

MINDFULNESS-BASED, SELF-DIRECTED INTERVENTION AS AN ADJUNCT
METHOD FOR COUPLES THERAPY

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ROBERT M. COLEMAN
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APPROVED:

Shelly Smith-Acuna, Ph.D., chair

John McNeill, Psy.D.

Jim Gallagher, Psy.D.

Abstract

Couples outcome research indicates that current practices yield marginal effectiveness and high relapse. Mindfulness-based interventions, demonstrating effectiveness with lower relapse, are absent in most couples models. Self-directed, adjunct interventions effectively extend current models addressing treatment gaps while simultaneously attending to individual and couple factors. Developing mindfulness skills concurrently with the first five weeks of couples therapy via experiential exercises using the Johari Window model is proposed. Self-directed skills training influences broader arrays of outcome variables and foster a change-focused therapeutic context. Protocol exercises, assessment data, and skills integrate with primary couples therapy processes. Primary target areas are individual differences, active learning, and values and commitment. Expected outcomes are increased experiential openness, self-observation, emotional processing, acceptance, responsibility taking, behavioral flexibility, and valued living.

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Mindfulness-Based, Self-Directed Intervention as an Adjunct Method for Couples Therapy

What if you, as a consumer, were told prior to making a purchase that there was only a 1-in-6 chance of being satisfied with the product or service you were considering. Would you still buy it? Is it acceptable if it works well in the short term, but there is a high risk of failure over time? Suppose it involves a major purchase like a home, car, or major appliance, or something of strategic importance like a retirement fund or selecting your child's college. Are 1-in-6 odds of achieving long-term customer satisfaction sufficient? I doubt it. Those odds are probably not suitable for purchasing items of limited value or consequence like clothing or a piece of furniture. And yet some argue that this is what's happening in the field of couples therapy where as few as 18% of couples (1 out of every 6) achieve long-term benefits from psychotherapy services (Gottman, Driver, & Tabares, 2002; Gurman & Fraenkel, 2002; Snyder & Schneider, 2002).

This study reviews existing practices in couples therapy and perceived problems with its models, methods, and modalities that contribute to less than optimal outcomes. It also reviews recent advances in individual and group therapy using the skill of mindfulness as a therapeutic resource and treatment strategy. Mindfulness-based interventions have demonstrated short- and long-term clinical effectiveness, high consumer satisfaction and adoption, and usefulness as a prophylactic in relapse prevention across a variety of psychological disorders (Baer, 2003; Segal, Williams & Teasdale, 2002; Kabat-Zinn, 2003; Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000; Williams, Teasdale, Segal & Soulsby, 2000). Currently, the use mindfulness skills has limited application in the field of couples therapy but holds great promise in overcoming potential limitations in current models. The primary purpose of this study is to extend current couples therapy methods by adding a second treatment modality, operating concurrently with standard clinical practices, that address unmet needs and gaps linked to marginal effectiveness and poor long-term

outcomes. This is accomplished through the use of a brief, self-directed adjunct intervention implemented during the first 5 weeks of couples therapy. The proposed adjunct intervention centers on teaching mindfulness, and using related experiential exercises focusing on individual skill building, as a means of enhancing couples work and facilitating attainment of primary treatment objectives. The central thesis behind this study is to stimulate and encourage individual change in the service of increasing relationship health. This is accomplished by way of personal skill development, increasing emotional processing and regulation, taking personal responsibility for one's life and behavior, increasing experiential openness and acceptance, and decreasing defensiveness, blaming, and avoidance behaviors. Mindfulness skill development combined with changes to client-specific factors resulting from exposure-based task performance are predicted to be the primary mechanisms of action linked to increased outcome effectiveness and lower relapse rates.

Approach

The protocol design is based on the premise of couples therapy being the primary therapeutic process and the relationship as the “identified patient.” The majority of therapy goals are anticipated to be couples-centric with typical treatment considerations given to such factors as emotions, individual and relational histories, communication skills, patterns of interaction, general behavioral styles, and degrees of personal strengths and weaknesses. The design assumes that the adjunct process is not a replacement for current models or practices, only an extension to them targeting specific treatment areas and clinical variables. Therefore the self-directed intervention focuses almost exclusively on the individuals comprising the couple and their unique values, goals, skills, perspectives, learning histories, personal styles, degrees of self- and other awareness, and contributions to relationship distress. The intention behind the adjunct protocol is to create a more holistic and balanced therapeutic process by attending to key individual issues in the context of couples therapy that facilitates improvement in both relationship quality and broader life domains.

On the surface, adding a parallel approach emphasizing the individual may seem paradoxical and counter-intuitive. Couples typically seek help for relationship issues and are usually not expecting couples therapy to be directed toward individual factors. However, trend analyses and corresponding needs assessments in the field, including recent historical reviews and critiques of current couples therapy models, stress the importance of returning to increased attention on the individuals in the dyad and integrating individual factors with relationship factors (Gurman & Fraenkel, 2002; Pinsof, 2002; Franklin & Jordan, in press; Gottman, 2002). This imperative is the foundational principle behind this study's protocol.

Goals and Objectives

The adjunct protocol's ultimate goal is to increase outcome effectiveness and lower relapse rates. This is accomplished by both process and strategic objectives. Major process objectives are:

1. Establishing a change-focused therapeutic context applicable to both individuals.
2. Becoming unstuck from current unworkable patterns (individual and couple).
3. Increasing active participation and level of effort in skills practice.
4. Increasing definition, clarity, and prioritization of issues that initiated seeking help.
5. Setting incremental, achievable goals along with realistic expectations for rates of change.
6. Committing to longer durations of therapy necessary to achieve goals.
7. Providing the therapist a means of gathering objective assessment data.

The benefits of achieving process objectives are: (a) getting the individuals quickly involved in therapy while decreasing blaming behaviors, focus on the partner, and responsibility avoidance; (b) unmasking motivational, behavioral, and characterological factors that may influence therapy; (c) empowering the clients to collaborate with the therapist to guide the therapy process; and (d) increasing efficiency and resource utilization. These process objectives and benefits are critically

important since couples wait an average of 6 years before seeking professional help (Gottman, Driver, & Tabares, 2002) and may have been developing unworkable patterns for 3-9 years.

The protocol's strategic objectives are based on teaching mindfulness skills and increasing experiential learning that promote skill development in other areas of functioning. Generalization of learning to the couples context is the main intent. Core strategic objectives include:

1. Increasing openness to experience and acceptance.
2. Decreasing experiential avoidance.
3. Increasing commitment to skills development, personal growth, and change.
4. Increasing responsibility taking while decreasing blaming, defensiveness, and other forms of maladaptive coping.
5. Increasing emotional processing and affect regulation.
6. Increasing flexibility in verbal narratives and meanings of experience.
7. Increasing definition and clarification of personal values promoting behavioral consistency.
8. Increasing lifestyle balance with emphasis on wellness and prevention.

The benefits of achieving these strategic objectives in the context of couples therapy are: (a) increased cognitive, verbal, emotional and behavioral flexibility that improve psychosocial and relational functioning; (b) increased awareness and openness to one's experiences without excessive evaluation that increase genuineness, empathy, and relational intimacy; (c) increased use of personal strengths and skills to resolve future problems or implement needed changes that prevent relapse; (d) increased use of acceptance and distress tolerance skills that decrease the risk of automatic, mindless responding and maladaptive coping; and (e) increased willingness for mutual influence from the relationship partner that increases positive-to-negative interaction ratios across contexts.

The skills-focused and experiential nature of the intervention is predicted to minimize the risk of typical therapy-interfering behaviors (i.e., blaming, responsibility avoidance, manipulating the

therapist toward changing the partner). At the same time, it sets the norm of therapy being an active, collaborative venture where each person has the power, responsibility and strengths to bring about desired changes. Active learning is predicted to increase the client's sense of empowerment, motivation, and commitment in addition to producing placebo effects by engaging in a culturally sanctioned "healing ritual" (Hubble, Duncan & Miller, 1999).

Chapter 2: Literature Review and Assessment of Couples Therapy Models

The progressive and radical changes in American culture over the past four decades can be measured in multiple ways including analyzing census information. The following data from the U.S. Census Bureau's 2000 Census (Divorce Trends, 2004; Households by Type, 2004; Median Age at First Marriage, 2004; U.S. Department of Commerce, 2001, 2003) depicts problems with permanent pair bonding and couples relationship that couples therapy has failed to impact:

1. Married couple households continued to decline in 2000 to 51.7% (54.5 million), down from 56% in 1990, 60.8% in 1980, 70.5% in 1970, 74.3% in 1960, and 78.2% in 1950.
2. 50% of men, and 44-52% of women, over age 45 had their first marriage end in divorce (average duration of 7-8 years).
3. 10% of all adults at any point in time in 2000 were divorced, up from 8.3% in 1990, 6.2% in 1980, and 3.2% in 1970.
4. Marital disruption results in much poorer economic circumstances for women than for men.
5. 77% of men, 73% of women, under 45 remarry after divorce. 50% remarry within 3 years.
6. 26% of households in 2000 were people living alone, up from 25% in 1990.
7. 27.1% of adults over age 15 have never married, and 18.5% are currently unmarried (widowed, 6.6%; divorced, 9.7%; separated, 2.2%).
8. Since 1950, the median age of first marriage increased by 5 years; males=26.8, females=25.1.

9. 5.2% of all households (5.5 million), and 9% of couple households, were maintained by unmarried partners, a 72% increase from 1990 (3.2 million). 600,000 were same sex couples.

Pinsof's (2002) millennial review of couples therapy indicates the necessity of evolving the field in light of the challenging 21st century sociocultural environment where divorce has replaced death as the most common end to committed relationships. In 1867, less than 10% of all marriages ended in divorce. By 1985, lifetime probability of divorce from first marriages was 54%. Today, half of all divorces occur before the seventh year indicating a fundamental breakdown in permanent pair bonding. Pinsof points to the drastic sociocultural changes over the past 30 years in household and family configurations, roles, and couple living arrangements. The most radical changes are derived from three major factors: (a) increased lifespan, (b) shifts in biopsychosocial roles of women, and (c) legal and social values changes. The significant increase in lifespan today compared to 1900 (from 48 to 74 years for men; 51 to 80 years for women) is the most salient factor affecting sociocultural norms. The second most critical factor is changing roles and opportunities for woman (previously unavailable lifestyles, freedoms permitted by contraception technology). Changing social values include increased cohabitation, delayed first marriages, same-sex couples, and increased isolation and people living alone. Pinsof contrasts radical changes in social norms with relatively unchanged standards of clinical practice in couples therapy developed during the systems movement. There is an urgent need for couples therapy to address the unmet needs and gaps in current models due to the high economic, social, and personal costs associated with relationship breakdowns.

Couples Therapy Research And Practice

Recent psychological literature in couples therapy, focusing on the transition to a new millennium, calls for the field to make bolder moves to differentiate itself as a unique sphere of influence (models, methods, measures, modalities) within the domain of mental health (Gurman & Fraenkel, 2002; Gottman, 2002; Pinsof, 2002). Couples therapy has made gains over the past several

decades in terms of refinement, extensions, diversification, integration, and compiling research data, primarily around its three dominant models (behavioral, emotionally-focused, and insight-oriented) (Gurman & Fraenkel, 2002). However, despite these advances and applying research data to clinical practice, the field suffers from making only marginal impacts on the lives of people receiving services. Outcome research indicates major therapy models achieve statistically significant short-term effects compared to non-treatment controls, but generally fail to demonstrate long-term benefits and have high relapse rates (Gottman, Driver, & Tabares, 2002).

Snyder and Schneider (2002) report 35% of couples fail to achieve significant gains from treatment, and only in 50% of the cases do both individuals show significant improvement. Gurman and Fraenkel (2002) report effect sizes for couples therapy are similar to those of individual therapy (60-75% “improved” versus non-treatment controls). However, the issue of clinical significance (i.e., moving from “distressed” to “non-distressed”), versus efficacy (i.e., statistically significant change), is a major concern since as few as 35-40% of couples achieve the post-therapy ideal of meeting criteria for the non-distressed category. Meta-analyses performed by Gottman, Driver, and Tabares (2002) of the best couples therapy models, using data from the work of Jacobson and Addis (1993), found that 55% of couples achieve moderate to high outcomes, but similar to Gurman and Fraenkel, found only 35% were in the non-distressed range. Of the non-distressed couples, 30-60% relapse within two years (Gottman, Driver, & Tabares, 2002; Snyder & Schneider, 2002). The final analysis shows that as few as 18% (1-in-6), and likely no more than 25% (1-in-4), of couples end up with clinically meaningful sustained gains two years after therapy. Gurman and Fraenkel echo concerns over high relapse rates since a significant portion of couples in their analyses return to the “distressed” category between 1 and 4 years.

Epstein and Baucom (2002) and Baucom, Epstein, and LaTaillade (2002) provide research data supporting the assertion that traditional couples therapy models, including cognitive-behavioral

couples therapy (CBCT), result in marginal outcomes and high relapse. They indicate behavioral couples therapy (BCT), the most researched area, is superior to wait-list controls and nonspecific (placebo) interventions. Of BCT participants, 33-66% complete treatment in the non-distressed category and maintain benefits for 6-12 months. However, the majority of BCT couples relapse 2-4 years after treatment. The authors report emotionally-focused couples therapy (EFCT) was superior to BCT in marital adjustment, and insight-oriented couples therapy (IOCT) equal to BCT overall and had better marital adjustment and fewer divorces after 4 years (3% vs. 38%). Gurman and Fraenkel (2002) also found that behavioral models tend to have higher relapse rates compared to emotionally-focused and insight-oriented models. However, caution should be used in comparing outcome effectiveness of different models since key population-specific variables (e.g., distress level, duration of conflict, learning histories, personal styles) may influence results. What Gurman and Fraenkel suggest is increased focus on and processing of affective variables within couples therapy while promoting skill development in emotion regulation, self-exploration, and flexible narratives.

EFCT is the second most empirically validated form of marital therapy in North America with an average effect size compared to controls above 1.3 (Johnson, Hunsley, Greenberg, & Schindler, 1999). This compares favorably with general psychotherapy (.95). Consumer adoption and satisfaction were high, and two year follow-up studies show 70-73% of EFCT couples remained in the “nondistressed” category. EFCT is a short term (8-20 sessions) experiential and systemic couples therapy helping partners reprocess the emotional experiences underlying rigid and negative interactional patterns that keep them stuck. EFCT seeks to resolve unpleasant emotions by working with them, and regards unpleasant affect as sources of useful information (Johnson & Lebow, 2000).

Several conclusions can be derived from this research data and historical reviews. First, current models and practices provide benefits to clients. Second, couples respond differently to various types of interventions based on their unique presenting problems, personal styles, and

histories. Clinical standards and practices require increased flexibility and diversity since “one size does not fit all.” Third, most current models and methods seem insufficient by themselves to resolve problems of marginal outcomes and high relapse rates. Fourth, a more integrative approach using best-practices and multiple empirically validated methods addressing a wider range of clinical variables and behaviors across multiple modalities are likely to be more efficacious than any single approach or ad hoc synthesis of techniques. Finally, current models may lose effectiveness because they are not aligned with today’s sociocultural environment. Current practices need to evolve in light of changing cultural norms including delayed first marriage, cohabitation, and general relationship wellness and prevention strategies apart from marriage. Modalities and methods need to be more “user friendly” to promote adoption and general application. Using an adjunct approach blending professional services and self-directed tasks targeting these gaps may provide a bridge for current models to address unmet needs, and improve outcome effectiveness while reducing relapse rates.

Needs Assessment and Trend Analysis

There is a fair amount of consensus in couples and family research and clinical practice suggesting how the aforementioned concerns can be addressed, clustering around the following major themes: (Gurman & Fraenkel, 2002; Pinsof, 2002; Gottman, 1998, 2002; Epstein & Baucom, 2002; Franklin & Jordan (in press); Jacobson & Christensen, 1996; Gottman, Driver, & Tabares, 2002; Gottman, Ryan, Carrere, & Erley, 2002; Hubble, Duncan & Miller, 1999; Snyder & Schneider, 2002; Lebow, 1997):

1. Individual in the system. The need to refocus attention on the individuals in the couple relationship, currently lacking in most models, and including psychological disorders, biological factors, and health wellness issues in the therapy process.

2. Active participation in therapy via skills development and practice. The need for sufficient time, level of effort by the couple, and working in multiple modalities (not just conjointly) to practice skills and implement techniques learned in therapy.
3. Change-focused therapeutic context fostering commitment and valuing. The critical nature of establishing therapeutic norms in early sessions focused on mutual change, commitment to therapy, and behavioral consistency as evidenced by active learning about one's own goals and values, increasing self- and other awareness, and decreasing partner blaming, defensiveness, and other maladaptive coping.
4. Affective engagement and processing. The increased emphasis in the therapy process on emotional processing and affective and cognitive-attribitional elements of the relationship, including personal meanings and narratives. Key elements include acceptance-based strategies, assessing emotional valence factors and ratios of positive-to-negative events, and emotion regulation and distress tolerance skills.
5. Collaboration and empowerment. Making therapy and associated interventions more client-friendly, collaborative, and culturally relevant (i.e., congruent with the client's values, goals, and normative practices) by focusing on the couple's ethnic background, lifespan factors, individual and collective strengths, and incorporating the client's theory of change and conceptualization of problems and solutions into therapy. A key factor is aligning interventions with the couple's demographic factors (e.g., distress level, age, SES, world view), which promote increased adoption of skills used in daily life, therefore increasing generalization of treatment effects.
6. Ecological perspective. Expanding case conceptualization, therapy techniques, and modalities to include the effects of the larger sociocultural environment and social roles, the couple's support systems, and the impact of occupational and lifestyle choices.

7. Empirically validated best-practice paradigm. Integration strategies moving toward empirically validated treatment techniques and methods, and practices endorsed from consumer feedback that correlate with better outcome measures.

Conclusions and Recommendations

One conclusion drawn from the information above is that couples therapy models and practices provide some benefits to consumers, but overall are marginal in long-term effectiveness and are vulnerable to relapse. Many traditional models either have not incorporated current capabilities and best practices into its framework that improve outcome, or have done so without applying sufficient scientific rigor. This study asserts that couples therapy may be grappling more with needing to create robust service delivery paradigms that tailor empirically derived clinical interventions to unique consumer needs and sociocultural factors than it is with inadequate models and methods. One method of addressing needs and gaps in current methods is by adding a second modality like the brief adjunct method in this study. This type of intervention is designed to target specific relevant contexts and areas of behavioral functioning while complementing and integrating with core couples therapy processes in a scientific and clinically useful manner. This is a simple way of extending current models without following the traditional mode of creating totally new and highly redundant models. There is no justification for adding a new model to the 200+ existing psychotherapy models employing 400+ specific, but highly overlapping, therapy techniques (Hubble, Duncan & Miller, 1999) when a simple best-practice extension can fulfill treatment needs.

Mindfulness-Based Adjunct Intervention as a Proposed Solution

While the field of couples therapy is seeking solutions for marginal effectiveness and relapse problems, there have been advances in these areas in individual and group therapy using the skill of mindfulness. The use of mindfulness in clinical interventions has become an increasingly popular approach in recent years with demonstrated effectiveness across a variety of disorders (Baer, 2003).

This study proposes teaching mindfulness skills to couples via a 5-week self-directed adjunct protocol predicted to improve short- and long term outcome effectiveness while decreasing relapse rates. The overall intent of the adjunct couples protocol, addressing aforementioned needs, is to:

1. Enable couples therapy to become a more holistic, balanced, and collaborative process with increased attention on the individuals in the relationship.
2. Increase the number of clinical factors (individual and couple) activated and addressed in therapy by engaging in experiential learning and skill development, and applying new skills in other contexts.
3. Develop or enhance awareness and observational skills (self, others, external environment) that increase experiential openness, acceptance, behavioral flexibility, and responsible/valued living while decreasing therapy-interfering behaviors.
4. Activate emotional processing, and increasing attention on verbal narratives and personal meanings, while teaching affect regulation, distress tolerance, and relationship effectiveness skills.
5. Provide a means of resolving current distress while equipping the individuals for future challenges across a variety of contexts, and across the entire adult lifespan (wellness and prevention/quality-of-life orientation).

The primary rationale behind using a mindfulness-based, adjunct intervention in couples therapy is found in research by Williams, Teasdale, Segal, and Soulsby (2000). The authors developed an 8-week mindfulness skills training program as a complementary follow-up intervention to core therapy designed to prevent relapse in patients with multiple, episodic severe depression. They discovered the intervention helped reduce over-generalized, and typically negative, summaries of experience recalled in response to internal and external stimuli. Selective and over-generalized recall of events is characteristic of patients with depression and PTSD. More summative verbal/cognitive descriptions of past experiences serve as an avoidance strategy for specific

unpleasant memories and corresponding aversive affect. But this style of retrieval tends to be less objective and accurate as a function of original event content and was subjectively experienced as increasingly negative and punishing. This summative recall style was associated with deficits in problem solving and distress tolerance, lower interpersonal effectiveness, increased hopelessness, and longer periods of recovery from distressing events. After mindfulness skills training, the participants tended to remember more event-specific and affectively balanced content and showed less avoidance behavior. The brief, adjunct mindfulness skills training program by Williams et. al not only increased mood stability and improved upon skills learned in core treatment, it also served as a post-treatment “early warning system” that helped reduce relapse rates. Participants using mindfulness skills showed increased levels of self-awareness, experiential openness, empowerment, lower avoidance behavior, and recognized and corrected maladaptive memory retrieval as it occurred. They also demonstrated increased tolerance and less sensitivity to negatively charged private experiences and developed skills in emotional regulation and distress tolerance. They used acceptance skills to develop perspectives of themselves as being separate from their emotions, and decreased excessive and literal evaluations of verbal and cognitive content. The participants also began to apply mindfulness skills and behaviors to other areas of life that decreased risks of relapse and improved quality of life.

There are strikingly similarities between the behaviors and levels of functioning of the participants in the Williams, Teasdale, Segal, and Soulsby (2000) depression study and distressed couples who come in for treatment. There also seems to be a moderately high correlation between the aforementioned gaps and needs in current couples therapy models, that may account for marginal outcomes and high relapse, and the target areas and treatment effects using a brief mindfulness skills program. This study proposes using a mindfulness-based skills development protocol with specific exposure exercises targeting perceived deficiencies in current couples models

as an adjunct method to existing couples therapy processes designed to increase outcome effectiveness and reduce relapse.

Chapter 3: Origins and Clinical Applications of Mindfulness

Mindfulness is a complex and uniquely human phenomenon with its origins in Eastern meditative, and later Christian contemplative traditions (Baer, 2003; Dimidjian & Linehan, 2003). The historical and cultural phenomenon of mindfulness predates scientific and psychological applications by thousands of years. This study asserts that one must first develop a rudimentary understanding of the original sociocultural, philosophical, and spiritual precepts that form the basis of mindfulness, as well as alternative views, before applying the skill in clinical applications to specific treatment populations (Dimidjian & Linehan, 2003; Kabat-Zinn, 2003). This argument is based on the perspective that mindfulness is more than a label for a class of behaviors, learned and practiced to achieve optimal personal functioning and well-being. It is also a philosophy of life guiding how one understands oneself as a human, and how one relates to the impermanent nature of one's own life circumstances.

This section provides a brief historical review of mindfulness, alternative views, how mindfulness skills have been applied to research and clinical populations, common techniques, applications in couples therapy, outcomes measures, and potential mechanisms of actions. This data is used to formulate a functional analysis of mindfulness behavior, develop protocol techniques, and to operationally define mindfulness used in the design of the adjunct protocol.

Historical and Alternative Views of Mindfulness

In today's Western world, mindfulness is usually associated with Eastern religious practices such as Buddhism that include personal meditation and yoga. Mindfulness behavior is intended to increase awareness of experiences, keep one's consciousness alive and focused to present reality (vs. past or future non-realities), and actively observe, approach, welcome, and allow one's life processes

to happen (Dimidjian & Linehan, 2003; Roemer & Orsillo, 2002; Chodron, 1997). Mindfulness can be characterized as an active first-person, phenomenological description about the nature of one's mind, emotions, body, and entire being connected to the world at that moment, and reflecting subjective states of happiness, suffering, or other personal-meaning constructs (Kabat-Zinn, 2003). The seven major characteristics of mindfulness from an historical-cultural perspective are non-judging, patience, a beginner's mind, trust, non-striving, acceptance, and letting go (Kabat-Zinn, 1993, 1994). The function of mindfulness is to promote spiritual transcendence, shedding individual desire through ascetic living, eliminating suffering by viewing individual essence or personality as an illusion, and becoming fully present with one's experience in the world (Brennan, 2003; Comparing Buddhism, 2003; Introduction to Buddhism, 2003; Basic Buddhism, 2003).

Mindfulness and meditation can also be found in monotheistic traditions (one creator God) that embrace dualism (humans have a material body and an enduring personal spiritual essence) like Islam, Judaism, and Christianity. In these traditions, mindfulness is a means of becoming grounded in one's spiritual life, worshiping and relationally connecting to God, recharging physical and spiritual energies, and allowing God to influence one's behavior. Humanistic/existential orientations view mindfulness as a human common factor and capacity with state and trait characteristics that can be developed to increase awareness of inner experiences and the external environment (Horowitz, 2002; Martin, 2002; Roemer & Orsillo, 2002). This orientation views mindfulness skills as a means of recharging creative energies and gaining internal power in pursuit of self-actualization. Langer (1989, 1997) describes mindfulness as a psychosocial and cognitive construct that increases one's awareness of the environmental context. From this perspective, mindfulness involves focusing on the present moment, being alert to distinctions in the environment, being able to create new verbal/cognitive categories of experience, openness to new information, and awareness of multiple perspectives (Langer & Moldoveanu, 2000a, 2000b). This often involves cognitive tasks, goal-

oriented behavior, and active problem solving designed to increase learning and creativity. While this orientation is significantly different from traditional views, Hayes and Wilson (2003) see Langer's work as a logical and potentially beneficial addition to mindfulness-based clinical applications.

Mindfulness in Clinical Interventions

Mindfulness has gained increasing popularity in recent years and has been applied to a number of clinical interventions across a variety of disorders. Baer's (2003) meta-analytic review of different clinical models using mindfulness skills as a key intervention factor include mindfulness-based stress reduction (MBSR) for chronic pain and stress-related disorders (Kabat-Zinn, 1985, 1990, 1994), dialectical behavior therapy (DBT) for borderline personality disorder (Linehan, 1993, 1994), and mindfulness-based cognitive therapy (MBCT) for depression (Segal, Williams, & Teasdale, 2002). MBCT has also demonstrated effectiveness in relapse prevention by reducing negative filtering of experience from retrieved memory and increasing self-regulation skills related to depression onset (Williams, Teasdale, Segal, & Soulsby, 2000). Mindfulness skills training combined with exposure and acceptance-based techniques targeting verbal behavior and experiential avoidance has been added to standard cognitive-behavioral therapy (CBT) for generalized anxiety disorder (GAD; Roemer & Orsillo, 2002; Borkovec, 2002) and obsessive-compulsive disorder (OCD; Schwartz, 1996). Other CBT interventions using elements of mindfulness include: (a) acceptance and commitment therapy (ACT) for experiential avoidance, cognitive defusion, and inflexible rule-governed behavior (Hayes, Strosahl & Wilson, 1999; Hayes & Wilson, 1994; Hayes, Wilson, Gifford, Follette & Strosahl, 1996), (b) relapse prevention (RP) for substance abuse treatment (Marlatt, 1994; Marlatt & Kristeller, 1999; Miller & Rollnick, 2002), and (c) flooding (a.k.a. prolonged exposure; PE) and exposure with response prevention (ERP) for PTSD and OCD (Foa & Kozak, 1986; Foa, Zinbarg & Rothbaum, 1992; Foa, Kozak, Goodman, Hollander, Jenike & Rasmussen, 1995).

Brown and Ryan (2003) apply mindfulness to the concept of wellness and increased quality of life, and have correlated mindfulness skills training with lower levels of mood disturbance and stress. Horowitz (2002) views mindfulness skills as having beneficial effects on psychological functioning and well being, and is an innate capability or common factor to all humans. Carson (2003) and Carson, Carson, Gil, and Baucom (in press) have applied mindfulness to relationship enhancement in non-distressed couples and found a positive correlation between mindfulness skills and high relationship satisfaction, lower relationship stress, reduced overall stress, and higher levels of coping skills. Kabat-Zinn (2003) has extended his work in stress reduction to include how mindfulness skills can influence autoimmune functioning. Mindfulness was shown to decrease symptoms in patients with skin disease like psoriasis, and slowed and sometimes arrested processes that increase metastatic spread of cancer from post-operation prostate patients.

Common Techniques in Mindfulness-based Interventions

Mindfulness-based interventions employ a number of different therapy techniques derived from various traditions including principles from Western existentialism and phenomenology (Finch & Van Dragt, 1999; Farnsworth, 1999; Finch, 1982). Existential and phenomenological traditions focus on subjective meanings of experience in addition to present moment centeredness. Mindfulness meditation, derived and modified for clinical use from Buddhism and other Eastern traditions, is the most common technique found in psychological applications (Dimidjian & Linehan, 2003). Mindfulness is designed to help the person become more aware of and connected to present moment experiences. The process involves increasing self-awareness and awareness of the environment, and merely observing thoughts and feelings as they come up. Other common skills include the “body scan,” a systematic tension release and relaxation technique, and breath meditation for relaxation and distress management. Breath meditation involves sitting comfortably in a chair or on the floor with your back straight, eyes closed, and concentrating on the process of

inhaling and exhaling. A major goal during meditation is a passive attitude allowing thoughts, images, and feelings to pass by almost unnoticed. This helps to clear the mind and allows the person to become grounded in the present. These techniques are widely accepted as an adjunct therapy for chronic pain, stress management, high blood pressure, insomnia, and other physical ailments (WholeHealthMD.com, 2003). Brain studies using electroencephalograph show meditation and contemplative prayer boost alpha wave intensity (i.e., quiet, receptive states) to levels not found even during sleep (Kabat-Zinn, 1993; Kabat-Zinn, Lipworth & Burney, 1985; Roemer & Orsillo, 2003).

Non-meditation based strategies are mostly cognitive-behavioral and experiential in their orientation, and integrate elements of mindfulness within the overall treatment model. The prime example is DBT where core mindfulness is the first skill taught, and used as a reference point for teaching later relationship, coping, and emotion management skills. Other approaches like RP use acceptance and distress tolerance skills to teach ways of resisting urges, skills in recognizing triggers and cues leading to maladaptive coping, and endorsing temporary suffering as normal.

ACT focuses on experiential avoidance and bringing people into contact with feared or avoided thoughts, feelings, and bodily sensations by direct exposure exercises. Exposure and experiential learning are means of deconstructing the literal and evaluative function of language that usually exert unduly rigid control over the person's behavior. ACT and relational frame theory (RFT; Hayes, Barnes-Holmes & Roche, 2001) acknowledge the importance of personal narratives and meanings of experience in behavioral responding and psychological distress. A major goal of ACT is to increase behavioral flexibility by decreasing the literal nature of language, and having clients become active observers of experience without automatic responding. Other exposure-based techniques correlated with mindfulness skills include PE and ERP. Experiential learning by means of direct contact with feared objects, private events, and situations (in vivo and imaginal) in a safe environment, without receiving the predicted negative outcome as in previous events, undermines

fear responding and co-occurring physiological and verbal constructs (Canli, Zhao, Desmond, Kang, Gross & Gabrieli, 2001; Hayes, Barnes-Holmes & Roche, 2001). Hembree, Rauch, and Foa (2003) demonstrate exposure-based techniques as the most effective means of treating PTSD. Kozak and Foa (1997) demonstrate effectiveness of PE in OCD.

Mindfulness in Couples Therapy

Most applications of mindfulness-based interventions found in psychological literature are based on methods and techniques from Kabat-Zinn's (1990, 1993, 1994) mindfulness-based stress reduction (MBSR; Baer, 2003). MBSR is an 8-10 week behavioral medicine program designed for chronic pain and stress-related disorders. There are few applications of mindfulness to couples therapy. The one major exception is Carson (2003) and Carson et al. (in press) who applied mindfulness to relationship enhancement for non-distressed couples. The Carson et al. model is an 8-week program based on MBSR and elements from Prevention and Relationship Enhancement Program (PREP; Markman, Floyd, Stanley & Storaasli, 1988). A positive correlation was found between mindfulness skills and high relationship satisfaction, lower relationship stress, lower overall stress, and higher levels of coping skills. Carson noted limitations using this approach including population characteristics (white, well-educated, middle-class, heterosexual, non-distressed, 11-year relationship history), lack of controls for nonspecific factors (attention from providers, interactions in group therapy), and reliance on self-report data. Major strengths of the design include a single one-day personal retreat, skills-based weekly homework assignments, and balance between didactic and experiential exercises, done individually first and then shared as a couple.

A potential weakness in the Carson et al. study is the heavy emphasis on yoga exercises and guided meditation (audiotape and sessions taught by certified yoga instructors). Various sociocultural groups, people from lower socioeconomic backgrounds, or people affiliated with some Western religious groups may not adopt these techniques. This problem may be potentially resolved by

teaching mindfulness skills from a more neutral context such as done in DBT (Linehan, 1993, 1994). This allows individuals to apply their own cultural, philosophical, and/or religious meanings to mindfulness skills. A second weakness involves the use of certain couple-focused exercises like “loving-kindness focus” to one’s partner since some of the behavioral components (e.g., eye-gazing, mindful touch) may be regarded as too provocative, especially during the early stages of couples intervention. A final weakness is program duration. An 8-week design may be too long and complex for many distressed couples because of their reduced coping resources, lower emotional investment in the other, schedule constraints, and a bias toward the partner being responsible for relationship problems. The adjunct intervention in this study has accounted for both strengths and weakness from this study and seeks to balance short-term needs (e.g., crisis factors, stabilization, motives and hidden agendas, desire for immediate change) with more strategic treatment objectives (e.g., skills, self-awareness, roles and responsibilities, interaction styles, affective ratios, and individual maturity).

Outcome Effectiveness of Mindfulness Interventions

Baer’s (2003) meta-analytic review of mindfulness-based clinical interventions offers three major findings. First, mindfulness skills training in psychological interventions demonstrate short- and long-term effectiveness. Second, mindfulness-based interventions show lower rates of relapse, even with treatment resistant disorders like chronic pain and severe major depression. Third, mindfulness skills training had high consumer satisfaction and acceptance, and high rates of skills adoption as part of ongoing practice of therapy techniques. Outcome effectiveness of mindfulness-based interventions are indicated in the following results: (a) effect sizes were statistically significant (average of .87); (b) effect sizes were clinically significant as evidenced by symptom reduction and self-report measures at post-treatment; (c) effectiveness of interventions remained statistically and clinically significant at follow-up periods ranging from 3-6 months and at 2 years; and (d) consumer interest in, and satisfaction with, mindfulness was very high. Consumer satisfaction and skills

adoption are evidenced by an average completion rate of 85% for 13 programs, high post-treatment customer satisfaction ratings, and 4 studies showing 75-95% of participants continued to use mindfulness skills at follow-up. These results underscore the critical nature of active participation across therapeutic contexts, using therapy techniques that are life-skills oriented, and using methods congruent with the client's world view and lifestyle that generalize to broader daily functioning.

Mechanisms of Action in Mindfulness Behavior

Baer's (2003) meta-analysis of mindfulness-based applications indicates the specific mechanisms of action are unknown as are the exact proportions of variance for mindfulness in these interventions. Therapeutic change is thought to be a combination of the following major factors: a) exposure, b) cognitive change, c) self-management, d) relaxation, and e) acceptance. Hayes (2002) and Hayes & Wilson (2003) discuss mindfulness in terms of several interrelated methods (i.e., mindfulness, acceptance, diffusion, interoceptive exposure, and values clarification) designed to target behavioral processes linked to the literal and evaluative functions of language and cognition. A key target behavior in ACT is experiential avoidance (Hayes & Wilson, 1994; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). ACT endorses increased awareness of one's public and private experience, willingness to be exposed to that experience in an accepting and nonjudgmental manner, to live a valued life by increasing flexible responding, and selecting behavior based on actual contingencies in the environment instead of arbitrary cognitive/verbal content. Mindfulness helps undermine rigid or unnecessary rule-governed processes that negatively influence or limit behavior.

Linehan (1993, 1994) focuses on mindfulness as a means of increasing skills in emotion regulation that result in interpersonal effectiveness and improved distress tolerance. Mindfulness-based skills are viewed as activating the client's strengths and resources for the purpose of cultivating awareness of self and others, developing wisdom and skillfulness in dealing with one's self and the surrounding social world, activating compassion and insight, and behaving according to

one's values despite internal distress. Similarly, Brown and Ryan (2003) discuss mindfulness as a means of improving self-regulatory functions by increasing positive forms of self-reflection. This leads to greater well-being and less cognitive and emotional disturbance. The authors show a positive correlation between attention and awareness skills and human health and well-being.

Functional Analysis and Operational Definition Of Mindfulness In This Study

A functional analysis of mindfulness practices in current interventions and related research was performed to develop a specific list of behavioral targets and outcome measures that would be incorporated in the adjunct intervention exercises. The behavioral targets and outcome measures have been organized into seven interrelated and quasi-hierarchical theoretical domains (Figure 1) and listed in Appendix A. While the exercises as a unit touch upon the entire hierarchy, the main emphasis for couples therapy is on the first four domains (experiential openness, equipping, empowerment, and emotional processing).

Dimidjian and Linehan (2003) and Kabat-Zinn (2003) discuss limitations in mindfulness research and the inherent problem of establishing in psychological science an adequate operational definition of the term. From an historical and cultural perspective, the very act of attempting to operationally define mindfulness goes against the very nature and philosophy of the practice. Daoist philosophers speak about how mindfulness as a practice brings into focus the symbiosis and mutuality between the particular and the totality. Therefore, to offer an operational definition of a behavior that defies definition from an Eastern perspective, as done below in the service of the scientific method, undermines its original intent. None the less, a definition is offered.

Mindfulness in this paper is proposed to be a universal phenomenon and common factor of human existence extending beyond current biopsychosocial viewpoints and including elements of phenomenology, existentialism, and spirituality (Horowitz, 2002; Martin, 2002; Roemer & Orsillo, 2002, Dimidjian & Linehan, 2003; Yalom, 1980). The operational definition of mindfulness used in

the design of the adjunct intervention in this study is based on elements of the original historical-cultural skill, current definitions from psychological literature, and extensions found in Langer's work (Langer, 1989, 1997; Langer & Moldoveanu, 2000a, 2000b). The emphasis is on the dialectic of acceptance and change (Linehan, 1994), full awareness and nonjudgmental stances toward one's experiences, and skillful and open responding to one's internal and external world. The expanded operational definition of mindfulness in this study is contrasted with "mindlessness," which is inflexible and maladaptive responding to imaginary and/or symbolic content and not the external world. "Mindlessness" typically involves a person using language to bind experience to specific cognitive categories, and acting in automatic fashion (external behavior and private experiences) with minimal regard for actual events unfolding here-and-now (Hayes & Wilson, 1994). Mindfulness is:

The process of skillfully adapting and expanding one's ongoing awareness and openness to present moment experiences (within yourself and in your environment), while suspending attempts to either change or control them or automatically evaluate their goodness or badness in either absolute or relative terms, for the purpose of increasing the quantity and quality of sensory perceptions and personal meanings that promote flexible learning, adaptive responding, enhanced social and relational connecting, and valued and purposeful living.

Chapter 4: Purpose and Rationale

The adjunct protocol is designed to be a parallel process during the beginning stages of couples therapy that helps facilitate resolution of relationship distress by targeting individual factors that adversely influence the couple relationship. The self-directed intervention is viewed as a delivery system, methodology, and context for change via exposure and mindfulness skills training at the individual level. This process is designed to establish a change-based therapeutic context that helps each person break out of "relational tunnel vision" and minimizing various therapy interfering behaviors. Protocol tasks are designed to: (a) help each person expand their perspectives and refocus on larger goals, values, and commitments; (b) increase self- and other awareness via skill building

that facilitates current and future couples work; (c) increase openness to experience while decreasing states of “emotional shut down” and experiential avoidance; and (d) increase exposure to their own contributions to relationship distress by emphasizing responsibility taking and acceptance.

Experiential exercises are designed to increase investment in the therapeutic process for the benefit of themselves and their partner, increase active learning, and encourage the couple to use self-reflection and self-discovery tasks as a means of exploring personal meanings of experience. The integration of the adjunct intervention with the primary couples process is both an ongoing activity and a specific event. Integration of variables and factors within weekly sessions is directed by the therapist as dictated by the couple and their experiences that week. There is also a specific integration event at the end of the adjunct process where each person shares with the other (i.e., integrative exposure exercise) what they discovered about themselves and the relationship.

Target Areas

The previous analyses on gaps and needs in couples therapy can be categorized into six major clinical target areas: (a) individual differences, (b) active learning, (c) values and commitment, (d) intimate relationship context, (e) sociocultural environment, and (f) wellness and prevention. The adjunct couples protocol primarily targets the first three areas. The area of Individual Differences focuses on the individual in the context of the couple relationship including personal histories and behavioral styles, personal narratives, biological or psychological disorders influencing the couple relationship, and unmasking hidden agendas and motivational factors. Developing mindfulness skills by each individual is predicted to facilitate increased self- and other awareness via improved observational skills, increased openness and acceptance of experiences, decreased experiential and responsibility avoidance, and decreased defensiveness and blaming. Mindfulness behavior is expected to promote changes in each person’s organization of experience that may increase flexibility in personal meanings and verbal narratives that influence behavior selection.

The area of Active Learning focuses on individual skill building and practice, welcoming new learning experiences, developing tolerance for ambiguity, increasing individual capacities by emphasizing and activating personal strengths, and developing distress tolerance, emotion management, and interpersonal effectiveness skills. Mindfulness skills training is expected to increase abilities via direct learning while discouraging over-reliance on verbal learning. Mindfulness skills are also expected to increase acceptance skills while decreasing excessive evaluations of experience (self and others). Active learning also provides a method of incorporating into therapy the client's theory and understanding of their problems, and possible solutions that facilitates the development of broad and flexible arrays of response options. This is expected to increase each person's motivational factors, sense of empowerment, and willingness to change.

The area of Values and Commitment focuses on increasing clarity and specificity of one's values, life goals, philosophy of life, and purpose for living. This area also focuses on increasing behavioral and verbal consistency based on personal integrity, congruence, and genuineness. This is predicted to establish or enhance the context for interpersonal safety (Najavits, 2002) necessary for later more intense couples work. This area also emphasizes commitment to a lifestyle of self-discovery, willingness, and personal growth. Mindfulness skills are expected to reinforce and normalize the dialectic of acceptance and change, as well as temporary suffering, as ongoing and natural life processes. This helps undermine maladaptive verbal/cognitive processes while increasing values-based personal meanings of experience that influence emotions and behavior. Developing mindfulness skills also reinforces responsibility taking and persistence, delaying short-term gratification, and increasing, empathy, compassion, and forgiveness.

Benefits

There are a number of anticipated benefits using a mindfulness-based adjunct intervention in couples therapy. First, the self-directed process establishes from the beginning the norm of therapy

as a place where both people work to bring about personal change for themselves and others. It undermines common therapy interfering behaviors as a means of resolving issues such as passive responding, partner blaming, and alliance with therapist to change the partner. The adjunct process is expected to set therapeutic norms and values that encourage responsibility taking, and conveying expectations for each person to be psychologically and emotionally invested and committed to the process. This includes willingness in conjoint sessions to process deeper emotions, become more open and vulnerable, and use direct communication skills in a respectful manner.

Second, the therapist can increase attention to building therapeutic rapport and alliance in conjoint sessions (accounts for 30% of the outcome variance; Hubble, Duncan, & Miller, 1999), while allowing the couple to perform other tasks outside of session. This permits the couple more time to “tell their story” and activate emotional processes. At the same time, the couple may become more empowered and equipped to perform therapeutic work independently using their strengths that may increase clarity and differentiation of core issues. Self-discovery is expected to reduce defensiveness and open up opportunities for acceptance-based work.

Third, the assignment of weekly tasks, and the standardized reports and data collected from them, are designed to reveal individual differences and factors. This helps with effective resource management on the part of the therapist and the couple by providing a means of gathering detailed assessment and background data in a standardized way without additional sessions.

Finally, the adjunct protocol is designed to help the couple become more active and collaborative in treatment planning to help clarify and specify their needs, core issues, and goals for therapy. Developing mindfulness skills is a major factor in facilitating treatment collaboration by increasing openness to experience, increasing self-awareness, clarifying quality of life issues and values, and recognizing individual and dyad relational and behavioral patterns.

Expected Outcomes

The primary expected outcome from the adjunct protocol is increased clinical effectiveness where both individuals move from the “distressed” to the “non-distressed” category. This outcome is expected to remain relatively stable over time and result in lower relapse rates. Mindfulness skills are predicted to be the primary mechanism of action for long-term clinical effectiveness and result in high consumer satisfaction and adoption of skills that generalize to other areas of functioning. Skills at the individual level are expected to produce behavioral change affecting other contexts and relationships outside of the dyad, and potentially provide resources that minimize external factors that adversely affect the couple relationship (e.g., work, environment, family relationships, larger cultural influences). The self-directed process is designed to integrate seamlessly with standard clinical interventions from multiple theoretical orientations, operating as a concurrent process facilitating productive conjoint work.

Mindfulness skills, practiced and adopted throughout therapy, are intended to become part of the person’s overall resource base and expanded skill set that provides continued clinical benefits. Overall, mindfulness skills training is expected to produce the following outcomes:

1. Increased present-moment awareness, observation skills, and experiential openness.
2. Increased acceptance of experiences and decreased attempts to change or control one’s private experience or the environments that occasion them.
3. Decreased escape or avoidant behavior linked to emotional distress, aversive external stimuli or internal bodily states, negative verbal/cognitive events, or uncomfortable situations.
4. Increased willingness, commitment, and action toward personal growth and change while accepting and tolerating various types of limitations (self, others, world).
5. Increased responsibility taking for one’s action and commitments.

6. Increased behavioral flexibility and strategies across a variety of contexts that contribute to consistent living according to one's values and goals.
7. Decreased evaluations and judgments of one's public and private experiences leading to inflexible, habitual, or maladaptive responding.
8. Increased affect integration, emotional processing, and skills in distress tolerance and emotion management that decrease maladaptive responding and coping.
9. Increased genuineness, authenticity, honesty, vulnerability, empathy, compassion, valuing differences, forgiveness, and acceptance that promotes intimacy and interpersonal effectiveness.
10. Increased flexibility of verbal narratives and personal meanings of experience.
11. Increase values clarification and goals assessment as a means of purposeful living and maintaining one's sense of personal identity.
12. Development of wellness and prevention strategies.

Chapter 5: Proposed Design

The self-directed adjunct couples protocol was developed using a best-practices, integrative approach incorporating recommendations about gaps and missing capabilities from published research and from experts in the field in couples therapy. The protocol design is primarily based on principles and features from the following research and clinical practice areas: (a) mindfulness-based interventions, (b) experiential avoidance and openness, (c) common factors in psychotherapy, (d) behavioral and emotionally-focused couples therapy; and (e) skills training based on the Johari Window model of self awareness and communication (Luft & Ingham, 1969; Chapman, 2003). Secondary design features were derived from Prochaska and DiClemente's (1992, 1994, 1998) stages of change model and principles of motivational interviewing (Miller & Rollnick, 1991).

Intervention Strategy

The adjunct intervention's core strategy and implementation methodology is based on the Johari Window model (Figure 2) combined with exercises from various mindfulness-based clinical models. A secondary strategy involves gathering and providing objective assessment data to the therapist to increase efficiency, improve resource management, and guide initial treatment planning. The first four weeks of the intervention are devoted to each major dimension of the Johari Window model and engaging in corresponding self-directed exercises. These are: (1) mindfulness training and self-discovery, (2) self-disclosure, (3) direct requesting and soliciting feedback, and (4) experiential integration (self-reflection, meanings of experience, life goals and purpose, and values clarification). The fifth session involves translating experiences and skills into a personal action plan. The primary behavioral target areas and expected outcomes for all exercises are experiential openness, equipping, empowerment, and emotional processing (i.e., the first four domains in Appendix A).

Johari Window Model

The Johari Window model ("Johari" is derived from Joseph Luft and Harry Ingham's first name) has many applications in business and social science, and is designed for skills training in self-awareness, personal development, improving communications, interpersonal relationships, and group dynamics. It is commonly referred to as an "influence and leadership model." It is also referred to as a "self-disclosure/feedback model of self awareness" representing skills in observing and gathering information about one's self, others, and self in relation to a group. The Johari Window model was selected for use in this study because of its simplicity, robust features, and theoretical neutrality that permit exploring mindfulness behavior from a broader perspective.

The Johari Window is divided into four areas or quadrants, each with a unique perspective about the person in relation to themselves and others. Quadrant 1 (upper left) is called the "Open" pane representing what the person knows about himself or herself that is also known by others. This

is a person's public image and open to observable behaviors. Quadrant 2 (upper right) is called the "Hidden" pane representing the person's private world of inner experience and invisible identity. This includes undisclosed aspects of one's experience and/or avoided or denied characteristics (false self or façade). Willing self-disclosure is the means of "moving" one's experiences from the hidden area to the open area. A healthy balance between the public and private domain gives rise to increased genuineness, openness, consistency, and congruence.

Quadrant 3 (lower left) is called the "Blind Spot" representing what is known by others via observations and interactions with the person but unknown to the person themselves. This publicly available information is typically outside of the person's direct awareness and ability to objectively observe. Willingness to directly request or solicit feedback from others is the means of "moving" experiences from the blind spot to the open area. This behavior requires significant vulnerability and risk taking for the person asking for feedback and the person giving it. It is also the area of greatest reward and benefit since feedback reveals unknown obstacles that undermine goal achievement. Quadrant 4 (lower right) is the "Unknown" area representing what is unknown by the person and others about him or herself. The "undiscovered person" is a target area for self-actualizing behaviors and realizing one's potential in the service of living a valued and purposeful life.

Participants

Participants are expected to be couples of any relationship type or status (i.e., married, cohabitating, elderly, any sexual orientation). Relationship duration can vary, but is expected to be greater than six months. The couple should have low to moderate levels of conflict, average intelligence, moderate strengths and personal resources, no diagnosis of severe psychopathology (e.g., thought disorder, bi-polar, Axis II diagnosis), nominal risk factors and lethality, no active substance abuse or engagement in addiction treatment programs, and no severe trauma history or medical limitations. The therapist should screen for these factors prior to the first conjoint session

along with assessing sociocultural factors that may contraindicate the intervention (e.g., age, SES, education, ethnicity, religion, culture of origin).

Risk Assessment and Safety

Several principles underlie the effective use of the model. First, engaging in exposure exercises must be the person's willing choice before self-awareness skills can be developed. Coercion and threats are primary contraindications of protocol effectiveness. Consequently, the therapist must encourage but not force the individual to engage in the exercises. Second, the smaller the person's "open" window, the poorer the person's communication skills tends to be. Smaller "open" windows also correlate with higher experiential avoidance and lower experiential openness, which provides key assessment information. Engaging in protocol tasks facilitates communication skills training, beginning with one's internal dialogue as part of mindfulness skills training and expanding to expressing one's personal meanings of experience.

A third principle is that increased self-awareness at the individual level opens up the opportunity for interpersonal learning at the couple level. This is based on the idea that as Quadrant 1 (openness) becomes larger, then the person has more available resources and skills to undertake a shared meaning or shared discovery exercise as a couple. These types of tasks are often assigned as homework for couples in current models, and may be an unwise choice until they demonstrate to the therapist basic skill levels. Protocol tasks may be a necessary first step in skill development in this area. A final principle, related to motivation and values, is the universal curiosity about one's unknown dimensions. However, exploring the "unknown" is mediated by cultural factors as well as certain aspects of one's learning history (e.g., trauma and abuse history, rape, major life events). The therapist must assess whether the individuals are appropriate candidates for these types of exercises. If so, engaging in self-discovery and self-awareness activities can be an adaptive learning experience in addition to taking the focus off the partner via redirection to more useful undertakings. This is

predicted to increase opportunities for values definition and clarification that influence identity factors and personal behavioral styles.

Integrating Self-Directed And Primary Couples Therapy Processes

The self-directed protocol is designed to integrate with the primary couples process in two ways: assessment data and weekly reports, and a final presentation at the sixth conjoint session (see Procedure section for details). Assessment data includes data collection instruments for Weeks 1-3 (Appendix C) while weekly reports used in all sessions include the Commitment Form and Therapist Report (Appendix D). Initial assessment data from Week 1 helps with initial conceptualization and treatment planning, and assessing for lethality, risk factors, and other required referrals. Assessment data from Weeks 2-3 evaluate overall progress, levels of commitment and motivation, and levels of mindfulness skills. The weekly Commitment Form and Therapist Report are primary integration points between self-directed and couples work leading up to the presentation session at Week 6. The Commitment Form lists what the client learned from the session's exercises and specific areas of change they intend to address in the coming weeks. The Therapist Report lists identified issues and concerns (individual and couple), larger behavioral and skill areas they are taking responsibility for, areas they want help with, and suggested goals for upcoming couples therapy.

For couples with appropriate skills and a moderate to high investment in the adjunct process, a couples-lead, therapist-facilitated presentation session to each other at Week 6 is recommended (see details in Week 5). This assumes low- to moderate-conflict couples meeting the above risk criteria. This activity is designed to give each person the opportunity to be heard and validated, to assert themselves in an appropriate manner in a safe setting, to solicit feedback from the therapist and the partner in terms of how they perceive revealed content and/or behaviors, and to set the stage for collaborative goal setting for future work. In the ideal, this is the culmination of significant effort on the part of each person, and is predicted to open up entirely new types of

dialogue not previously available due to relatively entrenched behavioral patterns. The key skill required to move into this type of therapeutic framework is each person's level of mindfulness behavior and experiential openness. After completing the adjunct protocol, the couple can choose to go deeper into their self-directed experiences and materials with each other as a shared meaning activity.

For couples where only one or neither person made a substantial investment in the self-directed process, a modified version of this process or eliminating it altogether may be the best option. Initial assessment data in Week 1 may be a significant resource in determining what services and actions to take next for couples not able or willing to engage in this type of self-directed activity.

Procedure

The manualized treatment protocol was designed to be flexible and adaptable in its application to promote ease of use, and to allow the therapist the ability of making adjustments based on the unique needs of the couple. Each of the 5 weekly sessions described below highlight client activities, client resources and instruments, session goals and objectives, and corresponding therapist activities. Protocol details are found in the Appendixes. Appendix B contains the session summary sheets that explain the exercises, goals and objectives, benefits, and risks. Due to space limitation, each session's detailed task sheets comprising the bulk of the manual are omitted. Ideally, the adjunct process culminates with individual presentations in the sixth conjoint session focusing on learned skills, new information about themselves and the relationship, areas of responsibility taking and planned change, and goals for couples therapy.

Week 1: One-day Personal Retreat: Developing Mindfulness and Self-Discovery Skills

Week 1 exercises focus on core mindfulness and self-awareness training, exposure and experiential openness, self-discovery activities, and increasing perspectives. This is accomplished by changing environments for a brief period of time via a one-day personal retreat (12-24 hours). This

can be as simple as going to a local park for the day or as elaborate as an over night trip. The purpose of the retreat is going to an unfamiliar setting where experiences can unfold naturally without interference from normal daily events, people, and demands. Ideally, the client completes all five exercises in a single one-day personal retreat. However, if this becomes an obstacle then a second approach is doing one set of exercises for 1 – 1 ½ hours daily during the week.

Week 1 exercises are designed to target the Hidden and Unknown panes of the Johari Window. It involves intentional exposure to one's private experience, especially avoided or denied elements. The purpose is to help the client take inventory of their own experiences, increase experiential openness, develop mindfulness skills, and decrease blaming and focus on the partner. Week 1 is predicted to be the optimal time for maximum investment and motivation, and maximum willingness to try new skills. This timeframe is also ideal for collecting baseline assessment data to be used in the primary couples process, case conceptualization, and initial treatment planning.

Client Activities. Each individual client is assigned four primary tasks. First, they schedule a one-day personal retreat right after the first conjoint session. Second, they complete assigned assessment instruments one day prior to the retreat. Third, they go on the retreat and complete assigned activities in the protocol's workbook. Session 1 (summary in Appendix B) has five groups of exercises: (1) core mindfulness; (2) breath meditation, body scan, and mindful eating; (3) reading and applying meaning to 3 short parables/wisdom stories; (4) "taking your mind for a walk" and 20 minutes of silence; and (5) journaling about retreat experiences and assigning personal meanings. Fourth, after the retreat, the client completes the remaining assessment instruments and reports and turns them in to the therapist at Conjoint Session 2. It is important that the client make a commitment not to discuss any aspect of the exercises with the partner outside of therapy until after the sixth conjoint session.

Client Resources and Instruments. The client's primary tool and resource for the entire adjunct process is a personal journal or notebook to capture and review experiences. Much of this information is used in later exercises, and is essential for integration and action planning during Weeks 4 and 5. The following instruments are to be completed prior to the personal retreat: (a) Brown and Ryan's (2003) Mindful Attention Awareness Scale (MAAS) to assess for level of mindfulness skills; (b) Hayes' (in press) Acceptance and Action Questionnaire (AAQ) to assess for levels of experiential avoidance; and (c) Quality of Life Inventory (QOLI). Other recommended assessment instruments are listed in the Summary section regarding future research. The pre-exercise assessment form (Appendix C) is completed the day of the retreat. The post-exercise assessment forms is completed one day after the retreat along with the Commitment Form and Therapist Report (Appendix D). The Commitment Form and Therapist Report promote increased responsibility taking behaviors, reinforce the norm of therapy as a means of personal change, and reinforce the practice of mindfulness and other skills learned during exposure to other contexts.

Session Goals and Objectives. A fundamental goal of the entire adjunct process is each person focusing on himself or herself, not the partner, and decreasing defensiveness and blaming behaviors. This goal is made explicit and highly reinforced during the first session. This prescribed "disengagement" is predicted to elicit many interesting and clinically useful dynamics facilitating systemic changes, much like a paradoxical intervention. However, the therapist should assess for evidence of power struggles, potential harm to either client, or other risk factors.

The primary objective of Session 1 is developing or enhancing basic mindfulness skills. The exercises encourage focused attention, active observing, and increasing awareness of present moment internal and external experiences. Mindfulness also applies to suspending automatic evaluations and judgment of experience, welcoming experiences as an opportunity to learn about self, others, and the external world, and accepting one's responses to these experiences without

trying to change or control them. Several tasks involve developing flexible and more accurate personal meanings and verbal narratives about one's experiences after exposure to them. Anticipated outcomes of the retreat and exercises are assessment data, initial mindfulness skills, broadened perspectives, values definition and clarification, increased specificity of therapy goals and needs, increased commitment and responsibility taking, initial activation of denied or avoided emotional processes, and increased awareness of how experiences are translated into personal narratives and other forms of language that influence behavior and coping.

Therapist Activities. Session 1 activities are highly challenging and may require additional time to complete before the second conjoint session. After exercise completion, the therapist collects and reviews assessment data, analyzes and evaluates the results, and assesses for lethality and other risk factors. Week 1 data may suggest other referrals such as to a PCP or psychiatry for medical or medication evaluations. Additionally, the data may also be used for differential diagnosis, initial treatment planning, and assessing motivational factors and degrees of initial investment. Assessing each person's level of experiential avoidance and mindfulness, in addition to the quality and quantity of work performed, may indicate hidden agendas, signs of underlying psychopathology, therapy interfering behaviors like resistance, or other clinically useful information. Resistance or low skill levels may provide guidance about whether to prescribe future couples activities found in many models (e.g., communication skills, behavior exchange, dating, romance and intimacy).

Week 2: Sharing the Hidden You: Experiential Openness and Vulnerability

This activity is designed to target the Hidden and Open pane of the Johari Window and having the client develop skills in self-disclosure, experiential openness, and vulnerability. The design is based on a graduated exposure model beginning with relatively easy and familiar tasks, then increasing in difficulty and risk. The exposure exercises involve the client choosing to make some part of their private experience public to a select group of people in various situations. The purpose

is to develop self-disclosure and observational skills, and increase the application of mindfulness skills in daily life. The client decides the content to be disclosed and the number of exercises to do.

Client Activities. The client first engages in a preparation exercise resulting in a list of possible self-disclosure items. They then rank order and prioritize the list, and reduce it to 10 items. Developing the list is a type of exposure exercise designed to reinforce mindfulness skills developed in Week 1. The content of the preparation exercise (journal and list of items) is used again in Week 4 activities. The session is comprised of three post-preparation exercises: (1) self-disclosure to a low-risk familiar person, (2) self-disclosure to a moderate-risk less familiar person, and (3) self-disclosure to a higher-risk unfamiliar person. A summary of Session 2 is provided in Appendix B. The client is instructed to complete the Pre-Exercise Form before the first exercise and to record experiences in their personal journal or notebook. After completing one, two, or all three exercises, the client waits one day and then completes the Post-Exercise Form and the Commitment Form and Therapist Report as in Session 1.

Client Resources and Instruments. The products delivered to the therapist at the third conjoint session are copies of: Pre- and Post-exercise Forms, Preparation Form, Commitment Form, and Therapist Report. The client's personal journal remains confidential and not disclosed.

Session Goals and Objectives. The overall goal of the exercises is to help the client develop exposure skills and openness to their private experiences without escape or avoidance behavior, and to learn how to appropriately reveal these hidden/private domains. Practicing willingness to trust others, taking appropriate relational risks, and experiencing the process of letting other people know them are key objectives. This provides the person with an opportunity to face real or imagined fears about how others may respond to them, and training them to develop flexible behavioral patterns and personal meanings of experience that influence identity and values. The exercises are designed to help the client increase awareness and observational skills, experiential openness, acceptance

skills, and increased tolerance of emotional distress linked to vulnerability. Practicing acceptance skills include taking a nonjudgmental approach to experiences and increasing a sense of empowerment and mastery. Exposure exercises are intended to undermine fear responding and escape/avoidance or denial behavior to nondangerous stimuli. They also promote taking necessary actions toward change, growth, and purposeful and meaningful living while minimizing excessive cognitive/verbal processes and corresponding rigid responding.

Therapist Activities. The therapist performs similar activities as in Week 1 including review of level of effort, the number of exercises performed and quality of the content, and scoring and analyzing the assessment forms. The Pre- and Post-assessment Forms provide feedback on progress made before and after the exercises and baseline changes compared to Week 1. The Therapist Report and Commitment Form provide qualitative data to guide couples work.

Week 3: Finding the Blind Spots: Direct Requesting and Soliciting Feedback

This activity is designed to target the Blind Spot pane of the Johari Window and have the client develop skills in direct requesting, asking for honest feedback, learning to tolerate feedback that creates emotional discomfort, and learning how to apply feedback in constructive manner. The process is essentially identical that of Week 2, with the primary differences being increased level of risk and vulnerability and a different direction of information flow. In soliciting feedback, the client is asking another person to disclose and make public their perceptions about them in a specific area instead of the client making a self-disclosure from their “Hidden” area. In some ways this process is similar to mindfulness and self-discovery from the “Unknown” area in Week 1 because the content is outside of awareness or in a fragmented form. The most obvious difference is having another person provide observations instead of self-observing as in mindfulness. However, the degree of required openness, acceptance, nonjudging, willingness, and emotional distress tolerance is much higher. These are the most difficult exposure exercises and are built upon skills in previous sessions.

The primary benefit to the client is gaining secondary observational data about themselves based on how others perceive and apply meaning to their behavior. Using feedback from others and analyzing themes from their various perspectives can help the client develop new levels of awareness about their public behavior that may be useful in modifying response patterns and personal styles.

Client Activities. Similar to Week 2, the client first completes a preparation task resulting in a list of potential feedback items. The irony of the preparation task is that in many cases the “Blind Spot” may not be completely outside of awareness. What’s “blind” may be the level of impact and specific features of behavior that may be perceived by others as problematic, maladaptive, or unacceptable. In some cases, awareness of problems is completely unknown even though the consequences of ones actions are experienced as aversive. The client may need to evaluate persistent and undesirable outcomes and work backwards for clues to problematic behaviors that may become candidates for the list. In either case, the preparation task and list helps guide the client toward skills in self-awareness and direct requesting. Similar to Week 2, the exercise has 3 parts: feedback from a low-risk familiar person, feedback from a moderate-risk less familiar person, and feedback from a higher-risk unfamiliar person. The remaining process, and the *Client Resources and Instruments, Session Goals and Objectives* and *Therapist Activities*, are exactly the same as in Week 2.

Week 4: Experiential Integration: Meaning, Valuing, and Purpose

Weeks 1-3 focus on foundational skill building while Weeks 4-5 focus on integration and preparation for change. Week 4 involves three types of exercises: Perceptive, Valuing, and Aspirational that integrates all four panes of the Johari Window. There are no external exposure exercises to do, only internally oriented ones. The exercises are designed to reinforce previous learning and mindfulness skill development, increase or maintain motivation and commitment, and promote experiential integration from earlier exercises. The timing of this exercise is a key design factor. The first three sessions are anticipated to have sufficiently taxed the client’s resources and

they may need to re-center and reorganize their experiences. The protocol foresees and accounts for these common experiences and provides a change of pace and emphasis. It is also predicted that the novelty of therapy and other influencing factors (e.g., false hopes, discomfort over change, regression to maladaptive coping, dominant culture's orientation toward quick fixes and avoiding suffering) may affect behavior, motivation, and commitment. Developing and reinforcing skills in frustration tolerance and dealing with ambiguity may require therapist intervention and support.

The primary focus in this critical transitional session is having the client begin the process of specifying and clarifying what is important to them in terms of purposeful and valued living, what types of change they need to make for themselves, what needs to change in the relationship, priorities for couples therapy, and their ideas on how to resolve relationship issues and personal distress. This is accomplished by exercises in self-reflection, journal review, assessing how one makes meaning of experience, needs assessment, values clarification, and clarifying life goals. This forms the basis of personal action planning in Week 5.

Client Activities. The first exercise (perceptive) involves the client's journal and the lists of self-disclosure and feedback items developed in Weeks 2 and 3. The client is asked to reflect upon what they learned from performing the exercises, what those experiences meant to them, and to develop themes about behavioral and personality factors based on their reflections and analysis. This is a "current state assessment" exercise. The product of the exercise is a 2-3 page report about themselves as a unique person, their strengths and weaknesses, their needs, and their goals and values. This is designed to engage their strengths, and to activate the development of their own theories and understandings of the problems they face and possible solutions. The exercise encourages the client to analyze their behavior and personal style, develop hypotheses, test them, draw conclusions, and develop options to make changes or resolve issues they discover. The exercise subtly incorporates new mindfulness skills by asking the client to consider non-traditional

solutions such as acceptance, tolerance, forgiveness, and applying their ethical and moral principles to behavioral responses. The goal behind this process is increasing self-awareness, promoting acceptance and change principles, and activating client strengths and sense of empowerment.

The second task is a valuing exercise involving an end-of-life scenario (knowing one was going to die and it could not be prevented) where the client has to decide how to spend their one remaining year on earth in a meaningful and values-driven way. The client is asked to develop a complete list of the most important aspects of living. They cross off half the list immediately, and then systematically cross the remaining items off one at a time as the end draws near. The process of elimination is an indirect ranking and prioritization procedure. They are given a brief reprieve and a few items can be added back to the list for a brief time. They complete the exercise by being reflective and affectively attuned to crossing off all but two items on the list, which represents their last two weeks of life. The exercise concludes with reviewing the list and analyzing what made the top 10 most important items, what got eliminated and when, what was added back, and what remained at the end (i.e., what is truly important not what they say is important). The exercise teaches three major principles: (a) clarifying what is really important, and how what we often say is important is not what we would choose to do in a limited timeframe, (b) balancing and prioritizing one's life goals and lifestyle toward what's really matters and aligning one's life toward meaning and purpose, and (c) motivating the client to increase valuing behaviors, which means living consistently with what one actually values and not by what others have said you should value. The client is asked to consider how each items made the list and why. Items that are crossed off the list early often reflect the influences and values of others that are not lived out consistently (e.g., culture, religion, family, friends, media), and can be linked to rule-governed behavior and potential maladaptive patterns. The exercise challenges behavioral patterns, values clarification, and reducing or reworking

(defusion) verbal-cognitive influences of behavior not tied to core values and life goals. The product of the exercise is a 2-3 page report on values and behaving consistently from them.

The final exercise is an aspirational exercise reflecting both identity and values involving role models. The exercise is oriented toward future growth and development and using vicarious learning as a means of self-discovery. The task involves the client selecting a person they admire from any walk of life, or a fictional character, and doing a functional analysis of their behavior as they perceive it. They are asked to describe in detail what it is they admire about the person, examples of behavior or character traits that are attractive to them, and what they perceive would happen if they had the opportunity to spend a week with this person as a mentor and friend. At the end of the exercise the client is asked to write a 2-3 page report applying the role model's personal styles and behaviors to their own lives and identify ways they could become like this person. A second option, if the client cannot or will not identify anyone, is to do the same exercise using a favorite song, musician, movie, actor/actress, play, artist, or art collection. The process is slightly different but the core principles of exploring the "Hidden" and "Unknown" pane for clarification of what's there is the same.

Client Resources and Instruments. The products delivered to the therapist at the fifth conjoint session are copies of summary reports for each integration exercise performed, Commitment Form, and Therapist Report.

Session Goals and Objectives. The primary goal of the exercise is practicing skills of integrating one's experience, applying meaning, identifying values, and developing a flexible set of verbal narratives reflecting one's values. Mindfulness skills are essential foundational factors but operate as background processes in these exercises. The degree and quality of work performed in this exercise is predicted to be a prime indicator of acquired skill levels in experiential openness, self-awareness, avoidance, motivation, and generalization of learning. The exercises are also expected to provide indications of inflexible behavioral or cognitive patterns, degree of excessive evaluations of

experience, and levels of rule-governed responding. The essence of the work in this session involves developing broader self-awareness skills, values clarification, identity cohesion and organization, and defining a valued life direction. The foundational work of this session is the linchpin for the entire adjunct process and establishes the context for Week 5 activities involving commitment, application, and action strategy based on content developed in this session.

Therapist Activities. The therapist reviews the exercise output and reports for indications of progress in mindfulness skills, experiential openness, self-awareness, avoidance behaviors, changes in motivation, and degrees of skill application to other areas. A thematic analysis of content may reveal clinically meaning data, including inflexible/rule-governed response patterns, excessive evaluations of experience, or identity/personality factors. The output of this session can help the therapist anticipate and plan for the shared presentation session in the sixth conjoint session. In the case of significant non-compliance or lack of effort, the therapist can determine appropriate courses of actions including terminating the adjunct protocol process or adjusting timelines.

Week 5: Application, Commitment and Action Strategy

Week 5 focuses on compiling individual experiences, mindfulness skills practice, self-reflection, and self-discovery exercises from previous sessions, especially Week 4, into a consolidate format. Also of significance are all the Commitment Forms and Therapist Reports that capture incremental skills development, areas of change, and lists of couples issues that need to be addressed in subsequent couples therapy work. All of this information is used in the development of change strategies that lead to specific goals and a personal action plan, and commitments to achieve them. The final exercise performed in the sixth conjoint session, culminating the adjunct process, is a presentation by each person about what they have learned and the plans and commitments they have made over the past five weeks. Having a safe, open dialogue with the partner and receiving feedback from them in this session represents a distilled version of the entire adjunct protocol.

Ideally in this final session, the individual can articulate at least some of the problems and issues affecting the couples relationship attributable to them, and how they commit to taking responsibility for personal growth and change on behalf of themselves and their partner. They are also expected to be able to specify goals and areas needing attention in couples work for which they are prepared to make investment. Negotiation of goals and problem areas is a first step toward increasing dyad interaction to each other, facilitated by the therapist, and sharing details about the exposure exercises and the effects on themselves. The final session also is expected to provide additional assessment data on communication skills, affect regulation, adaptive or maladaptive behaviors, and potential risks/benefits of future interventions.

Client Activities. The client performs three exercises in this session leading up to the presentation in the sixth conjoint session. The first exercise is to develop a list of applications for newly learned skills and knowledge, how these can be applied to their life, and corresponding actions they plan to take to bring about needed changes. The personal journal, Commitment Forms, Therapist Reports, and reports from Session 4 are anticipated to be significant resources in this exercise. The exercise concludes with a first draft of their personal action-plan. The second exercise involves applying new skills and awareness to couples issues, and what they perceive as important areas of change in the relationship with possible solutions. The emphasis is not on what the other person needs to do but what they can do. This exercise is guided by previous reflections on goals, values, and meaning and purpose in life. They may also consider couples strategies to develop “shared meanings” and using the Johari Window from a couples perspective to increase the “Open” pane (Gottman, Murray, Swanson, Tyson & Swanson, 2002). The task concludes with a prioritized list of goals, couples issues, and proposed actions for upcoming couples therapy.

The final exercise involves condensing the draft action plan, list of couples goals and issues, and other materials down to a brief presentation. The sixth conjoint session and presentation marks

the end of the adjunct process and transition to predominately couples work. The presentation is also the first disclosure of each person's activities to the other since the beginning of therapy. Each presentation is about 10 minutes long involving active self-disclosure of new information and skills, expressing meanings of experience reflecting their goals and values, sharing about environmental and other psychosocial stressors affecting them, identifying lifestyle areas important to them, and a summarizing their personal action plan and commitments. The person then requests feedback in terms of validation of experience and possible blind spots. The partner then performs the same set of tasks. Each person concludes their presentation with areas of individual responsibility for growth and change, perspectives on couples issues, and a list of needs and goals for couples therapy.

Client Resources and Instruments. The therapist receives copies of each individual's personal action-plan, lists of couples issues and goals, and copies of their presentation.

Session Goals and Objectives. The goal of this final session is to bring all elements of the adjunct protocol including mindfulness skills together in an organized manner and integrating them with the primary couples process. For couples that invest in the entire adjunct process, it is predicted that each person will have different perspectives and perceptions about what they require from couples therapy than they did initially. Ideally, each person will demonstrate increased levels of motivation and responsibility taking for themselves and relationship issues, reduced blaming and defensiveness, increased willingness to change, increased openness and flexibility, and increased awareness of themselves and others. This is predicted to increase the probability for productive couples work in the future by addressing complex and sensitive issues in an adaptive and helpful manner. The protocol is designed to increase collaboration while reducing therapy interfering behaviors found in the "Four Horsemen of the Apocalypse" phenomena (Gottman, Driver, & Tabares, 2002). This means reducing defensiveness and stonewalling behaviors, reducing contempt

and invalidation of the person and their experiences, increasing willingness to be influenced by the other person, and increasing positive responding while reducing negative habitual response patterns.

Therapist Activities. At the beginning of the session, the therapist should provide validation and praise reinforcing the hard work invested in this process. The therapist should have a solid case conceptualization by the sixth conjoint session, and act more in the capacity of a facilitator during the presentations. The most challenging element at this point is managing the presentation process and ensuring a constructive and balanced experience. This allows the client's new skills, strengths, theory of problems and possible changes, and motivational factors to drive the process. After the presentations, the therapist is able to offer objective observations and recommendations about future work based on their input. The therapist may also use presentation material and assessment data to prescribe other types of homework as a means of engaging in shared discovery tasks similar to those in the protocol.

Chapter 6: Summary

Mindfulness is not a panacea for human suffering and relational breakdowns. Those unpopular realities of human experience have existed since the Garden of Eden. Mindfulness is, however, a missing skill once valued in American culture taught as part of our sociocultural, educational, and spiritual traditions. It is a universal virtue that promotes personal growth and change. One of the side effects of recent technological advancement is the "instant everything culture." Mindless living and being trained to respond in sound-bite timeframes comes at a terrible societal and individual cost. The development of personal character and learning human relationship skills, especially intimate ones, does not occur in such an environment. Mindful and skillful living takes time, commitment, patience and tolerance. However, the benefits of such a worthwhile endeavor crosses into every conceivable context (internal, external, social, spiritual, relational).

The overall intent of the adjunct couples intervention is to teach mindfulness skills and use exposure and experiential exercises as a means of:

1. Increasing openness to experience.
2. Increasing self-awareness and observational skills.
3. Increasing self-management and emotional regulation abilities.
4. Increasing values-based, purposeful, and responsible living.
5. Developing a balanced lifestyle of wellness and prevention.

The intervention is predicted to facilitate development or enhancement of basic awareness and observational skills, promote generalization of skills to other areas of functioning, help couples expand their perspectives and refocus on larger goals and values, clarify couples therapy needs, and increase investment and commitment to therapy. The purpose is to enhance the primary couples process by adding missing capabilities and addressing unmet needs, and seamlessly integrating these value-added elements to improve outcome effectiveness and decrease risks of relapse.

Limitations and Future Research

Dimidjian and Linehan (2003) discuss the current state of mindfulness research and its limitations, and identify two major deficits: (a) the poor operational definition across studies, and (b) the lack of any study demonstrating how the pure skill of mindfulness accounts for overall change. Functional analysis of mindfulness applied to dismantling designs is required. The authors also discuss problems associated with taking mindfulness out of its historical/cultural context and what may be lost in secularization. They suggest research in the following areas: (a) determining what practices are suited for different clients (disorders, skills, and values), (b) what modalities are best for service delivery, (c) how therapists are to be trained, and (d) how does the therapist's and client's orientation and world views affect mindfulness practices. These questions arise due to the existential, philosophical, and spiritual nature of mindfulness that must be accounted for in a

pluralistic culture. This study addresses several of these concerns by establishing a more values-neutral context and self-directed methodology for mindfulness skills training, and allowing the couple to apply their own meanings, values, and world views to the process, skills, and outcomes.

One limitation and potential argument against using an adjunct protocol is that many couples models already use homework assignments and skill building strategies (e.g., behavior exchanges, pleasurable activities, communications skills). However, many common homework tasks have not demonstrated effectiveness or significance in therapy outcomes as mindfulness has done. Gottman, Ryan, Carrere, and Erley (2002) argue for major changes in couples clinical practices that are based on empirical evidence of what works and not just traditions from original models or theoretical ideas. The authors also endorse using more objective assessment instruments in clinical practice to help guide intervention planning, assessment, and measuring outcomes.

Finally, the major limitation in this study is the lack of empirical evidence validating the intervention. Future research should include a pilot study to verify short-term outcomes, assess methods, and establish needed measures. Feedback from the pilot study should be used to evolve the protocol, fill in missing gaps, eliminate ineffective elements, and streamline the overall process. This study offers both an expanded operational definition of mindfulness and a functional analysis of mindfulness behavior that can be applied to dismantling designs. The following additional assessment instruments are recommended for the pilot study to assess for baseline functioning at the beginning of treatment and outcomes: (a) University of Rhode Island Change Assessment Scale (URICA) assessing stages of change from Prochaska and DiClemente's (1992, 1994, 1998) Stages of Change model, (b) Dyadic Adjustment Scale (DAS), (c) Global Distress Scale (GDS) from the Marital Satisfaction Inventory-Revised (MSI-R), and (d) Brief Symptom Inventory (BSI). Continued research using the refined protocol would then be expected to assess for long term outcomes and effects on relapse prevention. A secondary recommendation is to use this methodology as part of

dismantling designs to develop an improved understanding of the mechanisms of action in mindfulness behavior that can be applied to clinical interventions.

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Appendix A: Behavioral Targets And Outcome Measures of Mindfulness Skills Training

Experiential Openness

Experiential openness is the most foundational domain and involves the frequency and extent of various forms of exposure (direct learning, imaginal, interoceptive), degrees of welcoming new experiences and willingness to engage in self-discovery with minimal experiential avoidance, levels of observational skills, ability to discriminate contextual cues, capacity for awareness of self and others across contexts, and the application of self-reflection as a means of enhanced learning from one's experiences or those of others (i.e., vicarious learning). Experiential openness means accepting all experiences as a means of better understanding oneself, other people, and the world.

Outcome Measures

1. increase openness and welcoming of all forms of experience
2. increase present moment awareness and active observing of the external environment and internal private events
3. increase acceptance of experiences while decreasing escape or avoidant behavior to non-dangerous people, places, events, symbolic content, or other internal stimuli
4. increase willingness, commitment, and receptivity to actively engage in new experiences and self-discovery activities that enhance learning

Equipping

The domain of equipping centers on preparing for action, discovering personal strengths and abilities, developing new skills and refining existing ones, and developing wisdom for adaptive and enhanced living. Equipping primarily involves learning or enhancing skills by direct experience and practice, determining how and when to apply specific skills in various situations, and increasing proficiency over time in broader applications. Equipping is oriented toward developing flexible behavioral options and strategies.

Outcome Measures

5. increase active learning and skills development for personal growth and change
6. develop and practice new and existing skills to increase proficiency and discovering what skills work best in a variety of situations
7. increase flexible options and strategies for behavioral application

Empowerment

The domain of empowerment involves energizing and activating existing skills and abilities and taking responsibility for action via personal commitments. It is also the ongoing process of developing an objective sense of skillfulness, mastery, and competence in dealing with one's physical, social, psychological, and relational world. Empowerment is a primary means of reinforcement and motivation to live consistently with one's values and to actively engage in adaptive growth and change. It also provides a means of accepting one's limitations and those of others, accepting an imperfect world around them, and developing tolerance for change and the temporary nature of things. Empowerment helps reduce maladaptive and/or destructive responding, and promotes positive action taking toward necessary change when required.

Outcome Measures

8. increase responsibility taking for one's action and commitments
9. use sense of skillfulness, mastery, and competence across contexts (physical, social, psychological, relational) as a means of self-reinforcement and motivation
10. increase consistency in living according to one's values and goals
11. actively engage in adaptive growth and change while reducing maladaptive and/or destructive responding
12. increase acceptance of limitations and (self, others, world) and tolerance for change

Emotional Processing

Emotional processing is a large and complex domain, and oriented toward using previous foundational skills in the service of affect integration, distress tolerance, and emotional regulation. This incorporates the idea of using one's openness to experience and skills as a means of fully engaging in and reflecting upon the deeper aspects of one's inner life. And it incorporates willingness to be genuine, vulnerable, honest, and authentic about them. Emotional processing means intentionally choosing not to hide, deny, escape, avoid, or minimize affective events or engage in other forms of maladaptive coping. Instead, the individual is encouraged to experience their own affective, perceptual, interoceptive, and proprioceptive processes and be willing to share them via self-disclosure with trusted others. Emotional processing promotes the ability to experience affectively charged events without automatic responding or acting in a manner inconsistent with their values. It also means developing skills like empathy, compassion, valuing differences, forgiveness, and using acceptance strategies in managing and tolerating subjective distress. Emotional processing is a key variable in relational intimacy and interpersonal effectiveness.

Outcome Measures

13. increase affect integration by openness to and engaging in one's emotional processes
14. increase positive self-reflection of affective experiences while decreasing denial, hiding, minimizing, or escaping/avoiding emotionally charged events
15. increase genuineness, vulnerability, honesty, and authenticity while decreasing maladaptive responding and coping
16. actively share one's emotional experiences with trusted others as a means of developing relational intimacy and interpersonal effectiveness
17. increase ability to tolerate distress by developing skills in empathy, compassion, valuing differences, forgiveness, and acceptance

Executive Functioning

The domain of executive functioning involves behavioral regulation, evaluation and meanings of experience, and cognitive defusion and change. The primary focus is on increasing exposure to one's full range of experiences while decreasing excessive evaluation and judgment of those experiences in either absolute or relative terms. Willingness to have experiences without judgment or unnecessary evaluation, or attempting to control one's private experiences and the environments that occasion them, promotes flexible responding to real world phenomena while decreasing habitual responding to arbitrary rules or cognitive/verbal constructs. Executive functioning also involves using experiential openness, observational skills and increased self-awareness as a means of accurate verbal reporting of experiences and developing flexible meanings of experience contained in personal narratives. This includes using self-reflection and feedback from others about one's behavior to make adjustments in verbal narratives, perceptual processes, and meanings of experience (i.e., cognitive flexibility via defusion), and selecting more adaptive and functional behavior for specific contexts.

Outcome Measures

18. increase exposure to public and private experiences while decreasing excessive evaluation, judgment, or attempts to control one's private experiences or the environment
19. increase flexible responding to real world phenomena while decreasing responding to cognitive-verbal constructs or arbitrary rules that comprise habitual response patterns
20. increase flexibility of verbal narratives and meanings of experience by using self-awareness and self-discovery skills, and feedback from others

Existential Integration

Existential integration involves using one's perceptions, meanings, phenomenological world, ethical and moral standards, and spirituality as a means of integrating all experiences into an

adaptively organized and meaningful experiential framework. This nonlinear organization of experience encompasses one's entire learning history and provides a means of sharing personal narratives and meaning propositions with others via language. It also helps one to define, validate, and clarifying core values and life goals linked to purposeful living and one's sense of identity. Existential integration also includes one's spiritual views and traditions, personal ethics and moral views, and cultural practices. This domain expands beyond the traditional biopsychosocial perspective of human functioning to include humanistic and phenomenological factors and subjective experiences beyond the realm of empirical science.

Outcome Measures

21. use perceptions, subject meanings, ethical and moral standards, and spiritual views and practices to develop an adaptive and meaningful experiential framework that guides behavior
22. increase values clarification and goals assessment as a means of purposeful living and maintaining one's sense of personal identity

Ecological Balancing

The final domain of ecological balancing is oriented toward wholeness, health, wellness, prevention, and lifestyle management over the entire human lifespan. Ecological balancing is the conceptual circle containing all other domains. This multifaceted area includes managing and caring for one's physical body by exercise, nutrition, rest, and self-care. It also includes the social domain such as being a responsible member of a community, enhancing intimate relationships and meaningful friendships, effectively managing one's family concerns, and attending to one's cultural and spiritual heritage. Ecological balancing includes environmental management such as where one chooses to work, play, and live, and choosing the type of individual, couple and family lifestyle that works best for all members. It also considers role and responsibilities in various dimensions like family structure, child rearing, division of labor at home, career choices, finances, balancing power,

and decision making. Ecological imbalance is often the precursor to other forms of distress and is a necessary treatment factor when considering change.

Outcome Measures

23. develop wellness and prevention strategies
24. increase values clarification and goals assessment as a means of purposeful living and maintaining one's sense of personal identity

Appendix B: Protocol Summary Sheets

Appendix C: Pre- and Post-Exercise Assessment Forms

Appendix D: Common Forms for All Exercises

Author Note

Robert M. Coleman, University of Denver, Graduate School of Professional Psychology.

This research was a requirement for graduation. The Doctoral Paper committee included Shelly Smith-Acuna, Ph.D. (Chair), John McNeill, Ph.D., and Jim Gallagher, Psy.D. Correspondence concerning this article should be addressed to robertmcoleman@comcast.net

Figure Captions

Functional Domains of Mindfulness Behavior

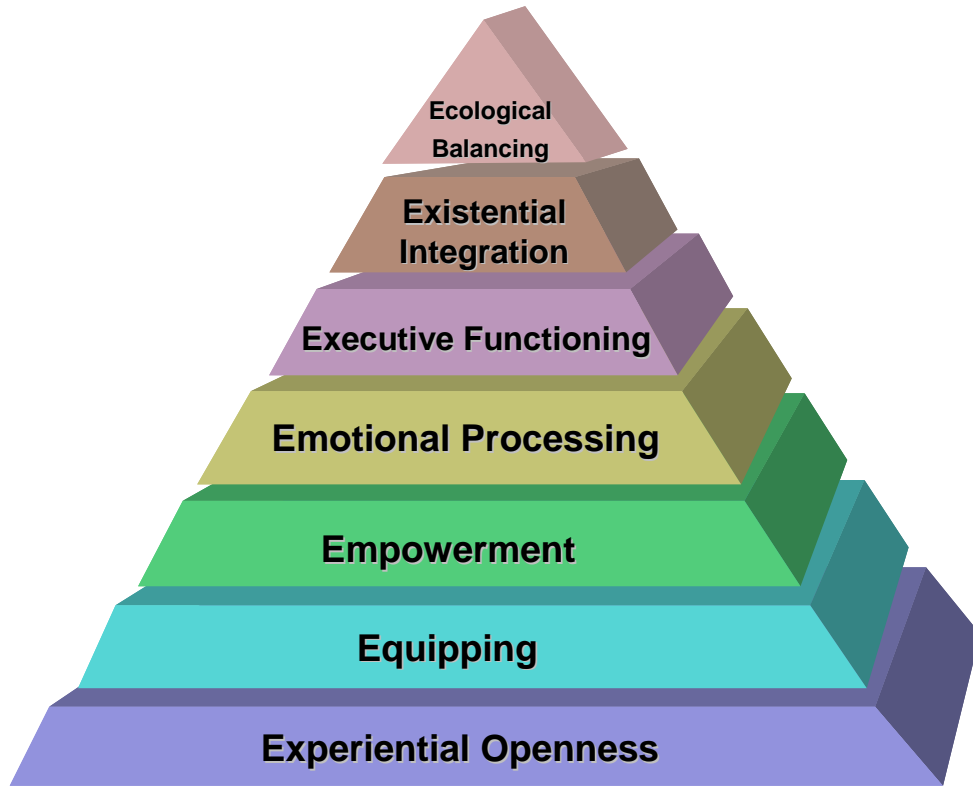


Figure 1. Functional Domains of Mindfulness Behavior

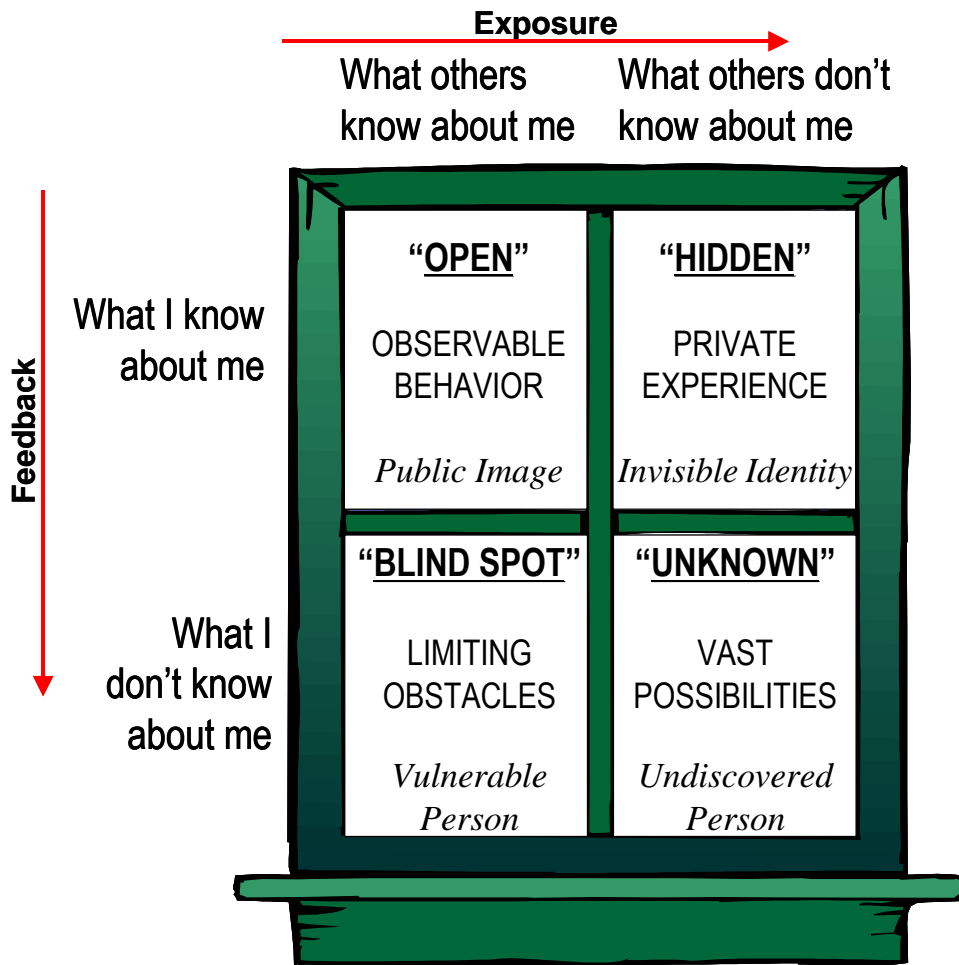


Figure 2. Johari Window