was intentional and has several advantages. For cultural and legal reasons, mindfulness training can be provided in a wider range of contemporary Western settings if the programs are

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genuinely secular. In addition, many codes of professional ethics for providers of health care and mental health services require respect for participants' right of self-determination and respect for diversity in multiple domains, including religion and culture, among others. Adherence to these ethical standards typically means that health care and mental health professionals must be careful not to impose moral frameworks or religious beliefs on patients, clients, students, or other participants. Helping participants to clarify their own values and behave in values-congruent ways is more consistent with professional ethical codes and is an important element of many MBPs. Psychological research on working with values in MBPs is discussed later in this chapter.

MBPs have exploded in popularity and are now available in a variety of mainstream environments, including medical and mental health settings, schools, workplaces, prisons, and the military. Numerous reviews of the literature (Chiesa, Calati, & Serretti, 2011; Eberth & Sedlmeier, 2012; Khoury, Sharma, Rush, & Fournier, 2015; Khoury et al., 2013; Tang, Hölzel, & Posner, 2015) have shown that MBPs have many benefits. Strong evidence supports their efficacy for reducing anxiety, depression, and stress and for helping people cope with illness and pain. Some studies show that MBPs increase positive moods and cultivate compassion for self and others. MBPs may also improve some forms of attention and memory and they appear to have measurable effects on the brain. Although the research base is stronger for some outcomes than for others, the efficacy of MBPs seems reasonably clear. However, concerns have been expressed about the relationship between contemporary MBPs and the ancient Buddhist traditions from which many mindfulness practices originate. Many of these concerns involve ethical issues, and they come from diverse perspectives, with some authors suggesting that contemporary MBPs are too close to their Buddhist roots while others argue that too much of the Buddhism has been stripped away (Baer, 2015).

For example, some authors have expressed the view that, because mindfulness has its roots in Buddhism, MBPs are inherently spiritual (Monteiro, 2016) or even Buddhist (Purser, 2015), and that claims of secularity are misleading and may violate professional ethical standards related to truthful communication and informed consent (Purser, 2015; Van Gordon & Griffiths, 2015). That is, if a program is Buddhist-based, professional ethics codes may require this to be communicated clearly in descriptive material and informed consent documents. Failure to do so may lead to accusations of *stealth Buddhism* (Purser, 2015) and may violate laws as well as ethical standards. These issues arose in the case of the Calmer Choice program, a public-school-based MBP in the USA, where the constitution prohibits religious programs in government-funded settings (Jennings, 2016). Calmer Choice was challenged by the National Center for Law and Policy, which argued that the program is Buddhist in orientation and violates the constitutional prohibition against government establishment of religion. Other legal experts disagreed. According to the Cape Cod Times (February 4, 2016), an attorney for the American Civil Liberties Union expressed the following opinion:

> Many mindfulness and yoga programs in schools are considered secular, nonreligious activities and do not violate the Establishment Clause…Simply because an activity or concept may be similar to that in one or many religions does not make it religious; otherwise, for example, schools would not be able to teach students to be kind to each other. Here, the school system has a secular purpose in using the Calmer Choice program, and there is no indication the town is endorsing any religion. This is not an Establishment Clause violation.

The legal challenge to Calmer Choice was dropped before the case went to court and the program remains in place. Although this case was never adjudicated, the circumstances suggest that mindfulness-based programs in American public schools, or other government-funded settings, may be subject to legal challenge if they are perceived as religiously based. American courts are likely to examine whether such programs have the effect of advancing religion or creating an excessive entanglement between government and religion (Lindahl, 2015; Witte, 2005). The inclusion in the curriculum of explicit instruction in a Buddhist ethical framework, such as the eightfold path or the five precepts, might make it more difficult to argue that a program is suitable for a secular setting.

On the other hand, some authors have noted that in Buddhist traditions, mindfulness is intended to facilitate the growth of insight, wisdom, and virtue over a lifetime (Davidson, 2016), rather than symptom reduction or improved well-being in the shorter term, and have raised concerns about the extent to which contemporary MBPs have "dissociated a practice from the ethical framework for which it was originally developed" (Harrington & Dunne, 2015, p. 621). According to this perspective, the absence of explicitly taught ethics in MBPs might contribute to the use of mindfulness for harmful purposes. A commonly cited example is the provision of mindfulness training within businesses or corporations, whose profit-driven activities might cause harm to the environment, the economy, or their employees' well-being. Some authors have suggested that without explicit instruction in ethics, mindfulness training might promote employees' acquiescence with unethical business practices or passive acceptance of oppressive working conditions (Purser, 2015).

In response to these concerns, MBPs have been developed that include explicit teaching of Buddhist foundations, including the eightfold path, the five ethical precepts, and conceptions of impermanence and nonself. Known as second-generation MBPs (Margolin, Beitel, Schuman-Olivier, & Avants, 2006; Margolin et al., 2007; Shonin, Van Gordon, Dunn, Singh, & Griffiths, 2014), these programs have been shown in several studies to have significant effects on psychological functioning. However, there is no evidence that they are more effective than MBPs that do not include explicit Buddhist-based training. Moreover, participants' willingness to resist unethical business practices or oppressive working conditions is rarely assessed. In a worksite study of one of the second-generation MBPs, middle managers reported that the program helped them to be "less preoccupied with their own agenda and entitlements" and "better able to align themselves with corporate strategy" (Shonin & Van Gordon, 2015). Shonin et al. (2014) suggested that:

> Via the meditation-induced understanding that there is not a self that exists inherently, independently, or as a permanent entity, employees can begin to dismantle their emphasis on the "I," the "me," and the "mine," and can better synchronize their own interests with those of the organizations. (p. 819)

The authors did not comment on the ethical practices or working conditions of the businesses in which the participants were employed. It is unclear whether or how the explicitly Buddhist-based elements of the training would have influenced participants' responses to an ethically problematic work environment.

This worksite study showed significant reductions in distress and improvements in job satisfaction and performance. Accordingly, we acknowledge that explicitly Buddhist-based MBPs may be useful and effective in some environments. However, we argue that for legal, ethical, and cultural reasons, secular MBPs are essential for many settings. We also argue that the adaptation of mindfulness practices from Buddhist traditions into contemporary MBPs for mainstream settings does not lead to a form of mindfulness that is devoid of ethics; rather, mindfulness becomes integrated into contexts and systems that have their own ethical standards (Crane, 2016). In the health care and mental health fields, these standards are articulated in codes of ethics that guide the conduct of professionals in the delivery of their services, including MBPs. In addition, psychological research and practice are increasingly concerned with the role of personal values in mental health. The recent psychological literature describes a variety of methods for identifying personal values and strengthening values-consistent behavior.

In the remainder of this chapter, we elaborate on professional ethics and personal values as two ways of addressing ethical issues related to MBPs. We argue that these two perspectives can work together to serve the interests and well-being of people seeking help through MBPs, as well as the teachers, therapists, and other professionals who provide the MBPs. We then conclude with a brief discussion of challenges facing the young but maturing field of mindfulness teaching as it develops its own standards of ethics and integrity.

Professional Ethics

In the following sections, we provide an overview of professional ethics codes for the health care and mental health fields and make three general points. First, current professional ethics codes are grounded in a long tradition that spans many centuries and reflects values held by many cultures around the world. Second, contemporary ethics codes for psychology and related professions articulate principles and standards that are both entirely secular and generally consistent with the ethical teachings of the eightfold path and the five precepts. Third, professional ethics codes support the health care and mental health professions as fields that are neither religious, necessarily spiritual, nor values-neutral. That is, when responsibly integrated into the health care and mental health fields, mindfulness-based training can be both entirely secular and firmly rooted in ethical values.

Background: Professional Ethics in Psychology

Most professions that serve the public are underpinned by codes of ethics. Such codes serve several purposes (Fisher, 2016). They educate and socialize students, trainees, and members of the profession by clarifying mutual expectations for professional behavior. They provide guidance for resolving ethical dilemmas that arise in professional work. A well-articulated ethics code demonstrates to the public that the profession has a consensus on acceptable professional conduct and clear standards for acting in consumers' interests. When consumers have complaints about professional services, an ethics code assists the courts, licensing boards, and other agencies empowered to evaluate professional behavior and, if necessary, impose consequences for ethical violations. Finally, a profession that shows convincingly that it can regulate itself with an ethics code may be less susceptible to regulation by external authorities, who might make rules that seem unreasonable to members of the profession (Fisher, 2016).

The health care and mental health professions, including medicine, psychology, social work, and others, are governed by long-standing and continually evolving codes of ethics. The first ethics code for psychologists was developed by the American Psychological Association (APA), beginning in 1947, when the professional activity of psychologists, which previously had focused primarily on research, was expanding to include provision of mental health services. The APA's code was developed using the critical incident method. APA members were invited to send in descriptions of ethically challenging situations they had encountered in their work and to comment on the issues involved. A committee reviewed over 1000 incidents and extracted ethical themes. Most of these were concerned with psychologists' relationships with and responsibilities to others, including clients or patients, students, research participants, and other professionals. A series of drafts of the proposed ethics code was provided to the APA membership for comment. After several revisions, the first version of the code was published in 1953 (Fisher, 2016).

APA's ethics code is frequently updated, with ten revisions published since 1953. The revision process continues to be based on the experiences and perspectives of APA members and reflects the evolving roles of psychologists in society; these include therapy or counseling, teaching, supervision, consultation, administration, program development and evaluation, and research (Fisher, 2016). The current version of the code (APA 2002, 2010) has separate sections for aspirational principles and enforceable standards of conduct. The five aspirational principles intended to "guide and inspire psychologists toward the very highest ethical ideals of the profession" (APA, 2002, p. 3) are:

Beneficence and nonmaleficence: Psychologists strive to benefit the people with whom they work and to avoid causing harm. They protect the rights and welfare of all who might be affected by their work. They guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.

Fidelity and responsibility: Psychologists strive to establish relationships of trust with the individuals and groups with whom they work and with their communities and society.

Integrity: Psychologists strive to be honest, truthful, and accurate in all aspects of their work. They keep their promises and do not "steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact" (p. 3).

Justice: Psychologists strive for fairness in all aspects of their work, including equal access and quality of services for all.

Respect for rights and dignity: Psychologists recognize people's rights to privacy, confidentiality, and self-determination. They respect diversity based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status. They strive to eliminate bias based on any of these factors from their work.

Because they are defined as aspirational, the five general principles of APA's ethics code do not provide a basis for disciplinary bodies to impose sanctions on psychologists charged with ethical violations. In contrast, the standards of conduct are enforceable and cover a variety of specific issues relevant to the practice of psychology, including confidentiality, informed consent, conflict of interest, advertising, record keeping, fees, and many others. Some of the standards of conduct do not require specific behavior, but instead describe issues to be considered in managing potentially challenging situations. For example, multiple relationships (e.g., providing professional services to a neighbor or relative) are not firmly prohibited, but should be avoided if they are likely to impair the psychologist's objectivity, competence, or effectiveness, or if they pose a risk of harm or exploitation to the client. For other standards, specific behaviors are required or proscribed. For example, psychologists must obtain informed consent before conducting a psychological evaluation. They are prohibited from making false statements about their credentials or their services and from engaging in sexual intimacies with clients.

Historical Roots of Psychological Ethics Codes

Although psychology is a relatively young profession, the APA's ethics code follows a centuries-long tradition of medical ethics codes from many parts of the world. According to Sinclair (2012), the field of medicine has the longest documented history of ethics codes of any profession. The oldest known code of medical ethics is found in the *Code of Hammurabi* from the Babylonian empire (eighteenth century BCE); it includes nine laws related to the practice of medicine, as well as numerous laws covering other matters. Two other medical ethics codes have survived from before the common era. The *Ayurvedic Instruction*, from India in the sixth century BCE, provides instructions to medical students on ethical medical practice. The *Hippocratic Oath*, from Greece (fourth century BCE), is part of a larger work called the *Hippocratic Corpus* and describes ethical responsibilities of

physicians to those they serve. The *Corpus* has been studied for centuries by physicians in many parts of the world. Modified versions of the Hippocratic Oath are still used today in many medical schools as part of a ritual for graduating students.

Medical ethics codes from within the common era include *Advice to a Physician* (from Persia, 950), whose first chapter is devoted entirely to medical ethics; the *Seventeen Rules of Enjuin* (1500), written for Japanese medical students and based on Buddhist thought and the Shinto tradition; the *Five Commandments and Ten Requirements* (1617), the most comprehensive description of medical ethics in China from before the twentieth century; and *A Physician's Ethical Duties* (1770), also from Persia. More recent codes include the *Medical Code of Ethics of the American Medical Association* (1847) and the *Nuremburg Code of Ethics in Medical Research* (1946); the latter was developed in response to the atrocities of medical experimentation with prisoners in concentration camps during World War II.

As the first ethics code for psychologists, the APA's code served as a model for related professions (forensic psychiatry, psychiatric nursing, pastoral counseling, psychoanalysis, marriage and family therapy, school counseling, substance abuse counseling, etc.) and for ethics codes in other countries. Many adopted the organizational structure of the APA's code, with separate sections for aspirational principles and enforceable standards of conduct. Others adopted a "moral framework format" (Sinclair, 2012, p. 16) in which the entire code is organized around core ethical principles. One example is the British Psychological Society's (2009) ethics code, which articulates four core principles: respect, competence, responsibility, and integrity. Subsumed under each principle is a statement of values to guide ethical reasoning and a set of behavioral standards describing the conduct expected of the Society's members. For example, the principle of respect is defined by valuing the dignity and worth of all persons; specific behavioral standards are related to privacy and confidentiality, informed consent, respect for individual and cultural differences, and self-determination. The principle of integrity is defined by the values of honesty, accuracy, clarity, and fairness; the behavioral standards govern all forms of professional communication, avoidance of exploitation and conflict of interest, maintenance of personal boundaries (no sexual or romantic relationships with clients, students, or junior colleagues), and avoidance of all forms of harassment.

Commonalities Among Historical and Current Ethics Codes

The *Universal Declaration of Ethical Principles for Psychologists* (2008) was developed by a joint committee of the International Union of Psychological Science and the International Association of Applied Psychology (Gauthier, Pettifor, & Ferrero, 2010). Based on a six-year study of psychological ethics codes from around the world, it describes ethical principles that are common to most codes and believed to be based on widely shared human values. The *Universal Declaration* is aspirational only and provides values related to each core principle but no enforceable

Table 4.1 Core principles and related values of the *Universal Declaration of Ethical Principles for Psychologists*

Core principle	Related values
I. Respect for the dignity of persons and peoples	• Respect for the unique worth and inherent dignity of all human beings • Respecting diversity, customs, and beliefs • Free and informed consent • Privacy and confidentiality • Fairness and justice
II. Competent caring for the well-being of persons and peoples	• Active concern for well-being • Taking care not to do harm • Maximizing benefits and minimizing harm • Correcting or offsetting harm • Developing and maintaining competence • Self-knowledge • Respect for the ability of persons and peoples to care for themselves and others
III. Integrity	• Honesty • Truthfulness and openness • Avoiding incomplete disclosure • Maximizing impartiality and minimizing biases • Avoiding conflicts of interest
IV. Professional and scientific responsibilities to society	• Increasing knowledge in ways that promote the well-being of society and all its members • Using psychological knowledge for beneficial purposes and preventing it from being misused • Conducting its affairs in a way that promotes the well-being of society and all its members • Adequately training its members in their ethical responsibilities and required competencies • Developing ethical awareness and sensitivity • Being as self-correcting as possible

standards of conduct, which are expected to vary across cultures. A central objective of the *Universal Declaration* is to provide a moral framework that psychological organizations anywhere in the world can use to develop or evaluate their own ethics codes. Its four core principles are very similar to those of the British Psychological Society, the Canadian Code of Ethics for Psychologists, and several others; they also overlap substantially with the five aspirational principles of the APA's code. The core principles and related values of the *Universal Declaration* are shown in Table 4.1.

To examine commonalities among the historical ethics codes described earlier and to compare them with contemporary codes, Sinclair (2012) organized elements of the historical codes into categories based on the four principles of the *Universal Declaration*. This work, summarized in Table 4.2, shows considerable consistency across history and cultures in ethical principles for the medical and psychological professions. A notable exception is the *Code of Hammurabi*, which, according to Sinclair (2012), has little in common with the four principles of the *Universal*

Table 4.2 Elements of medical ethics codes across centuries and cultures and their relationships to the four principles of the *Universal Declaration of Ethical Principles for Psychologists* (Sinclair, 2012)

Ethical codes	Respect for dignity	Competent caring for well-being	Integrity	Professional and scientific responsibilities
Code of Hammurabi Babylonian empire Eighteenth century BCE	If a physician…saves the eye, he shall receive ten shekels… If the patient be a freed man, he receives five shekels…If he be a slave, his owner shall give the physician two shekels	(None)	(None)	(None)
Ayurvedic Instruction India, sixth century BCE	It is the duty of all good physicians to treat…all Brahmins, spiritual guides, paupers, friends, neighbors, devotees, orphans, and people who come from a distance as if they are his own friends.	You should, with your whole heart, strive to bring about the cure of those that are ill. There is no end to medical science, hence, heedfully devote yourself to it.	You shall speak words that are… truthful, beneficial, and properly weighed and measured. You should give up… deception, falsehood…and other reprehensible conduct.	You should always seek, whether standing or sitting, the good of all living creatures.
Hippocratic Oath Greece, fourth century BCE	Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice…	I will keep them from harm… I will apply dietetic measures for the benefit of the sick according to my ability and judgment…	Whatever houses I might visit, I will come for the benefit of the sick, remaining free of… all mischief, and in particular of sexual relations with both male and female persons, be they free or slaves.	…to give a share of precepts and oral instruction and all the other learning to my sons and the sons of him who has instructed me, and to pupils who have…taken an oath according to the medical law.
Advice to a Physician Persia, 950	A physician should respect confidences and respect the patient's secrets. In protecting a patient's secrets, he must be more insistent than the patient himself.	A medical student should be constantly present in the hospital so as to study disease processes and complications under the learned professor and proficient physicians.	A physician is to prudently treat his patients with food and medicine out of good and spiritual motives, not for the sake of gain.	Be kind to the children of your teachers and if one of them wants to study medicine you are to teach him without any remuneration.

(continued)

Table 4.2 (continued)

Ethical codes	Respect for dignity	Competent caring for well-being	Integrity	Professional and scientific responsibilities
The Seventeen Rules of Enjuin Japan, 1500	You should rescue even such people as you dislike or hate. You should not tell what you have learned from the time you enter a woman's room.	You should be delighted if, after treating a patient without success, the patient receives medicine from another physician and is cured.	You should not exhibit avarice, and you must not strain to become famous.	(None)
The Five Commandments and Ten Requirements China, 1617	Physicians should be ever ready to respond to any calls of patients, high or low, rich or poor. They should treat them equally. The secret diseases of female patients…should not be revealed to anybody...	A physician or surgeon must first know the principles of the learned. He must study all the ancient standard medical books ceaselessly day and night, and understand them thoroughly so that the principles enlighten his eyes and are impressed on his heart.	If the case improves, drugs may be sent, but physicians should not visit them again for lewd reward.	(None)
A Physician's Ethical Duties Persia, 1770	He must not be proud of his class or family and must not regard others with contempt. A physician…must protect the patient's secrets and not betray them	He must never be tenacious in his opinion, and continue in his fault or mistake, but, if it possible, he is to consult with proficient physicians and ascertain the facts.	Practice medicine with integrity… Do not replace precious herbal materials provided by the family of patients with inferior ones. A physician…must not hold his students or his patients under his obligation.	He must not withhold medical knowledge; he should teach it to everyone in medicine without discrimination between poor and rich, noble or slave.
Medical Code of Ethics of the American Medical Association USA, 1847	…such professional services should always be cheerfully and freely accorded. …none of the privacies of personal and domestic life… should ever be divulged…	Every case committed to the charge of a physician should be treated with attention, steadiness, and humanity. Consultations should be promoted in difficult cases…	…unnecessary visits are to be avoided as they…render him liable to be suspected of interested motives.	As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens.

Declaration and indicates that not everyone was considered of equal worth in the society of the time. The remaining comparisons show that contemporary psychological ethics codes, as reflected in the principles of the *Universal Declaration*, are rooted in traditions that extend at least 26 centuries into the past and come from many parts of the world. Common values include concern for well-being, professional competence, maximizing benefit and minimizing harm, confidentiality, avoiding conflicts of interest, and truthfulness.

Professional Ethics and Buddhist Ethics

Contemporary ethics codes provide a "common morality" (Knapp & VandeCreek, 2006, p. 4) among professionals whose religious and spiritual backgrounds, moral beliefs, and philosophies are likely to be diverse. The APA acknowledges this diversity among psychologists by making its code entirely secular and applicable "only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists" and not to "purely private conduct of psychologists" (APA, 2002, p. 2). This respect for the religious and cultural diversity of the psychologists themselves parallels the code's requirement to respect the diversity of people with whom psychologists work. That is, neither psychologists nor their clients are required to adopt an ethical framework based on a particular religious or spiritual tradition.

Even so, substantial commonality between the APA's code and the ethical teachings described in the eightfold path and the five precepts is evident. The entire code can be seen as an attempt to ensure that the practice of psychology, in its many manifestations, is a form of right livelihood; i.e., a way of earning a living that is benevolent and minimizes harm. In both general and specific ways, much of the code deals with right action and/or right speech. The aspiration to do no harm is central to the ethics code and is expressed in many of the standards of conduct; for example, psychologists are prohibited from engaging in discrimination, harassment, and exploitation. Following a controversy about psychologists' involvement in military interrogations of post-9/11 detainees, they are also prohibited from activities that would "justify or defend violating human rights" (APA, 2010, p. 4, 2015).

The general principle of integrity and numerous related standards require psychologists to be truthful and to refrain from stealing (or taking things not given, Goldstein & Kornfield, 2001); for example, psychologists must not make false or deceptive statements about their credentials, fees, services, or other aspects of their work. They may not use bait-and-switch tactics (i.e., luring clients with an initial low fee and then unexpectedly raising their rates), and must not submit false information to insurance companies to increase reimbursements. The code explicitly prohibits sexual intimacies with clients, clients' relatives or significant others, students, and supervisees. Misuse of intoxicants is not explicitly mentioned, but psychologists are required to refrain from undertaking professional activities when personal problems (such as substance misuse) could interfere with their ability to work competently.

The APA's code also includes standards related to preventing harm when working in organizations. Fisher (2016) notes that organizations often hire psychologists to meet the organization's goals, rather than the employees' goals. For example, an organization might hire a psychologist to develop a screening test to identify applicants likely to be competent and productive in particular positions. If the psychologist follows the ethical standards for test construction and use, i.e., develops a test that meets adequate standards for reliability, validity, and culture-fairness and explains the nature and purpose of the test to applicants, there is no conflict with the ethics code. On the other hand, if a business wishing to let go of senior employees as a cost-cutting strategy asks a psychologist to develop a test that would be difficult for older employees to pass, this would violate the principle of justice and the ethical standards related to unfair discrimination, test construction, and use of assessments (Fisher, 2016). The psychologist in this situation is ethically obligated to refuse to design or administer such an instrument.

Ethical Professional Services and Values-Neutrality

Several authors have noted that psychological practice is not a values-neutral enterprise (Hathaway, 2011; Monteiro, 2016); indeed, values pervade the process in a variety of ways. In addition to the professional ethics codes, which imbue the process with widely shared values (benevolence, non-harming, respect, integrity, responsibility, competence), individual psychologists have their own values, as do their clients, students, and other participants. Despite the inescapable and complex influences of these sets of values on professional work, the delivery of psychological services sometimes appears to be values-neutral. This paradox is attributable to elements of the ethics codes that require professionals to respect the right of self-determination and the diverse perspectives of their clients in a wide range of domains, including domains in which professionals and clients may hold very different views.

For example, if a client in psychotherapy discloses that she is accidentally pregnant and considering an abortion, the ethical therapist may help the client explore her thoughts and feelings on the matter and the possible impact of this decision (either way) on her mental health, but must maintain an evenhanded openness that honors the client's right to make her own decision about whether to continue the pregnancy, regardless of the therapist's personal or religious beliefs about the morality of abortion. The same applies to clients with problems related to sexual orientation, divorce, end-of-life questions for the terminally ill, and other potentially controversial matters, and to clients who express racist, sexist, political, or other opinions that the therapist finds objectionable.

Maintaining this stance of apparent neutrality regarding specific issues that arise in treatment does not require professionals to give up their religious, spiritual, or other values; however, professionals are more likely to work competently with

diversity in these areas if they are aware of their own beliefs and values and their potential impact on their work (Vieten et al., 2013). For example, a therapist who is clearly in touch with her belief that homosexual behavior is immoral may have better awareness of her responses to an adolescent client reporting same-sex attraction; similarly, a self-aware therapist who supports legal abortion may be better able to monitor his responses to a client who finds purpose in life by picketing abortion clinics. Self-awareness and reflection are essential if therapists are to make sound decisions about how to work ethically with clients who present them with difficult conflicts between their personal values and their professional obligation to respect their clients' values.

The stance of apparent neutrality about clients' values has limits. Respect for clients' autonomy and diversity does not require unqualified endorsement of moral relativism, which holds that all standards of conduct are equally valid (Knapp & VandeCreek, 2007). For example, if a client expresses an intention to commit an act of violence (e.g., to assault or kill someone, or to set off an explosion in a public place), the therapist must take steps to prevent it, and if unable to dissuade the client is legally required (in most of the USA) to warn the intended victim (if identifiable) and to inform the police. That is, the therapist is not required to respect the client's intention to commit violence, even if this intention is based on a religious, moral, or philosophical belief system to which the client is deeply committed. Similarly, a therapist working with parents who use abusive forms of punishment with their children must try to help the parents modify their disciplinary strategies and, if unable to do so, may have to notify child protection authorities, even if the parents believe their disciplinary methods to be normative within their culture.

In these difficult situations, respectful dialogue may enable skilled professionals to help their clients find non-harmful ways of achieving their goals while respecting their belief systems and cultural norms. However, when abuse is clearly occurring, or when violent harm is imminent, the principles of benevolence and non-malevolence temporarily supersede respect for clients' autonomy. Knapp and VandeCreek (2007) describe this stance as a form of *soft universalism*: a middle position between ethical absolutism, which holds that there is one universally valid ethical code, and moral relativism. Soft universalism assumes that many values are widely endorsed, but that cultures and societies differ on how they are expressed. Soft universalism underlies the Universal Declaration of Ethical Principles for Psychologists described earlier, which articulates core principles and related values, but includes no specific standards of conduct, because the latter "will vary with different religious, social, and political beliefs and conditions" (Pettifor, 2004, p. 265).

Professional Ethics for Spiritually Oriented Interventions

Spiritually oriented interventions are difficult to define. Hathaway (2011) notes that some authors use this term for interventions that include clearly religious elements such as references to scripture, religious imagery, or prayer (Richards

& Bergin, 2005). Other authors describe meditation, exploration of meaning and purpose, kindness, forgiveness, and gratitude as spiritual practices or tools (Plante, 2009). Kapuscinski and Masters (2010) suggest that a focus on God or the transcendent distinguishes spirituality from constructs such as meaning, purpose, and wisdom; from this perspective, interventions that work explicitly with these concepts are not necessarily spiritual. Kristeller (2011) states that within contemporary therapeutic contexts, "a wholly secular practice of meditation has developed" (p. 197), while noting that "the spiritual foundation has never been too far away" (p. 198).

In the mindfulness literature, a variety of views is evident. Monteiro (2016) notes that the Buddhist roots of mindfulness mean that MBIs can be considered "a class of spiritually oriented approaches" (p. 216). Vieten and Scammell (2015) state that many mindfulness and yoga programs are "largely secularized" but may include elements with "quasi-spiritual undertones" such as the ringing of bells and prayers of compassion (p. 114). The developers of MBCT (Segal, Williams, & Teasdale, 2013) do not discuss spirituality; however, in an adaptation of MBCT for the general public, Williams and Penman (2011) state that meditation and mindfulness are not a religion and can be practiced by people of any religion as well as by atheists and agnostics. Linehan (2015), the developer of dialectical behavior therapy (DBT), states that mindfulness can be taught and practiced in either a secular or a spiritual way; accordingly, the mindfulness skills in DBT are "purposely provided in a secular format" (p. 151) while guidelines for optional discussion of mindfulness as a spiritual practice are provided for therapists whose clients are interested in this perspective.

Clearly, MBPs are not always conceptualized as spiritually oriented; however, when they are, professional ethics for spiritually oriented interventions should be considered (Vieten & Scammell, 2015). Several mental health disciplines have begun to discuss spiritual and religious competencies and ethical guidelines for providers of spiritually oriented programs, including psychology, psychiatry (Campbell, Stuck, & Frinks, 2012; Verhagen & Cox, 2010), social work (Sheridan, 2009), and counseling (Young, Cashwell, Wiggins-Frame, & Belaire, 2002). Division 36 of APA (the Society for Psychology of Religion and Spirituality) developed a set of preliminary practice guidelines for clinical work with religious and spiritual issues (Hathaway, 2011; Hathaway & Ripley, 2009). These include obtaining informed consent for the use of spiritually oriented methods, accommodating clients' spiritual or religious traditions in helpful ways, and setting spiritual or religious treatment goals only if they are functionally relevant to the clients' concerns, among many others. Awareness of contraindications for spiritually oriented methods is also recommended; these might include psychotic symptoms, substantial personality pathology, and bizarre or idiosyncratic expressions of religion or spirituality. If iatrogenic effects become evident, spiritually oriented methods should be discontinued.

Personal Values

In the discussion of ethics in MBPs, personal values are important for two reasons. First, in secular settings, where teaching a particular ethical framework may be problematic, a promising alternative is to help participants to clarify their own values and strengthen their values-consistent behavior (Davis, 2015). Second, in addition to the values reflected in the ethics codes, professionals bring their own values to their work. The personal values of mindfulness-based teachers are likely to be generally consistent with ethics codes (benevolence, non-harming, integrity, etc.); however, values conflicts can arise around specific issues or circumstances and self-awareness is essential to navigating these situations skillfully. The following sections discuss psychological theories and research about personal values and the methods used in MBPs for working with values. Most of the literature on values in MBPs examines benefits to clinical or general populations; however, a few studies suggest that working with values also improves clinical skills and attitudes in mental health professionals.

Working with Values in MBPs

Among the evidence-based programs in which mindfulness skills are central, acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012) provides the most comprehensive theoretical formulations about values and mental health, as well as methods for helping participants identify their values and behave in accordance with them. Values in ACT, therefore, are described in detail in the next section, followed by discussion of values-based methods in other MBPs.

ACT is based on a comprehensive theory of human functioning that integrates mindfulness- and acceptance-based processes with personally chosen values and values-consistent behavior (known as committed action). The mindfulness and acceptance processes in ACT are similar to those described in other MBPs and include flexible attention to the present moment, acceptance of present-moment experiences, defusion from thoughts (similar to decentering in MBCT), and a transcendent sense of self (recognition that thoughts and feelings are transitory events that do not define the person who is experiencing them). In ACT, values are conceptualized as essential to good psychological health because they intrinsically motivate behavior that leads to a deep sense of meaning, vitality, and engagement. The goal of ACT is to help clients develop lives that feel rich and satisfying—though not painless or easy—by the clients' own standards (Hayes et al., 2012).

In helping clients to identify their values, ACT therapists typically encourage the exploration of several domains that are important in many people's lives. Domains are suggested, rather than prescribed, to help clients focus on what may be most important to them. Commonly discussed domains include relationships (with fam-

ily or friends), work (career, education, or running a household), community involvement (working for worthy causes, participating in community activities), spirituality (church involvement, communing with nature, or other practices identified by the client), and self-development (learning new skills, taking care of one's health, engaging in satisfying leisure activities). The importance of choosing one's own values, rather than those prescribed by authority figures or societal norms, is emphasized.

Discussion of values in ACT also includes qualities or characteristics that clients would like to embody in the domains that are most important to them. In the work domain, for example, clients may aspire to be creative, competent, or productive. In the relationship domain, they may wish to be loving, kind, supportive, assertive, or strong. Values are distinguished from goals, in that goals can be completed (e.g., learn a new software program, teach coworkers to use it), whereas the underlying values (to be competent and helpful at work) continue over the longer term. Upon completion of specific goals, other ways to be competent and helpful will present themselves.

Behaving in accordance with values can be stressful and difficult. Unpleasant thoughts and emotions may arise and these may become obstacles to committed action. Mindful awareness is conceptualized as a way to help clients work constructively with internal obstacles to values-consistent behavior. For example, a person who values helpfulness at work, but is anxious about speaking in groups might practice contributing to discussion with mindful acceptance of the unpleasant sensations (racing heart, sweating), rather than keeping quiet in meetings to avoid the stress of speaking up. The goal of ACT is not to decrease anxiety in meetings, though this may occur with consistent practice. Rather, the goal is to help the client develop a life that feels satisfying and meaningful, even when it is distressing or painful.

ACT has developed several tools to help clients explore their values. The Valued Living Questionnaire (Wilson, Sandoz, Flynn, Slater, & DuFrene, 2010), which is often used as a structured interview (Wilson & DuFrene, 2008), asks clients to consider 12 potentially valued domains: marriage, parenting, other family, friends, work, education, recreation, spirituality, community life, physical self-care (diet, exercise, sleep), the environment, and aesthetics (art, literature, music, beauty). Clients are urged to remember that not everyone values all of the domains; for example, some prefer not to marry or raise children, others may have little interest in community activities or spirituality. Discussion centers on the self-rated importance of each area, the client's actions in each area, and their satisfaction with their level of action. Clients who discover that they have been focusing on areas of low priority while neglecting domains they identify as important are helped to redirect their energies in more satisfying ways. Mindful compassion provides a helpful way of relating to the pain and regret associated with realizing that one's priorities may have been misplaced.

ACT also uses experiential exercises to help clients identify important values. Clients may be asked to write a brief epitaph for their own future tombstone that captures how they would like to be remembered; e.g., "He participated in life and

helped his fellow human beings" (Hayes et al., 2012, p. 306). Alternatively, they might write a short speech they would like someone to give at a birthday party in their honor; for example, "John always puts the needs of his children first, guiding them with love, patience, and respect" or "Through her tireless volunteer work, Camille has helped to make our world a safer and cleaner place for all living beings" (Fleming & Kocovski, 2013, p. 32). Such exercises are followed by discussion of behaviors consistent with these values, especially behavioral changes needed to address values-behavior discrepancies. Mindfulness skills that may be helpful in working with barriers to committed action, such as pessimistic or self-critical thoughts ("This will never work," "I've wasted too much time"), and negative emotions (anxiety, sadness) are also practiced.

Many studies have shown that ACT leads to significant increases in self-reported psychological flexibility, defined as the ability to fully contact the present moment and behave in values-consistent ways in the presence of difficult thoughts and feelings (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ruiz, 2010). Treatment outcome studies have not examined the effects of values work independently of the other components of ACT; however, laboratory studies suggest that even brief consideration of personal values leads to reliable changes in behavior. For example, in a study of pain tolerance using the cold pressor task (immersing a hand in very cold water), Branstetter-Rost, Cushing, and Douleh (2009) asked one group to imagine tolerating the pain for the sake of a highly ranked personal value (e.g., swimming in icy water to rescue a loved one), whereas a second group was coached in how to practice mindful acceptance of the pain with no reference to personal values, and a third group received no instructions for tolerating the pain. The values group tolerated the pain for significantly longer than the acceptance and no-instructions groups (means of 156, 69, and 36 s, respectively, $p < 0.001$). Several other laboratory studies have reported similar findings (Levin, Hildebrandt, Lillis, & Hayes, 2012).

Most treatment outcome studies of ACT are conducted with clinical populations or other volunteers; however, a small literature suggests that ACT is also helpful for improving professional skills in mental health clinicians. For example, Hayes et al. (2004) randomly assigned substance abuse counselors to an ACT-based training, multicultural training, or psychoeducation, and found that at 6-month follow-up, the ACT group showed significantly lower frequency of stigmatizing thoughts about their clients as well as reduced burnout. Clarke, Taylor, Lancaster, and Remington (2015) found that both ACT and psychoeducation, delivered in workshop format over two days, led to significant reductions in stigmatizing attitudes and improvements in therapist–client relationships in a large group of clinicians working with people with personality disorders.

Working with values has been incorporated into other evidence-based MBPs. During a sitting meditation in the final session of MBCT (Segal et al., 2013), participants are invited to contemplate a personal value (such as caring for themselves or spending more time with their children) that provides a reason to maintain their meditation practice. They write the values that come to mind on cards to keep with them. Mindfulness-based relapse prevention (Bowen, Chawla, & Marlatt, 2011) includes discussion of reasons to stay sober; these typically reflect important values

such as working responsibly at a job, caring for a child, or relating to a spouse. Dialectical behavior therapy (DBT; Linehan, 2015) includes exploration of values as part of building a life that feels satisfying and meaningful. Although potential values are suggested to help clients consider possibilities (e.g., healthy relationships, productive work, contributing to the community), clients are strongly encouraged to identify values that are truly their own. Acceptance-based behavior therapy (Roemer, Orsillo, & Salters-Pednault, 2008), which integrates elements of ACT, MBCT, and DBT, uses writing exercises to help clients explore what they value in a variety of domains and includes goal setting and behavior change methods for increasing values-consistent behavior. Mindfulness-based eating awareness training (Kristeller, Wolever, & Sheets, 2014) helps participants consider the time and energy they spend thinking obsessively about food, eating, and weight, rather than work, school, family, or friends, and encourages them to increase their involvement in these valued activities.

Even when explicit values work is not part of the curriculum, participation in MBPs may implicitly cultivate awareness of personal values. Kabat-Zinn (2005) notes that mindfulness facilitates awareness of "the whispered longings" of one's own heart (p. 22). Although this point is not elaborated, these whisperings may reflect what participants value most deeply. Carmody, Baer, Lykins, and Olendzki (2009) found significant increases in a measure of purpose in life in participants in mindfulness-based stress reduction (MBSR). Following the eight-week course, participants reported a stronger sense of meaning, goal-directedness, and clarity about what they value. The recently proposed mindfulness-to-meaning theory (Garland, Farb, Goldin, & Fredrickson, 2015) also suggests that mindfulness training leads to increased purposeful engagement with life. Additional study of this promising theory is needed.

The Importance of Self-Chosen Values

Several theories of optimal human functioning emphasize the importance of autonomy: the ability to make one's own decisions and evaluate oneself by one's personal standards, rather than relying on approval from others. For example, self-determination theory (Ryan & Deci, 2000) identifies autonomy as one of three basic needs (along with competence and relatedness) that are essential for psychological health and life satisfaction. Ryff's (1989) comprehensive theory of psychological well-being also includes autonomy as a critical element of healthy functioning. The self-concordance model (Sheldon & Elliott, 1999) states that psychological well-being is enhanced when people pursue goals that reflect their authentic personal interests and values rather than goals prescribed by others (Gillet, Lafreniere, Vallerand, Huart, & Fouquereau, 2014; Sheldon, 2002). Similarly, self-affirmation theory (Steele, 1999) posits that affirmation of personal values protects against stressors by expanding participants' views of themselves and facilitating perspective on what is most important. All of these theories have strong empirical support.

In laboratory studies, participants asked to contemplate a self-identified personal value consistently show better outcomes than those who contemplate a value that is less important to them. Dependent variables have included helpful behavior, academic performance, health-related behavior, and cardiovascular functioning (see Cohen & Sherman, 2014, for a review).

There is no guarantee that self-identified values will be consistent with any particular ethical framework. However, clinical experience, especially with ACT, suggests that when clients are encouraged to think carefully about their deepest aspirations, most choose prosocial values, such as meaningful work, loving relationships, and contributions to a community (Hayes et al., 2012). When this does not happen, e.g., a client says that he values making a lot of money, further discussion about why money is important is likely to reveal prosocial underlying values, such as providing security or opportunities for one's family. The prevailing tendency to identify prosocial values is believed to reflect universal human requirements for biological survival, social interaction, and the welfare of groups (Schwartz & Bilsky, 1987, 1990). That is, individuals and societies are more likely to thrive if people take care of themselves, help each other, and work for the benefit of the group.

These universal needs do not invariably prevent harmful behavior or disagreements about what will cause harm. Experience suggests that a few clients identify values that are not prosocial, e.g., becoming wealthy to enjoy a materialistic lifestyle, rather than to benefit others. Some clients may identify prosocial values but choose to enact them in ways with that conflict with the therapist's personal values. For example, in advance of an important election, a client may decide to act on his value of community involvement by volunteering for the campaign of the therapist's non-preferred candidate. Another client may act on her value of generosity by donating money to an organization whose goals the therapist finds reprehensible. As noted earlier, adherence to professional ethical standards generally means that the therapist must not attempt to persuade these clients to do otherwise. Exceptions are made only when necessary to prevent specific types of harm.

Cultivating the Core Values of Kindness and Compassion

Kabat-Zinn (2005) and Segal et al. (2013) note that MBSR and mindfulness-based cognitive therapy (MBCT) are offered with a spirit of gentle compassion, friendliness, kindness, and warm hospitality. Segal et al. (2013) describe this attitude as fundamental, noting that without it, a mindfulness course "loses one of its foundational features" (p. 137). The personal mindfulness practice to which most teachers are committed is believed to cultivate their ability to embody these qualities in their teaching. This creates a warm and friendly atmosphere in their mindfulness courses, which encourages participants to experiment with treating themselves more kindly and compassionately.

Indeed, several studies have shown that mindfulness training leads to increases in empathy and compassion in clinical or community samples (Birnie et al., 2010; Condon et al., 2013; Keng et al., 2012; Kuyken et al., 2010) and in health care professionals and therapists in training (Gokhan, Meehan, & Peters, 2010; Shapiro, Brown, & Biegel, 2007; Shapiro, Schwartz, & Bonner, 1998). These findings are consistent with definitions of mindfulness that emphasize qualities of attention such as acceptance, nonjudgment, openness, friendliness, and kindness. For example, Feldman (2001) states that "true mindfulness is imbued with warmth, compassion, and interest" (p. 173). Grossman (2015) described these qualities as *virtuous* and suggested that, because mindfulness training involves consistent practice of these qualities, it cultivates an inherently ethical stance toward self and others.

Conclusions

As MBPs become more widely available around the world, the diversity of people who participate in them is likely to increase. Programs offered in secular settings must be able to accommodate participants from a wide range of religious, spiritual, and cultural backgrounds. Whether deeply committed to a particular faith or espousing no religion at all, participants must feel assured that their beliefs and values will be respected (Crane, 2016). Moreover, as the demand for MBPs expands, the diversity of people seeking professional training in how to provide them will also increase. Training that requires participation in overtly Buddhist practices or relies heavily on Buddhist frameworks or belief systems may create barriers to teachers from other traditions. For these reasons, while acknowledging that explicitly Buddhist-based programs may be beneficial in some settings, we have argued that mindfulness-based training will be more widely accessible if genuinely secular MBPs, with secular foundational ethics, are available.

This chapter has discussed two related approaches to ensuring that mainstream MBPs have strong ethical foundations that can be widely endorsed by people with diverse cultures and beliefs systems. First, codes of ethics for the health care and mental health professions are based on principles and values that have been recognized for centuries, in many parts of the world, as essential to the work of those who serve the unwell. While entirely secular, current ethics codes provide a shared set of principles and behavioral standards that are generally consistent with core ethical teachings from the Buddhist tradition. Of course, ethics codes do not ensure that all professionals will always behave ethically—no ethical framework can accomplish that. However, the organizational structures associated with professional ethics codes encourage ethical conduct in a variety of ways. Training and continuing education programs that keep professionals' knowledge up-to-date probably prevent many ethical violations. Boards and committees empowered to receive and investigate complaints can require remedial training, extra supervision, or other courses of action for professionals found to have committed ethical violations.

Second, when respect for diversity and self-determination makes it untenable to teach a particular ethical framework to participants in a secular program, well developed and empirically supported methods for helping participants to clarify their own values and behave consistently with them are available. Although self-identified values may not always be consistent with a particular ethical framework, theory, research, and clinical experience suggest that most people, when encouraged to think deeply about their most important aspirations, identify prosocial values. On the rare occasions when participants are causing harm, or seem likely to do so, professional ethics codes and legal standards support professionals in guiding clients toward less harmful behavior, within limits. When participants' values conflict with those of their teachers or therapists, awareness of their own values may help professionals navigate these difficult situations skillfully. The regular practice of mindfulness, to which most teachers of MBPs are committed, probably enhances clarity about their personal values while cultivating the ethical qualities of kindness and compassion.

This chapter has discussed professional ethics from the perspective of psychology and related professions. An important issue in the mindfulness-based field is that teachers of MBPs have a wide range of professional affiliations. Although many belong to the medical, mental health, or teaching professions, some do not. This means that as a group, teachers of MBPs follow a variety of ethics codes, and some may have no training in a code that addresses the ethical difficulties that teachers of MBPs are likely to encounter. Lack of familiarity with or commitment to a particular ethics code could impair the ability of mindfulness teachers to work skillfully with ethically challenging situations. It remains unclear whether mindfulness teachers should have their own professional ethics code or should adopt an existing code from one of the mental health or health care professions. Efforts to work with this critical issue are currently underway through professional discussion, the development of good practice guidelines for teachers of MBPs and their trainers, and through the articulation of professional training pathways that include training in ethics (e.g., http://mbct.com/training/mbct-training-pathway/).

Mindfulness teaching is a much younger profession than psychology. Crane (2016) suggests that this new field must develop its own form of professional integrity, and in doing so, it must prioritize two key concerns: the interests of the public to whom mindfulness courses are offered, and the quality of the training and support for teachers' work. We argue that ethics codes are essential to the protection of the public and therefore must be central to the development of this new field and to the training of teachers; we also emphasize that clarity about personal values, which is probably cultivated through regular mindfulness practice, contributes to the wise and compassionate application of the standards provided by the ethics codes. We hope that understanding of professional ethics and personal values, and how they work together, will be of help to this promising new field as it develops into a mature profession.

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