Chapter 5
Self and Mindfulness[1,2]

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I think therefore I am.

Rene Descartes

Descartes' statement has given birth to countless philosophical theses, books and scholarly papers. In the present context our interest is in the psychological level of analysis, more specifically, functional analysis. From this functional perspective several speculations can be made about Descartes based on his statement. First, it seems he knew who he was and that his experience of 'I' the thinker, was stable. Thus we would not expect Descartes to request therapy to discover 'who he is' or complain that he feels like a chameleon who changes his persona depending on the circumstances in which he finds himself. Descartes' statement also implies that he was self-observant or aware of the private experience of thinking as an activity or process independent of the content of his thoughts. It suggests that he could step back and objectively observe the raw data of his experience. The act of being non-judgmentally aware of the process of thinking enters into the definition of *mindfulness*, an increasingly popular strategy in treatments for psychological problems (e.g., Linehan, 1993; Hayes, Follette, & Linehan, 2004), and one that plays an important role in many FAP cases.

The goals of this chapter are to provide a behavioral account of self and mindfulness, explain how a lack of sense of self may interfere with mindfulness, and provide suggestions to shape treatment interventions that target the self and mindfulness in FAP.

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[2] Portions of this chapter are based on Parker, Bolling and Kohlenberg (1998).

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A Behavioral View of Self

Let us begin with a simple two-step exercise. Do step 1 right now—look at your hand for approximately five seconds. Now do step 2—look at your hand again for a few seconds, but while doing so, try to become aware that *you* are looking at it. If this exercise worked effectively, the steps should have involved two forms of awareness. During step 1 you were simply looking at your hand—noticing the hand itself. You may have noticed certain features and wondered what we wanted you to see. Such awareness involves simple discriminations that all creatures make, verbal or otherwise. It is pure awareness, automatic and unconscious. The second step, however, incorporated an additional type of awareness. Not only were you seeing your hand, but you were *seeing that* you were seeing your hand. That is, you were aware of a 'you' a 'something' or 'someone' that was looking, noticing or wondering. You might have even tried to metaphorically step back in order to observe you looking at your hand. The experience of a 'you' that is observing is what the general public and most social scientists refer to as 'the self.' Deikman (1999) defines this self as an 'I' with an abiding, resting awareness, featureless and unchanging, a central something that is witness to all events, both exterior and interior.

The Experience of Self

In this chapter the terms 'consciousness,' 'self-awareness' and 'self observation' are used interchangeably to refer to the second type of awareness described in the exercise above. Skinner posited that, "...a person becomes conscious in a different sense when a verbal community arranges contingencies under which he not only sees an object but 'sees' that he is seeing it. In this special sense, consciousness is a social product" (Skinner, 1974, p. 220). Skinner thus emphasized the way in which a particular social history is required for one to learn to see *that* one sees. To the extent that this history is normative in our culture, commonalities can be expected in descriptions of a 'normal' or 'ideal' self. Not everyone, however, develops the purported ideal self. That is, despite some similarities, a sense of self is learned and thus is dependent on the vagaries of this learning history; consequently the experience of self should vary a great deal. We conceptualize a continuum of experience; on one end an ideal experience of continuity and selfsameness, a 'central something' corresponding to the descriptions and experiences of Descartes and Deikman; on the other an empty or unstable sense of self, corresponding to the experiences of clients who state, "I don't know who I am," or who report multiple selves.

Our behavioral view is that the experience of self consists of a 'central something' that is experienced, and the process of being aware of or perceiving that 'central something.' The functional analysis of the experience of self thus focuses on the discriminative stimulus (Sd) that one becomes aware of and

identifies as this 'central something.' This focus on self as an object is congruent with its use by clients and conventional self psychologists. Our task is thus to identify the experienced thing that is self. This analysis is guided by Skinner's discussion of the self (1953, 1957) and functional analysis of the verbal behavior of labeling stimuli (e.g., ball, car) known as tacting (Skinner, 1957; Barnes-Holmes, Barnes-Holmes, & Cullinan, 2000). This approach is complementary with the contemporary behavior-analytic innovator Steve Hayes and his colleagues' analysis (Hayes & Gregg, 2000; Hayes & Wilson, 1993). Although we focus on the self as an experienced or perceived object, we do not give it agency properties (e.g., the psychoanalytic concepts of id, ego and superego) and then use it to explain self problems. Rather, we attempt to understand the self functionally, by elaborating the nature of the interpersonal environments that influence how the self develops and the conditions under which 'normal' and problematic experiences of self occur.

In non-technical language, suppose we are trying to understand a person's *experience* of being hot. We could put a man in a temperature-controlled room, vary the temperature, record body temperature, and find out what temperature is required for this person to report that he is hot. This report would be a tact, a response controlled by the specific discriminative stimulus of the experience of heat. Our understanding would be even greater, however, if we knew more about this person's previous experience (history) with hot and cold surroundings. If he grew up in the desert, a considerable increase in room temperature might be required for him to say he is hot, more than would be needed for someone born and raised in Alaska. The more known about the historical and contextual variables that result in the individual reporting that he is hot, the more we can say we 'understand' his experience. This approach to understanding a person's experience is connected intimately to understanding the stimulus (the thing) that led to the verbal report, and the assumption is that the same factors that affect one's inner private experience also affect the verbal report of that experience.

Our approach to understanding the experience of self parallels that of heat described above. Just as we would explain the experience of heat by identifying the stimulus and history for the response "hot," we explain the experience of self by describing the stimuli and history that account for the words used to identify the self. These words include 'I,' 'me,' 'baby,' or the child's proper names such as 'Davie' or 'Dottie' (when used to refer to one's self), and 'you' (as commonly misused by very young children to refer to themselves). We would contend that such terms are all members of the same equivalence class. For illustrative purposes the following discussion will use the generic 'I' to represent this class. Thus the analysis of 'I' can be viewed as a prototype for the analysis of other verbal responses associated with the self. Indeed, an understanding of 'I' in particular does appear to account for a wide range of experiences of self. Specification of the stimuli for 'I' thus illuminates the 'phenomenon' or the illusory 'central something' that is experienced as the self.

Development of the Sense of Self

When learning to talk, children actually are learning to tact, or to say the sounds or words evoked by specific discriminative stimuli (Sds). The process begins with the learning of the meaning of individual utterances (in FAP, 'functional units'). As an example, consider how a child learns the tact 'apple.' A parent may show his or her child an apple and then encourage the utterance 'apple.' It is obvious to the parent (as an observer) what object the child should be attending to that is referenced by the term 'apple.' To the pre-verbal child, however, it is at first a confusing situation. Consider the myriad of potential discriminative stimuli that are present that could mistakenly be linked to the word 'apple.' For the infant, the situation is a stimulus soup consisting of irrelevant publicly observable stimuli that happen to be present in concert with the prompt to say 'apple.' To confuse the issue, there is also a myriad of private stimuli (e.g., bodily sensations associated with neural and hormonal activity) that are available only to the child. Nevertheless, remarkably, the child learns to identify the publicly observable apple from the stimulus soup as the Sd that evokes 'apple.' Of course for this to occur the parents (the 'verbal community') need to be consistent and use contingent reinforcement to ensure that 'apple' is only applied when an apple is present, and is not an appropriate response to other stimuli (e.g., mommy, daddy, particular bodily responses, or any of the other objects in the environment). The child learns to say 'apple' because it was the one stimulus that was consistently present on each occasion saying 'apple' was reinforced. Verbal behavior researchers suggest that what is learned at this stage is the behavior of bidirectional verbal relating (e.g., the word 'apple' shares equivalence with the object apple, and vice versa) (Lipkens, Hayes, & Hayes, 1993).

Linguists and developmental psychologists call the period of life from about six months to two years the 'single-word speech period.' (Cooley, 1908; Dore, 1985; Fraiberg, 1977; Peters, 1983). At this early stage, even multiple word phrases such as 'Mommy come' and 'juice all gone' serve as single functional units and are not understood as individual words. To illustrate, consider the case of a parent trying to teach the phrase 'I see apple,' once the child has learned to tact 'apple.' The parent intends for the child to report his or her private experience of 'seeing an apple.' If the parent is successful, 'I see apple' can be used to report both physical and imagined apples, such that the child can describe and be aware of his or her private activity of seeing the apple even if there is no public apple stimulus present. In order to have the child's 'I see apple' reflect this subtlety, the parent has the difficult task of teaching the child to come under the control of the private activity of seeing an apple when saying, 'I see apple.' This task is difficult because the parent cannot tell with certainty if the child is really having the intended private seeing experience. Instead the parent relies on public stimuli for this purpose, including the overt orienting of the child toward the apple by head-turning, pointing, widening of the eyes and

intense staring in the direction of the apple. The public stimuli would vary slightly depending on the location of the apple, child, ambient lighting and so on. If the parent is successful, however, the private stimulus associated with the private seeing will gain control over 'I am seeing apple,' as it is the one stimulus consistently present each time saying 'I see apple' was reinforced.

Although we have taken poetic liberty in the above description by implying that the parent is purposely attempting to teach the child the difference between the public stimulus 'apple' and the private stimulus of seeing an apple, it is likely there is no such pre-conceptualization involved when parents interact with their children. The fact, however, that most of us can report when we are seeing an imaginary apple or having a private visual experience is evidence of this prior learning. Although others may well disagree with our view on this matter, we do not believe we are born with the ability to see or report private images; instead we would argue that we have our parents or caretakers to thank for teaching us how to do this. This same complexity is present whenever we or our children are taught to tact or to identify any private event such as feelings of hunger, sadness, happiness or anger.

Kohlenberg and Tsai (1991) provide a detailed behavioral account of the three stages of language development leading to the tact 'I' emerging as a separate functional unit (pp. 125–168). The three stages are shown in Fig. 5.1.

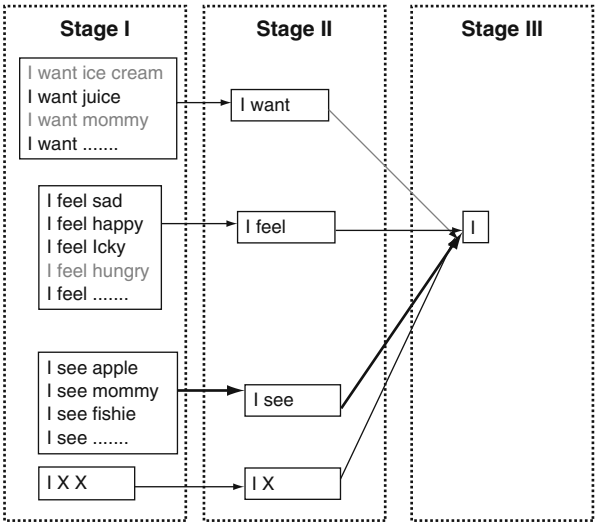

Fig. 5.1 The three stages of verbal behavior development that result in "I" emerging as a small functional unit show how variations in learning experience might ultimately influence one's experience of self (the "I"). For example, the bold letters and lines stand for "I x"s that are privately controlled, and then combine with publicly controlled responses (shaded letters and lines), leading to a somewhat weakened sense of self

As illustrated in Fig. 5.1, during Stage I the child learns larger independent units that are the basis of the more abstract intermediate-size units of Stage II. Then the 'I' of Stage III emerges from the medium-size units of Stage II. As an example that illustrates the variability in emergence of 'I,' the terms in bold represent the strength or degree of private control that may be in place for a given individual. Thus the phrase 'I want juice' occurs when the child truly 'wants juice' and is experiencing the private aspects of 'wanting juice.' In contrast, the phrase 'I want ice cream' is prompted by the mother (who actually wants ice cream at the time). The net result is that in Stage II, the 'I want' is only partially under the control of private stimulation and partially under the control of the child's perception of what the mother wants.

The experience of 'I' that emerges in Stage III can be thought of as the experience of a 'perspective' or 'locus' as defined by Hayes (1984). This perspective is the one stimulus that remains constant across all 'I want x' and 'I see x' statements, as the activity (wanting or seeing) and the object (the 'x' that is wanted or seen) varies. Hayes, Barnes-Holmes, and Roche (2001) argue that additional verbal behavior is necessary for the complete experience of self as a perspective to develop. In particular, the growing child learns to distinguish 'I' from 'you,' 'here' from 'there,' and 'now' from 'then.' The self as perspective emerges from this more complex relational verbal behavior. For example, sometimes the child may be five feet from the parent and at other times 50 feet, but the child is always 'here' and never 'there.' The private stimulus that is always 'I, here, now,' and which includes some sensations within the body, seems likely to gain control. Thus, the response 'I' as a unit over time comes under the stimulus control of the perspective (the locus) from which other behavior emanates.

It is crucial to recognize that this locus from which behavior emanates is not the body, although it observes things that happen inside the body. 'I hurt my finger,' 'I have a tummy ache,' and the like teach us this discrimination, as the 'I' observes the body but can not be the body. Because the perspective from which these observations occur appears to be located behind the eyes, however, the 'I' is experienced as within the body. Activities under private control—activities attributed to the 'I'—are experienced as coming from within. The experience of self as continuous over time (e.g., you at your 10th birthday party is the same you as now, even though your body is completely different) adds to a learning history that distinguishes the sense of self as something other than the body, but that emanates from within the body (Hayes, Strosahl, & Wilson, 1999). Ideally, the self comes to be experienced as relatively unchanging, centrally located, and continuous, and a sense of interiority develops.

Our theory that the self develops as a result of language acquisition (and the meaning of 'I' emerges from the meaning of larger phrases in which 'I' is embedded) is not new. In 1908, Cooley collected data on the acquisition of 'I' as a child was learning to talk. Although not stated in behavioral terms, his theory is remarkably similar to ours. Cooley concluded that at age 26 months, 'I' phrases such as 'I don't know,' 'I want…' and 'Come see me' seem to have

been learned as 'wholes' (p. 355)—in our terminology, large functional units. Cooley states, "From these she probably gets the 'I' idea by elimination, (that is) the rest of the sentence varies but the pronoun remains constantly associated with the expression of the will, the self attitude" (p. 355). In our terminology, 'I' emerges as a small functional unit.

Although ideal development leads to a large degree of control of the 'I' response by private (within the skin) stimuli, more problematic development involves the opposite—the development of a small degree of control of 'I' by private stimuli. In such situations a number of 'I x' Stage II responses have come under public control (as illustrated in Fig. 5.1). This usually will have come about through some parents or other early caretakers inadvertently teaching children to receive their cues for 'I' statements from public stimuli (people or situations outside themselves), rather than from the private events and responses that only the child can access.

Take as an example a young girl, Tammy, in a grocery store with her mother. Tammy says, "I wanna candy bar." Her mother, in a hurry to finish shopping, says, "No you don't." This statement prevents Tammy's private experience of 'wanting' from gaining control over her 'I want' response. If this occurs regularly in a wide variety of circumstances, 'I want' will increasingly come to be under public control. For example, Tammy's 'I want' behavior may eventually be influenced heavily by the presence of any important person who looks anxious or hurried. Public discriminative stimuli will come to control whether she really wants something or not, and the experience of wanting, which ideally would come to control Tammy's report of wanting, will go wanting (if we may), and finally have no control over Tammy's behavior. This process operates outside of Tammy's awareness.

If similar invalidations of Tammy's other 'I x' statements occur, her problems with her experience of self may become more severe. For example, imagine the statement "I feel sick today," receiving the response, "Nonsense, you're perfectly fine." Or the statement, "I am hungry," is returned by, "No you aren't, it's not lunch time yet!" Such exchanges may pervade the history of people who eventually say their actions do not come from within, or that they are not doing what they appear to be doing. This may still sound a little far-fetched, but how many times have you heard interactions such as "Do you want to go out tonight?" "I don't know, do you?" Or "Do you want dessert?" "Well, I'm not sure, do you?"

Although the above statements are relatively non-pathological, they illustrate self-referent behaviors that are being spoken of (tacted) as being under public control. There is a continuum of severity of problems with self, depending on the degree of private control of the functional unit 'I.' Keep in mind that this situation does not involve someone suppressing a verbal report of feelings or needs. Rather, this section involves pinpointing the developmental antecedents of being aware of one's feelings (private stimuli) and needs (reinforcers), and how one comes to notice them in the first place. In addition, note that this discussion does not simply refer to unassertive individuals—such people may

know what they would prefer but are reluctant to speak their wishes. In contrast, people whose 'I's are under public control actually do not know what they want, what they can do, what they feel etc., unless they discover what significant others want or will allow. Under ideal conditions, the 'I' emanates from within, and thus in cases such as those described above, a strong sense of emptiness, a void where the self should be, may well be reported if most of what a person refers to as 'I' is actually under the control and subject to the modifications of others.

Kanter, Parker, and Kohlenberg (2001) report on the development of a measure of public versus private control over the experience of self (the Experience of Self Scale, or EOSS). The EOSS was administered to a sample of undergraduate students and participants diagnosed with borderline personality disorder (BPD). BPD participants reported significantly more public control over the experience of self, and EOSS scores also correlated strongly with measures of self-esteem and dissociation, such that more public control predicted lower self-esteem and more dissociation. These findings provide preliminary empirical support for the above theory.

A vast body of literature also supports the basic premises of the behavioral theory of the self, dating back to Asch's (1951) classic studies investigating social influences on basic perceptual processes. These early studies demonstrated that the public can exert strong influences on how individuals report perceptual experiences. In addition, early research on locus of control (Rotter, 1966) identified that individuals differ to the degree they experience their behavior to be controlled internally (by themselves) or externally (by others). These social psychological theories, however, do not offer an account of how these individual differences develop. For instance, why do some people respond to public influence in the Asch experiments while others do not? What developmental issues account for these differences between people? Our current theory provides an account of how this pattern of behavior might develop. Real life processes, of course, are much more complex and not as linear as suggested by the framework provided above. We acknowledge the above theory is a mere sketch of a rich continuum of phenomena (for a more detailed description of this process, refer to Kohlenberg and Tsai, 1991, 1995).

The sense of self, in summary, develops in partnership with language. Under ideal conditions, the sense of self is an internal, stable perspective under the control of private stimuli. If one's tendency to behave a certain way is consistently checked by a punishing or invalidating environment, however, one may perceive that one's own behavior does not come from within. Indeed, in a sense it does not if it is always (or nearly always) determined by what is going on outside—if the tendency to behave is under public control. This history of invalidation leading to public control of the sense of self is a major factor in the development of disorders of the self in our culture.

Mindfulness

As an introduction to what is meant by mindfulness in a therapeutic setting, consider the clinical example in the following quote from Germer (2005) in Germer, Siegel and Fulton's (2005) book *Mindfulness in Psychotherapy* (p. 3–4).

> People are clear about one thing when they enter therapy: they want to feel better, they often have a number of ideas about how to accomplish this goal, although therapy does not necessarily proceed as expected. For example, a young woman with panic disorder, let's call her Lynn, might call a therapist hoping to escape the emotional turmoil of her condition. Lynn may be seeking freedom from her anxiety, but as therapy progresses, Lynn actually discovers freedom in her anxiety. How does this occur? A strong therapeutic alliance may provide Lynn with the courage and safety to begin to explore her panic more closely. Through self-monitoring, Lynn becomes aware of the sensations of anxiety in her body and the thoughts associated with them. She learns how to cope with panic by talking herself through it. When Lynn feels ready, she directly experiences the sensations of anxiety that trigger a panic attack and tests herself in a mall or on an airplane. This whole process requires that Lynn first turn toward the anxiety. A compassionate bait and switch has occurred.

What may be surprising to some readers is that Germer does not mention therapeutic interventions such as sitting still and focusing on a thought, mantra or breath. Such techniques often are referred to as meditation and are considered prototypical mindfulness interventions. In fact, it appears that Lynn received something along the lines of a traditional CBT (Cognitive Behavioral Therapy) treatment for panic. Here we extract several generalizations from Lynn's case that are relevant to the discussion of mindfulness: (1) patients may enter therapy wanting to 'get rid of' negative feelings and thoughts; (2) nevertheless, the treatment process involves facilitating the patient coming into contact and being present with avoided negative thoughts and feelings; (3) the therapeutic relationship provides a safe environment and fosters the courage needed for the client to come into contact with situations that evoke these avoided thoughts and feelings; and (4) 'remaining present' in evocative situations may occur under the guise of doing the opposite—the therapy is presented to the client as a means of getting rid of negative thoughts and feelings. Therapists themselves may or may not be aware of this contradiction, and hence unknowingly participate in the so-called 'bait and switch.' We contend that a variety of techniques lead to greater mindfulness, remaining present and improved outcomes. Consistent with this sentiment, we suggest that mindfulness-promoting interventions often occur naturally during all types of psychotherapy, whether intended or not.

A Behavioral View of Mindfulness

Our behavioral view of mindfulness is intended to help therapists decide how and when these interventions might help. Techniques to increase client

mindfulness are suggested, many of which are easily integrated into current CBT as well as other treatment modalities. A case example below illustrates how to tweak CBT interventions to enhance the naturally occurring mindfulness that occurs in most therapies. Although we avoid defining mindfulness as a specific intervention, a particular meditation procedure based on Herbert Benson's relaxation response (Benson, 1975) is presented, and we discuss how it can be used in a manner consistent with FAP.

Not surprisingly, mindfulness is considered a behavior in the context of FAP. That is, being mindful is considered a type of self-awareness that also plays a role in the development of self. Consistent with the functional analytic approach, we eschew topographical descriptions of mindfulness and instead examine its effects or consequences. The focus is on those effects that have therapeutic implications. We fully recognize that defining mindfulness in terms of therapeutic effects excludes many commonly accepted notions and topographic descriptions, particularly in contexts such as spiritual practice or self-development. To avoid confusion, we will refer to the phenomena of interest as 'therapeutic mindfulness.' Keeping this limitation in view, we begin by considering how others define mindfulness and then attempt to extract the implied functions or effects of its practice.

Alan Marlatt, among the first cognitive behaviorists to recognize the therapeutic potential of mindfulness (Marlatt & Marques, 1977), has researched and written about its clinical application. Recently, Witkiewitz and Marlatt (2005) defined mindfulness as a metacognitive state of nonjudgmental awareness, with a focus on moment-to-moment direct experience of ongoing thoughts, feelings and physical sensations. In this conceptualization, attention is focused on the breath as a touchstone of awareness, and if one becomes distracted, one returns attention to the breath as soon as one realizes that awareness has shifted to other cognitive events.

Janet Surrey's (2005) description of mindfulness emphasizes the interpersonal aspects of mindfulness while doing relational psychotherapy.

> Connection, whether to her own experience or to others, is never static. It is a process of successive moments of turning toward, turning away, and returning. Mindfulness cultivates awareness of this movement, informed by the intention to return to connection again and again. In mindfulness, the object of our investigation is our connection to whatever arises in awareness. (p. 94)

She then describes the process from the therapist's perspective and notes its therapeutic effects.

> . . .the therapist remains attentive to moment to moment changes in his or her own sensations, feelings, thoughts, and memories. . . Through the relationship, the therapist offers the patient the possibility of staying emotionally present with the therapist, perhaps staying with difficult feelings for 'one more moment,' thus enhancing the patient's capacity for mindful awareness of self-in-connection. The therapist's empathic attunement helps to draw out the truth of the present moment without flooding or shaming the patient—with acceptance. (p. 94–95)

Both Marlatt and Surrey describe mindfulness as a type of awareness or consciousness that has two characteristics: (1) it is non-judgmental; and (2) it has a focus on the here and now. These elements are found in nearly all definitions of mindfulness (Germer, 2005). First, we discuss the non-judgmental element of mindfulness.

Non-judgmentalness. In keeping with the clinical relevance of this analysis, the 'judging' of interest is defined as an evaluative tact that is under the control of an aversive stimulus. For example, the tact 'bad' indicates that an aversive S^d (such as being criticized) was contacted. This aversive Sd could be a thought, feeling, an action by others, or other real world occurrences. The associated response repertoire evoked by aversive Sds includes avoidance, escape, attack and related actions to control or eliminate the aversive Sd. Such tacts and responses often are functional; think of avoiding the aversive Sd of a car racing down the street towards the spot where you are standing. Here we restrict our analysis, however, to those instances when negatively charged judgments and associated response repertoires are problematic for the client. The implication is that being mindfully and therapeutically non-judgmental involves an absence of avoidance or other attempts to control the aversive Sd, also known as acceptance.

This view is consistent with Hayes et al. (1999) discussion of acceptance in Acceptance and Commitment Therapy (ACT), although these authors emphasize experiential avoidance (avoidance of aversive Sds that are thoughts, feelings and other private experiences). From their perspective, acceptance involves making contact with the automatic or direct stimulus functions of experiences without acting to reduce or manipulate those functions and without acting on the basis of their derived or verbal functions (Hayes, 1994). Hayes and colleagues' behavioral analysis of language (Hayes et al. 2001) provides an elegant, empirically supported and comprehensive account for how a verbal tact (e.g., 'bad') can become functionally aversive in and of itself—through stimulus equivalence and related processes—and evoke avoidance. Their analysis also provides a model describing how such tacts can serve other stimulus functions that contribute to clinical problems. FAP therapists are encouraged to learn ACT theory and interventions.

Focus on the here and now. A focus on the here and now is the second element in mindfulness definitions. Some data suggest that a here and now focus (also referred to as 'being present in the moment') has similar functions to those of acceptance (Brown & Ryan, 2003). The widely read author, Tolle (2004), expressed this sentiment by pointing out that giving "fullest attention to whatever the moment presents... implies that you also completely accept what is, because you cannot give your full attention to something and at the same time resist it" (p. 56). Thus, although being non-judgmental and focusing on the here and now may imply different topographies in the various definitions of mindfulness, their primary therapeutic function is defined here as reducing problematic avoidance repertoires.

Therapeutic Mindfulness

We define therapeutic mindfulness functionally as a type of self-awareness that helps the client to remain in the presence of aversive Sds (such as negative thoughts, feelings and events) that typically evoke avoidance repertoires. In turn, this provides an opportunity for new, more adaptive behavior to emerge and be reinforced. Using a functional definition can help reduce the considerable confusion in the mindfulness literature resulting from the failure to distinguish specific techniques from a psychological process (Hayes and Wilson (2003).

One possible approach intended to help the client remain present can be ruled out summarily, namely interventions aimed at blocking escape or otherwise forcibly blocking the avoidance. Over and above ethical and therapeutic alliance issues, such interventions would be nearly impossible to implement as avoidance still can occur in the private realm and is not subject to external control. Instead, we focus here on techniques to change the stimulus functions of those aversive Sds that typically evoke avoidance. For example, consider a client, Millie, who fears contamination and avoids touching doorknobs. The doorknob serves as an aversive Sd that evokes negative evaluative tacts and avoidance repertoires, thus depriving her of the opportunity for extinction of anxiety and the emergence of new productive behavior. Assume that Millie is asked to give up 'trying to get rid of thoughts' and instead is encouraged to observe (e.g., 'step back and see') her own thinking as a process rather than as content.

The observation of thinking as process is a function of the emergence of 'I think' as a functional unit (Stage II), the client tacting the private activity of thinking as an independent unit regardless of thought content. The same applies to other 'I x' Stage II behavior, such as 'I feel' and 'I sense.' Thus Millie might be asked to notice (be aware of) other events when in the presence of the doorknob. She might momentarily shift her attention and become aware of the flow of her breath, the ticking of a clock, the taste of garlic on her tongue, and other bodily sensations. Being mindful transforms the original doorknob aversive Sd (in Relational Frame Theory (RFT) terms, there has been a transfer of discriminative functions (Hayes et al., 2001)), reducing its aversive properties and evoked avoidance and thus providing an opportunity for productive behavior.

Clinical Implications for Problems of the Self

In broad terms, clients with extensive problems of the self begin treatment displaying in-session behaviors such as being wary, overly attentive and concerned about the therapist's opinion of them. They do not confidently describe feelings, beliefs, wants, likes and dislikes. All these behaviors are likely to be CRB1s, and indicate a lack of control over the experience of self by private

stimuli. If treatment is successful, clients' within-session behaviors should become more confident and trusting, and include the CRB2s of freely describing thoughts, feelings, wants and beliefs.

The description of client behaviors in the foregoing paragraph could pass for the generic psychotherapeutic endeavor. A primary source of such clients' difficulties is a lack of private control, and thus treatment by a therapist who is accepting, responsive, and who encourages expression of feelings naturally can provide the contingencies to strengthen private control. Such a generic therapeutic environment is the antidote to the invalidating early environment that failed to reinforce control by private stimuli. In addition, the FAP behavioral model leads to some specific suggestions for treatment.

Reinforce Talking in the Absence of Specific External Cues

For clients with self problems, much behavior is under the tight stimulus control of others. They appear vigilant and are focused intently on the therapist, watching for nuances in facial expression and voice inflection. Although often not obvious at first, almost everything these clients say about themselves and what they think and feel may be heavily influenced by the therapist as Sd. The therapy procedure described below is aimed at loosening this control by encouraging and reinforcing talking in the absence of specific external cues. In other words, treatment consists of strengthening the CRB2s of privately controlled 'I x' statements, which will also aid in the eventual emergence of private control over 'I.'

One means of helping clients establish private control is for the therapist to sit mindfully in silence—simply be present, listening without judgment—rather than structuring each moment of the session with questions. A variant of the psychoanalytic free-association task may be given to the client to enhance the chance of evoking CRB2s in the form of 'I x' responses under private control. It is problematic to use this strategy during the early stages of treatment, as it can evoke a strong CRB1 of avoidance in the client. Numerous clients have complained about previous treatment failures because of their former therapists' passivity.

Additionally, rigidly adhering to a rule of therapist silence is likely to preclude reinforcement of CRB2s should they occur. For example, a client might say, "I can't stand this." This is an 'I x' response that the therapist should take seriously, thus reinforcing private control of an 'I x' statement. FAP therapists often use strategies from other therapies, provided they address the functions of problematic behavior in the client's life. It is essential, however, that the therapist be clear that the topography of the strategy (e.g., therapist silence) is less important than its function, in this case that of evoking private 'I x' statements.

In the early stages of treatment therapists will benefit from a mindful, present-moment focus so that they can respond flexibly and appropriately when clients emit CRB2s. Later in therapy, after clients have made progress in gaining a privately controlled repertoire of 'I x' responses, more passivity on

the therapist's part can be useful. The following case involving a client named Terry is illustrative.

During the initial months of therapy with RJK, Terry focused primarily on his medical treatment and the medications he was using to control a psychosomatic symptom. When RJK posed more general questions about mood or an emotional state, Terry became stymied and anxious. Early in treatment RJK would suggest an answer based on specific public stimuli. For example, when a severe medical symptom appeared that was similar to one that resulted in a relative's death, it was suggested that Terry was feeling fear (thus RJK provided the public stimulus by saying "fear"). This is similar to what parents do when they impart to their children the tacts for emotions. Gradually over the next few months, however, the specificity was reduced. Rather than continue to name a feeling, RJK would provide Terry with a list of emotions to choose from (e.g., pain, fear, anger, disappointment, irritation or frustration). In other words, RJK was still prompting a response based on public stimuli, but the specificity of the stimuli was broadened. Terry was assured that he would not be punished for answering as he was given an 'approved' answer in the first case, and a list of approved answers in the second. The general idea is that structure was gradually reduced to allow more private stimuli to gain control.

Match Therapeutic Tasks to the Level of Private Control in Client's Repertoire

Unstructured free association. Just as the general strategy of a therapist can vary from passive to highly structured, this free association task (adapted from traditional psychoanalysis) can be presented with more or less structure. In its most unstructured form, the free association instructions are as follows.

> Tell me everything that enters your mind—all thoughts, feelings, and images. It's important not to censor anything. Report whatever comes up, even if you think it's unimportant, nonsensical, trivial, embarrassing, or whatever.

The client is asked to continue without feedback and may even be asked to sit so the therapist is out of sight. Interestingly, this is similar to some mindfulness exercises, except that instead of allowing thoughts, feelings and images to arise and pass uncensored solely in the private realm, the client is asked to tact them aloud. Indeed this 'tell me everything' technique may be a prerequisite for later mindfulness practice for persons who lack private control over the experience of self.

This task requires talking to the therapist with a minimum of external cues, making it possible for clients to say 'I feel x' or 'I see this image' under conditions that favor control by private stimuli. Clients with extensive self problems likely will become anxious and be unable to perform this task because of the lack of public stimuli. They may experience a 'loss of self' in the absence of therapist cues. A similar phenomenon occurs when therapists use relaxation or meditation techniques and find that their clients become highly anxious when

the task is too unstructured. FAP therapists using free association can vary the classic unstructured format depending on the client's level of private control.

Structured free association. More structured tasks that call for a gradually increasing degree of private control can be used, such as sentence completion and word association. Another more structured variant of free association is the 'movie theater in your mind' task, where clients are asked to close their eyes and imagine they are sitting in a movie theater. First they are instructed to see a blank screen in their mind's eye. When the movie begins, the first scene is stipulated to be of the client and the therapist sitting in the office at that moment. Next, the movie is described running backward, with the client walking backwards out of the office and back into his or her car. The movie is then said to run faster and faster, turning into a blur. The client is asked to view the blur, and then have it suddenly stop and to describe the scene at that point. It is still vital to reinforce any 'I x' responses that occur because they are likely to be under at least a modicum of private control. A wide variety of such imagery tasks used in gestalt therapy, psycho-synthesis and hypnotherapy can be adapted for FAP.

Another more structured adaptation of free association involves the use of a computer and word processor. The client is asked to type everything that crosses her or his mind and not to censor anything. An advantage of this method is that it lends itself to shaping the process. At first, the client is given the option of erasing any or all of the material before the therapist reviews it. In order to reinforce talking (typing) in the absence of public stimuli, the therapist uncritically reviews the word processing file during the session. Over time, the client is encouraged to erase as little as possible.

In summary, four adjustments can be made to imagery or free association tasks borrowed from other therapies. First, they should be presented to the client as a task whose value is derived from the process (e.g., imagining and describing in the presence of the therapist). Ideally, clients should be told in everyday terms that what is important about the task is that it is likely to evoke CRB2s under private control. Second, the task should be selected or modified to vary the degree of private control required to match the level of the client's repertoire. For example, the 'movie theater' task could begin with no image present on the screen or could be time-limited. Third, the client should be reinforced for making 'I x' statements. Fourth, the therapist should keep in mind that CRBs other than those related to self problems could be evoked and thus provide therapeutic opportunities. A case study illustrating the clinical application of imagery and free association tasks can be found in Kohlenberg and Tsai (1991, pp. 161–164).

Reinforce as Many Client 'I x' Statements as Possible

When clients have self problems, it is particularly important for therapists to treat with respect differing ideas and beliefs. In this context 'respect' is defined

such that the client's behavior should be strengthened or reinforced by a therapist's reaction even though he or she may indicate different beliefs. Special significance is given to those client 'I x' statements that differ from the therapist's own feelings and impressions, because it is precisely these behaviors that are most likely to be under private control. Ideally the therapist should reinforce as many 'I x' statements as possible.

As noted previously, if a client's self problem is related to a lack of private control over 'I want,' it is critical to reinforce if at all possible such a response if it occurs. One important clue that a client's 'I want' is under private control (as opposed to public control) is the therapist's inclination to reject the request. For example, a client whose self problem was that she did not know what she wanted asked RJK to try hypnosis to find out what she wanted. RJK's first reaction was to turn her down and give the reasons why he did not use hypnosis. This inclination to reject her request signaled the possibility that her 'want' was under her private control and that her request was a CRB2. Realizing that this was something that she truly wanted, RJK agreed to hypnotize her.

A delicate juncture is broached when a client whose self problems include a paucity of 'I feel' responses says, "I feel you don't care about me." Such a comment is not unusual and should be treated as a CRB2 (assuming it is not a disguised request for reassurance). The most reinforcing response would be to validate the client's response by reviewing interactions in the therapy that may have led to his or her feeling that way. For example, the therapist may have been distracted or preoccupied during the session or even may have been irritated by the client. Needless to say, this validation of the client's tact does not preclude the importance of the therapist emphasizing his or her caring about the client in general. Even more difficult situations are encountered when a client makes 'I x' statements that are counterproductive, self-maligning, suicidal, or homicidal. The following suggestions for dealing with these types of statements are more relevant for clients with self problems who are just beginning to develop private control over 'I x' statements, rather than clients who chronically engage in destructive behaviors.

1. Counterproductive statements. Client behaviors that lead to avoidance often appear counter-productive to the therapist. For example, MT supervised a case in which the client said, with tears in her eyes, "I don't want to talk about my mother's death. It's just rehashing old stuff and it doesn't get me anywhere." Appropriate therapist responses would include emphasizing that she does not have to talk about the issue (non-judgmental acceptance on the therapist's part) and exploring the situation further (in the service of being present). Here are three variants of such responses.

- You look like you are about to cry, like you're really hurting inside... What are you feeling? Are you afraid that if you keep talking you'll start crying? How did your Mom and Dad deal with you when you cried as a child?
- What do you mean by 'rehashing old stuff'? What's happened before when you talked about your Mom's death?

- I'm feeling conflicted because I really want to respect your feelings about not talking about your Mom's death, and yet I don't want to collude in your avoiding grief feelings because I think that avoiding them is related to your avoiding close relationships in general. What do you think would be more growth-enhancing for you right now—to push yourself to talk and to feel your feelings about your Mom, or to respect your feelings of not wanting to talk about her even though you know that's what I want? How can we honor both your desire of not wanting to talk right now, which is important in developing your sense of self, and also your desire to make progress in therapy in general by feeling your feelings?

2. Self-maligning statements. "I am a whore and a slut. I feel like the scum of the earth. I'm scared I'm going to become schizophrenic because my Mom was." These were all statements made by a client to MT. MT's initial reaction was to reassure the client that these statements were not true, but she felt angry and invalidated by MT's response. She acknowledged that while reassurance was important, it cut her off from describing feelings with which she was getting in touch. Gradually the client trained MT to combine her reassurance with allowing her the opportunity to explore her feelings. For instance, "You're definitely not a slut, but tell me all your feelings and thoughts about being a slut before I tell you why I don't think you are... The research on schizophrenia indicates that if you haven't developed it by now, it's highly unlikely that you will. But it must be scary for you to have that fear. Tell me about it."

3. Suicidal or homicidal statements. Although suicidal and homicidal fantasies are too aversive for most therapists to listen to in any detail, it is not uncommon for clients with self problems to get in touch with these feelings because their histories are so replete with unmet needs. It is important to reinforce these expressions by helping the client tell his or her story until the therapist thoroughly understands why it makes sense for the client to feel this way. Furthermore, it is important that the therapist forbid these harmful actions not just by mandate, but by helping the client separate feelings from actions (i.e., the connection between thinking about suicide, feeling suicidal, and engaging in suicidal behavior is that of a behavior-behavior relationship and one need not lead to the other), and by exploring in depth the consequences of suicidal or homicidal actions. If these suicidal or homicidal statements are threats made because more attention is wanted from the therapist, then the client should be confronted and taught how to ask directly for what is wanted without threatening hurtful behavior.

Clinical Implications and Techniques for Promoting Mindfulness

Self-Observation or 'Being Aware That You Are Seeing'

We will now turn our behavioral lens to understanding and using mindfulness. Earlier in this chapter a distinction was drawn between two types of consciousness,

illustrated through use of the exercise 'seeing your hand' and 'being aware that you are seeing your hand.' We refer to the 'being aware that you are seeing' as consciousness or self-observation. Self-observation of an event is under the control of a different Sd (discriminative stimulus) than the Sd for the event itself. Thus, if a client is anxious, the aversive Sd that evokes that anxiety (a bodily state) is different from the Sd that controls the self-observation of that anxiety. Typically, anxiety motivates problematic avoidance and escape whereas self-observation of that anxiety as 'noticing bodily sensations as sensory phenomena' reduces its control over avoidance and thus allows for more productive responses. It is a shift in stimulus control that provides the opportunity (referred to as 'giving space' in the mindfulness literature) for new behavior to emerge and for openness to experience to occur. Similarly, the thought, "I am stupid," an automatic response to an aversive Sd that may in turn evoke problematic avoidance, is different from the stimulus control (Sd) resulting from self-observation of the thinking (i.e., "I am having the thought I am stupid"). In the latter case presence to experience is enhanced, avoidance is reduced, and there is an opportunity for more effective behavior to occur. Consistent with our earlier analysis of the sense of self, there is considerable individual variation in the ability to self-observe. Accordingly there is overlap between being mindful (being aware that you are seeing, feeling, etc.) and having a stable sense of self. Both involve strengthening private control over the repertoires, 'I see, I feel, I x.'

We contend that strengthening of self-awareness naturally is reinforced by therapists during most therapeutic encounters. For example, the ubiquitous therapeutic move of asking clients to report what they are feeling is an opportunity for self-observation and for improving the private control of their 'I x's.' Not surprisingly, at the beginning of treatment clients may have difficulty answering the question, "What are you feeling right now?" With a therapist's compassionate prompting, attunement and sensitivity, clients are reinforced for both contacting private feelings and being aware that they are doing so (self observation or self-awareness). Similarly, the thought record routinely used in cognitive therapy asks clients to label and rate thoughts, feelings, and even how much they 'believe' a thought. All of this requires self-observation—awareness that one is having thoughts. As therapists help clients become more skilled at using the thought record, they are also prompting and reinforcing them to become more skilled at self-observing, first in the presence of the therapist. This skill of self-observing is then more likely to generalize to corresponding daily life situations.

Noticing (being aware of) bodily sensations when in the presence of an aversive Sd also changes the Sd somewhat and thus aids in being present. Transfer to daily life of this noticing will be enhanced when reinforced in an interpersonally evocative therapist-client environment (e.g., being asked to take risks and develop trust). Progressive muscle relaxation training or body scanning strengthens this observational skill and makes it more likely to occur when the client is confronted with aversive Sds. Similarly, asking clients to notice and describe the qualities of external visual and tactile stimuli produces

a shift in the controlling Sd (the stimulus they are attending to). This attention shift can then aid in being present to the experience of the aversive Sd that evokes avoidance.

Awareness/Relaxation/Acceptance Exercise (ARA)

In concert with opportunities for remaining present that occur during the course of therapy, specific exercises can be introduced to help clients be mindful. The following exercise is based on three sources—Herbert Benson's relaxation response (Benson, 1975), an ACT (Acceptance and Commitment Therapy) awareness exercise in Woods, Wetterneck and Flessner's (2006) treatment manual, and a respondent conditioning model for producing a self-induced, rapid anti-anxiety response. In keeping with the interpersonal emphasis in FAP, the ARA is taught in-session where encouragement and reinforcement of self-observation enhances the possibility of transfer to daily life. In addition, the exercise emphasizes the utility of awareness, relaxation and acceptance skills in the presence of others, particularly during difficult interpersonal situations. During in-session trainings therapists should watch carefully for negative reactions and frequently ask clients how they are reacting. The therapist also should remain alert for CRBs that this exercise might evoke, and alter the technique depending on client response.

The following is a rationale for the ARA exercise. Therapists may choose to paraphrase this rationale and emphasize those issues most relevant to their clients.

> (1) It increases your ability to stay with your awareness of moment-to-moment experience, even when in the presence of another person or evocative situation. (2) It increases your skills in noticing having thoughts as a process, and accepting thoughts and feelings without having to avoid them or change them. (3) It increases your ability to observe sensations in your body and stimuli around you. (4) It provides a cue to break a chain of automatic unproductive responding and sets the scene for more productive behavior even when in difficult situations involving other people. (5) It provides a cue that can be used for momentary coping with stress or strong negative feelings so that you can remain in the situation and not show avoidance. (6) According to Benson (1975), it reduces your accumulated daily arousal/stress.

An example of a paraphrased rationale is as follows.

> Often the buzz of mental activity and daily life routine dominate, and we get thoroughly caught in it. We forget to pay attention in the moment, to pause and reflect on what we are doing and what our choices are. The following meditation practice and the conditioning of a cue word [explain classical conditioning if it is appropriate] allows us to practice observing the buzz of mental activity and gives us a tool to help us become aware of choices—even when being with, noticing, and interacting with other people. (Based on Woods, Wetterneck, & Flessner, 2006 and modified for use in FAP.)

The instructions for the ARA exercise are as follows.

STEP ONE: Pair Breath (Exhale) with Cue Word or Phrase

Always start each practice session with this step. You can be in any position—standing, sitting, or even in an uncomfortable position. You can be alone or with others like you are now. Select a cue word or phrase that you will be using. It can be a fairly neutral word or one that has meaning for you. Examples are 'blue sky,' 'moonlight,' 'canoe,' 'let it be,' or the first few words of a familiar prayer. You will be using this same word or phrase throughout your daily practice sessions.

With your eyes open, focus your attention on your breath. Breathe naturally. After noticing one to three breaths, say the cue word or phrase (e.g., 'moonlight') to yourself as you exhale.

STEP TWO: Brief Muscle/Body Scan (approximately a minute or two for this step)

Sit in a comfortable position. Close your eyes if you would like—it's not critical that you follow these instructions exactly. Do a brief inventory or mental scan of muscle tension in your body. Spend only about ten seconds on each of areas listed below. See if you notice any muscle tension. If you have tension, try to release it. If you can't release it, that's okay, move on to the next area.

Feet, legs, and thighs.
Buttocks and pelvic area.
Abdomen, stomach, and lower back.
Chest and upper back.
Shoulders, arms, hands.
Neck, back and top of head.
Jaw (it's okay if your mouth is open).
Eyes and eyebrows, forehead.

STEP THREE: Mindfulness/Acceptance

Breathe naturally, focus your attention on your breath. Follow a breath as it comes in through your nose, travels through your lungs, moves through your belly in and out, and leaves back through your nose. Ride the waves of your breathing without attempting to alter it; just notice it as it happens. Each time you exhale, say the cue word or phrase to yourself (the practice). Assume a non-judgmental, passive or 'let it happen' attitude. Do not evaluate how you are doing. There is no need to 'make it happen,' 'do it right' or to be critical of yourself (either for not following these instructions or for anything else that comes to mind). If you notice that you have stopped doing the practice, just notice the distraction, and gently return to your breath or cue word. When distracting thoughts go through your mind, notice whatever thoughts you are having and say, "Oh well, those are just my thoughts," and gently return to the practice. Your distracting thoughts may be judgmental, self-critical and/or other-critical and it is likely you will go back and forth between various distractions and doing the practice.

Allow yourself to completely experience the present moment. Be deeply present with yourself. Even if you are having thoughts or feelings you don't like, do not push them away. Adopt an attitude of acceptance and curiosity towards all parts of your experience: treat every experience, thought and feeling gently, even if it is undesirable or distressing. Gently be present with yourself. Continue this process for ten to twenty minutes. It's okay to peek at a clock or watch. Do this mindfulness/acceptance procedure twice a day, preferably in the morning and the evening.

Although Benson suggests doing this exercise for twenty minutes, twice a day, in reality any practice is better than none. The ARA, when practiced in-session, is an

interpersonal situation that has the potential to evoke CRBs. For example, considerable interpersonal vulnerability and risk can be evoked by asking clients to close their eyes, shift attention to bodily sensations and relax while in the presence of a therapist. Thus if taking interpersonal risks and trusting others are daily life problems, the ARA has the potential to provide therapeutic opportunities to evoke and shape CRB2s. Correspondingly, inadequate mindfulness repertoires (e.g., weak or absent 'I see' responding) might appear as CRB1s during ARA.

Similarly, the ARA has a component that resembles free association, in that the patient is instructed to let thoughts occur, to notice them, and to let them pass in and out of awareness. This may be particularly beneficial for individuals whose interpersonal vulnerability is based on inadequate private control over 'I x' repertoires. As discussed earlier, this task could evoke CRBs related to being in touch with one's own private experiences, as opposed to relying on cues from the therapist. In this case, the therapist might observe that the ARA evokes anxiety and avoidance, and could be restructured along the lines suggested for altering traditional free association instructions. Another potential benefit of the ARA is that the client learns a way to cope with situations that evoke very strong anxiety (bodily) responses. When this happens during the session, the client is prompted to momentarily shift attention to his or her breath and then return to being in contact with the therapist and the evocative content. Momentary focus on the breath provides an alternative to complete avoidance and can facilitate the expression of more productive behaviors. Similarly, if naturally occurring thoughts during ARA practice in the presence of the therapist are related to aversive stimuli that evoke anxiety and avoidance, the process resembles desensitization. That is, the thoughts can be considered items on the hierarchy that are paired with relaxation.

In contrast to the emphasis on the role of the client-therapist relationship presented above, the highly interpersonal nature of mindfulness-based therapeutic interventions are rarely discussed (although for an exception refer to Surrey, 2005). Interestingly, Fischer (1999) points out that traditional meditation-based forms of Buddhist practice are built on the student-teacher relationship and "cannot be learned from books and is impossible to do alone." He goes on to say, "For me, the magic of the teacher-student relationship lies in trust" (p. 2).

Case Example: Exposure and Response Prevention, FAP and Mindfulness for Obsessive Compulsive Disorder

The empirically supported treatment for Obsessive Compulsive Disorder (OCD) is Exposure and Response Prevention (ERP). Although OCD is usually not viewed as an interpersonal problem, Kohlenberg and Vandenberghe (2007) underscored interpersonal issues present for clients with OCD and reported using the therapist-client relationship to shape CRBs relevant to OCD treatment. Even the straightforward implementation of ERP requires a strong

therapeutic alliance and a client who is able to trust the therapist enough to engage in previously feared activities. In essence, an ERP therapist is saying to the client, "Trust me—if you follow my suggestions, you can deal with the negative emotions and thoughts evoked by remaining present."

Self-awareness, self-observation or mindfulness as discussed in this chapter plays an important role in remaining present—the essence of ERP. Thus, one way to look at OCD is that the client lacks necessary self-observation repertoires. Given our behavioral conception of self-observation is that it occurs to the degree it has been encouraged and shaped by others, therapists can reinforce tacts that underlie a stable self and evoke and nurture self-awareness.

In the present case example, the client Jane, age 25, was fired from her job as a medical laboratory technician due to excessive checking and contamination anxiety. Although Jane had an extensive history of being assured by others that her fears were irrational, she did not trust the assurances enough nor did she have a readily available self-observation repertoire to help her stay present in evocative situations. Instead, when confronted with the possibility of making an error (and being discovered by others) or becoming contaminated with germs and inadvertently making others ill, she displayed checking behaviors and avoided contact with contaminated objects.

Her treatment involved nurturing self-observation (the core of mindfulness) and enabling the development of 'trusting' others (at first her therapist RJK) that underlie exposure and response prevention. Jane agreed that it would be helpful for her to work toward the goal of being able to observe herself having thoughts and feelings and telling RJK about them. Specific treatment elements included: (1) being prompted and encouraged in-session to step back, notice and describe bodily sensations, negative feelings and thoughts as an aid to remaining present with evocative stimuli; (2) using the ARA to develop a coping response that could be used during interpersonal situations (e.g., at work) as a means of reducing high levels of anxiety and facilitating ERP; (3) using FAP to establish a safe therapeutic environment that facilitated the trust and courage required for exposure work; and (4) generalizing trust of the therapist that enabled in-session ERP to others in her daily life.

It was explained to Jane (Rule 5) that her avoidance and other OCD behaviors were reinforced by an immediate reduction in anxiety. Contributing to the problem was the support she received from her husband and others that reinforced avoidance behavior. The goal was to trust RJK's and others' reassurances that she could deal with her fears, remain present in evocative situations, and thereby be positioned to be emit more productive behavior (e.g., working in her chosen profession).

Trust issues that immediately surfaced and were dealt with included her belief that RJK was holding her in low regard because she was not able to do 'normal' life activities. During ARA training, she was anxious when asked to notice bodily sensations and relax with her eyes closed, as she would be deprived of the public stimuli needed for sense of self and also was concerned that RJK would be looking at her with pity or degradation.

The context for the session described below was occasioned by Jane's discovery of a sanitary pad in a hallway in her condominium. Although the pad appeared to have been washed, it evoked contamination anxiety and avoidance of that hallway. She asked her husband to dispose of the pad. Based on the strength of her therapeutic relationship with RJK, Jane subsequently asked her husband to retrieve the pad from the trash container and risked bringing it to session (enclosed in a ziplock baggie and an additional plastic bag) with the understanding it would: (1) be used for exposure; and (2) provide an opportunity to practice and learn to be mindful in the service of remaining present. In the session prior to the one excerpted below, at the urging of RJK, Jane opened the plastic bag, stared at the ziplock baggie and pad, touched the outside of the baggie, but did not open it.

Transcript Excerpt 1 from Session 6

Therapist: Okay, are you willing to do some work on the pad? [Implied: Are you willing to trust me enough to go along with my urging you to remain present, to practice self-observation, and be willing to have negative feelings and thoughts?]

Client: Sure.

T: How about taking the ziplock baggie out of the plastic bag and tell me how far you are to willing to go. Then try to follow through while stepping back and watching yourself having thoughts and feelings. [Jane is asked to help structure the exposure and provide an opportunity to self-observe while remaining present and committing to an action.]

C: Sure. (She gingerly takes out the baggie and looks at the pad inside)

T: You're looking at it. [An attempt to emphasize the observer role—of her seeing herself looking.]

C: Yes. I am looking. There is a spot of some kind there.

T: You are *seeing* a spot, is that right? [Emphasizing the activity of 'seeing,' as opposed to whether a spot is there or not.]

C: Yes, I see there is a hair. I feel the anxiety. [An improvement—reporting "I feel the. . ." rather than "I am anxious."]

T: Alright, that's good—you notice yourself feeling the anxiety. [Emphasizing the observation rather than the feeling.]

Excerpt 2

T: As you are touching the bag, do you notice if you are feeling something on your hands? ['Noticing' a feeling is self-observation.]

C: Yeah, I do, my hands get sweaty right away. I think it contributes to feeling dirty. It's sticky.

T: So you are noticing the sweatiness. What other sensations do notice you are feeling right now? [Encouraging self observation—a shift in focus to other stimuli while remaining present.]

C: My breathing feels kind of tense, my chest is kind of tight.

T: Where do you feel the tightness? [Objectifying the sensation, adding the stimulus control of location, thus encouraging a shift in stimulus control aimed at enabling her to remain in contact with the baggie.]

C: (Places hand on her chest.)

T: Okay, that is the place you feel it. Anything else you notice?

C: Um, my eyes feel kind of damp, not like I'm going to cry, but just a little extra damp.

T: Okay, let's just take a moment, continue touching the baggie, and at the same time take a few breaths, saying "on the beach" [client's cue word used during ARA practice] to yourself each time you breathe out. [Historically for her this particular eye symptom occurs with high anxiety and interferes with the perception needed to do her laboratory work, thus RJK is cautiously using the ARA response as a coping strategy; the downside is that it momentarily strengthens the avoidance of feeling.]

C: With my eyes open?

T: Yes, this is something you can do on the spot. It isn't going to get rid of the anxiety or the tears, but it does give you a diversion for a moment. [An attempt to validate the ultimate importance of remaining present with the feeling even though the purpose of the relaxation response is to attenuate the intensity. This also an example of using attending to an immediate experience of breath as a means of aiding the "process of successive moments of turning toward, turning away" (Surrey, 2005).]

C: Okay (takes two breaths).

T: Now let's stay with what you are doing with the baggie. [Emphasizing using the momentary shift in attention in the service of remaining present and continuing with the task at hand—the exposure.]

C: Okay. I think I should touch it and take it out of the ziplock bag at the least.

T: You are being courageous and are doing great.

C: I think this is how far we got last week. I feel like I don't want to touch the inside of the bag. I feel like it has been dirty up here (indicating the upper inside portion of the baggie).

T: And are you aware of the sensation of something being on your fingers? Anywhere else?

C: I don't know, I think I am aware it is on my sleeve. I don't want to do this—can you help me. [CRB2, asking for help in remaining present rather than support for avoidance.]

T: I think it's important to stay with what you are doing. I am sensing how intense your feelings are and how difficult this is for you. I can't stop the feelings but I will be here with you [Emphasizing the

trust and caring established in the client-therapist relationship.], and you will get through this. [Reinforcing her asking for help without directly supporting avoidance.]

C: (Pulls pad out of baggy.) Aaag! Okay, so there it is.

T: Did you notice your strong negative response—even though you had it you still went ahead with taking out the pad? Okay, so why don't you just hold it (the pad) for a while and look at it. What do you see?

C: It's not quite white, and there is a little spot. Or maybe it's a little flower embroidered in the cotton. Yeah, now it looks like it might be crunchy, and of course I don't want to touch it there.

T: So, you are having the thought that it's crunchy. Can you step back from yourself and watch yourself having the 'crunchy' thought. [Practicing seeing herself see.]

C: Okay, I'm getting better at doing that.

T: If you touched it there, what would happen?

C: It would get on my fingers, and then my finger would be tainted, dirty (laughs).

T: You are able to be amused by your negative thought. So you were aware that it was just something you were thinking.

C: (Client holds up her hands and pad for RJK to see and smiles.) See what I am doing? I was careful to keep my sleeves away from it, but now I'm touching them to it. [Acknowledges the interpersonal support for remaining present and self observing.]

T: So, what you have done here is go beyond what most people would do when they are confronted with touching a used sanitary pad—even though it has been washed. And here you are, an OCD client who is aware of all these thoughts and feelings, and you are willing to trust me enough to still touch and handle it.

C: Wow, yeah. But now I am starting to get anxious and I would like to run out of here.

T: You notice that feeling of wanting to run out of here, but you are not running out of here, you are staying here with me and your feelings (and the pad).

C: Yes.

T: I think you are doing great, because you are not trying to avoid these feelings, but just learning to notice them, to stand back, watch them and tell me about them. And you seem to be doing okay.

C: Right, yeah. I think I'd rather be doing something else, but I'm doing okay.

T: Are you willing to try some of this [being aware of her thoughts, feelings, sensations, and remaining present] and accept Bill's (husband's) support?

In Jane's evaluation of the above session (from her session bridging form, see Appendix D), she stated, "I touched the pad to my clothes all over, I never thought I would be able to do that." She reported that high points for the week were accepting Bill's support and trusting his reassurance that she would not get contaminated, being able to remain present while touching the pad, and not asking Bill to help her avoid evocative situations.

Conclusion

Being mindful involves being aware of the private activity involved in such behaviors as seeing, feeling, thinking and hearing. Therapeutic mindfulness occurs when being aware alters the stimulus control of those events that evoke dysfunctional behavior and creates opportunities for the development of more productive responses. In FAP, client mindfulness is nurtured and shaped in the context of the therapist-client relationship. Therapist mindfulness is also an important T2 (therapist target behavior). Indeed, the most important guideline for practicing FAP is awareness—Rule 1. As stated by Kohlenberg (2004), "My job as a FAP therapist is to remain present in the moment so I can be sensitive to the needs of the client and be aware of my own reactions such that I can nurture CBR2s and not strengthen CRB1s."

Being aware of these private activities (self-awareness) occurs if the private activities themselves have acquired discriminative properties, and thus function to evoke tacts about them. It follows that clients with inadequate private control of 'I' will have difficulty acquiring mindfulness repertoires. Treatment in such cases should be staged with an initial emphasis on developing private control ('I x').

This behaviorally based interpersonal view of self and mindfulness was designed to be consistent with the emphasis in FAP on the development and use of the therapist-client relationship. When one's sense of self is stable, one is more able to be in the present moment, increasing connection not only with oneself, but with others.

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