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CALM-MO: An integrative tool for psychological mindfulness

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CALM-MO: An Integrative Tool for Psychological Mindfulness

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Table of Contents

List of Figures

Abstract

Henriques has developed a "Unified Theory" that consists of eight key ideas he argues can effectively frame both the science of psychology and the practice of psychotherapy. CALM-MO, the eighth of these ideas, offers an integrative, principled approach to psychological mindfulness. CALM-MO is an acronym that encapsulates the process of cultivating a "calm" meta-cognitive observer that embodies the attitudes of curiosity, acceptance, loving compassion, and motivation toward valued states of being. Henriques posits that the idea consolidates key elements from across the various schools of thought to bring together essential therapeutic principles geared toward seeking and maintaining well-being. As such, it potentially affords the field a frame that could be readily adopted and metabolized by clinicians training in any theoretical orientation. The current project seeks to further elucidate the nature of each element of CALM-MO and to bring these threads together to develop a more nuanced understanding of each element and of how they interact. Through this process, the project aims to make the argument that CALM-MO represents a powerful integrative psychotherapeutic tool that is valuable not only for client well-being, but also for the training of beginning clinicians.

Chapter 1: Introduction and Overview

Over the last several decades, mindfulness has emerged in the psychological literature as a promising pathway to promoting well-being and has been incorporated into a broad range of therapeutic approaches (Keng, Smosky, & Robins, 2011). This is especially true of cognitive and narrative approaches, though its clinical applicability reaches across nearly all theoretical paradigms within psychology. All approaches to mindfulness involve the process of cultivating awareness and acceptance of experience, which can be contrasted to mindless reactivity and the rejection of feelings, events, or ideas. Despite the core overlap, it is also the case that there are many different approaches to mindfulness. For example, an important distinction can be made between approaches that can be framed as meditative mindfulness emphasizing phenomenological perception and directing attention to witnessing embodied experience, in contrast to approaches that emphasize psychological mindfulness, which are insight-based reflections that focus more on the motivations and emotions of the self and what the experience means to the individual.

The current project aims to explore a particular application of psychological mindfulness developed by Henriques (2016) called "CALM-MO." CALM-MO can be considered a "psychotechnology" that ties the concept of mindfulness together with principles of psychological well-being that emerge from Henriques' "Unified Theory" (Henriques, 2011; in press). The "Unified Theory" is a broad metapsychological framework that seeks to unite into a coherent whole the disparate paradigms of psychological thought that have historically competed for dominance in the field (Henriques, 2019). Although Henriques has written several pieces on CALM-MO (e.g.,

Henriques, 2015; Henriques, 2016), no work has deeply explored the central elements of the model, nor a nuanced understanding of their interconnections and how they relate to the tool's clinical applicability both for clients and for those being trained in psychotherapy. The current work seeks to fill this gap in the literature.

Given its grounding in the Unified Theory, CALM-MO is situated in a unique position of having broad applicability with a variety of client characteristics and presentations. As such, it is a tool that may have appeal for nearly any psychological practitioner. Prior to delving into a summary of the work in which it is embedded, it is useful to briefly articulate the key elements of the tool. The MO portion refers to an individual's metacognitive observer. This refers to the shift in perspective, such that the individual shifts attention from being inside their immediate stream of thought to stepping outside and adopting a position from which they can perceive and consider their thoughts and feelings as an object of analysis. In addition, by virtue of being a "meta" perspective, the view taken is one "from above" or "beyond," with the goal of cultivating a perspective of a wiser, more thoughtful individual.

The CALM portion is an acronym that refers to the way in which a psychologically adaptive, wise, and healthy individual's MO would observe and relate to their inner experience. First, the wise view from above would be curious, meaning the attitude is one of openness and wonderment and the individual is open to understanding what is happening, what has happened to them and how their experiences are activating various parts of themselves, in addition to learning more about their drives and feelings. The "A" stands for acceptance, which refers to the capacity to be both in the world and be present with one's feelings and thoughts without rejecting or judging them as bad or

unacceptable and needing to be avoided or controlled or escaped from. The “L” calls for the person to approach their inner experience with loving compassion, in contrast with a self-critical stance that does not leave one room to be human. It also calls on them to adopt a loving compassionate attitude toward others and humanity in general. Finally, using the framework, the metacognitive stance is one that is motivated toward valued states of being in the short and long term, taking into consideration the realities of the situation and the core needs and values of the individual.

CALM-MO was developed as a tool for aiding clients and clinicians in recognizing and shifting clients’ positions along a spectrum of well-being. While CALM-MO is not itself a model of well-being, the ability to effectively adopt this stance of self-observation would likely contribute to an overall sense and state of psychological health. In addition, as we will see, the CALM-MO stance can readily be framed as the antithesis of the stance adopted by those suffering from neurotic conditions take when faced with difficult situations and negative feelings. That is, many become critical, controlling, judgmental, and blaming, getting trapped in cycles of thoughts and feelings that leave them feeling helpless and hopeless.

Having been developed from a unified metapsychology that seeks to contextualize the various paradigmatic viewpoints on human functioning and experience, CALM-MO contains elements that are likely to be familiar to clinicians from across the spectrum of theoretical orientation. At the most general level, all psychotherapies can be framed as fostering psychological mindfulness, in that they attempt to cultivate awareness of psychological dynamics and ways to shift maladaptive, reactive patterns to more reflective adaptive ones. They also pull from insights across the various major schools of

thought. For example, practitioners identifying with cognitive schools of thought would quickly recognize and be grounded in the metacognitive observer, while humanistic oriented clinicians would likely resonate with acceptance and loving self-compassion as familiar therapeutic values. This suggests that in addition to its potential clinical utility, CALM-MO may represent a bridge between clinicians training primarily under one theoretical identity and the integrative approaches enacted by more experienced clinicians (Norcross, 2005). In addition, as a specific and easily metabolized example of integrated therapeutic principles, CALM-MO may benefit beginning clinicians by providing exposure to integrated approaches in an actionable format. That is, CALM-MO could provide a "foot in the door" for principles and pathways toward integration that beginning clinicians are likely to seek as they gain more experience. In order to develop a nuanced understanding of CALM-MO, it is important to ground the tool in the context from which it emerged.

A Proposal for a Metapsychology that can Define and Unify the Field

Most fields in the natural sciences are organized to a great degree around broad theories that are generally supported by the consensus of experts in their respective fields. For example, in physics, the standard model of elementary particle physics, general relativity, and the Big Bang model ground our understanding of the material universe. Likewise, genetics, cell theory, and evolution by natural selection ground the science of biology. However, this is not the state of affairs in psychology. If one were to ask a psychologist to explain some aspect of human behavior or mental experience, the theoretical framework that would be invoked to respond will not be broadly representative of the field of psychology as a whole. Instead, it would be grounded in a

school of thought or research program that is not broadly shared. This because psychology is pre-paradigmatic, meaning that it lacks a shared set of ideas that cut across the entire field. Although every field of scientific inquiry has diversity, psychology resides in a state of "fractured pluralism" in a way that physics and biology do not (Henriques, 2011). Available approaches to human change processes and ways of conceptualizing client experience are tied to broad paradigms that have historically competed for relevance. Although they may produce internally consistent models of human behavior, none have managed to convincingly rise above the others as the go-to model of people for the field as a whole.

Henriques (2011) has developed a unified metapsychology that he argues can define and theoretically unify the field. Although a detailed exploration of the Unified Theory is beyond the scope of this project, some background is necessary to ground CALM-MO within the context from which it emerged. The Unified Theory is intended as a metapsychology that contextualizes the varying paradigmatic views, as well as their particular vantage points, within a broader conceptualization of knowledge.

The Problem of Psychotherapy

It should come as no surprise that the fractured nature of the field of psychology would produce a "problem of psychotherapy." The philosophical difficulty of reconciling the world of mind and the world of matter, disagreement regarding the epistemology of human experience and a lack of consensus on the values and mission of the field have produced competition between various paradigms of psychological thought and their application to human concerns. Each paradigm has historically claimed to hold *the* key insights for psychological health. Indeed, each does hold valuable insights; however, they

each use different language systems to describe human experience. Henriques (2011) likens this reality to the parable of the blind men and the elephant. Like the blind men, the traditional psychological paradigms are convinced that their perspectives offer a conclusive understanding of their subject, without realizing that they are all experiencing different aspects of a greater whole. Henriques' Unified Theory attempts to describe "the elephant" directly by introducing a common language system to unite the varying paradigms and their insights into human functioning.

For clinicians in training, however, the current landscape can feel daunting. Some training programs emphasize specific paradigms and approaches to client well-being, and so the theoretical underpinnings of a psychologist's training may depend on which (or which type of) program they attend. As of 2008, forty percent of practicing psychologists reported that they utilized a cognitive-behavioral orientation in practice (APA, 2009), as did the majority of teaching faculty in graduate psychology programs. The concentration of cognitive-behaviorally oriented faculty tends to be even higher among programs with a strong research focus (Heatherington et al., 2012). In addition, Norcross and colleagues (2020) found that faculty orientation predictably differed across competency focuses within doctoral psychology programs (e.g., clinical, counseling, and school psychology), with clinical programs more likely to emphasize cognitive-behavioral training and counseling psychology programs more likely to include humanistic or psychodynamic oriented faculty.

The Move Toward Integrative Therapy

How well does training primarily in single paradigms prepare beginning clinicians for what practice actually entails? As each broad theory of human behavior paints an

internally consistent but incomplete picture of human experience, so too do clinicians often find themselves searching outside of their own training models to aid them in understanding and intervening with clients (Holloway, 2003). This may help to explain why, over time, experienced clinicians are more likely to identify as integrated (Norcross, 2005), as did 14% of practicing psychologists in 2008 (APA, 2009). These practitioners wish to link, incorporate, or draw from the strengths of multiple paradigms in understanding and intervening in the lives of clients. As elaborated by Norcross (2005), several strategies for doing so have been developed: technical eclecticism, the common factors approach, assimilative integration, and theoretical integration. A brief discussion of these frames for psychotherapy integration can help situation CALM-MO in the integrationist landscape.

Among the four models of psychotherapy integration, technical eclecticism is the least theoretically bound, and is exemplified by practitioners who sample from across psychology's paradigms and approaches for intervention techniques that have been demonstrated to be efficacious for particular symptoms or presentations, without being beholden to consistency with the traditions that produced those techniques. The common factors approach de-emphasizes theoretical orientation, in this case because neither the paradigm nor the particular techniques applied from it seem to be the strongest predictors of positive client change. Instead, certain aspects common to virtually all approaches, such as the development of a strong therapeutic alliance, opportunities for catharsis, the development of new behavioral expression, and positive client experiences, seem to promote client well-being independently of their theoretical foundations (Norcross, 2005). A practitioner of the common factors model is likely to focus their energy on

building those aspects of therapeutic change that transcend theoretical boundaries, such as the quality of the relationship.

Practitioners who follow the assimilative integration route ground themselves in a particular paradigm but maintain openness to aspects of other theories that can be made congruent with their primary theoretical orientation. This model maintains more theoretical coherence than eclecticism or the common factors approach, but it allows practitioners to utilize empirically validated techniques that originated outside the practitioner's home paradigm. Models that fall under the umbrella of theoretical integration seek to harmonize two or more theoretical approaches into a single coherent framework. Unlike eclecticism, this approach to integration emphasizes treatment grounded in blended theory rather than the synthesis of techniques from their parent paradigms.

In addition to these models of psychotherapy integration, a growing movement of theorists have put forward a fifth option focused on unification of the field of psychology (Marquis, Henriques et al., 2021). Unified approaches seek to develop a broad, metatheoretical framework by drawing on the strengths and insights of each constituent theoretical paradigm. Taking a metatheoretical approach involves a more philosophical vantage point from which such foundational assumptions are themselves weighed and contextualized alongside core concepts and knowledge from varying traditions of inquiry. The metatheoretical approach can be described as "meta-modernist," in that it recognizes both the value and limitations of the empirical tradition and the post-modern critiques that developed in response to it. For example, the meta-modern perspective embraces scientific analysis while recognizing how it has contributed to an empirical "horse race"

of competing and intractable theoretical traditions within institutions such as psychology. The meta-modern perspective also seeks to contextualize systems of knowledge while cautioning against the idea that truth is merely an artifact of interpretation based on human power dynamics (Marquis et al., 2021).

Unlike theoretical integration, unification is not an attempt to reconcile aspects of particular theories, but rather to contextualize their varying perspectives and explore how they inter-relate. Unified approaches attempt to do so with the assumption that each theoretical tradition has developed a particular viewpoint of an extant overarching truth of human experience. The clinical applications of each theoretical tradition are therefore inherently limited by the frame of reference from which they view human behavior and change processes. The pathway to unification posits that each of these traditions offer the benefits of their particular frame of reference in approaching human well-being, they also tend not to have access to the fundamental insights of other perspectives because that same frame of reference offers no means of contextualizing those insights (Marquis, et al, 2022).

However, a unified approach to psychotherapy that grounds each perspective in a broader metatheoretical framework can metabolize the insights offered from each perspective because it is not limited by the epistemic boundaries that the specific schools operate from in conceptualizing human functioning. One such approach to unification of psychology and psychotherapy is Henriques' (2011) Unified Theory, from which CALM-MO arises.

Chapter 2: The Unified Theory and its Model of Socio-Emotional Functioning

Henriques' Unified Theory (2011) attempts to ground the field of psychology within a larger philosophical context, reconcile psychology's major theoretical traditions, and develop coherent and applicable views on well-being and the change process for practitioners. In 2020, Henriques updated the continued growth of his metapsychology, characterizing it as a "Unified Theory of Knowledge," which will be referred to here as the Unified Theory. It consists of eight "key" ideas that Henriques argues provides a coherent unified theory of psychological science and a unified approach to the practice of psychotherapy.

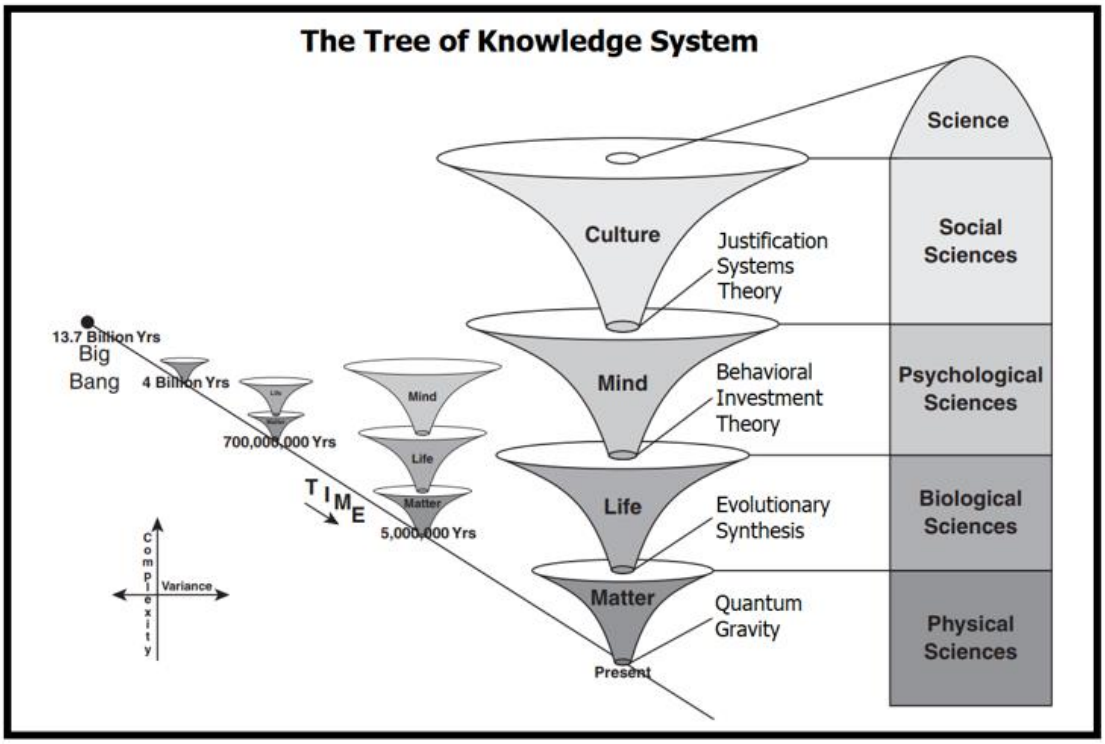

Figure 1. Tree of Knowledge System. From Henriques, 2011

The first key idea is the Tree of Knowledge System (Figure 1). It provides a new map of big history organizes both reality and our scientific knowledge of it into four planes of existence (i.e., Matter, Life, Mind, and Culture). Each plane emerges as a new

level of complexity of behavior expressed by four corresponding kinds of entities (i.e., objects, organisms, animals, and people). The behavior patterns they exhibit are then mapped to four domains of scientific understanding (i.e., physical, biological, psychological, and social). The second key idea is Justification Systems Theory (JUST), which is a theory of how the evolution of language created the problem of justification which in turn shaped both the nature of human self-consciousness and gave rise to the Culture Person plane of existence. In so doing, it provides a model of human consciousness that updates Freud's model of how the human ego is positioned to manage the tensions between the primate id and social world of justifiable action and influence.

The third key idea, Behavioral Investment Theory (BIT), is an economic model of the energy investment of living systems that arises from modern cognitive science and evolutionary theory. BIT posits that nervous systems function to maximize returns on behavioral investment by modeling the relationship between an animal and its environment.

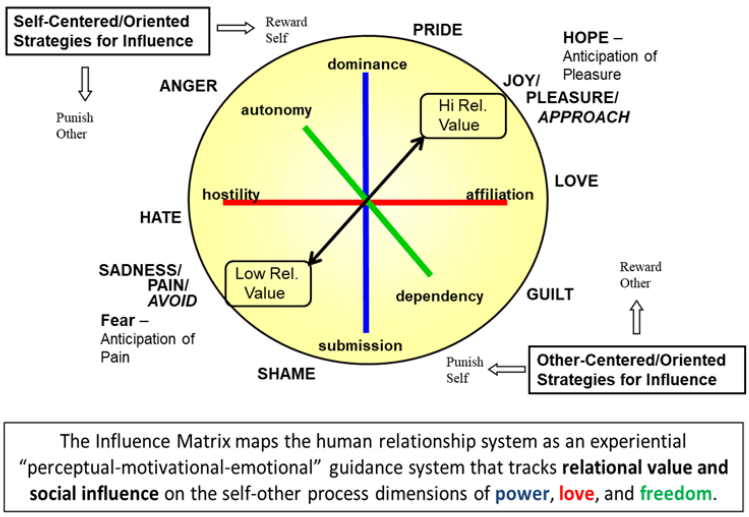

Figure 2. The Influence Matrix. From Henriques, 2011

The Influence Matrix (Figure 2), the fourth key idea, is a theory of human relational systems that synthesizes attachment theory and Leary's interpersonal circumplex. It offers a map of social influence dynamics based on evolutionarily developed interpersonal needs. Together, the first four key ideas make up the unified theory of psychology, a model of human functioning, behavior, and experience.

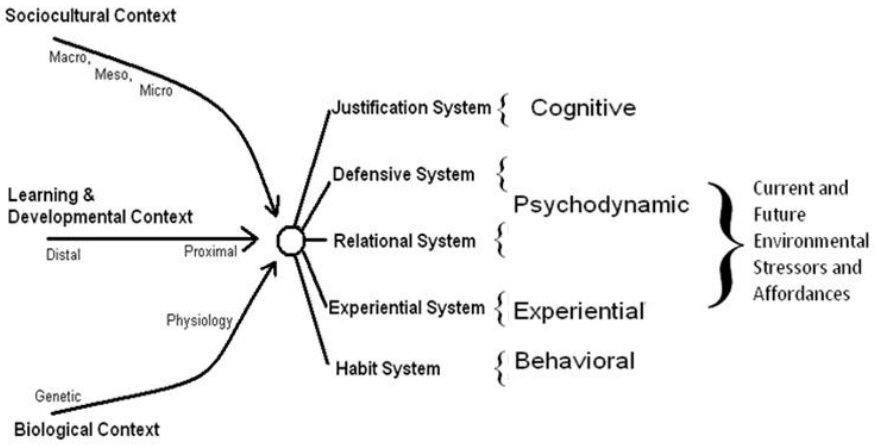

Figure 3. The Character Adaptation Systems Theory. From Henriques, 2011

Henriques developed the unified theory of psychology to provide a metatheoretical synthesis that could coherently ground the professional practice of psychology. Toward that end, he developed four key ideas that form a "unified approach" to psychotherapy through framing adaptive change processes, development, and well-being.

The fifth key idea is Character Adaptation Systems Theory (CAST, Figure 3), which links psychotherapy to current models of personality. It does so by dividing psychological adjustment processes into five domains of character adaptation: 1) a habit system, which corresponds to behavioral forms of therapy; 2) an experiential system that corresponds to emotion-focused therapy3) a relational system that relates to attachment and interpersonal processes; 4) a defensive system that correspond to psychodynamic

approaches; and a justification system that corresponds to the focus of cognitive and narrative approaches to psychotherapy. Building from CAST to elucidate specific domains of character development, the sixth key idea, the Wheel of Development, distinguishes 1) five major dispositional traits, 2) identity or self-concept, 3) one's values and moral beliefs, 4) abilities and aptitudes, and 5) an individual's particular challenges, including pathology. The seventh key idea defines human well-being such that the systems of knowledge described by the Unified Theory might be applied through endeavors such as psychological intervention while being ethically grounded.

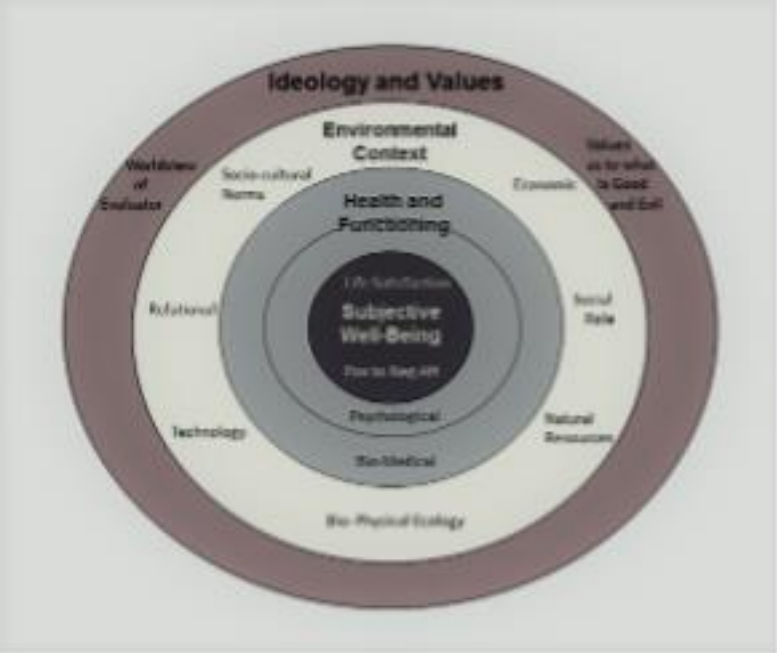

Figure 4. The Nested Model of Well-Being. From Henriques (2011)

The Nested Model of Well-Being (Figure 4) describes four domains: 1) subjective experience, 2) biological and psychological functioning, 3) social and material contexts and needs, and 4) the values of the individual who is "doing the experiencing." The Nested Model emphasizes alignment between these four domains in conceptualizing well-being.

CALM-MO is the eighth key idea, and it was developed by Henriques in part to elaborate on a concept introduced by Dan Siegel, who developed Interpersonal Neurobiology. Interpersonal neurobiology is an interdisciplinary framework for conceptualizing human growth and functioning that unites cognitive science, neurobiology, and relational psychology to describe how relational experience impacts brain development, which then goes on to further influence relational experience. The concept, dubbed COAL by Siegel, describes a process of mindful awareness that provides space for nonjudgmental observation. This process involves curiosity, openness, acceptance, and love. CALM-MO further develops and elaborates on this concept and contextualizes it within the Unified Theory. To fully grasp CALM-MO and its role in cultivating psychological well-being, it is necessary to place it in the larger context provided by the Unified Theory. Although a detailed description of the Unified Theory is beyond the scope of this work, there are some elements that are essential to highlight. Toward that end, a greater elaboration on the Updated Tripartite Model of human consciousness, which arises out of JUST, and the Influence Matrix will be given. These elements set the stage for understanding the common problems that people encounter in adapting to psychological stressors, which CALM-MO seeks to address.

The Updated Tripartite Model of Human Consciousness

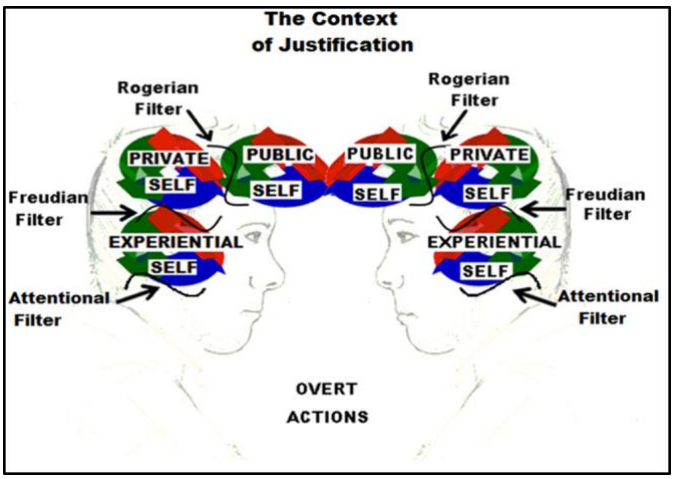

Figure 5. The Updated Tripartite Model of Human Consciousness. From Henriques, 2011

The Updated Tripartite Model is so named because of its structural similarity to Freud's famous model of the id, ego, and superego. As depicted in Figure 5, the *experiential self* refers to phenomenological consciousness, the first-person experience of being. This domain includes sensations and perceptions, motivational drives, and feelings and emotions, all woven together to form an experienced and embodied gestalt. The experiential self overlaps conceptually with Freud's conception of the id, in the sense that both can be framed as representing the seat of human-animal consciousness. However, the two are not synonymous in that Henriques' experiential self is grounded in modern work on primate behavior and conscious experience, rather than Freud's core focus on a hydraulic model of energy release. The second domain, the *private self* or *ego*, is a self-oriented and interpreting position that engages in reflective self-awareness. Grounded in language, the private self contributes to experiential continuity by narrating the what, how, and why of experience. In doing so, the private self translates the experience of being in the world into narrative form, which then feeds back into the experiential self via image and affective implication. Henriques (2011) suggests that this is one of the major structures differentiating human consciousness from that of other animals, mainly due to

the evolutionary pressures surrounding the development and functions of language and the problem of justification. Henriques describes the private self as the mental organ of justification to emphasize that the private narrator operates via propositional networks to develop and maintain justified states of being. The third domain of self-consciousness, the *public self* or *persona*, is engaged in the intentional communication of inner experience to others. This also often involves the projection or performance of desired states of experience, such as when one seeks to appear calm to others despite the felt experience of anxiety or stress.

The interactions between these domains of consciousness and their operation in relational and cultural contexts are governed by three filtering processes. The *attentional filter* refers to the process of selecting particular stimuli for conscious awareness out of the vast amount of experiential data collected by the brain. Consider, for example, how one is normally unaware of the clothes against one's skin, until attention is brought to bear on those sensations. The *Freudian filter* works, as its name would suggest, through inhibition, avoidance, or repression of experiential stimuli that would be disruptive or dysregulating. Regulating the relationship between the self-conscious private self and the experiential self, the Freudian filter is tasked with maintaining homeostatic continuity between reflective awareness and what is experienced, especially when what is experienced is incompatible with the status quo of the system. Finally, the *Rogerian filter* governs the interaction between the private and public selves based on expectations of social and relational consequences. Each filter is developmentally sensitive; for example, certain types of relational injuries might lead the Rogerian filter to be more

discriminating of inner experiences which, if shared, may lead to further injuries that would dysregulate the system.

The Influence Matrix

The Influence Matrix (Figure 2) is a relational model that emerges from Behavioral Investment Theory (BIT). BIT is a metatheoretical formulation for animal behavior that describes the process of allocating energy toward particular goals and weighing the returns of those transactions toward further investment in such goal-directed behavior. In extending Behavioral Investment into the realm of social motivation, Henriques (2011) developed the Influence Matrix, which functions to bridge Bowlby's Attachment Theory and Leary's Interpersonal Circumplex model into an integrative map of the human relationship system. A basic assumption of the matrix, reflecting both psychodynamic and humanistic psychological principles, is that among the most fundamental needs of humans are a sense of relational value and social influence. High relational value corresponds to the experience of being seen, known, and valued by important others, while social influence involves the ability to impact the behavior of others based on one's own interests. The Influence Matrix posits that humans have in-born schematic templates for the recognition of particular social dynamics, specifically being known and valued and their opposites (e.g., rejection and abandonment).

The Matrix maps human social exchange via three process dimensions, which reflect the "how" of relational transactions. The *power* dimension deals competitive and rank processes and is marked via the poles of dominance and submission. The power dimension relates to both status expectations of participating individuals (e.g., cultural, role) and expressions or assertions of power within an interaction. The *love* dimension

reflects a spectrum of interpersonal alignment ranging from affiliation, in which individuals are motivated come together, to hostility, in which individuals seek to expel or change each other based on some unacceptable difference. The *freedom* dimension reflects a spectrum of relational involvement and social exchange and is marked by the poles of autonomy and dependency. Each of these process dimensions provides implications for self-other relations as transactions occur.

The Influence Matrix recognizes an evolutionarily functionalist view of human emotion as it relates to social exchanges. Emotions are conceived of as energized motivational states that orient the individual toward particular patterns of incoming information relative to goal states. In the context of the relational world, the experience of relational value and desired social influence result in positive emotions, while negative emotions are evoked by losses (or the threat of loss) in relational value and social influence. Of course, depending on how individuals have adapted to maximize their relational value and social influence, competing desires and seemingly paradoxical or confusing emotions may arise from the expression of the above dimensions. This suggests that one correlate of relational and emotional health is the ability to recognize one's needs and valued outcomes in the moment.

The Processing of Emotions and the Emergence of Neurotic Loops

Both the Updated Tripartite Model and the Influence Matrix suggest that there are more and less adaptive ways of relating to the self and of making sense of one's experience. CALM-MO was therefore developed as an integrated approach to psychological mindfulness, whose use might increase an individual's agency by helping to orient them toward valued outcomes. Such an approach to mindfulness validates the

essential necessity of emotions as markers of movement toward or away from relational value and social influence. It also addresses how the varying elements of consciousness often interact to produce deleterious results. One such example that is likely to be familiar to clinicians is the vicious cycle of reacting negatively to negative feelings sparked by negative situations. That is, clients will encounter situations or ideas that are unwanted and begin to experience the concomitant negative feelings that track the implications of these events. The paired negative situation and negative feelings then provoke a negative secondary reaction, often involving avoidance, blame, or misguided efforts to control. As a pathway to psychological mindfulness, CALM-MO seeks to break this and similar cycles of reactivity by cultivating a particular kind of attitude toward negative feelings that arise as a function of negative events or ideas.

Although the brain works hard to construct a single continuous thread of experience, the Unified Theory (and others, see Kahneman, 2011) suggests two continuously interacting processes interwoven into that experience. The first, more "primitive" process includes basic drives (e.g. hunger) and emotions that orient the system relative to goals. Emotions also function to propel us to either approach "good" things or avoid and withdraw from "bad" things, based on ingrained, evolutionarily derived preferences as well as on experiential learning, which often takes place outside of our awareness. This "primary" process is immediate, involuntary, and automatic. Broadly speaking, this system of primary processes overlaps with the experiential self in the Updated Tripartite model and corresponds with our primate mode of being in the world.

The second system of processes involves reflective awareness of experience and is slower to emerge and unfold. Capable of deliberation, one of the functions of this

"secondary" process is to evaluate what *is* in relation to what *ought to be*. Because of the differences in their timing, the secondary process can and does react to the products of the first, and in some circumstances acts as an inhibitory control on the more reactive primary process. This is essential because the drives and needs expressed through the primary process are not necessarily advisable in the context of an individual's current situation. This system of processes corresponds to the ego, and it is consistent with Freud's conception of secondary egoic processes functioning much like a rider on top of a horse (i.e., the primary process functions).

In addition to the ego evaluating negative feelings, the Updated Tripartite Model also highlights the role of the persona and the fact that individuals tend to evaluate how they feel and their potential reactions via the potentially judgmental perspective of others. Thus, whereas the ego position might be expressed by asking "Why am I feeling this?," the persona is managing questions such as, "How are other people going to view me if I show this feeling to them?" When these dynamics are aligned with the Influence Matrix, we can better understand how a person develops impressions about what ought to be, especially in relation to their internal states. In seeking connection and interpersonal value, individuals fine-tune their motivational emotion states through learning what does and does not lead to relational value and social influence. This process is especially evident and impactful in early social development (i.e., attachment).

As will be made clear, the picture of human psychology presented by UTOK is such that emotions play a key role in shaping the psychological system and need to be coherently integrated into the individual's modes of being in the world if they are to function optimally. This means that, when experienced, feelings are attended to with

attunement and acceptance, and then adaptively regulated to meet one's goals. However, what often happens is that negative feelings are seen as being problematic. The secondary processes, positioned from either the ego or self-conscious persona, may work to close off awareness to avoid the feeling or its implication, reject the feeling as invalid, or leverage self-judgement for experiencing it. Because the primary process' expression of needs remaining unmet, a feedback loop forms based on the lack of attunement between the two processes. Suppressed rather than regulated, these emotional signals cannot be integrated toward the valued states to which they would otherwise orient the individual.

As an example, imagine a client who seeks counseling for interpersonal insecurity that impacts her intimate relationships. Exploration of her developmental environment reveals that one of her parents reacted negatively to most attempts by the client to seek help in fulfilling her needs (e.g., for affection, safety, and care). The client quickly learned to regulate her needs-seeking in order to preserve her relationship with her parent (i.e., her persona molded to her perception of the parent's desires). In adult relationships the client continues to over-regulate emotions that would orient her toward her needs, often through self-judgement and criticism as though she ought not to have needs or feel unsatisfied when they aren't met. Her needs, remaining unaddressed, only announce themselves to her more strongly. These neurotic loops of negative situations resulting in negative feelings that are then reacted in an unproductive way are at the heart of the internalizing conditions (i.e., depression, anxiety, low self-esteem and relational conflicts). CALM-MO is situated as a generalized tool to help identify and adaptively reverse these cycles.

Chapter 3: A Brief Summary of CALM-MO

The ability to inhibit urges or feelings being essential to successfully navigating the world, one would not maximize well-being by simply ceasing to do so; we would describe such a state of being carried away by feelings as under-regulation. However, the neurotic loop described above suggests that our emotions can also be over-regulated; emotions are crucial markers that are tuned toward the fulfillment of one's needs. Instead of either extreme, the Unified Theory implies the need for the ability to balance between awareness and attunement on one side, and adaptive regulation on the other. Effectively maintaining this balance is associated with more optimal functioning. This is called the "emotional sweet spot" (Henriques, 2015) and it is a key aspect of adaptive psychological functioning. The emotional sweet spot is not a fixed-point; instead, balancing the processes of awareness and attunement and adaptive regulation requires responsiveness to the particular person in a particular context. CALM-MO can be framed as a principle-based process for finding and homeostatically maintaining the emotional sweet spot.

As was discussed briefly above, the MO portion of CALM-MO stands for Metacognitive Observer, a way of orienting the self to facilitate the exploration of one's experience. Henriques (2011) describes it as a "participant-observer" stance that would likely seem familiar to practitioners well-versed in cognitive-behavioral frames of intervention. In fact, this stance is one of the elements that is routinely modeled within psychotherapy to help generalize the exploration of experience from the therapy room to a client's everyday life. This reorientation of the self-consciousness system takes practice to internalize, and Henriques suggests that this practice take place in relatively low stress environments until automaticity allows it to activate in more stressful circumstances.

Eventually this stance of exploring the self becomes a characteristic response to negative feelings, becoming an individual's *modus operandi*.

If the MO describes *what* an individual might do in order to allow for the exploration of their experience, CALM describes *how* this would most adaptively be done, or the attitude of the metacognitive observer. Curiosity involves active seeking of authentic understanding, usually in the form of questioning that is unencumbered by judgement. Judgement and self-criticism would function to limit the scope of any otherwise curious exploration. It is important to note that this is an aspect of self-approach that is especially susceptible to systems of defense as described by psychodynamic-oriented practitioners. Acceptance describes a state of openness to whatever one's curiosity might unearth. As conceptualized by Henriques, acceptance involves experiencing whatever comes without resistance or avoidance, emphasizing the development of distress tolerance and the capacity to remain healthily detached from preferred versions of reality. Loving compassion reflects a recognition of humanistic value for the basic dignity of people, and would ideally be as present in relation to the self as it is in our most valued relationships to others. Finally, motivation toward valued states of being reflects an individual's guiding principles and goals as well as their ability to muster energy toward seeking them. It is evident in explorative questions such as "Where do you want to be and how do you want to see yourself after this decision?"

However, in order to maximize both its clinical utility and potential to aid in the growth of beginning clinicians, CALM-MO requires more nuanced elaboration than is currently available. The elements of CALM-MO (e.g., curiosity, acceptance) are represented in the literature by the theoretical perspectives that unified approaches seek to

contextualize into a coherent whole. As such, varying definitions of each element exist that are theoretically bound and may be difficult to translate between practitioners of different theoretical identities. As a tool of unified psychotherapy, the elements are in need of specific, trans-theoretical definitions that would allow researchers, practitioners, and clients to engage with them in meaningful ways. Researchers may benefit from new ways of measuring the expression of curiosity or acceptance. Practitioners could more easily identify, track, and intervene with clients' expressions of self-compassion in clinical settings. Clients are likely to benefit from exploration and communication of valued states of being that is contextualized within an easily graspable correlate of psychological health. Such definitions may also allow for the development of more specific assessment tools and techniques centered around CALM-MO.

Additionally, exploration of the interactions between the elements of CALM-MO is required to understand its utility. What does it mean to be curious but not accepting of what that curiosity reveals, or to seek valued growth without self-compassion? Further exploration of these issues may begin to reveal *how* clinicians can best pursue the integrative principles underpinning CALM-MO.

Chapter 4: The Metacognitive Observer: Mindful Metacognition

While metacognition and mindfulness are distinct concepts, they are intimately interrelated in the application of CALM-MO. As described previously, mindfulness involves the active and intentional engagement of awareness to current experience. While meditative forms of mindfulness emphasize attending to embodied experience, "psychological mindfulness" as defined here is an inherently metacognitive process, engaging executive inhibition and attentional control to produce insight-based reflective awareness of unfolding experience. Such reflection is at least partly based in linguistic thought, allowing an individual to represent and communicate aspects of their inner experience to others. Psychological mindfulness therefore has greater clinical utility in forms of therapy that are grounded in interpersonal interaction.

One proposal for the mechanism behind the therapeutic effects of mindfulness, dubbed "reperceiving" by Shapiro (2006), involves a shift in perspective producing a metacognitive state Shapiro called the "observing self" that closely resembles the Metacognitive Observer. Re-perceiving involves de-identifying with the content of awareness and re-engaging with a focus on awareness itself. This perceptual shift allows an individual to monitor their own internal processes as internal stimuli are encountered, without necessarily severing them from the subjectivity of their experience. This is the intended perspective of the MO: connected to but not framed from within internal events, and therefore able to contextualize current experience without being swept away by reactivity to it. To understand the stance, function, and engagement of the Metacognitive Observer, the next sections will first review metacognition and associated therapeutic approaches before turning to mindfulness and its clinical applications. The final section

will lay out how the insights produced by these therapeutic traditions can be applied to the development and engagement of the Metacognitive Observer.

Metacognition

Metacognitive process lies at the core of CALM-MO, with curiosity, acceptance, loving self-compassion, and motivation each representing adaptive and growth-oriented attitudes of the metacognitive observer. Commonly described as "thinking about thinking," metacognition is a complex set of interconnected processes that we utilize when we assume a "virtual observer" stance to notice or attend to our experience. In doing so, metacognition samples from each sphere of experience to which we have access, including embodied, emotional, and cognitive processes. Metacognition operates on experience that is emerging in the moment, as well as on a larger sense of self (Lysaker et al., 2019). Because metacognition involves a top-down regulation of information as well as inhibitory control, the prefrontal cortex is heavily implicated in metacognitive process (Jankowski & Holas, 2014).

Several constructs have been identified as integral to enacting and maintaining metacognition. The first is "decentering," which is the process of shifting one's experiential perspective onto the experience itself (Bernstein, Hadash, Lichtash, Tanay, Shepherd, & Fresco, 2015). Bernstein and colleagues argue that decentering represents a core mental phenomenon that underpins, and in some cases is virtually synonymous with, many of the constructs central to metacognitively-oriented therapeutic models (e.g., cognitive defusion in ACT, cognitive distancing in CBT). Metacognitive awareness, in contrast, describes the perception of mental content (e.g., thoughts, emotions) as mental

events, rather than as the things those mental events represent (Dunne, Thompson, & Schooler, 2019).

The literature on metacognitive awareness suggests that it is comprised of two major components: knowledge of cognition, or an individual's understanding of their own cognitive processes, and regulation of cognition, which refers to an individual's efforts to monitor and control those processes (Shaw & Sperling-Dennison, 1994). A third proposed component, self-evaluation, has more recently been characterized as a mediating variable between knowledge and regulation (Kallio, Verta, & Kallio, 2018). Self-evaluation involves an individual's perception of self-directed progress toward a reference goal or objective. Importantly, both decentering and metacognitive awareness are involved in many models of mindfulness; indeed, metacognitive awareness is responsive to mindfulness-based training and can reduce the risk of depressive relapse (Teasdale, Moore, Hayhurst, Pope, Williams, & Segal, 2002).

There are several potentially therapeutic benefits of engaging in metacognitive process. Metacognition places an individual's immediate experience of the moment within a larger context. Such contexts include identity (e.g., I have experienced failure, but it is not a self-defining attribute) and time (e.g., I am in pain now, but this will not always be so). Metacognitive process also has the effect of placing time between a stimulus and a response, which is especially useful in social contexts where one's immediate inclination may not always be beneficial to enact. Engaging in metacognitive process may, for example, allow a few seconds to dull the motivating impact of fear or anger to make room for other types of responses, even when this is not the focus of that metacognitive process (e.g., when simply noticing and acknowledging the emotions and

resulting thoughts). Metacognitive process may further reduce reactivity through intentional, goal-directed strategies designed to monitor and weigh the varying influences of behavior. In the context of CALM-MO, this means that metacognitive process provides an opportunity to shift from "mindless reactivity" to "mindful responsivity" through engagement of the Metacognitive Observer, even absent the growth-orienting attitudes of curiosity, acceptance, loving self-compassion, and motivation that the MO would ideally reflect.

Metacognition is therefore a potential strategy of increasing an individual's agency in responding to the world, especially as relates to the responding individual's values and goals. Placing one's immediate experience into a larger continuum not only dulls the impact of emotional motivators, making room for other possible responses, it subsequently allows an individual to evaluate their current experience with regard to their values, goals, and sense of self. In addition, while attending to one's own first-person experience, it may be the case that one's ability to take into consideration the experiences and processes of others is strengthened. This would aid in navigating social spheres, as well as in constructing and maintaining a sense of how the self fits into social contexts. In therapeutic contexts, the effortful engagement of metacognitive process is often encouraged when cycles of reactivity (such as that discussed above) limit an individual to less adaptive ways of feeling, thinking, and behaving. Consistently applied and coupled with desired outcomes, this effort can give way to automaticity, and generalize to new situations to the benefit of a client's functioning.

Metacognitive Therapies

The common thread of metacognitive-based therapies is a focus on active engagement with thought content and process. They distinguish experience from reality, and encourage clients to recognize, evaluate, and change cognitive processes that promote or enable the same kinds of "mindless reactivity" that CALM-MO was developed to target. However, unlike CALM-MO, most metacognitive-based therapies narrow their focus to an individual's thoughts and beliefs (specifically, thoughts and beliefs about thoughts and beliefs), and do not portray emotional and embodied experience as having the same degree of influence on behavioral outcome.

Metacognitive Therapy (MCT) is theoretically grounded in the self-regulatory executive function model developed by Wells and Matthews (1994, 1996). This model posits that an individual's beliefs about thoughts, emotions, and behavior can incite and maintain various psychological disorders through a perseverative thinking style (Wells, 2008). Dubbed the Cognitive Attentional Syndrome (CAS), this thinking style involves dysfunctional strategies for managing distressing thoughts, feelings, and behavior. Resulting metacognitive beliefs may include that worry is uncontrollable, that thoughts and behavior must be tightly controlled, or that individuals cannot be confident in their cognitive processes.

According to Wells (2005), the CAS biases low-level automated processing and focuses attention on potential threats while failing to provide opportunities to correct erroneous perceptions or beliefs. MCT's focus on styles of metacognition differentiates it from more traditional Cognitive Behavioral Therapy (CBT)'s focus on thought content and draws comparison to the Metacognitive Observer's CALM orientation. Like CALM-MO, MCT focuses on disrupting feedback loops in which individuals' reactions to their

own cognitive process lead to dysregulation and distress. However, MCT does not prioritize the contextualization of internal process and behavior within an individual's values system, nor does it emphasize psychological acceptance of those processes. While these aspects point to CALM-MO's Buddhist influences, MCT's roots in CBT are apparent in its narrower focus on cognition and its foundations in empiricism, relying on hypothesis and reality testing to provoke shifts in meta-beliefs.

In practice, MCT, like CBT, utilizes a skills and practice-based approach, often assigning homework to aid clients in generalizing gains and forming habits of adaptive metacognitive styles. A similar focus on hypothesis-testing contributes to de-centering and draws out the metacognitive perspective in clients. However, an examination of MCT's techniques reveals its theoretical differences from more traditional CBT. Recall that the purpose of MCT techniques is to disrupt the Cognitive Attentional Syndrome (CAS), a set of inflexible styles of metacognition that impact cognitive content and attention.

The *attention training technique* involves actively focusing on auditory stimuli that varies in volume and directionality, and is practiced in three phases, usually during each session of an 8-12 session MCT regimen (Knowles, Foden, El-Deredy, & Wells, 2016). The first phase involves practicing selective attention by focusing on individual sounds while filtering out distraction. The second phase requires an individual to rapidly switch attention between different sounds in different directions. The final phase involves intentional division of attention to multiple simultaneous sounds in different directions. In performing these actions, individuals are instructed to focus on the task at hand, treating internal events (e.g., thoughts, feelings) as additional sources of "noise" to be filtered by

attentional processes. The resulting development of attentional control skills provide an individual with new resources for intentionally disrupting the otherwise automated metacognitive beliefs of the CAS, and serves as a foundation for other, more complex metacognitive interventions.

A number of such techniques build off of increased attentional control to develop a skill called *detached mindfulness,* which involves disengaged observation of one's experience. According to Wells (2005), this is particularly useful in targeting anxious thought process. To develop this skill, the therapist aids a client in noticing a thought that would usually trigger a cascading worry process. However, rather than engaging with the thought to analyze its truth value as in CBT, the client is encouraged to identify the thought as a discrete cognitive experience and choose not to engage with it. Imagery and metaphor may be helpful in this endeavor, with one example comparing the brain to a busy station, with thoughts and feelings as trains passing through that can either be boarded or watched as if by a bystander. *Free association tasks* can also be utilized to encourage passive observation of internal events when verbally cued. *Prescriptive mind-wandering,* in which an individual is instructed to relinquish control of their thoughts and allow the mind to wander freely, is particularly useful when individuals display excessive efforts at mental control. According to Wells, such control can serve as a form of cognitive-emotional avoidance.

The theoretical foundations of MCT can be observed in its therapeutic techniques. Like CBT, it is deeply rooted in classical behavioral theory. However, while CBT seeks to decrease the frequency of anxious thoughts by examining how realistic they are and therefore changing the associated emotional reaction, MCT's emphasis on disengaged

observation of internal experience seeks to promote change in metacognitive beliefs such as “worry is uncontrollable” by providing behavioral counterevidence that can serve to disrupt the Cognitive Attentional Syndrome.

Metacognitive therapy appears to be a highly efficacious treatment modality for a variety of psychological disorders, with the strongest evidence in support of its use with anxiety and depression. In a systematic review, Normann and Morina (2018) found large effect sizes in comparison to wait-list controls, while Callesen, Reeves, Heal, and Wells (2020) reported the results of a randomized single-blind trial that found MCT to be superior to CBT for depression. Similarly, Solanto and colleagues (2010) found metacognitive therapy to be significantly more effective in the severity of adult ADHD symptoms than did supportive therapy, and Wells and Sembi (2004) demonstrated its efficacy in reducing symptoms of posttraumatic stress disorder. Elements of metacognitive therapy have also been adapted to target deficits present in individuals with schizophrenia (Lysaker et al., 2019), though more research is needed to determine its broader efficacy with this population.

Mindfulness

Mindfulness is a concept that is thousands of years old and was until recently constrained to philosophical and religious contexts. Its inclusion into counseling and clinical psychology was relatively recent. As a result of its rich history, there are many things that could be meant by the term “mindfulness.” The Unified Theory is concerned with “psychological” mindfulness, as distinguished from “meditative” mindfulness in the context of CALM-MO and its implications for adaptive human functioning.

Meditative mindfulness is explicitly focused on the phenomenology of being. This form of mindfulness emphasizes the mind's "witnessing function," (Henriques, 2020) the process of bringing current experience into conscious awareness. The goal of meditative mindfulness is often to experience more fully, and to establish a sense of acceptance of that experience. It is phenomenological in that it focuses on the embodied and the felt, often pairing control of perceptual attention with detachment from goals, values, and other similar constructs.

While psychological mindfulness also makes use of embodied and phenomenological experience, it is entered through the ego or the "justifying mind," an individual's language-based and self-conscious internal narrator. Through this socially developed human capacity, phenomenological experienced is contextualized in a justification framework that constructs the meanings of that experience and its relationship to what is known about reality as well as to an individual's values. While meditative mindfulness might result in identification of an emotion's physiological signs and nonjudgmental acceptance of the presence of that emotion, psychological mindfulness would go on to ask what an individual's emotion might tell them about what is happening in reality and how they developed to feel and respond to that emotion, and to contextualize this information within that individual's past and present values and goals. The grounding of psychological mindfulness in the justifying mind provides a framework for both fully experiencing and for sharing that experience in a social context.

Mindfulness-based therapies follow one of two major theoretical threads: that introduced by Kabat-Zinn (1982) and that proposed by Self Determination Theory (SDT, Brown & Ryan, 2003). While a thorough review of the history of mindfulness principles

and their incorporation into psychotherapy is not within the scope of this work, a brief delineation between the two above schools of thought is useful to place the psychological mindfulness underpinning CALM-MO within the broader theoretical context.

Within the context of SDT, mindfulness refers to "open or receptive awareness" (Brown & Ryan, 2003), and is not necessarily an intentional or conscious process. Instead, the presence of mindfulness is a natural consequence of individual differences in interaction with conditions favorable to mindful process. Kabat-Zinn (1982), however, characterized mindfulness not as a natural state but as an inherently intentional and effortful skill, responsive to the effects of guidance and practice. It is Kabat-Zinn's conceptualization with which CALM-MO most closely aligns, adding insights from behavioral theory and neuropsychology to envision psychological mindfulness as a skill that can be practiced with the goal of generalizing to automaticity across situations and environments.

As previously described, not all mindfulness is psychological mindfulness, and some therapeutic applications focus on the contributions of phenomenological perception on experience, rather than insight-based reflection. Additionally, some approaches to psychological mindfulness emphasize detachment from subjective experience (e.g., negative thoughts or feelings). In more extreme cases this may come in the form of rejecting the very notion of wants or desires as undesirable attachments, which could potentially divorce an individual from ethics and morality. Other versions of detachment seek to reject attachments to certainty and other potentially rigid concepts. As will be discussed in more detail later, CALM-MO emphasizes metacognitive awareness, or the perception of mental content as an observed experience of the self, in order to promote

striving for acceptance of that psychological experience and its integration and contextualization within individual and socio-cultural values. CALM-MO is therefore incompatible with more extreme concepts of detachment, and is influenced by those emphasizing flexibility and tolerance of experience.

Mindfulness-Based Therapies

Mindfulness-Based Therapy (MBT) and adapted derivatives like Mindfulness-Based Cognitive Therapy (MBCT) and Mindfulness-Based Stress Reduction (MBSR) have been developed not only to target acute symptoms of disorders such as depression and anxiety, but also as relapse prevention strategies to be used in conjunction with other therapeutic approaches (Teasdale, Moore, Hayhurst, Pope, Williams, & Segal, 2002). Like CALM-MO, MBT aims to promote reflective, rather than reflexive, responses to stress. A present-centered focus attempts to separate an individual from forms of anxious distress that most often involve a past or future-oriented perspective. However, such thoughts are not usually explicitly challenged in MBT; instead, attention is directed to the present moment in all its intensity and variation (e.g., physiological, psychological, emotional experience) to eliminate the availability of cognitive resources for less adaptive, past-and-future oriented strategies.

MBT techniques are selected to promote awareness and detached acceptance of present experience (Germer, 2005). Breathing exercises aid in calming the autonomic nervous system while providing an intentional physiological process to which an individual can attend in the moment. Visualization exercises aid individuals in connecting to valued goals and to explore potential outcomes, as well as providing a virtual space

that may elicit different responses than an individual's physical environment. Sensory stimuli are often provided as targets of mindful experience.

Available research suggests that various forms of MBT do promote and help to maintain therapeutic change in clinical populations. In a meta-analysis of over 200 studies, Khoury and colleagues (2013) found that MBT was more effective than psychoeducation, supportive therapy, relaxation, and art therapy in reducing symptoms of psychological disorder. They concluded that MBT was comparable to CBT in the effect sizes it produced post-intervention and at follow-up, but had a significantly better attrition rate, suggesting advantages in treatment engagement. Across available research, MBT appears more effective in treating anxiety and depression than other psychological disorders (Hoffman, Sawyer, Witt, & Oh, 2010).

Integrated Therapies

Several treatment modalities have been developed that blend metacognitive and mindfulness-based therapeutic theory and techniques. Two that will be reviewed here for their implications regarding the Metacognitive Observer are Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT). More thorough descriptions of each modality and their theoretical foundations can be found in Heard & Linehan (1994) and Hayes (2006).

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) was developed in the 1980s by Marsha Linehan in order to target treatment-resistant Borderline Personality Disorder and associated self-harm and chronic suicidality. It adds emphases on distress tolerance, mindful awareness, and acceptance to traditional cognitive-behavioral elements such as

emotion regulation and reality testing. The therapeutic regimen generally includes four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

DBT is based upon a biosocial model which posits a human spectrum of emotional sensitivity, an inborn trait that for people high on this spectrum, produces universally more intense emotional experiences which can be either positive or negative. This model hypothesizes that high emotional sensitivity produces dysfunction (e.g., pervasive emotional dysregulation) through interaction with invalidating developmental environments, such as familial and social circumstances in which individuals' high experiential sensitivity leads to them being rejected or punished by others. Thus, the social context provides the medium for reinforcement of less healthy emotion regulation strategies.

DBT's first module focuses on mindfulness in the meditative sense, seeking to incorporate aspects of traditional spiritually-based contemplative practice without explicitly religious concepts or meaning. DBT utilizes mindfulness techniques that emphasize awareness of the present moment, including physiological sensation and emotional experience, as well as what is termed "radical acceptance," or experiencing without judgement. The mindfulness module's main goal is the development of six specific skills which contribute to a "wise mind," or one that non-reactively responds to stimuli by effectively synthesizing the "rational mind" and the "emotional mind." Each of the six skills builds upon the last in terms of complexity. The first two, Observe and Describe, are most directly related to meditative mindfulness, and allow an individual to attend to and acknowledge current experience, respectively. The third, Participate,

emphasizes active engagement with current experience. These three skills represent the actions to be taken by a wise mind. The next three skills represent how these actions are to be taken. Non-judgement refers to the process of perceiving and allowing experience to simply *be*, without imbuing it with negative or positive value. One-mindfulness involves attending fully to the present moment and focusing on one task at a time. Effectiveness emphasizes the distinction of what works from what feels "right," seeking to reduce the influence of the emotional mind in an individual's approach to problem solving. Owing to the influences on its development, this approach to problem solving is especially salient within the context of borderline personality disorder.

DBT presents mindfulness as foundational to effective distress tolerance, emotion regulation, and interpersonal functioning. While it utilizes a meditative approach to mindfulness to encourage an individual to seek, engage with, and accept their experiences as fully as possible, that mindfulness also serves as a stepping stone to self-regulatory metacognitive process. One of the ways this is achieved in the room is by moving the process from the mind onto paper, with worksheets serving as tools for establishing metacognitive awareness and as bridges for the therapist and client to share their understanding of that experience.

Mindfulness techniques such as the "mindful body scan" serve as the basis for behavioral re-calibration of an individual's experiential system. The biosocial theory on which DBT is based posits that many individuals with high emotional sensitivity tuned their self-regulatory processes within socially invalidating contexts. In the therapeutic setting, DBT presents individuals with the opportunity to mindfully explore and re-engage with their experiences in a guided, self- and other- validating environment.

Changing clients' relationships with their physiological perceptions and emotions, as well as disrupting patterns of interpersonal reactivity in the therapy room, thus result in the disruption of patterns of social reinforcement that maintain those behaviors outside of therapy.

One of the specific tools utilized within DBT is the chain analysis. This technique of linking problematic behaviors, especially self-sabotaging and self-harming behaviors, with their antecedents and consequences ties directly to DBT's behavioral roots, casting the continued expression of such behaviors as dependent on their consequences. Often utilizing worksheets, therapists and clients typically trace back from undesired behaviors to the situations that they arose in response to, emphasizing "links" in the chain as sequential in nature.

The focus of DBT on affect regulation, and specifically on balancing often opposing processes such as reasoning and non-avoidant emotional experience, makes it a useful resource for intervention with individuals with borderline personality disorder. However, these same intervention strategies can also be applied to clients with classic internalizing disorders such as anxiety and depression. The techniques that arise out of DBT are applicable to CALM-MO's focus on reducing negative reactivity by disrupting aspects of the triple-negative neurotic loop, as previously described. While DBT does not explicitly emphasize the engagement of an MO-like perspective, its arrangement of what behaviors maximize the impact of psychological mindfulness and how these behaviors can be adaptively utilized maps well to the structure of CALM-MO. Furthermore, many of the techniques and strategies utilized in a DBT approach would contribute to the development and maintenance of an adaptive MO.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT), like DBT, is at its core based on traditional cognitive and behavioral principles of human functioning. However, whereas CBT strives to teach individuals to better control mental processes like thoughts and feelings, ACT emphasizes the observation, acceptance, and embracing of inner events, especially undesirable ones. This is because ACT views experiential avoidance as the ultimate cause of psychological distress, and the process by which individuals build patterns of cognitive rigidity that entrap them within that distress. At the core of this view of human development and functioning is Relational Frame Theory (RFT), which stipulates that the development of human language introduced a fundamental difference in the cognitive structure of human minds as compared to other animals (Hayes, 2004). While relatively simple cognitive processes throughout the animal kingdom develop primarily through associative learning (i.e., Behaviorism), Hayes posits that language allows for higher cognition based not only on the presence and strength of the associations between stimuli in memory, but also on *how* stimuli are related. Reinforcement therefore operates within contextual relationships between stimuli. RFT holds that a significant portion of psychological distress and dysfunction stems not from the mere inaccuracy of thoughts, but from the way that language can lead to their reification such that thoughts about reality become confused with reality itself. An individual's beliefs therefore become a frame of reference from which examination of the outside world is made, biasing attendance and interpretation of stimuli toward that which further reifies the frame. A more comprehensive review of RFT can be found here (Hayes, 2004).

ACT emphasizes experiential avoidance as the process by which individuals develop unhealthy patterns of relating to their experience. In doing so, individuals become rigid in their responses to undesirable thoughts and feelings, both through biases toward methods of circumventing directly experiencing them, and through a lack of skill development in alternative methods of being. ACT therefore strives not to correct the accuracy of thoughts as CBT does, but to build psychological flexibility, which is the state of being minimally constrained by the necessity to avoid negative experience. This allows an individual to experientially recalibrate their mental models of reality through the natural process of interaction with the world. In practice, ACT emphasizes six core principles to aid individuals in building psychological flexibility: cognitive defusion, acceptance, being present, self as context, personal values, and committed action. While each will be reviewed, these principles differ in their relevance to the Metacognitive Observer; as such, some will be discussed in more detail in later chapters.

Cognitive defusion was earlier described as analogous to decentering, or the process of shifting one's experiential perspective onto the experience itself. However, it is important to understand what this means in the context of ACT practice. The goal of ACT is not to diminish the form or frequency of negative experiences, but to alter how one relates to them and thus diminish their negative impact on behavior. Cognitive defusion thus presents contexts in which one's relationship with negative thoughts and feelings can be experienced in new ways. For example, the thought "I am worthless" and the observation "I am having the thought that I am worthless" are very different ways of relating to what is, at its core, the same psychological event. One of these ways of relating to the event has the effect of reifying it, and the perspective of the speaker is

from within the "reality" of the thought. The other treats the thought as what it is, an experience that the speaker is having, which reduces its literal quality and resulting emotional and behavioral implications.

ACT therapists employ a number of specific techniques to aid client in moving from cognitive fusion (identifying from within the perspective of a thought" to defusion. One is to progressively reframe the experience through multiple levels of separation from a fused thought (e.g., "I'm useless"). This might be achieved by suggesting a client replay the thought with the addition of "I'm having the thought that…" and reflecting on the difference this produces. Defusion might be further enhanced by adding an additional step back from the fused thought, such as adding "I notice that I'm having the thought that…", again followed by reflection on the difference between both experiences. Another technique involves casting a negative thought or feeling as an externally observed event, which might be done by giving it qualities such as shape, size, color, etc. A therapist could also guide a client through the process of exploring feelings and memories that have tended to accompany a particular thought in the past. For clients who have built the necessary mindfulness and detachment skills described above, dispassionate observation of negative thoughts can have the same effect. All of these techniques seek to change an individual's relationship to an internal event in order to separate it from undesirable functions that the event tends to perform.

Acceptance is presented as an alternative to avoidance, and involves the active and intentional embracing of both positive and negative internal events without seeking to change their frequency or content. This construct will be covered in more depth during a later chapter.

Being present in the context of ACT refers to the process of developing and maintaining awareness of the here and now, and to experience this moment with openness and receptiveness. While the latter emphasis on non-judgement will be explored in more depth in the context of discussion on curiosity and acceptance, the former emphasis on awareness of the present moment is directly relevant to the function and purpose of the metacognitive observer. In applying this principle in the therapy room, the ACT clinician aids the client in framing thoughts and feelings in the present. This may involve defusion, such as re-casting the thought "I will never feel better" as "I am having the thought that I will never feel better." The client is also encouraged to make use of previously described mindfulness techniques to explore various aspects of their present experience.

Self as context refers to the process of recognizing and identifying with a continuity of consciousness that is stable over time and which is "doing" the experiencing. Relating to defusion, the self is the consistent "I" that has the thought that it is worthless, and is just as capable of having the thought that it is valuable. According to relational frame theory, this sense of a continuing, distinct self arises from linguistically-based relational frames that distinguish "I" from "you," "here" from "there, and "then" from "now." Within ACT, fostering the self as context facilitates decentering and therefore processes for countering experiential avoidance. It also provides contexts for self-empathy, as well as a conduit for connecting one's behavior to one's values. One specific technique for fostering a self-as-context perspective is known both as the Observer Meditation and Role Observation. This involves an individual listing their varying roles (e.g., mother, teacher, friend, leader) and focusing on what remains constant

when navigating between them. A therapist may aid a client in identifying the consistent entity that engages with the world in varying ways by describing the aspects of the self that are commonly expressed through each role. The process emphasizes how the self is not defined by the roles it undertakes. Further variations of this technique involve substituting roles for emotions, behaviors, or other experiences that are expressions of a continuous experiencing self.

Values are presented not as achievable ends but as chosen qualities that can be enacted in the moment. This aspect of ACT will be discussed in more detail in a later chapter on motivation toward valued states of being.

Committed action is directed by an individual's values and is expressed through the setting and completion of concrete and achievable goals. Such goals are intentionally placed within the context of the individual's pre-established values. Committed action and techniques for effective implementation will be further explored in a later chapter on motivation toward valued states of being.

Techniques for Engaging and Growing the Metacognitive Observer

Each of the above therapeutic modalities illustrate unique perspectives and insights into human functioning, and their methods reflect these differences. However, we can glean from them common therapeutic values, pathways, and specific techniques that could be applied to engage and maintain the Metacognitive Observer in a therapeutic context.

Mindfulness techniques such as breathing exercises are likely to aid clients in attending to the embodied moment, and present the opportunity to ground an individual's experience of the self in physical sensation. Metacognitive techniques to promote

decentering may then be used to turn attention to psychological experiences such as feelings and thoughts. A number of techniques for promoting cognitive defusion, a concept analogous to decentering present in ACT, could be applied for this purpose. Among them are linguistic-based steps separating the self from its experience, such as moving from "I cannot endure" to "I think I cannot endure," "I'm having the thought that I cannot endure," and "I notice I'm having the thought that I cannot endure." Additionally, ACT provides exercises such as role observation, in which an individual lists their unique roles in life and focuses on that which remains constant throughout in order to identify a consistent core of experiencing self. Roles can be replaced in this exercise by emotions, behaviors, and experiences. Throughout these processes, clients might engage in additional attentional exercises to hone necessary skills in alertness, inhibition, and selective attention.

Clients who engage in these therapeutic exercises will likely begin to develop skills essential for attending to and engaging with their experiences in new ways. Requiring significant attention and effort at first, engaging the Metacognitive Observer in the therapy room is likely to become easier over time, and can be encouraged in other settings which may be more stressful but could produce even greater behavioral rewards. The goal of generalizing engagement of the Metacognitive Observer with relative automaticity relates to another meaning of MO: that of an individual's *modus operandi*. Ideally, CALM-MO can become an individual's go-to approach for coping with various forms of stress, breaking cycles of reactivity that might negatively impact their emotional and interpersonal functioning and inoculate them against future relapse.

The Metacognitive Observer: An Integrated Construct

Through the metacognitive observer, an individual has the opportunity to both build insight into their functioning and to be active in creating a growth-oriented intrapersonal relationship as a stage for the intentional enactment of that insight. In counseling settings, this occurs in the context of a therapeutic relationship. The therapist enters into the metacognitive space alongside the client, modelling the process and providing curiosity and support to promote exploration. Early in therapy, the therapist may effectively adopt the role of the client's metacognitive observer, slowly shifting this role back to the client as they become more skillful and motivated in engaging their own MO process. Throughout this process, the therapist provides perspective and guidance, and aids the client in constructing a coherent narrative of their experiences. As therapy is a dynamic and constantly developing relational enterprise, techniques for engaging with a client's MO will change over the course of therapy. Some are better suited to honing foundational skills and establishing the MO, while others are more aligned with the development and growth of the MO once the client can reliably engage with it.

Psychological mindfulness, as previously discussed, lays the foundation for engagement with the metacognitive observer. Access to current experience, and the ability to linguistically represent it through engagement with the justifying mind, are essential components. Therefore, techniques geared toward bodily awareness (e.g., the "mindful body scan"), breathing exercises, and visualization are useful in the context of the therapy dyad which necessitates engaged communication of experience. One specific component that might be drawn from MCT is the "attention training technique," which provides opportunities to build skill in discriminating between, and focusing on, various forms of stimuli. Such skills would act as essential building blocks for psychological

mindfulness and engagement with the MO, especially for individuals with histories of reactive avoidance of their experiences who are likely to have deficits in applying attentional control to negative internal events.

Each of the above approaches seeks to establish some level of decentering, distancing the individual from a frame within an experience to perceive a continuity of self that is undergoing such experiences. Both DBT and MCT make use of visualization and metaphor in doing so, and the ACT model adds techniques geared toward cognitive defusion including progressive reframing that aid in the linguistic representation of this distance.

As was previously noted, mindfulness-based approaches have diverse perspectives on the role of attachments as contributory to dysfunction. More extreme versions of detachment involve the letting go of wants and desires categorically, and casts the concept of attachment itself as that which is to be discarded. The purpose of establishing and maintaining the metacognitive observer is not to sever connections between the self and various forms of motivation. Rather, the task of the MO is to evaluate experience in the context of such attachments (i.e., values), and to find and pursue pathways to align them with behavior. In doing so, some problematic and inflexible attachments may become targets for intervention, as unclarified or conflicting values could produce “oughts” and “shoulds” in which an individual may invest to their detriment. Such “oughts” can be characterized as unhelpful attachments between the world as it is desired and the world as it actually is. As such, it is the task of the MO to reduce reactivity to what “ought” to be, but not necessarily to give up the values involved.

Recall that one of the functions of the ego is to evaluate what is in relation to what ought to be, a process essential for navigating both intrapersonal and interpersonal spheres of experience. Increasing an individual's tolerance of distance between what "should be" and what is provides an opportunity to fill that space with mindful action, and ACT techniques aimed at cognitive defusion are both theoretically and practically aligned with CALM-MO in this goal. Linguistically separating the self from the experience by injecting "I'm having the thought…," metaphorically casting internal experiences as externally observed events with observable properties, and raising insight into the continuity of repeated experience are all techniques that can reduce reactivity to one's "oughts" without maligning the often important values they connect to.

Radical acceptance, as characterized by Dialectical Behavior Therapy, provides a helpful next step to follow (and continue) defusion in reducing the power of clients' "ought" attachments and grow the MO. Radical acceptance focuses not only on the sensations and feelings an individual is experiencing in the moment, but on broader meaningful narratives that include them. While acceptance will be discussed in depth in an upcoming chapter, it is important to note that it holds a role in establishing and maintaining the function of the MO by increasing the possible ways that individuals can interact with their experiences. One helpful technique within DBT to promote radical acceptance is to re-cast the subject of negative self-talk as a loved one. An individual could then develop a list of less judgmentally laden statements that remain situationally salient, before finally redirecting those statements to the self, as applicable. Building skills not only in the perception of inner experience but in representing it to the self is essential to strengthening the function of the MO, and over time, changes in the linguistic

representation of the *private self* are likely to result in changes to an individual's experiential frame.

Recall that the Influence Matrix aids in understanding how an individual develops impressions of how the relational world "should" be, and how these reflect and are reflective of internal states (e.g., emotions), based on their developmental history of if and how they were able to maximize relational value and meet their needs. Reactivity to these internal states likely develops in environments where shortcuts are adaptive, such as an unsupportive or abusive family or peer social environment. Adopting the perspective of the metacognitive observer provides the opportunity for re-experiencing many of these automatized patterns of responding to the world, both from the perspective of the MO as a continuous observer of the self, and as those parts of the self being observed and heard in ways that may have been rare throughout their development. Thus, continued engagement of the metacognitive observer, especially expressed in a CALM manner, would allow individuals to recalibrate XXXX based on both the action of the MO in engaging the justifying mind to evaluate experience (as in CBT) and through ongoing experiential interaction with the world through the frame of the MO.

Chapter 5: Curiosity

Although curiosity is a commonly used word, there is not an accepted operational definition of what the term means in psychology and cognitive science. Researchers across various fields of study have enacted numerous strategies in attempts to operationalize it, from a "common core of language" approach utilizing nomological networks (e.g., Pekrun, 2019) to functionalist approaches (e.g., Lowenstein, 1994) and dimensional analyses (Kashdan et al., 2018). Despite these different approaches, there are common features produced by each of the above strategies: each describes curiosity as the combination of motivation (i.e., interest and desire) and action toward attending to and seeking new or ambiguous situations and information. As Kashdan and colleagues (2018) summarize, curiosity is "the recognition, pursuit, and desire to explore novel, uncertain, complex, and ambiguous events." This definition has significant overlap with a number of other constructs, such as openness, sensation-seeking, wonder, and uncertainty tolerance.

Curiosity has been associated with a number of behavioral propensities that that tend to be desirable in the therapeutic context. Curious individuals are more likely to be able to attain and integrate knowledge independently from their cognitive ability (von Strumm, 2018). This is especially true if the information to be integrated is challenging to an individual. Kashdan, Afram, Birnbeck, and Drvoshanov (2011) investigated curiosity in the context of change processes by exploring its relationship to mindfulness and defensiveness against worldview-challenging stimuli. The authors found that, in evaluating the argument and author of a worldview-threatening essay, individuals high in mindfulness but low in curiosity (but not those high in both) tended toward

defensiveness. Defensiveness was operationalized as a negative attitude toward the writer, illustrating potential implications for the therapeutic relationship, given that the role of the therapist sometimes includes offering challenging perspectives on client experiences. Interestingly, those low in both curiosity and defensiveness were also less likely to report negative attitudes toward the essay author. Consistent with a CALM-MO approach, Kashdan and colleagues posit that the combination of curiosity and mindfulness translates to a tendency for exploration that is non-judgmental.

Curiosity has also been found to relate to greater creativity in solving problems (Csikszentmihalyi, 1996; Gross, Zedelius, & Schooler, 2020) and greater persistence when faced with challenging tasks (Sansone & Smith, 2000), which are likely to occur in clinical settings. In addition, curious individuals tend to display more willingness to take to take risks and try new things (Zuckerman, 1994), implying that curiosity may have a role in countering experiential avoidance.

Much of the literature on defining, identifying, and promoting curiosity arises from educational research rather than clinical intervention (e.g., Peterson & Hidi, 2019; Pekrun 2019; Menning, 2019). Researchers in this field are in the process of differentiating curiosity from related concepts such as interest and openness, as well as identifying enduring (trait-based) and momentary (state-based) expressions of curiosity in the context of engagement and learning in educational settings. This research may prove valuable to the broader field of psychology, as well as having clinical implications, as trait-based curiosity may inform our understanding of personality while state-based curiosity may represent a target of in-the-room intervention.

Psychological research into curiosity has also focused on differentiating it from associated constructs (e.g., openness), and many researchers have taken a functional view of curiosity to do so (Lowenstein, 1994; Kidd & Hayden, 2015). The most influential functional model is currently that put forth by Lowenstein (1994), who noted that curiosity appears to function as a motivational factor to close a gap in knowledge. Under this view, neither an individual who knows very little about a subject, nor an individual who believes that they know nearly everything about it, is likely to be highly curious. Instead, curiosity is activated when an individual has at least some knowledge of a subject but perceives a gap between what they know and the level of understanding they'd like to have. This view is supported by recent studies linking the neural correlates of curiosity to enhanced information retention (e.g., Galli et al., 2018).

In conceptualizing state-based curiosity as a system of motivation and reward, Gruber and Rangonath (2020) differentiate curiosity from other states associated with reward motivation. They point out that while reward delivery generally motivates behavior toward seeking the same reward in the future, information that resolves curiosity would no longer motivate further exploration, requiring the seeking of entirely new information. However, this might be resolved by viewing the experience of satisfying curiosity, rather than the information sought, as the reinforcer. The clinical implications of the "knowledge gap" conceptualization of curiosity suggest that to promote curiosity, an individual needs enough understanding to know that there is more to learn and that such learning that would be valuable in some way.

According to Kashdan and Fincham (2004), another helpful frame for understanding expressions of curiosity is Self-Determination Theory (SDT), which is a

humanistic theory that posits three core psychological needs: autonomy, relatedness and competence. SDT holds that individuals are actively growth-oriented and tend to act to further a sense of unified, integrated self. Individuals respond to several needs in doing so, including the need to determine and control their behavior and goals so that they are in harmony with one's interests (autonomy), the need to learn and master challenging tasks (competence), and the need to feel attached to others and experience belongingness and intimacy (relatedness). SDT also posits two types of motivating forces that help to reinforce goal-directed behavior. Intrinsic motivation is reflected in the pursuit of interests and exercising of personal capabilities in activities for which a sense of accomplishment or success is its own reward. Extrinsic motivations are those created by external factors and incentives such as rewards and punishments. According to SDT, those who satisfy their needs for autonomy, competence, and relatedness go in to internalize external motivators as part of their identity and values.

Kashdan and Fincham (2004) note that individuals exhibit greater curiosity when they feel that their behaviors are self-initiated and that they have access to more possible choices, coinciding with the need of autonomy. They suggest that maintaining a sense that rewarding aspects of curiosity are directly related to internally initiated actions (e.g., not tied to an external system of rules) helps to promote and develop curiosity. Curiosity is also increased when individuals feel that they can effectively interact with their environments, highlighting the importance of engaging in tasks that are challenging enough to hold interest but attainable enough to be successfully achieved in contributing to a sense of accomplishment. Curiosity as a style of interaction is more likely when an individual feels connected to others and believes their inner experiences to be understood

and accepted. Kashdan and Fincham suggest that feeling connected to sensitive and responsive others minimizes concerns about pleasing or impressing them, freeing resources to take risks and engage more openly with the world.

It is not surprising that there is still some disagreement over how to operationalize curiosity, given that various disciplines understand human experience from a variety of angles (e.g., education, as above). To address this, Kashdan et al. (2018) sought to consolidate disparate literature and competing understandings of the construct through three scale development studies, yielding a measure sensitive to five distinct factors of curiosity: the Five-Dimension Curiosity Scale (5DC). The authors' five-dimensional model included *joyous exploration,* which contained the pleasurable aspects of seeking, *deprivation sensitivity,* which mapped to a sense of frustration with not knowing, *stress tolerance,* referring to the ability to cope with things that are new and/or uncertain, *social curiosity,* or interest in understanding the behavior of others, and *thrill seeking,* the tendency toward taking risks in order to encounter positive emotional states. Each of the 5 dimensions showed strong concurrent validity in comparison with previously established measures of curiosity.

In contrast with previous conceptualizations of curiosity as a one- or two-dimensional construct best represented on a spectrum, Kashdan and colleagues (2018) identified four distinct categories of curious people. *Fascinated* individuals, comprising 28% of participants, are inquisitive, social, enthusiastic, and active in seeking new stimuli. The authors point out that this group tends to be the most educated and affluent. *Problem solvers* (28%) tend to strongly value independence, and their curiosity seems to be expressed through working to address problems they feel must be resolved, rather than

through social curiosity. *Empathizers* (25%) are especially socially perceptive and self-reflective, and were the most likely to report consistently feeling stressed. Representing 19% of respondents, *avoiders* are at baseline lower in curiosity, and tended to be the least interested in exploration, the least confident, and the least educated and affluent.

In a clinical context, Kashdan and colleagues' (2018) findings suggest several measurable individual difference factors regarding how curiosity tends to be expressed. While some clients will become curious as part of a problem-solving process, others may engage with curiosity for its own pleasurable sake, and still others as a pathway to interpersonal interaction. An understanding of how a particular client tends to engage with curiosity may help to tailor interventions to be resonant with that client's experience.

In revisiting the 5DC more recently, Kashdan and colleagues (2020) sought to refine the measure to improve its psychometric properties and to broaden its application from that of a research tool to a measure capable of clinical application. The 5-Dimension Curiosity Scale Revised (5DC-R) is therefore shorter and may allow clinicians to track the impact of curiosity-enhancing interventions.

Intervening with Curiosity

While the construct of curiosity does not form the foundation of any established therapeutic approach, it is widely recognized as an essential feature of both insight-oriented and experiential therapies. The most basic form of curiosity-oriented intervention is the stance taken by the clinician to learn about the client's experience with genuine interest and concern. Through the therapeutic alliance, the clinician models curiosity by explicitly asking questions and reframing assumptions and certainties as possibilities. The clinician also works to create a culture of curiosity in which openness

and engagement with the novel or uncertain is woven into the language spoken in therapy.

Kashdan and colleagues' (2018) curiosity scale development research suggests four distinct characteristic expressions of curiosity that may be helpful in designing curiosity-oriented therapeutic interventions. For those individuals who fall into the *fascinated* group, little encouragement toward curiosity is likely to be necessary, as across most situations these individuals tend to gain pleasure through exploration and open engagement with various aspects of their environment. Therapeutic intervention may take the form of celebrating existing tendencies toward exploration and directing this impulse toward new avenues, such as the self, an individual's developmental history, or interpersonal process. These individuals are likely to build insight quickly and use new knowledge to approach existing issues.

Individuals who fit into the *problem solvers* group tend to be motivated toward curiosity by the experience of tension accompanying an unanswered question or unresolved obstacle. These individuals may be especially responsive to interventions that make use of this tension as an opportunity to explore new possible solutions. For example, a therapist may encourage an individual to adopt the quantity principle in approaching a problem, which involves generating as many possible and relevant avenues of approaching the problem as possible while deferring judgment of the merit of those solutions until all possibilities are presented. This process may yield new and creative approaches to life challenges, as previously dismissed strategies may become viable in combination or as situationally responsive options. While such interventions may be especially relevant to a solution-focused approach, practice in deferring judgment and

creativity may encourage the generalizing of these strategies to other arenas. Another exercise that problem solvers may benefit from is one in which the familiar structure of solution-finding is turned into an enjoyable activity. For example, an individual might be asked to imagine or list all the things they could make with popsicle sticks. After exploring their own ideas, they could be encouraged to explore possibilities that others have come up with. This process may help to associate openness and curiosity with pleasant feelings such as anticipation, as well as to open up avenues of consideration that had not originally occurred to the client.

Empathizers tend to express curiosity in seeking to attempt to understand the behavior of others, and they may benefit from imaginal exercises to engage perspective-taking skills in engaging curiosity as valued others might. For example, a client might be guided to consider a person they admire who approaches situations with curiosity, and to role-play their approach to a situation the client is facing. The exercise may benefit from an embodied approach, in which the client is encouraged to attend to, and express, speech, tone, and posture that for them expresses curiosity.

Individuals who fit into the group of *avoiders* tend to be the least curious. They may experience a gap in knowledge or understanding as a stressor to be regulated, rather than as an indicator of opportunity. They may also be less tolerant of uncertainty in general. These individuals may benefit from tasks, like the popsicle stick exercise described above, designed to minimize the impact of possible negative outcomes to exploration. Avoiders are likely to benefit from a focus on tolerating uncertainty in order to broaden the ratio of curiosity outcomes that are reinforcing.

Kashdan and Fincham (2004) emphasize the importance of interventions that serve to meet needs for autonomy, competence, and relatedness. Tasks or exercises that capitalize on novelty, such as those that place clients in unfamiliar situations that do not match their experiences, as well as exploration and expression of personal values, aid in engaging with autonomy needs. Such tasks are especially salient when clients are guided to maintain a sense of enduring self as they navigate different contexts (e.g., identifying with the position of the MO as an experiencer observing its experiences). Tasks should, where possible, arise out of the natural interests of the client. In judging the competence-building qualities of potential tasks, a therapist might consider Vygotsky's concept of the zone of proximal development as a guide. In the therapeutic context, this describes the space between what an individual is capable of independently and what that individual is capable of with the collaboration and guidance of the therapist. This approach not only fosters competence by setting challenging but attainable goals, but also a sense of relatedness as the client is seen and accepted throughout the process of striving to achieve a goal.

Cognitive-behavioral approaches tend to contrast curiosity with automatic judgements and expectations regarding the need for, or likely results of, exploration. Clinicians emphasizing a traditional CBT approach (e.g., Beck, 1993) are likely to take an experimental approach to intervention, helping clients to test their assumptions through Socratic questioning and collaborative empiricism and encouraging them to evaluate evidence for and against their automatic thoughts. Other CBT-based interventions involve noticing judgmental thoughts and re-framing them as questions to be answered. This is similar to the experimental approach, but it does not necessarily

involve testing of the thought. Often, framing a judgmental thought in the form of a question results in changes to the emotional and behavioral consequences of the thought on its own. The development of skills in questioning one's experience should contribute to increased curiosity, as the potential information to be gained becomes less black-and-white, more nuanced, and more available for engagement.

Exercises in perspective-taking may be helpful for clients who become stuck in viewing things from a particular frame of reference. For example, a client might be encouraged to describe a situation through their eyes, and then to imagine that same situation through the eyes of real, involved others or hypothetical people with given experiential contexts. Exercises such as this are likely to prioritize social curiosity as individuals lessen dependence on their own perspectives and contexts to understand various situations.

Clients are often unaware of many of the pressures that influence their behavior, and this may lead to feelings of confusion and a sense of powerlessness. Teaching new ways of exploring one's motivations may offer a curiosity-based avenue for seeking insight that is carried forward through a client's life after therapy. Socratic questioning, reflective listening, and other methods of engaging in exploration of the cultural, social, and familial influences on individual development and behavior not only builds skills in such exploration, but also provides opportunities for clients to effectively answer questions about themselves in ways that connect them to the human experience as a whole and may be deeply validating to put into words.

While most of the above suggestions focus on building the motivational aspects involved in curiosity, this is not the only determinant of curious action. It is also

important to build skills in the varying kinds of exploration necessary in therapy. For example, in order to promote social curiosity, a client may need to improve social skills such as effective listening. Doing so is likely to have an impact on motivation as well, because greater skill in exercising curiosity is likely to result in more rewarding outcomes and increased desire to re-engage in this strategy.

A Curious MO

Most of the techniques described above are geared toward building aspects of a general curiosity, as befitting the definition of the construct offered by Kashdan and colleagues (2018). Some researchers have differentiated general curiosity from that which is self-directed (e.g., Litman, Robinson, & Demetre, 2017; Aschieri, Durosini, & Smith, 2020), characterizing the latter as interest in and motivation toward acquiring knowledge about one's emotions, past, identity, and purpose. While the narrower, self-focused curiosity construct may seem more consistent with the function of CALM-MO, namely curiosity in mindful observation of the experiences of the self, there are several reasons that encouraging a more general curiosity about the world, including the self, would be beneficial.

First, in building both the skills and motivation involved in taking a curious approach to external events, an individual is building many of the same resources involved in curious introspection. An individual who is actively working to approach the world in a more curious manner is likely to find themselves applying the same approach to evaluating inner experiences. This is especially true on the context of social curiosity, as many clinicians attest that clients' desire to understand others is often an expression of a longing for self-understanding. This is resonant with the Unified Theory's

conceptualization of social and relational mechanisms as integral to the construction of the self.

Second, the Unified Theory recognizes that our perceptual experience is the only filter through which we have access to the outside world. The development of curiosity in a general sense therefore implies an openness to the inner experiences involved in interacting with various elements outside the self. An individual's internal events regarding various aspects of their environment are just as much a focus of the metacognitive observer as internal events in reference to the self.

Finally, CALM-MO seeks to aid individuals in constructing a cohesive, consistent sense of self in context. An individual is no better served by developing a curiosity of the self but not of other aspects of life as they might be by being curious of their environment but closed to inner exploration. Recall that in seeking to place inner experiences in their appropriate contexts, the MO is necessarily engaged in applying continuity between the experiences of the self, what is known about reality, and values held by the individual.

Chapter 6: Acceptance of Self, Others, and the World

One of the most frequently referenced criteria for overall well-being across theoretical perspectives of human functioning, acceptance as a psychological construct has a long and rich history. In connection with exploration into other theoretical constructs such as the self, acceptance has been studied since the early 1900s, though its philosophical roots reach back much farther (Williams & Lynn, 2010). Today, it is one of many aspects of modern psychology and therapy influenced by the inclusion of Eastern tradition and philosophy, especially Buddhism. The concept has been interpreted somewhat broadly in the context of psychotherapy, primarily based on differences in focus regarding what is to be accepted. Some prioritize elements of moment-to-moment experience (e.g., Acceptance and Commitment Therapy), some emphasize broader application toward the self (e.g., Rogerian and other Humanistic approaches), and still others are primarily concerned with strong negative feelings and aspects of the environment that individuals lack the power to change (e.g., Dialectical Behavior Therapy).

The common thread throughout these perspectives is that acceptance refers to the ability to tolerate rather than reject or avoid what is. This work will discuss conceptions of acceptance from four distinct clinical approaches: Rational-Emotive Behavior Therapy (REBT) and its derivatives, Rogerian and other Humanistic approaches, Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT). Each of these approaches' differences are reflected in the therapeutic techniques they employ, and it is through exploration of these techniques that the concept of acceptance put forward by CALM-MO will be clarified and further operationalized.

Rational-Emotive Behavior Therapy

Rational-emotive Behavior Therapy (REBT) is a form of cognitive-behavioral intervention pioneered by Albert Ellis starting in the 1950s (e.g., Ellis, 1957). As with other forms of cognitive-based approaches, a key component of REBT is the conceptualization of dysfunction not as a response to reality, but rather to distortions in beliefs held about reality. Adaptive beliefs are considered those that are logical, flexible, and consistent with reality, whereas beliefs that are illogical, inflexible, and inconsistent with the world are cast as the source of problematic emotional and behavioral expression (Ellis & MacLaren, 1998). In treatment, clinicians take an active and directional stance in educating clients to identify and dispute problematic beliefs, though expression of warmth and caring are not seen as necessary to the construction of a successful therapeutic alliance. Once identified, the engagement of various beliefs is characterized as a choice between the emotional and behavioral consequences implied by whether the chosen beliefs are logical or illogical, flexible or rigid, consistent or inconsistent with the world.

One of the fundamental premises of REBT is that individuals are not emotionally disturbed by the presence of adverse events but by the ways in which beliefs about such events are constructed through language, meanings, and evaluative structures. This core premise foreshadows the role of acceptance in counteracting dysfunction. REBT draws heavily from Buddhism in its approach to self- and other-acceptance (David et al., 2013), and the ultimate goal of the approach is a shift in a client's philosophical approach to evaluating and valuing themselves, others, and the world. Whereas other forms of CBT (e.g., Beck, 2011) tend to characterize only belief structures with negative valence as

problematic, REBT holds that all forms of self-evaluation are inherently problematic and that emotional health and well-being is achieved through self-awareness that is free of both negative and positive judgment (Elli s& MacLaren, 1998). In REBT, the problem is the act of judgment itself. As such, REBT seeks to foster three forms of unconditional acceptance: that of the self, that of others, and that of life.

Ellis contrasted unconditional self-acceptance with self-esteem to highlight the role of even positive self-judgement in setting what he considered to be problematic expectations of functioning. REBT clinicians view self-esteem as conditional acceptance that is contingent upon performing well despite natural human fallibility. The measuring stick for such performance may be that of others or of irrational expectations for the self. In either case, REBT casts self-esteem as a fool's errand, a self-judgement process whose goalposts move once it is approached, resulting in a futile and lifelong chase. Additionally, REBT's theoretical foundations reject a direct connection between performance and distress. An REBT clinician would contend that one's performance is simply an activating event, and it is our irrational beliefs and expectations of our performance that lead to the distress otherwise labelled as low self-esteem.

Ellis rejected the idea that any sense of one's worth should be tied to performance. Furthermore, he viewed the self as too complex to be a legitimate target of judgment, and the common tendency to do so as due to irrational beliefs about the self that often led to global negative evaluations he described as *ego disturbance*. In contrast, unconditional self-acceptance is the application of non-judgement to the self while maintaining the ability to accurately evaluate one's behavior. By distancing the self from

behavior, REBT seeks to allow individuals to rate what they do independently from evaluations of themselves as people.

Similarly, Rational-Emotive Behavior Therapy holds that general or universal judgement of others, as exemplified by the fundamental attribution error, leads to dysfunction based on discrepancies between our expectations of what others "should" do and who they are. While it is true that others will treat an individual unfairly at times, REBT holds that there is no justification to believe that others *must* treat that individual fairly, and that this is not the measure of their worth as people. The goal of "letting go" of judgement of others is to negate the impact of frustration and anger based on their transgressions. This does not equate to giving others a "pass," as one must still hold others responsible for their emotions and behavior. However, it does seek to undermine justifications for an individual to hold others accountable for the individual's own emotions and behavior.

In applying universal acceptance broadly toward life experience, REBT seeks to aid clients in severing attachments to how life is "supposed to be." While Ellis viewed negative emotions as healthy in response to many of life's circumstances, he emphasized that individuals develop beliefs about how life "should" be that lead to unnecessary suffering once violated by a world that is not beholden to those beliefs. Unconditional life acceptance is therefore described as the acknowledgement of and engagement with unpleasant events without the expectation that things "ought to" be any other way.

There is meaningful overlap between the concept of unconditional self-acceptance and loving self-compassion in the context of CALM-MO, and much of this overlap regards the adaptiveness of a humanistic "set-point" regarding judgement of the self.

CALM-MO and REBT take different paths to this self-perspective, with REBT emphasizing non-judgement in ways that CALM-MO does not. This will be discussed in more depth and detail in the upcoming chapter on loving self-compassion, and is also relevant to the value structure that emerges in the Unified Theory. With regard to acceptance, this aspect of REBT is relevant for its intended impact on self-judgement as a path to non-reactivity, and the REBT techniques presented will be geared toward this goal.

The first necessary aspect of enacting REBT is gaining insight into one's functioning, and to highlight mismatches between an individual's beliefs, behaviors, and goals. A clinician will often utilize ABCDE worksheets to aid clients in recognizing the role of their beliefs (B) in the emotional and behavioral consequences (C) that follow activating events (A). Clinicians take an active and directive role in helping clients to challenge target beliefs thought the process of *disputation* (D) before enacting the results of this process as an effective alternative behavior (E).

Disputing irrational beliefs is the primary method of inducing change in REBT, and clinicians generally help clients to evaluate their beliefs on several different grounds. Recognition of irrational beliefs can be aided using handouts and other resources regarding common pitfalls, including black-and-white thinking, overgeneralizing, and thinking in absolutes, among others. Once recognized, beliefs themselves can be challenged as non-functional, in that they fail to help in the accomplishment of some desired goal. Empirical challenges encourage clients to question whether assumed "facts" comport with reality. The logic of an individual's thinking process is also often a target of evaluation. Additionally, intervention may highlight areas where positive emotions and

outcomes are being passed over due to preoccupation with negative aspects that become over-generalized. The therapist's active-directive role in addressing client beliefs results in a process called disputation, in which the goal is active and direct questioning of beliefs and thought process. Disputation does not emphasize the development or "root cause" of beliefs, and instead involves a therapist asking challenging questions regarding the logic, factual quality, or functionality of beliefs (*cognitive disputation*) and imaginal exploration of different aspects of upsetting situations (*imaginal disputation*).

Imaginal disputation may involve exercises like common distress tolerance techniques such as imagery and visualization, but its emphasis is not on improving the subjective quality of the current moment. Instead, the goal of imaginal disputation is to produce insight into alternative ways of experiencing a situation. One example of an imaginal disputation exercise involves a client re-creating a distressing event or situation in their mind and allowing themselves to re-experience the dysfunctional emotions that arose from the application of problematic thoughts and beliefs. Once the client can successfully access these feelings, they are encouraged to change their emotions to one that might arise from the application of more rational beliefs (e.g., sadness in response to a loss) while holding the image of the situation constant.

Cognitive disputation may be approached through Socratic questioning, the use of metaphor, didactics, or humor. Ellis identified the intentional use of humor as one of the features that differentiated REBT from other approaches, and therapists sometimes use it to "poke fun" at clients' dysfunctional beliefs (e.g., following a belief to its logical and absurd extreme conclusion). The therapist's stance in cognitive disputation is to be firm and sometimes even forceful in focusing on the relevant qualities of thoughts and beliefs

to ensure the client actively confronts them. This can be an intense and unsettling experience, not least because corrective, rational beliefs are no more likely to be positive ones than the irrational beliefs they replace. Disputation therefore requires a strong therapeutic alliance and clarity regarding informed consent, as well as careful debriefing afterward. Acceptance is a necessary component to successful disputation because unconditional acceptance influences the set of possible replacement beliefs considered to be rational, and a client is required to engage with a newly rational belief and accept the emotions that accompany it.

The REBT approach acknowledges that although insight is an essential component of recognizing and changing distorted beliefs, it is not adequate to promote change in and of itself. REBT therefore employs several techniques to aid in the experiential development of universal acceptance as applied to the self, others, and life. Most are geared toward helping clients to practice engagement with new, more rational beliefs that emerge out of the disputation process. This may involve active engagement in a feared situation, or purposefully attempting a task that had previously resulted in failure and negative emotional consequences, often assigned as “homework” between sessions. The client is tasked with taking over the role of the therapist in disputation of their thoughts, and REBT often utilizes worksheets to provide structure and aid clients in generalizing from the therapy room to outside situations. The goal is to allow newly rational beliefs and thinking to produce more positive emotional experience through interacting with a world with which those beliefs are well-matched.

Humanistic Perspectives

Humanistic ideas of acceptance, centered around that of the self, are a result of the approach's foundational view of human beings as essentially good, and naturally tending toward positive growth when unrestrained by negative experiences that are then judged negatively by others. Theorists like Maslow and Rogers held that acceptance of one's faults, flaws, and limitations was an essential component of self-actualization, the fulfillment of human needs, growth, and potential (Hoffman et al., 2013). The self is characterized wholistically and cannot be broken down into components to be individually modified in the way that behaviorist theorists and practitioners advocate.

Humanistic conceptualizations of pathology and distress focus on the features of the environment that interrupt or obstruct the natural tendency toward self-actualization. Illustrating such features may involve exploration of an individual's developmental environment, with an emphasis on the qualities of important relationships (e.g., primary caregivers) who may have inadvertently or intentionally placed limitations on the expression of aspects of a child's whole, developing self. For example, a parent's own unmet needs may distort their ability to attend to a child's experience of negative emotions, resulting in the child's suppression or redirection of those emotions to maintain a desired and essential relationship and the fulfillment of their more basic needs.

The primary method of guiding clients toward self-acceptance is not based on particular techniques but is instead centered in the relational stance taken by a humanistic-oriented therapist as exemplified by three primary therapeutic principles: congruence, accurate empathy, and unconditional positive regard. Humanistic practitioners strive to express *congruence* through being open, honest, and genuine, which reflects the approach's emphasis on a wholistic self. Humanistic clinicians seek to

engage and reflect with accurate *empathy* in order to maximize both the therapist and client's access to and understanding of that whole self and the breadth and depth of their lived experiences. Finally, humanistic practitioners approach clients with *unconditional positive regard,* accepting and supporting the client as a whole person whose value is not diminished by what they do. In placing no conditions on such interpersonal acceptance, clinicians hope to provide an environment in which clients can engage with natural self-growth processes that may have been unavailable in other developmental settings. While these three principles of therapeutic relational attunement were originally coined by psychologist Carl Rogers as part of a humanistic response to the impersonal and disconnected stance advocated in early psychoanalytic and psychodynamic practice, nearly all modern psychotherapy approaches have adopted them in recognition of research highlighting the role of the therapeutic alliance in predicting therapy outcomes.

Acceptance of the self is also fostered through guided exploration of developmental limitations of that self, as described above. Throughout this process clients are encouraged to recognize their development in the context of the choices and responses that were available to them at the time. This can be contrasted with the biases in thinking individuals tend to employ toward themselves in hindsight, such as evaluating their performance in the past based on what they know now. Clients' self-judgements are commonly paired with self-empathetic statements that recognize the limitations of the individual as well as their environment. In doing so, clients are encouraged to accept responsibility for meeting their own needs given the resources available to them, rather than blaming others for denying something entitled to them. Clients are also encouraged to accept responsibility for behavior that contrasts with their values, and to access and

process the natural feelings (e.g., remorse, regret) that may arise. Self-judgement is characterized not merely as a behavioral obstacle to growth, but as a natural consequence of a client's developmental process and therefore another target of empathic listening, reflective exploration, and acceptance. As a consequence of acknowledging an individual's self- and environmental limitations, that individual is confronted with the necessity of experiencing and accepting feelings of powerlessness.

Dialectical Behavior Therapy

Previously elaborated in discussion of the Metacognitive Observer, Dialectical Behavior Therapy (DBT) was originally developed to address the intensity, lability, and negativity of emotional experience in those dealing with suicidal tendencies and borderline personality disorder. Its theoretical underpinnings posit that these features associated with borderline personality disorder arise through high inborn emotional sensitivity that is activated by invalidating developmental environments unable to adapt to the expression of that emotional sensitivity. The consequence of this combination ends up producing self-destructive emotion regulation strategies. Much of DBT focuses on teaching skills to individuals for dulling the impact of emotional intensity, allowing navigation of social environments more able to meet the needs of individuals with borderline personality disorder. Acceptance is an essential theme of DBT, both in terms of immediate experience (as discussed briefly in the context of nonjudgment as a way to grow the MO) and more broadly in fostering "radical acceptance" of one's needs, obstacles, and environment as they truly are.

Owing to the conceptualization of borderline personality disorder as stemming partly from high emotional sensitivity, Dialectical Behavior Therapy incorporates distress

tolerance techniques as an essential component of self-regulation. Much of the focus of distress tolerance is directed toward ensuring that an individual can endure a crisis such as urges toward self-harm or other instances of overwhelming emotional negativity or intensity. However, distress tolerance techniques also play a role in facilitating non-judgment of immediate experience by taking an individual from a state of emotional overwhelm, in which intentional access to current experience is impossible, toward a state of emotional intensity that is manageable enough to act upon. Not all therapy clients will find themselves in crisis, but the ability to "take the edge off" of emotional intensity can make engagement with one's immediate experience more accessible. One cannot accept what cannot be tolerated. To this end, distress tolerance techniques such as sensory mindfulness exercises, focused breathing, positive imagery, and others can help to bring acceptance within reach.

The approach to mindfulness taken by Dialectical Behavior Therapy, like those of many other approaches, incorporates non-judgement as an essential component of accessing immediate experience. Several techniques have been suggested to aid in this endeavor, some of which have been reviewed in previous chapters. For example, imagery exercises in which clients are guided to visualize their thoughts and other inner experience as clouds drifting through the sky or leaves floating past on a river can aid in separating experiences from the experiencer and in engaging language to describe mental events as experiences of the self that are transitory and limited in scope. A therapist may also aid an individual in constructing a list of the ways in which they express judgement in their speech and communicated thoughts, which could aid them in recognizing judgements that occur in the moment. DBT characterizes inner experiences not as good

or bad, but as an expression of preference, and reframing judgements in this manner can aid clients in transforming their evaluations of themselves and their world into non-judgmental descriptions of experience. Clients then begin to describe their thoughts and emotions as experiences they are having rather than realities they inhabit.

Once an individual begins to develop skills in nonjudgmentally accessing various aspects of their immediate experience, DBT begins to shift toward applying acceptance more broadly to navigate situations in which that individual has limited or no power to change their external circumstances. This process is exemplified by grief and loss when that which is no longer present cannot be re-obtained by any means. Under such circumstances, continuing futile attempts to re-acquire what is unavailable is likely to lead to non-adaptively allocated resources as well as feelings of frustration, sadness, and hopelessness. With an eye to the emotional sensitivity common to individuals with borderline personality disorder, DBT does not suggest complete detachment from emotion, but a refocus on differentiating pain from suffering. In this view, suffering is conceptualized as distress arising from resistance to pain based on a need for the world to be different than it is (e.g., for a source of pain to not exist). As a skill, radical acceptance therefore involves recognizing situations in which an individual does not have the power to change their circumstances, as well as accessing and acknowledging the natural emotions produced without becoming caught up in them. DBT utilizes techniques of distress tolerance as well as a cognitive approach that focuses on recognizing thoughts and other internal events that can contribute to disproportionate emotional reactions to the world as it is. The dialectic of the ”wise mind” is employed to aid individuals in balancing validation of their emotional experiences and the logical evaluations of those

experiences. Recall that in DBT, the "wise mind" is one that effectively synthesizes the rational and emotional spheres in order to respond to stimuli in a way that is not reactive but instead reflects and expresses a more wholistic experience.

There is no standard procedure for aiding clients to exercise radical acceptance, but strategies commonly employ a sequential process that incorporates ways to help recognize situations that cannot be changed, non-judgement of emotions as they arise, and empathetic self-statements that help to reframe situations into a more adaptive perspective in line with the "wise mind." DBT often encourages clients to externalize their thought process onto worksheets designed to elicit context, list those aspects over which the individual has control and those over which they do not, and to visualize what their approach to a challenge would look like were they able to let go of unhelpful attachments.

As a complement to present-centered mindfulness, clients are reminded that "the past is the past," and therefore unavailable as targets of change, while the future remains unwritten and responsive to decisions made in the present moment. Clients are supplied with, and encouraged to create, coping statements or "mantras" to act as reminders and aspirations for problem-solving, while reminders of unhelpful thinking styles such as black-and-white thinking and catastrophizing aid clients in recognizing deleterious paths of thought. Throughout this process, clients are encouraged and aided to access and process the natural emotions that arise from "giving up" attachments, including disappointment, grief, and loss. DBT clinicians emphasize practicing radical acceptance in everyday life, as building an adaptive habitual process is more likely in low-stress, emotionally manageable moments rather than first employed during crises.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy approaches broader ideas of acceptance such as that of the self or of the world as it is through their representations in immediate subjective experience. Thus, to be accepting of the self is to have access to and tolerate the variety of inner experiences that make up one's experience of the self, including evoked emotions and thoughts. According to Hayes (2002), acceptance refers to the willingness to be in contact with the full range of one's private experiences (e.g., thoughts, emotions) without regard to their subjective quality and without unnecessary avoidance. Acceptance of one's flaws and limitations is therefore expressed in ACT as tolerance of the feelings and thoughts that accessing them evokes. This view has significant overlap with that of CALM-MO because of its implications for psychological mindfulness and applicability to the sort of in-the-moment reactivity that CALM-MO was developed to address.

Acceptance and Commitment Therapy promotes in-the-moment acceptance of inner events through the practice of mindfully accessing these experiences, acknowledging and managing distress, and applying a stance of non-judgement in order to de-couple inner events from the reactive and often overwhelming emotional responses that lead to ongoing avoidance. In addition to techniques for mindfulness and cognitive defusion previously discussed in the context of the metacognitive observer, ACT practitioners have developed several general guidelines and specific exercises to increase motivation for, develop, and maintain experiential acceptance.

One technique tailored to enhancing an individual's motivation to consider acceptance as an alternative to control encourages a client to consider a problem or

negative emotion inducing thought, and estimate how often it has "crossed their mind" during the past week. Over a period of several minutes, the client is then encouraged to actively suppress the thought as best they can, while tracking how often the thought arises during this time. Finally, the client is allocated an equal amount of time but instructed to spend it doing whatever comes naturally, including thinking of other things and exploring their environment. During this period the client again tracks any occurrences of the target thought. Following this exercise, the ACT clinician aids the client in debriefing, focusing on how each chosen strategy actually affected the frequency of the unwanted thought. Often, clients find that active avoidance of the thought results in no fewer, and sometimes more numerous, occurrences of the thought. Active avoidance may also correspond to a higher subjective rating of distress regarding the target thought.

Techniques for increasing access to and tolerance of negative emotions are often adapted from mindfulness meditations as described in the previous chapter on the Metacognitive Observer. However, these exercises build upon these strategies of increasing non-judgmental distance between the experiencing self and the internal events it observes, and encouraging clients to actively and intentionally "touch" unpleasant emotions and thoughts. In the context of anxiety, this may involve a mindfulness meditation in which clients are encouraged to shift their attention toward discomfort as it arises, and to visualize "making space" for the thoughts and feelings that result while maintaining a nonjudgmental stance. Clients are reminded to be mindful of their physiological reactions to the exercise, and to openly acknowledge urges to turn away or avoid discomfort while "making space" for these experiences as well. Regular practice is intended to decouple direct access to discomfort from the felt necessity to avoid it.

Clients begin to enact this strategy with the guidance of a clinician in the context of a therapy session, and work toward developing the necessary skills to do so in their daily lives outside of therapy.

Once sufficient skill in experiential acceptance is developed, clients are encouraged to continue generalizing the practice to as many areas of their daily lives as possible. This may involve transitioning from worksheets created after-the-fact to an emphasis on in-the-moment tracking of acceptance strategies. The goal is to reach a state of automaticity in which the enactment of acceptance self-interventions itself becomes a fluid and flexible process that is responsive to what is happening in the moment. Strategies previously only available to practice in low-stress, low emotional intensity situations become available options even in circumstances that would previously have resulted in overwhelm and detrimental avoidance behaviors. Clients are encouraged to reflect on a sense of success and even mastery of these skills, and continued engagement with the world is expected to result in experiential change through the responses of the client's social and personal environments to their new approach to avoidance.

As a result of the development of ACT as a research grounded psychotherapy approach, several resources have been generated to promote and track change throughout the intervention process. One such resource is the Acceptance and Action Questionnaire, 2nd Edition (AAQ-2). The AAQ-2, which was developed in 2011 (Bond et al., 2011), is an update to the original AAQ and was developed as a measure of experiential avoidance, or an individual's reluctance to engage with private events (e.g., emotions, thoughts, memories) and tendency toward behaviors that seek to decrease the frequency of such private events. The AAQ-2 is intended for use in clinical settings, both as a screening tool

and as a way to track treatment progress within ACT-oriented intervention. Items emphasize an individual's need for control and negative evaluations of their inner experiences, as well as their difficulty in taking action without such control. Several studies of the AAQ have found it to be internally consistent and reliable across administrations, settings, and populations (Bond et al., 2011). Validity is bolstered by the AAQ's adaptation to numerous languages (e.g., Spanish, Mandarin, and Turkish) without deleterious effects on the scale's psychometric properties.

Acceptance in the Context of CALM-MO

The four theoretical approaches discussed above differ in their ideas of what constitutes acceptance, but these differences are mostly reflective of the way each of their philosophical foundations impact their views of people, behavior, and dysfunction. While Rational-Emotive Behavior Therapy sees any form of judgement based on expectations of what "should" be as problematic and mismatched to the way the world works, Dialectical Behavior Therapy seeks a balanced approach to the expression of judgement that focuses on an individual's experience of distress, especially in situations in which an individual is powerless to enact change over their environment. Humanistic approaches emphasize acceptance of the self as an irreducible whole, while Acceptance and Commitment Therapy breaks down all of these forms of acceptance in terms of their in-the-moment expression.

The view of acceptance found in CALM-MO corresponds most strongly to ACT's general perspective because of its applicability to situational and experiential reactivity, which can arise in response to how an individual sees themselves as well as how they experience often unyielding environmental stressors. Overlap also exists between

CALM-MO and DBT, and to a lesser extent REBT, regarding “radical acceptance” which eschews the process of judgement itself to varying degrees. CALM-MO does not necessarily subscribe to the philosophical foundations of REBT in determining judgement to be fundamentally incompatible with acceptance of what is, but it does reflect the practical value of rejecting judgement processes emphasized by DBT. Whether our evaluations are reflective of reality or not, it is the dysfunction and distress they produce that is the target of therapeutic intervention, rather than their empirical value.

The role of acceptance in both Acceptance and Commitment Therapy and CALM-MO reflects fundamental humanistic assumptions about human growth and potential. The goal of reducing experiential reactivity is one of removing developmentally grounded barriers to natural growth processes. Both CALM-MO and ACT rely on these processes to, once such barriers are removed, allow an individual to accumulate corrective emotional experiences by navigating the world through a new frame of reference for making meaning of those interactions. Behavioral Investment Theory helps to describe how these changes might begin to re-orient individuals’ behavior toward a positive feedback loop based on changes in the individual’s internal model of how they and their environment interrelate. The developmental lens through which this change has been conceptualized points to a developmental approach in promoting such change.

Effective application of CALM-MO would take a developmental approach not only regarding the skills involved, but also in applying those skills to more and more complex phenomena. With mindfulness skills as a foundation, acceptance work would follow a similar path to that outlined above in ACT in which interventions are tailored to

the motivational and skill level of the client. Interventions designed to introduce acceptance as a viable alternative to clients' preferred strategies, such as tracking the frequency of unwanted internal events in a "field experiment" between options, are an excellent starting point and can be impactful at early stages of treatment in which clients are just learning new mindfulness and distress tolerance skills. The same mindfulness skills that aid clients in learning to observe and describe their inner events can then be used to more actively and intentionally access those experiences, especially those that are subjectively negative and challenging to tolerate.

As clients begin to develop some level of automaticity in these skills and spontaneously generalize them to new situations and environments, this micro-level intervention strategy may shift to allow the therapy room to hold explorations of a client's perceptions and beliefs about themselves, about others, and about the world and their lives. Exploration of these broader concepts with a focus on acceptance is important because this is the level at which narrative meaning is constructed. It is therefore essential to engage with a client's ego (i.e., internal private narrator) to connect gains in experiential tolerance to the self-narration processes that aid in building continuity of self and the related task of justifying our methods of pursuing needs, both to others and to ourselves. While building tolerance of discreet, potentially dysregulating inner events involves adaptive adjustment of the *Freudian filter* that works to maintain homeostatic continuity between experiential stimuli and self-reflective awareness, engaging in broader forms of acceptance works to adaptively modify the *Rogerian filter* by allowing for the open social expression of previously withheld aspects of self. The potential impacts on an individual's interpersonal environment are immense, as the possibility of being known

and valued as a more wholistic and genuine self provides a higher sense of relational value, and would be expected to correspond with increases in positive emotions that reflect those relational value changes, as described by the *Influence Matrix*.

The goal of reducing reactivity is served not only by promoting acceptance of inner experiences and broader conceptions of the self, but also by increasing acceptance regarding our expectations of what we are "due" from others, life, and our environments. As previously described, the Influence Matrix aids in describing the processes by which individuals developmentally calibrate expectations of their social environments based on which internal states do and do not lead to increased relational value. On the micro-experiential scale, ACT impacts outwardly-oriented acceptance by allowing individuals to more readily tolerate the inner events produced by interactions with the world. REBT seeks to do so by severing all attachments to expectations of others and of the environment, as it characterizes such attachments as inherently problematic and mismatched to reality. While CALM-MO does not share this philosophical position, clients are still likely to benefit from using psychological mindfulness skills to reflectively evaluate their perceptions of what they are owed by others and the world. This is especially salient if individuals' perceptions of what they are owed relates to their own sense of control, in which case DBT-based exercises to identify and accept areas in which that individual does or does not have power, and to adjust goals and behavior accordingly, are likely to be relevant. This form of radical acceptance is consistent with CALM-MO, and is responsive to connections between one's perceptions of the world and held values such as fairness and justice.

Henriques describes the role of the therapist as akin to that of a guide and recommends a stance corresponding to the principles laid out by Carl Rogers: genuineness, accurate empathy, and a deep, foundational positive regard toward the dignity of the person. These principles have been generally acknowledged across theoretical approaches as leading to strong therapeutic alliance, which remains the most powerful predictor of positive therapeutic change (Baier, Kline, & Feeny, 2020).

Practitioners of REBT emphasize the same principles in their approach to clients, but their expression in REBT is very different from that in humanistic therapies. Ellis advocated for an active-directive approach that involves identifying problems to clients and up front firmly to counter resistance such as efforts to divert attention, rather than the employment of curiosity to aid clients in recognizing therapeutically relevant issues on their own. Generally speaking, CALM-MO is most consistent with the latter approach both because of its alliance-building strengths and because it showcases modeling many of the components clients might benefit from applying to themselves, such as curiosity and acceptance. However, REBT clinicians maintain that it is possible to be forcefully directive without being judgmental. It may also be the case that other therapeutic factors may tip the balance of which approach is more advised. REBT tends to be a short-term therapeutic modality, while humanistic therapies tend to emphasize longer-term work. Additionally, some clients may be more responsive to an active-directive approach, or respond negatively to the approach of a humanistic practitioner. While this negative reaction may in fact become “the work” in therapy, it may be helpful for therapists to be flexible with their approaches based on factors of the client, of the presenting problem, and of the time available.

Chapter 7: Loving Compassion Toward Self and Others

The development of approaches to psychological intervention centered around compassion is a relatively recent phenomena, although as a concept compassion has been featured within many theoretical paradigms, especially Humanistic approaches. Leading figures in applying compassion toward therapeutic ends such as Paul Gilbert, Kristen Neff, and Christopher K. Germer define compassion in slightly different but largely overlapping ways. Gilbert describes it as "a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it." Neff considers compassion to be an expression of "the recognition of suffering… feelings of kindness for people who are suffering, so that the desire to help emerges" and that it involves "recognizing our shared human condition, flawed and fragile as it is." While they differ on whether effortful action is required, each of their definitions include several key elements in common, including those of awareness, understanding, orientation, and motivation. Specifically, compassion requires an awareness of the existence of suffering as well as recognition of the universal nature of pain within the human condition. Compassion then involves an orientation of kindness that does not retreat from pain, and finally motivation toward alleviating that suffering.

Self-compassion, then, is the act of directing these elements inward: to attend to our own suffering, understand and normalize it in the context of human experience, directing feelings of warmth and kindness inward, and focusing energy and action toward relieving our suffering. In the clinical context, self-compassion takes a step beyond non-judgment of the self, which was discussed in the previous chapter on acceptance. Instead of a focus on deterring both positive and negative self-evaluation, self-compassion

implies an inherently kind and connected baseline, which becomes a frame of reference for evaluating the self and the world it navigates. This work will attempt to review the knowledge and experience of practitioners and theorists in the clinical application of compassion as it applies to the stance taken by the metacognitive observer in promoting therapeutic growth. While the general focus in therapy is on self-directed compassion, CALM-MO also embraces building a compassionate view of others based on the relationally-bound nature of human behavior.

Compassion-Focused Therapy

Paul Gilbert's Compassion-Focused Therapy (CFT) is philosophically derived from Buddhist ideas of compassion and mindfulness, and theoretically grounded in an evolutionarily informed and functionalist view of the interactions between social motivation systems and emotional systems. Called social mentality theory (Gilbert & Irons, 2005), this view highlights the role of social selection processes in the evolutionary development of the human brain and argues that these pressures have shaped our nervous systems to be disproportionately devoted to social processing, as compared to the rest of the animal kingdom. Gilbert argues that the cognitive capacities that take center stage in many therapeutic approaches (e.g., Beck's CBT) are relative newcomers to human functioning, and are predated and heavily influenced by social motivations and related emotions. In Gilbert's view, these more recent cognitive functions are "domain specific" processes: they evolved to facilitate information processing within the context of more basic motivational systems (e.g., attachment, sex), and are embedded in expression of these drives.

The expression of basic motivation systems is facilitated by emotions, which serve to track and provide orienting information regarding the dynamic relationships between motives and the environment. CFT focuses on three regulatory emotion systems, each evolved to perform a particular function in the context of social interaction. These are the *threat protection system*, the *drive and excitement system*, and the *contentment and social safeness system* (Gilbert, 2014). The threat and protection system evolved to orient attention toward potential social or other dangers, and to utilize subjectively negative emotional states such as fear, anger, and disgust to enact contextually-bound self-protective behaviors like the fight or flight response, submissive behavior, and others. This system also organizes cognitive biases that act as shortcuts within the domain of self-protection that are responsive to experience, such as attentional biases and stereotyping. The drive and excitement system directs individuals toward behaviors that facilitate the acquiring of resources via positive emotions like anticipation and pleasure. In social contexts this system is also active in fostering competitive behavior which seeks to broaden resource access through gains in relative social position. The contentment system seeks a positive state of being socially connected, cared for, and safe. The associated emotion is happiness, which in contrast with emotions for responding to threats of seeking and achieving is focused on calming and soothing, thus acting as a regulating system for the threat and drive systems when an objective has been obtained and no threat is present. It is worth noting here that these perspectives are congruent with how UTOK frames humans as primates via Behavioral Investment Theory and the Influence Matrix.

In practice, CFT emphasizes the links between these systems, their associated needs, and domain-specific cognitive patterns of expression. These elements have a history of evolutionary development that involves several "trade-offs" regarding the layered nature of human nervous system organization, a pattern of form that appears to relate to a similar pattern of function. In recognizing that many cognitive functions are domain-specific, that is, embedded within more basic motivational systems, CFT recognizes the pattern of evolutionarily newer systems operating in regulatory roles in relationship with evolutionarily older systems. In modern humans, the relatively recent development of cognitive capacities such as imagining, anticipating, symbolic representation, and a discrete since of objective self are capable of stimulating threat detection systems absent the presence of an actual threat. This gives rise to the possibility of emotion-system activation in response to a simulated stimulus rather than one actually present in the environment. According to Gilbert this process describes the source of much psychological distress, but it also presents opportunities to engage the same process for the purposes of personal growth and psychological well-being.

According to its theoretical foundations, Compassion-Focused Therapy is distinct from cognitive behavioral approaches like those of Beck and Ellis because it targets the evolutionarily older and more basic motivation and emotion systems directly, rather than seeking to correct cognitive processes that are embedded in, and heuristic expressions of, those systems (Gilbert, 2009). Gilbert also differentiates CFT from approaches that focus on the experiential quality (e.g., Emotion-Focused Therapy) or avoidance (e.g., Acceptance and Commitment Therapy, Dialectical-Behavior Therapy) of negative

emotions, with CFT instead emphasizing the facilitation of affiliative emotions toward the self and others.

In order to facilitate positive change, Compassion-Focused Therapy seeks to activate the contentment system in order to aid in the regulation of the threat system, and to augment the availability of the growth-seeking drive system. Interventions follow a two-pronged approach: while some are focused on the development of a caring and nurturing attitudes toward the self and others, additional intervention seeks to augment the ability of the individual to receive and engage with such care and nurturance from others and from the self. Skills in mindfulness, non-judgement, stress tolerance, and meta-cognitive monitoring are fostered in order to facilitate access to the benefits of interventions that develop compassion and the ability to receive it.

The initial phases of CFT revolve around providing theoretically grounded psychoeducation and insight-forming exploration centered around de-shaming and de-blaming and the development of an individual's threat-based, drive-based, and affiliative coping strategies. Foundational skills in mindfulness and distress tolerance are taught during these initial phases, and these have been reviewed in previous chapters. However, CFT is more likely to target mindfulness toward the intentional experiencing of positive and enjoyable stimuli in order to focus on the expression and receiving of soothing compassion later in treatment.

Following this, CFT focuses on what Gilbert (2009) terms "compassionate mind training," which involves the development of skills to counter internal shame, self-criticism, and self-condemnation. According to Gilbert and Procter (2006), self-criticism may be a regulatory strategy to maintain attentiveness and to avoid and correct mistakes.

Self-criticism may also function as a method of self-harm in an expression of self-directed contempt or anger, serving to rid the self of negative aspects. This functional view has implications for treatment in that simply removing self-criticism without providing an alternative strategy for fulfilling the functional role that criticism served is likely to result in excessive distress and relapse. The following exercises are designed to encourage self-compassion as a more adaptive substitute in that functional role.

Many interventions follow behavioral principles such as encouraging behaviors that are incompatible with self-criticism during moments that it is likely to occur. For example, a therapist and client might explore recalled experiences of receiving compassion, or to express what their ideal form of receiving compassion from another would be. This information would be used by the client to practice visualizing caring and encouraging expressions directed at them. The client is then directed to visualize the receipt of compassion in this way during difficult situations that arise both in the therapy room and in everyday life. This is seen as especially impactful for clients who are prone to feelings of guilt or fear in response to positive emotions and situations, and is intended to aid them in building the ability to receive compassion that they will later be directing toward themselves.

Imaginal exercises encourage clients to visualize the benefits of having certain desired qualities such as wisdom, strength, and compassion. In the process of imagining this aspirational “best possible self,” clients are guided toward reflecting, reasoning, and acting from that self. For a client who displays excessive self-criticism, and example of this process might be to encourage the client consider how they approach a loved one with compassion, and to imagine how they would go about attending to, understanding,

and behaving toward themselves in a similar manner. This includes attending to aspects of facial expression, posture, tone of voice, and other important non-verbal aspects of communicating warmth in addition to compassionate speech content and action. The goals of this exercise are to build skills in the experiential application of desired attributes, especially self- and other-compassion, and to behaviorally practice a compassionate self-identity. In other words, the client works to develop a sense of what it is like, or what it could be like, to be a compassionate self. The client is encouraged to be mindful of which "part" of them is active during these exercises, and to explore how their different parts would approach situations in different ways.

The insights gained from such imaginal exercises are often applied to role-play or method acting exercises in which clients play the role of a deeply compassionate person, again focusing on the expression of both verbal and nonverbal communication in projecting this role. Such role-play may involve the client acting compassionately toward another or taking on the role of another in acting compassionately toward themselves. Debriefing focuses on reinforcing the positive affiliative emotions that are evoked by the exercise.

Exercises in the receiving of compassion are intended to aid clients in accepting warmth and caring from others, as well as remaining open to the expressions of compassion they practice toward themselves. Recall exercises, like imaginal and role-playing interventions, include an emphasis on the embodied aspects of compassion. For example, a client may be prompted to recall an instance in their past when a person was kind to them, without focusing on potential distress that the kind person was responding to. The client is then encouraged to adopt a facial expression and physical posture

cultivated in earlier exercises and which is consistent with the open receipt of warmth, caring, and safety. The client is guided in mindfully reflecting on what it felt like to receive kindness, and the sensory input that accompanied it, such as the person's words and tone. Finally, the client is encouraged to mindfully experience and express resulting feelings of gratitude and warmth toward the kind person and themselves.

Once a client begins to develop adequate skills in approaching the self and others with compassion, and in receiving warm and caring support from themselves and others, CFT shifts toward using the now-trained compassionate mind to approach specific problems that the client may be facing. This may include current relational stressors, symptoms of psychosis, or traumatic memories and their impacts. Owing to the fact that individuals tend to approach unresolved problems in ways that are familiar but not necessarily historically effective, clients may benefit from refreshing access to compassion via imagery and role-play exercises previously described with a specific focus on how that compassion applies to the problem at hand.

Kristen Neff's Self-Compassion

In describing the role of compassion in psychological treatment, Dr. Kristen Neff identifies mindfulness and experiential acceptance as necessary but inadequate agents of self-growth. While open and nonjudgmental awareness has the potential to allow an individual access to the full range of their experiences, and acceptance provides the opportunity to disentangle those experiences from negative emotional states, Neff holds that to heal more fully the individual must embrace the experiencer (themselves) with the warmth and tenderness they are due as a person (Neff, 2015).

In emphasizing basic dignity as afforded to all, Neff de-emphasizes self-esteem as a target of enduring psychological well-being (Neff, 2011). Echoing Albert Ellis, she points out that positive self-evaluation is sometimes an exercise in self-inflation at the expense of acknowledging our limitations and flaws, with those perceived negative attributes acting like land mines that may be triggered whenever our environments expose them and our attempts at self-inflation fail. Furthermore, Neff says that "chasing" self-esteem involves constantly moving goalposts that never allow an individual to feel "good enough," especially in the context of social comparison.

Neff departs from Ellis' solution that logical reasoning is the key to overcoming dependence on positive evaluation. Instead, she emphasizes compassion as an antidote to self-critical internal process that does not depend upon the need for positive comparison to others or to unrealistic expectations. She suggests that self-compassion is an enduring, long-term growth strategy because it is not dependent upon our behavior meeting a particular standard of performance and is therefore most impactful in instances where an emphasis on self-esteem is likely to result in negative feelings such as moments of failure and feelings of inadequacy. Several studies appear to support the idea that high self-compassion holds similar benefits to high self-esteem in varying situations without the negative drawbacks identified above (e.g., Neff, Kirkpatrick, & Rude, 2007; Neff & Vonk, 2009).

In seeking to differentiate the construct of self-compassion from self-esteem, and to highlight differences in outcomes associated with each, Neff (2003) developed the Self-Compassion Scale (SCS). The SCS consists of 26 items loaded onto 6 factors of overall self-compassion, including a tendency of warmth toward the self (*self-kindness*),

tendency for inwardly-directed criticism (*self-judgment*), connectedness to the broader human experience (*common humanity*), feelings of separateness associated with failure (*isolation*), awareness of inner experience (*mindfulness*), and becoming stuck in negative emotions (*over-identification*). Low overall self-compassion scores are associated with higher likelihood for depression and anxiety, and individuals who underwent self-compassion training both increased their SCS overall scores (Neff, 2016) and had reduced incidence of depression and anxiety. Discriminant validity is strong, in that the SCS is moderately related to measures of self-esteem but does not share those measures' associations with scores on scales of narcissism.

The SCS was originally created in a research context, and this along with its length may make it ill-suited as a clinical screening or tracking tool. However, a short form version (SCS-SF) was more recently developed that consists of 12 items and is more likely to be useful in clinical contexts emphasizing self-compassion intervention (Raes, Pommier, Neff, & Van Gucht, 2011). This version demonstrates acceptable internal consistency and a near-perfect correlation with the long-form SCS using the same six-factor structure with an overall self-compassion score.

Neff identifies several exercises that individuals can use to increase self-compassion in their everyday lives, and many of these can be utilized in a therapeutic context. Mindfulness skills are a prerequisite for successful engagement with these exercises, and methods for developing mindfulness has been covered in a previous chapter. One such exercise is called "supportive touch," and it involves engagement of the parasympathetic nervous system to regulate negative emotional intensity and seek a sense of safety and security through self-directed physical contact. Once stress is

detected, a client would be encouraged to take several intentional and mindful breaths, and then to use their bodies to enact the sort of warm and comforting gestures that they might use to calm a loved one or child. This may involve placing a hand over the heart, gently stroking one's arms, or cradling one's face in one's hands, among many other possibilities. The therapist would encourage trials of several options as well as mindfulness of how each position feels and is received in order to find those most effective for a particular client. Once preferred touches are found, clients are further encouraged to mindfully attend to various aspects of the experience, such as the physical pressure or warmth as well as the subjective meaning of their gestures. Similar to many of the techniques of Compassion-Focused Therapy such as role-play, this exercise emphasizes embodied aspects of both giving and receiving compassionate attention.

Another exercise suggested by Neff involves challenging critical self-talk. While Cognitive-Behavioral Therapies tend to focus on evaluating evidence and the truth value of self-talk as a method for counting negative self-evaluation, this exercise emphasizes the application of compassion both to the self being criticized and the part of the self acting as the critic. Beginning with elements of mindfulness as applied to the "voice" of the inner critic, Neff suggests attending not only to the situations in which it tends to speak and the content of that speech, but to the tone, affect, and any reminders of past real people in the individual's past or present life. The next step is to effortfully soften the critical voice as if speaking compassionately to another. This may involve recognizing the emotion energizing the voice (e.g., fear or worry), acknowledging that these emotions are connected to a lack of perceived safety, and recognizing the negative effects on the self that the voice has (e.g., pain). After this acknowledging statement, the individual

intentionally engages a compassionate "counter-voice" to communicate the same core information as the critic, but in a more loving way. This voice's statement would be akin to what an especially compassionate loved friend would say and would acknowledge the criticized behavior and its intended and undesired consequences, the behavior's influences and associated emotions, self-affirmation (e.g., "I want you to be happy) and suggestion of a comforting behavioral response. Neff encourages pairing this compassionate reframe with physical gestures of tenderness and support such as those featured in the "supportive touch" exercise.

The exercises detailed above are not necessarily designed for use in the context of clinical practice. They are intentionally constructed to be applicable to nearly anyone in the navigation of daily life, and this is part of their potential value as clinical techniques: to extend and practice any gains resulting from guidance in the therapy room to the client's other roles and environments. This applicability may also place them on a spectrum of potential interventions that is responsive to client needs and skill development. Such exercises might be introduced with guidance in-session, assigned as generalizing, between-session practice without guidance, or suggested as tools for the maintenance and further growth in self-compassion after the conclusion of therapy.

Mindful Self-Compassion

While much of the focus of intervention discussion thus far has been in the context of individual therapy, this is not the only medium for promoting growth in individuals who are interested in change. Like CALM-MO itself, compassion-focused intervention has a potential role with individuals seeking self-growth in non-clinical settings, as well as in therapeutic group settings. Dr. Kristin Neff and Dr. Christopher

Germer developed Mindful Self-Compassion (MSC), a group-therapy oriented approach to accessing the benefits of self-compassion. As described by Germer and Neff (2019), the program relies on mindfulness for the purposes of recognizing suffering and to ground awareness through a process that can evoke challenging emotions. Indeed, in the application of self-compassion an individual might naturally be confronted with the instances in which such compassion was missing, both from the self and from important others. However, Germer and Neff differentiate MSC from mindfulness-based interventions (e.g., Mindfulness-Based Cognitive Therapy, Mindfulness-Based Stress Reduction) in that these focus on awareness and engagement with experience, while compassion is directed at the experiencer. This shift in focus from experience (e.g., of pain and suffering) to experiencer of that suffering has implications for the purpose of practicing self-compassion. As Germer and Neff write, "When we suffer, we practice not to feel better but *because* we feel bad."

Rather than a focus on "healing old wounds," which Germer identifies as the territory of psychotherapy, Mindful Self-Compassion emphasizes skill and resource development within the general population, although Neff and Germer also note that in developing a new way of approaching the self, an individual also tends to learn a more compassionate approach to navigating previous injury. A typical group consists of 8-25 individuals, and the structure makes use of 8 meetings of 2 ½ hours each, followed by a 4-hour silent meditative "retreat." The program also encourages at least 30 minutes of home-based practice per day. Sessions 1 and 2 are primarily didactic, and function to orient group members to the course and to introduce and build core mindfulness skills. Session 3 introduces "loving kindness," which Neff and Germer describe as a less-

challenging precursor to compassion and aids individuals in identifying personally meaningful "compassion phrases" for later meditation. Session 4 is focused on compassionate self-motivation as an alternative to self-criticism, as well as processing the challenging feelings that may arise as a result of approaching the self compassionately. Session 5 is devoted to compassionate listening, both to the self and to others, and is followed by a 4 hour silent "retreat" in which immerse themselves in applying skills learned so far. Following this, session 6 emphasizes skills and practice in approaching difficult emotions, while session 7 turns members' attention toward challenging relationships with emphasis on anger, caregiver fatigue, and forgiveness. Finally, session 8 closes the course with positive psychology practices such as savoring and gratitude.

The exercises taught in the Mindful Self-Compassion course, which often come in the form of guided meditation, are tailored to members' skill development and in later sessions build upon those skills learned earlier on. One example, called the "self-compassion break," is provided in the introductory session of MSC and immediately follows didactic information on the constituents of compassion (i.e., recognition of suffering, identifying with the human condition, and kindness) as practice in enacting them. Beginning with mindful awareness of some form of suffering (e.g., physical pain), an individual is encouraged to locate the suffering in the body. The individual is then guided to acknowledge contact with this sensation as a moment of suffering through self-talk (e.g., "this hurts," "I feel stress"). The individual is then guided to remind themselves that suffering is a part of life (e.g., "I am not the only one who feels suffering," "this is how it feels when a person struggles"). Finally, the individual is encouraged to wish

kindness upon themselves (e.g., “may I do the best I can for myself”). This exercise reflects MSC’s early focus on loving kindness as a precursor to self-compassion.

Another exercise, introduced in session 6, is focused on addressing difficult negative emotions. Called “soften-soothe-allow,” this exercise begins with emotion mindfulness, including locating the expression of the emotion in the body and labelling the emotion, with individuals encouraged to repeatedly name the emotion to themselves. After identifying the emotion as well as a single location in the body in which it is most strongly expressed, the individual uses skills taught in mindfulness practices (e.g., progressive muscle relaxation) to “soften” that location, either by relaxing associated muscles, or imagining the application of a warm compress. The individual then is encouraged to soothe themselves for their suffering by utilizing self-touch and compassionate self-directed speech, personalized through earlier exploration regarding experiences of receiving compassion. The individual them seeks to allow their discomfort to exist and to let go of wishes for it to disappear. Each of these steps is intended to express a compassionate approach to the self, and this differentiates the exercise from one focusing on mindful acceptance and non-judgment.

Neff and Germer emphasize the relational nature of the teaching of compassion in MSC, through modeling by facilitators and through interaction between them and group members. They note that many individuals find pathways to self-compassion through receiving compassion from others in combination with an environment that promotes safety and exploration. Facilitator self-disclosure may aid in this process, as the expectation is that each will have had their own journey to self-compassion and that exercising it is less a destination and more an ongoing process in refining compassionate

skills. This may be especially salient as group members first begin to confront difficult emotions in group, which may feel like hitting a "wall." Facilitators can help members recognize that growth can mean the exercising of self-compassion in the process of stumbling and failing to learn self-compassion.

The Compassionate MO

Due to their common focuses on emotional and behavioral reactivity, CALM-MO and Acceptance and Commitment Therapy have significant practical overlap. However, because of CALM-MO's foundations in the Unified Theory and especially the Influence Matrix, CALM-MO assumes that both internal experiences and observable behavior are relationally bound, developing in the context of needs-seeking among socially dependent individuals. The Influence Matrix, as described previously, details how individuals construct and develop their emotional systems based on the social consequences of their attempts to fulfill their needs, including efforts to elicit relevant behavior from others. This development then impacts the ways in which an individual relates to themselves based on that social learning. An individual is not merely responding to a world of objects and agents but embedded within interdependent networks of relationships, including evolutionarily and developmentally essential relationships (such as a child with their caregiver). Non-judgment is important as a pathway to allowing the self to experience its environment as fully as possible, but it is inadequate for navigating those aspects of the environment that are steeped in social meaning. CALM-MO takes a step beyond ACT by incorporating the work of Gilbert, Neff, Germer, and others to represent compassion as the ideal baseline orientation of the growth-oriented introspecting self. It is for this reason that CALM-MO includes an intentional separation between Acceptance

and Loving Compassion as aspects of how a healthy metacognitive observer would operate.

One of the most important targets of self-compassion intervention is the experience of shame. As illustrated by Gilbert, Henriques, and others, shame is not necessarily a problematic emotion, and likely evolved to imbue our ancestors with behavioral motivations that were socially adaptive. In the language of the Influence Matrix, shame is a response to the activation of in-born templates adapted to recognize and ward off rejection and abandonment, losses in relational value which in socially interdependent creatures like people represent potentially existential threats. Shame tends to motivate an individual toward submissive withdrawal, expressing weakness and defeat. It also tends to motivate the individual to hide the perceived source of that shame from others in order to avoid further damage to relational value. Among the social purposes of shame, its expression may serve to return the shamed individual to interpersonal acceptance and a tolerable level of relational value through the adoption of the judgement of others and submissive self-punishment in order to sate that judgement. As a signal of threatened relational value, shame is one of the most deeply unpleasant emotions humans can feel, and its avoidance is likely to be negatively reinforcing. This may help to explain why many individuals in therapy find themselves driven not by a desire for growth, but by the avoidance of failure.

With the development of language and its impacts on human cognition, however, shame that might otherwise have been confined to the specific situations that signal an immediate threat of relational value loss can now be maintained outside of these boundaries, and according to Henriques (2012), this is when shame is most likely to

become maladaptive. Individuals' expression of shame tends to include narrative expression of the pre-emptive self judgement described above, which can habituate to a shame-tinged self-concept. This might be recognized through clients' expressions of characterological shame, which refer not to an individual's behavior but to their nature as people. This is the difference between self-directed statements such as "I have failed and must accept the consequences" and self narratives like "I am a failure, I will continue to fail, and therefore I deserve the consequences." The former is situationally bound, while the latter is global and implies stability over time and across situations. Additionally, as the word "deserve" implies, such narratives tend to incorporate representations of enculturated morality and other similar beliefs to construct internalized and pre-emptive self-judgement. This self-judgement then becomes a frame of reference through which the individual navigates the world, biasing attention and perception toward confirmatory information that, if true, would represent existentially essential relational threat. The resulting inhibition of internal experiences perceived to be relationally problematic is likely to result in cascading disharmony between experiential processes and the individual's reflective awareness of them: a neurotic loop.

The Influence Matrix also holds implications for the role of other-oriented compassion interventions. Exercises in applying affiliative feelings and motivations toward others and in receiving them in return not only brings about positive emotions tied to being seen and valued, but also aids in the development of self-directed compassion by establishing it as an experientially reinforced pathway to meeting an individual's needs. However, other-oriented compassion interventions are likely to have benefits in addition to their impacts on the development of self-compassion. For example, compassion for

others aids in developing a frame of reference in which both the self and others have inherent value, dignity, and connection to broader human experience. Individuals navigating social relationships from this frame would have access to greater nuance in weighing the interests of others and contextualizing social interactions, potentially reducing the impact of the fundamental attribution error and other biases in the interpretation of social behavior. This frame would also likely help to reduce the distress that might arise when an individual becomes attached to others not as they are, but as that individual's own interests require them to be.

In addition to arguments for the practical utility of self-compassion, there is also significant philosophical overlap between the Unified Theory and self-compassion focused approaches to well-being. The inclusion of loving self-compassion in CALM-MO reflects humanistic values regarding the basic dignity of people, and this is deeply resonant with a focus on loving awareness not just of experience but of the experiencer. Self-compassion is worthwhile for its own sake, not just because it "works" but because it is due based on the universality of human suffering. This is an important aspect to hold in the context of intervention, as illustrated in an example from Germer (2015): an individual with insomnia might find that in exercising self-compassion (e.g., kind self-directed talk) one night that it results in them falling asleep. However, that same individual might feel discouraged when, the following night, the same self-directed words produce a different, less satisfying result. The individual is likely to miss the subtle change in their motivation between the two nights. At first, they were acting out of sympathy for their own suffering. The second night, they were instrumentally enacting the language of self-compassion for a desired effect. Many individuals will require

skilled guidance to recognize the difference and to remain compassionate in the face of such failure.

While any of the exercises discussed above may serve to aid a client in adaptively orienting their metacognitive observer, a therapist using a CALM-MO approach would do well to adopt the two-pronged strategy of Compassion-Focused Therapy in emphasizing both the expression and receipt of compassion. The development of skills and motivation in expressing warmth and caring for others necessarily builds an individual's ability to express compassion toward themselves. However, this does not necessarily mean that they are able to accept that compassion, reconcile it with feelings of guilt and shame, and feel loved by others or by themselves.

Chapter 8: Motivation Toward Valued States of Being

The M in CALM-MO stands for motivated toward valued states of being in the short and long term. Although motivation and values are somewhat different constructs, in the context of CALM-MO, motivation toward valued states of being is framed in much the same way that velocity is in physics. Velocity refers to the rate at which an object changes position with respect to a frame of reference, and can be represented by a vector. In a CALM-MO approach, motivation is considered from the reference point of an individual's values, and this grounds the metacognitive observer's frame of reference in the interests and meanings that the individual holds dear. The MO then is positioned to frame the individual's orientation toward valued states like a vector. With this metaphor in mind, a brief description of what is meant by motivation and values will aid in grounding later discussion of relevant interventions.

Motivation is generally considered to be the *why* of behavior: it describes that which initiates, guides, and maintains goal-oriented action. Grounded in Behavioral Investment Theory, UTOK frames the nervous system fundamentally as an investment value system that spends behavioral energy on outcomes the individual is attempting to approach or avoid, depending on factors like the effort required, risk, and other opportunities. Consistent with this, many models of motivation (e.g., the Trans-Theoretical Model, Prochaska & DiClamente, 1983) distinguish between factors and conditions that activate behavior and those that promote persistence of goal-oriented action in the face of various obstacles. This implies that different forms of intervention are likely to be relevant depending on an individual's placement on a spectrum of motivational process (e.g., initiating action, persisting through obstacles, or maintaining

changes in behavior). A review of two theoretical models of motivation and change processes will help to ground discussion of intervention strategies.

Self-Determination Theory

Self-Determination theory was introduced in the context of previous discussion of curiosity. Central to SDT is the humanistic view that people are inherently growth-oriented and tend toward action that promotes self-actualization in the absence of environmental obstacles. In contrast to many previous models of motivation that emphasized a single construct that is stable across time, SDT views motivation as contextually grounded and expressed based on the influences of development and the present moment. SDT grew out of research differentiating extrinsic motivational factors, such as environmentally or socially derived rewards (e.g., praise, money) or punishments (e.g., criticism, pain), from intrinsic motivations, or those derived internally from engagement in a behavior (e.g., enjoyment of the activity itself; alignment with closely held values). While both can influence behavior, intrinsic motivation is associated with greater interest, enjoyment, and persistence, and is more likely to result in an internal locus of control and greater self-efficacy. This contributes to the potential for longer-lasting and self-sustaining change, especially in therapeutic contexts.

Self-Determination Theory posits that intrinsic motivation arises out of the pursuit of basic and universal human needs, specifically those for autonomy, competence, and relatedness. *Autonomy* refers to the need to act with volition, to have control over one's behavior in relation to one's interests, and to achieve the sense of authenticity that interest-resonant action brings. Striving for *competence* is to seek learning and mastery of challenging tasks, as well as establishing and maintaining a felt sense of effectiveness in

meeting environmental demands. The need for *relatedness* involves seeking a sense of social belonging, connection, and intimacy and to feel that one is cared for by others.

According to Self-Determination Theory, the fulfillment of the basic needs of autonomy, competence, and relatedness in the context of extrinsic motivational factors (e.g., social approval) can result in a developmental process by which extrinsic motivators are *internalized*, or incorporated into an individual's identity and values. SDT implies that this is the process by which many cultural mores are integrated and expressed as deeply held values, such as an individual's sense of morality.

The Influence Matrix can be a useful guide to understanding the process of extrinsic motivation internalization based on its recognition, in common with SDT, of relatedness and autonomy as basic and universal human needs. Internalization can be illustrated through via the interactional dimensions of power, love, and freedom at the interpersonal level in reinforcement and punishment of efforts to maximize relational value, and at broader levels of examination through the development of positive and negative emotional signals as they relate to an individual's experience of what has and has not historically led to relational value. In addition, the Matrix helps to illustrate how individuals repeatedly placed in relational double-binds might develop characteristic response tendencies. Double-binds are interpersonal situations in which conflicting messaging creates a dilemma in that a successful response to one message negates the possibility for a successful response to another, and the contradiction is either covert or otherwise unavailable to directly resolve. They are especially relevant when one of the interactional participants is dependent upon another (e.g., a child and a parent). Individuals whose development involved repeated exposure to such interpersonal no-win

scenarios are likely to carry forward response patterns based on the resulting emotional learning and internalization of conflicting messages as ways of relating to the self.

Placed together, SDT and the Influence Matrix provide useful frames for thinking about the relational motivators that drive the human primate system. The Matrix orients us to note the broad and general themes of having social influence and being seen, known, and valued by important others. In addition, individuals need to feel competent and powerful, affiliated and intimate, and autonomous and self-determining. There can be significant conflicts between these domains, such as when one feels both the need to be connected and the need for distance and independence. These core relational motives can be crucial in reflecting on the valued states of being an individual may be consciously or unconsciously striving for. Although not covered in the current work, these frames can readily be bridged with perspectives from the psychodynamic and interpersonal tradition that focus on processes of attachment and needs for security and individuation.

The Trans-Theoretical Model (Stages of Change)

The Trans-Theoretical Model (TTM), also known as the Stages of Change model, was put forward by Prochaska and DiClemente (1983) as an integrative psychological description of the motivational and socio-environmental factors that predicted successful and lasting behavior change. Originally described within a population of individuals seeking to quit smoking, the model was later applied across substance use research and practice, and generalized to change processes in other clinical settings (Krebs, Norcross, Nicholson, & Prochaska, 2018). As its name suggests, the TTM arose from a comparative analysis of factors contributing to behavior change within many theoretical orientations such as psychoanalytic/psychodynamic, behavioral, and humanistic traditions. The result

of this analysis was the identification of five stages of behavior change: precontemplation, contemplation, preparation, action, and maintenance, with a sixth, termination, added later.

The *precontemplation* stage corresponds to a lack of intention to take action in the immediate future. It refers both to individuals who may be unaware that a problem exists or who have some vague or aspirational endorsement of future plans for change but are not considering making those changes in any serious way. The *contemplation* stage describes individuals who have begun to recognize their behavior as problematic and intend to take action in the immediate future; however, they have not yet done so and may be naïve to the demands and process of successful behavior change. The *preparation* stage builds on this intention with some small behavioral steps taken toward change and a commitment to make the systematic attempt. The *action* stage corresponds to the presence of specific and overt efforts to modify existing behavior or to gain new behavioral strategies. In the *maintenance* stage, individuals have enacted behavioral change (usually for at least 6 months) and are working to prevent relapse. The *termination* stage (added later, Prochaska et al., 1992) corresponds to a lack of temptation to regress to previous behavioral strategies and high confidence in one's ability to maintain gains in the future. The attributes of each stage implied alignment with intervention strategies that reflected the strengths of various traditional perspectives, but centered that effectiveness within particular windows (i.e., stages) in which they could be most effective.

A clinically-focused measure of an individual's expression of the stages of change was developed by McConnaughy, Prochaska, and Velicer (1983). Called the Stages of

Change Questionnaire (SoCQ), this measure produced distinct client profiles that correlated to therapy outcomes. These profiles and the measure's strong psychometric properties were supported by a replication study (McConnaughy, DiClemente, Prochaska, & Velicer, 1989) and the measure has been adapted for work with numerous clinical populations including individuals with anorexia nervosa (Rieger, Youyz, & Beumont, 2002) and bulimia (Martinez et al., 2007), high-risk cancer patients (Gonzalez-Ramirez et al., 2017), and individuals with chronic pain (Carr, Moffett, Sharp, & Haines, 2006).

A clinician using a CALM-MO approach would keep these frameworks in mind as they engage with clients to promote growth-oriented change. Self-Determination Theory helps to operationalize basic humanistic principles of therapy regarding the importance of client agency and autonomy in any intervention. Some of the behaviors that therapists might traditionally label as "resistance" are likely to make a great deal of sense with an understanding of how humans naturally respond to intrinsic and extrinsic motivators, and an understanding of how an individual goes about fulfilling their basic psychological needs is essential for co-constructing value-resonant therapeutic goals to maximize client buy-in and engagement. Similarly, the Stages of Change can be a useful clinical framework for contextualizing an individual's readiness, interest, and movement and describing motivation in terms of the sorts of behavioral patterns that tend to be visible in the room.

In reviewing methods of intervention into motivation and values, this work will include approaches that prioritize on one or the other (e.g., Motivational Interviewing) as well as those that integrate them much like CALM-MO does (e.g., Acceptance and Commitment Therapy). It is important to note that both of these approaches recognize a

connectedness between motivation and values, but they take different pathways toward intervention, with Motivational Interviewing adopting a more structured therapeutic stance. Techniques will initially be presented as arising out of the theoretical perspectives in which they developed, and following this their connection to and expression of CALM-MO will be explored.

Motivational Interviewing

Motivational Interviewing (MI) is a well-supported intervention approach, grounded in elements of Self-Determination Theory and the Transtheoretical Model, designed to aid clinicians and clients in working with ambivalence toward change by emphasizing and building intrinsic change motivations (Lundahl et al., 2010). Developed by Miller and Rollnick (1991), and arising from experience treating problematic drinkers ambivalent to reducing consumption, MI is not a set of techniques, but instead a progression of emphases taken by a clinician in response to clients' expression of the Stages of Change as described above.

Like humanistic approaches discussed previously, MI is a client-centered approach in which empathy and genuineness are emphasized as features of the therapeutic approach. However, MI differs from Rogerian tradition in being directive, with clinicians actively working to influence clients to engage in decision-making processes. Four basic therapeutic processes guide this direction. The first is the expression of *empathy* and genuine caring through reflective listening and accurate understanding of client perspectives. Therapists utilizing MI seek to *develop discrepancy* between a client's behavior and their deeply held values, and it is this discrepancy which MI casts as the client's motivation for change. A clinician strives to *roll with resistance,*

meeting ambivalence with reflection rather than confrontation. In MI, resistance is seen as an expression of attachment to the status quo, and a sign that the therapist should change their responses. Reflecting an emphasis on developing intrinsic motivations, MI does not seek to convince clients to change through argumentation, but to allow them to explore their behavior and values in a curious and non-judgmental space. The client, rather than the clinician, should be the source of "change talk." Finally, therapists work to *support self-efficacy* by maintaining the attitude that the client is capable of change, with brief interventions designed to build skills and reinforce small steps toward change. Each of these emphases are expressed as factors of the clinician's approach to the client, while the Stages of Change reflect factors of the client that should draw contextually appropriate intervention from the therapist.

Clients in the *precontemplation* stage are not currently considering changing their behavior. This stage is likely to be encountered when a client is not in counseling of their own volition, such as court-mandated therapy or individuals attempting to alleviate pressure from loved ones to seek treatment. This stage is also likely to be expressed by clients who seek treatment because of an awareness of distress but may lack insight into or be attached to behaviors that maintain maladaptive behavior. MI during this stage is an exploratory process, emphasizing empathy, non-judgment, and validation regarding motivations to continue with the status quo. The therapist's task is to provide relevant information (e.g., risks and rewards) and emphasize the client's agency regarding their behavior. A harm-reduction approach may be helpful during this stage as clients begin to perceive and communicate doubts about their behavior.

During the *contemplation* stage it is also important to validate unreadiness for change, but once doubts are established the focus shifts to more explicit exploration of ambivalence and the "pros and cons" of change. Externalization exercises (e.g., listing pros and cons on paper) and imagery (e.g., visualizing potential outcomes) may aid the client in connecting to varying aspects of a potential choice. The therapist aids the client in communicating reasons for and against making changes, and works to increase the client's confidence in change-related skills and strategies.

The *preparation* stage involves the expression of genuine intent toward change. The clinician's role revolves around setting clear goals and expectations and developing a realistic plan for meeting them. This includes exploring and addressing potential obstacles, such as skill deficits or social support. The therapist works to reinforce small steps taken by the client toward change, but does so by connecting them to the client's self-generated goals and values in order to engage with intrinsic motivations.

During the *action* stage, the clinician is engaged in helping to reinforce changes that the client is attempting to make or has made, boost self-efficacy, and validate stressors associated with change. The therapist also addresses feelings of loss connected to the client's expressed reasons for maintaining previous behavior, while reiterating long-term benefits and emphasizing client-originated reasons for change.

Intervention during the *maintenance* stage is devoted to the planning of follow-up support and preparing coping strategies for relapse. Acceptance and compassion-based strategies may be especially impactful here, as interventions that rely solely on relapse prevention may not prepare clients for the high likelihood that previous habits will be expressed throughout the change process. Clients able to employ acceptance and self-

compassion may be more likely to maintain gains and momentum than those acting out of an avoidance of failure.

The *termination* phase generally consists of ensuring clients have independently actionable plans regarding maintenance of changes and relapse response. It is likely that grounding these strategies in existing relational contexts (e.g., explicitly involving a spouse or other loved one) may make clients more likely to stick to such response plans. The therapist also emphasizes the currently experienced and anticipated gains of client changes that have manifested since the start of treatment.

Acceptance and Commitment Therapy

As previously described, Acceptance and Commitment Therapy (ACT) conceptualizes most psychopathology as the result of normal psychological processes which conspire to produce avoidance of internal and external stimuli that, if experienced, might otherwise serve to decouple negative emotional content from those stimuli. Many such forms of avoidance are uniquely human and based in the evolutionary development of language, such as predictive worry, meaning-making processes, and attitudes toward one's inner events. ACT stresses that it is our attempts to control aspects of our experience in order to avoid suffering that ultimately brings that suffering about, especially when these attempts reflect inflexible patterns of responding to the world. Such rigid patterns of behavior are not necessarily problematic, but they are likely to become so when they act as impediments to an individual's ability to act in furtherance of deeply held values.

Owing to its developmental roots, ACT defines values in behavioral terms with an emphasis on linguistic construction. This includes five components: an individual's

values are *freely chosen*, and not contingent solely upon external pressures. They are linguistically *constructed* from an individual's ongoing engagement with the world, and capable of being communicated verbally. Because of this, they are *dynamic and evolving* in response to their expression in interaction with an individual's environment. This differentiates values from goals, which involve particular and achievable results. Instead, values are meaning structures serve as directional guides rather than destinations, and are not sated by values-consistent behavior. Values are therefore *ongoing patterns of activity*, rather than being reflected by single behaviors out of context. Finally, values *establish intrinsic reinforcers* that act as markers of distance to and from a valued path. According to Relational Frame Theory (Hayes, 2004), reinforcers are not constrained by the immediate consequences of an action because human language allows for the capacity to separate meaning from current experience and carry it beyond the place and time in which it is encountered in an individual's environment.

Arising out of Cognitive-Behavioral (CBT) approaches and utilized by Acceptance and Commitment Therapy (ACT), *values clarification* is an intervention process comprised of multiple components that seek to aid clients in understanding, communicating, and engaging with their value systems. Consistent with Self-Determination Theory (SDT) as discussed above and in the previous chapter on curiosity, an individual's engagement in goal-directed behavior such as a therapeutic change process is maximized when that individual feels an agentic connection to those goals and any strategies for achieving them (i.e., autonomy). In clinical work, sometimes clients are unclear on what is most important to them, and indeed this may be part of what brings them into therapy. Exercises such as a "values sort," in which a client is encouraged to

choose and rank the 5-8 most important from a list of commonly held values and then explore how these are expressed in the client's life, can help build insight and skills in communicating needs and desires. Another exercise that may build on this foundation involves listing the chosen values and describing their expression in terms of behavior. For individuals in the precontemplation or contemplation stages, these exercises may aid in developing insight into discrepancies between closely held values and actual behavior while building a strong therapeutic alliance based on curious exploration. If a client has difficulty distinguishing their own values from those of the people or society around them, a clinician can lead them in listing pressures that they identify as coming from internal or external sources, and asking the client to reflect on how much they *wish* to be guided by each. This aids in identifying the client's internal values by means of distinguishing external pressures that are resonant with those values from those that are not.

An alternative pathway for clarifying and intervening in the area of values from an ACT perspective involves the Valued Living Questionnaire (VLQ), developed by Wilson and Groom (2002). The VLQ is a short measure of 10 domains commonly identified as pertaining to valued living (e.g., family, parenting, spirituality, etc.), which a client is instructed to rate from 1-10 in importance. Following this, clients estimate the degree to which their values are consistent with the way they have lived their lives over the past week, again using a 1-10 scale. The VLQ shows adequate psychometric properties and has been applied to the measurement of values in a number of populations, such as college student drinkers (Miller et al., 2016), dementia caregivers (Romero-

Moreno, Gallego-Alberto, Márquez-González, & Losada, 2017), and individuals with PTSD (Donahue, Khan, Huggins, & Marrow, 2017).

According to Wilson and Murrell (2004), the results of the VLQ are used to identify and target inflexibilities in behavior that represent obstacles to a client's pursuit of specific, deeply held values. Previously discussed areas of focus in ACT such as nonjudgmental mindfulness, defusion, and exposure can then be utilized toward growth. This is what is meant by "committed action," one of the six core processes of ACT: behavior that is consistent with an individual's values, especially in the presence of obstacles.

Values as Grounding for the Action of the MO

Values are often characterized as internalized cognitive structures, including beliefs, attitudes, and emotional associations, that are consistently expressed over time and are active in making meaning of experiences to guide action. They may do so through evoking feelings and thoughts of right and wrong, and through adding "weight" to interests in order to establish priorities. Values are developed in the context of cultural messaging as well as interpersonal development and familial dynamics. An individual is not necessarily explicitly aware of all of their values, but this does not detract from their influences on that individual's behavior. It is also not necessarily the case that all of an individual's values are in harmony with each other, and conflicting values may create confusion, emotional dysregulation, and ambivalence to action.

Of the features that differentiate a CALM-MO approach from traditional cognitive-behavioral approaches, the inherent grounding of the metacognitive observer's action in the held values of the individual is among the most important. Some reasons for

this are practical, as engaging with values-resonant intervention leads to the enactment of intrinsic motivations that are more likely to promote shifts in behavioral expression. Challenging reactive responses to inner experiences based on their usefulness, truth value, or other metric can be a practical intervention strategy, but it is less likely to take hold and endure via internalization if the motivation behind making such change comes from external sources such as familial or social pressure. Avoidance, too, makes sense in the context of external motivators that are at odds with, or at least disconnected from, individual values. Why should an individual be expected to attend to their own process, manage the resulting negative emotions, and make difficult changes when distress is perceived to be sourced from social rejection rather than internal disharmony?

An emphasis on integrating values into intervention is also part of the philosophical foundations of the Unified Theory and therefore CALM-MO. Carrying forward humanistic emphases on autonomy and inherent human worth, CALM-MO incorporates values in human well-being, dignity, and integrity and represents a resonant expression of those values. That CALM-MO would intentionally make space for similar resonant expression in the output of clients engaging in this approach, whatever they hold to be most important, should come as no surprise. The meaning made by the client in therapy should be theirs, and not necessarily that of the clinician or intervention approach.

The goal of motivational interviewing is to notice and respond to discrepancies between individual values and behavior, and while in MI this is initiated by the clinician, it is also a function of a healthy metacognitive observer. This implies an important distinction between a CALM-MO approach and that of MI: in Motivational Interviewing

the clinician works to facilitate change in clients, while a clinician enacting a CALM-MO approach seeks to engender the capacity to attend to, recognize, and act on the need for change on an ongoing basis. MI is a process for producing behavioral change, and CALM-MO is a process for producing change processes.

Motivational Interviewing does not emphasize the teaching of its process so that clients may engage with it outside of the therapeutic context, and the "teach a man to fish" approach is not well matched to the active-directive stance taken by clinicians engaging in MI. That is not necessarily a weakness; MI was developed for, and is generally applied to, situations in which an individual is ambivalent toward change. MI would not be appropriate for clients who come into therapy already aware of and motivated to address their challenges. Additionally, some obstacles such as patterns of substance abuse are so disruptive to an individual's self-corrective mechanisms that their removal can produce significant and long-lasting positive growth without the need for ongoing intervention. Sometimes one fish is all a person needs.

The action of a healthy metacognitive observer is akin to that of a therapist, and indeed this is one way that Henriques describes the role of the therapist in modeling and promoting curiosity, acceptance, loving compassion, and values-based motivation in interaction with the client. The clinician's goal is redundancy, in that upon termination the client will ideally carry this therapist-like MO forward as a component of the machinery they use to interact with their environment. This internalized perspective is intended to be self-monitoring, self-repairing, and self-adapting. So what is the role in this model for a directive therapeutic approach that requires clinicians to actively influence clients' decision processes?

In CALM-MO, the attitude of the metacognitive observer is important to engage in developing motivation to address ambivalence is curiosity, which is reflected in the intervention strategies matched to the *precontemplation* and *contemplation* stages. A curious MO responds to distressing feelings with openness and exploration, the same approach the MI clinician uses to develop discrepancy between an individual's values and behavior. Curious exploration is then supported by acceptance of what is encountered (e.g., ambivalent feelings), a position of loving compassion for the experiencer whose ambivalence represents a very human discomfort, and an awareness of and desire for harmony with one's values, behaviorally discrepant or otherwise. Like a clinician enacting MI, a healthy MO does not shy away from the feelings that value-discrepant behavior produces, but leans into them. In many ways, a CALM-MO approach does promote the internalization of essential MI processes.

Much like Acceptance and Commitment Therapy, CALM-MO emphasizes the intersection between motivation and values through promoting insight, clarity, and expression of consistent behavior in service of those values. The emphasis on values-consistent behavior as a path to psychological well-being grounds values in their expression, rather than in the conceptual realm. In this view, values are fully engaged when they are experienced, enacted, and embodied. This can be expressed linguistically by shifting from concepts like "honesty" to descriptions of value-resonant behavior such as "being honest." CALM-MO recognizes that an inherent part of a held value is not just that it is abstractly important, but that enacting the behavior is part of what makes it valuable, connecting the meanings people make to the impact of that meaning in the

world. This is why CALM-MO explicitly grounds healthy motivation to valued states of *being*.

If well-being is maximized when values are done rather than merely held, then a foundational goal of therapy is to aid individuals in finding and maintaining pathways toward valued goal states in ways that are reasonably efficient and sustainable. Henriques (2016) calls this "enhancing adaptive living," and it stands in contrast to the triple-negative loop where negative feelings are avoided or controlled, or elicit self or other-directed blame. This pattern of distress reactivity is one that requires a great deal of energy, and that energy is seldom directed toward growth; instead, it tends to be unnecessarily and ineffectively devoted to self-preservation in the face of threats that often need not be so. According to Henriques, enhancing adaptive living involves analyzing clients' adaptational systems in the context of their developmental and current environments, and co-constructing a shared narrative of what is happening. This conceptualization should allow both therapist and client to linguistically represent and relationally ground the client's valued states of being and motivation to achieve them.

Chapter 9: The Interrelationships Between CALM-MO Elements

Each of the reviewed theoretical approaches brings important insights to clinical practice, and most offer at least some form of integration of two or more broader theoretical paradigms, whether through a common factors approach (e.g., the Trans-theoretical Model, Prochaska & DiClemente, 1983), assimilative integration (e.g., Dialectical Behavior Therapy, Heard & Linehan, 1994) or theoretical integration (e.g., Acceptance and Commitment Therapy, Hayes, 2004). Arising from an attempt at unification, or the contextualization of varying theoretical perspectives within a broader metatheoretical framework, CALM-MO is not a tool of eclecticism that seeks to pull together therapeutic techniques that are useful but decoupled from their theoretical roots. Rather, CALM-MO is an integrative expression of broad therapeutic principles that are consistent with and expressed by the reviewed perspectives, but whose importance is grounded in an understanding of the Unified Theory as it contextualizes those perspectives in relation to each other and a broader understanding of human experience.

This also applies to each of the elements of CALM, which should be considered as set of interrelated principles contextualized within an understanding of human functioning and well-being. As has been discussed previously, there is considerable overlap across the therapeutic techniques applicable to promoting each element of CALM, and this is reflective not only of overlapping concepts but potentially interdependent elements of functioning. In order to understand the value of CALM-MO as a cohesive and integrative therapeutic tool, it is essential to discuss how the elements of CALM relate to one another and to understand what it would mean to express or intervene in the elements in isolation.

Curiosity and Acceptance

Curiosity can be described as an openness to, and motivation toward, new or ambiguous situations and information. Setting aside for a moment the implications of a motivational component to the expression of curiosity, the components of openness and novelty seeking are deeply tied to processes of acceptance. While it may be possible to express such openness and seeking without the ability to tolerate some or all the resulting experiences, it is unlikely that this would result in an individual developing or maintaining a broadly curious approach to the world. Rather such an individual's expression of curiosity would be confined to those aspects of experience for which they are also able to maintain acceptance. This would imply that acceptance acts as a necessary mediator for the reinforcement of curiosity, and in some ways is a gatekeeper for the benefits of curiosity, such as the availability of new growth-promoting experiences and learning, increased creativity, and adaptive social engagement.

Conversely, an individual high in acceptance but low in curiosity would likely present as someone willing and able to access a high proportion of their inner experiences but uninterested in expanding the domains of stimuli available to be experienced. It is not clear if this would represent a stable presentation; while interest in new stimuli could conceivably remain low, a lack of experiential avoidance would seem to lead to a naturally expanding set of experiences in which to be engaged. Because of this, it may be the case that the development of experiential acceptance necessarily unlocks curiosity toward new or previously intolerable opportunities for growth, reaffirming the clinical interconnectedness of these elements of CALM.

Curiosity as a Motivating Force

As was briefly mentioned previously, curiosity by definition includes openness to, an orientation toward, and energy expended in the pursuit of new or ambiguous stimuli and experiences. Curiosity can therefore be considered a combination of openness and motivation, specifically directed toward novelty. While some have convincingly argued that curiosity serves a function as motivation to reduce negative states such as uncertainty or gaps in information (e.g., Lowenstein, 1994), for many curiosity is also an intrinsic motivating force that fosters learning and exploration for their own sakes. Such motivations may be described as situationally bound, or as consistent traits of individual expression, characteristic ways of approaching the world (Pekrun, 2019). It may be that as individuals develop in a given context, pursuits that might be motivated extrinsically (i.e., through external rewards and punishments) become internalized as they aid in the fulfillment of basic needs such as autonomy, competence, and relatedness. In the context of therapy, promoting curiosity as a situationally relevant (e.g., state-based) pathway to problem-solving tied to desired outcomes may over time lead to internalization of curiosity as a stable approach to uncertainty across situations, provided those outcomes are appropriately grounded in the fulfillment of autonomy, competence, and relatedness needs.

Loving Compassion as both Motivation and Value

As was previously discussed, loving compassion is not only a set of behaviors but an orientation of kindness toward the self and others that directs attention and effort. It is also a frequently cited priority in the lives of individuals, both in their approach to others and in others' approach to them. Compassion is therefore both a healthy valued state of being and a growth-promoting motivating force. While an intervention might target

motivation or values without addressing compassion, no intervention that effectively promotes compassion can avoid acting on an individual's motivation and values. Compassion may be a value and a motivation that a client holds but feels unable to realize, or an element of life which a client does not honestly believe they are due. Even clients who are not ready to accept compassion from others or from themselves are likely to have, or have had, those in their lives toward whom they feel compassion. Empathetic exploration of how compassion as a value is or is not expressed in a client's life may reveal ambivalence and provide value discrepancies that are ripe for the kind of motivation-building processes that Motivational Interviewing was designed to work with. Similarly, identifying and naming clients' affiliative values can be essential in navigating the process and content of therapy.

Motivation for Change and Acceptance of What Is

Dialectical Behavior Therapy recognizes an inherent tension between acceptance and change (Heard & Linehan, 1994). Considering the clinical presentations that DBT was originally designed to address (i.e., borderline personality disorder), DBT emphasizes acceptance by aiding individuals prone to becoming stuck in efforts to control and therefore change their circumstances, when often they lack the power to do so. Through this emphasis, CBT seeks to recognize that a lack of acceptance of what is can blind individuals to possibilities for growth, and can act as an obstacle to the kinds of meaningful change that would promote it. As previously described, acceptance is distinct from resignation, and does not refer to the act of giving up on self-betterment. Instead, acceptance refers to the process of learning tolerance for what is so that it can be engaged with fully and effectively.

Acceptance is also essential to the navigation of the Stages of Change, and establishing an intrinsic motivational grounding for efforts toward self-growth. To transition from the Precontemplation to the Contemplation stage, this includes acceptance that change is needed in the first place, and that the self has at least some responsibility for enacting that change and therefore for some of the maintenance of current distress. Transition from Contemplation to Planning involves acceptance that the status quo will not bring about the desired outcome, and usually involves empathetic exploration of an individual's attachment to that outcome or an aspect of the world they feel should be a particular way. Acceptance is also applied in realizing that some outcomes are not actually possible, and that striving toward them produces its own unnecessary distress. Among all of these stages, acceptance of internal experience is in essential component of engaging with such questions in the first place. A metacognitive observer that seeks to observe discrepancies between behavior and held values must have access to the discomfort that arises from such incongruity in order to understand what these emotional messages are communicating and to contextualize these messages relative to values and goals.

In summarizing the elements of CALM-MO, Henriques (2016) speaks of a tension between acceptance and motivation for change toward valued states of being. Acceptance is the process of acknowledging and engaging with the world (as represented by inner experience) as it is, not as we would like it to be. Acceptance of inner experiences like negative emotions involves tolerance and a willingness to engage fully, and broader forms of acceptance might be applied to situations in which an individual lacks the power to progress relative to desired outcomes. Motivation toward valued states

of being involves the recognition of a discrepancy between where one is and where one would like to be with regard to some deeply held aspect of life, and the desire to close that gap. It is certainly conceivable that in some situations these two principles might seem to come into conflict with regard to psychological well-being. How is an individual to navigate situations in which a discrepancy is found that causes distress?

The first answer arises out of Dialectical Behavior Therapy, and revolves around an individual's power to enact change relative to desired states of being. In setting goals for personal growth, a client should be encouraged to explore whether a goal should be problem-focused or emotion-focused. Problem-focused goals are those that seek to change the nature of a situation so that it's no longer distressing or otherwise problematic. Emotion-focused goals, on the other hand, are applicable when an individual does not have the power to remove a source of distress from the equation. Loss represents the quintessential example of an emotion-focused goal: the past cannot be recovered, and so goals prioritize acceptance, forgiveness, and coping with the world as it has become. DBT includes numerous exercises to aid clients in recognizing situations in which they do or do not have power to make substantive changes.

Another pathway to reconciling the tension between acceptance and motivation for change comes from the inclusion of compassion. An individual experiencing distress may be pulled toward accepting the world as it is or motivated by that discomfort to grow, which may or may not be a negative avoidance process. However, compassionate recognition of the universality of their suffering may aid in accepting and metabolizing that discomfort in adaptive ways. Many trauma-focused treatment strategies, which often focus on avoidance of trauma triggers as a major factor maintaining distressing

symptoms, seek to connect survivors of trauma to each other and through their shared recognition of suffering accept what has happened and intentionally move toward healing despite the obvious discomfort of confronting trauma reminders. Through connecting to others who have had similar experiences, clients learn that they are not alone in either their reactions or exposure to traumatic events, and begin to shift focus from a self-centered explanatory trauma narrative (e.g., "I am to blame," "I am deficient") into one that incorporates the fallibility and vulnerability to suffering inherent in all human beings (e.g., "no-one can avoid all negative events," "pain and suffering occur regardless of our intentions").

Ultimately, CALM-MO employs a conceptualization of acceptance focused on immediate inner experience, and through this focus allows for broader forms of acceptance. In other words, it is not the situation itself, but the negative feelings caused by the situation that are to be accepted. The ability to tolerate negative inner events, along with recognition that we are not alone in the experience of such suffering, allows the Metacognitive Observer to place those inner experiences in context relative to what is and what could be. Acceptance does not preclude motivation toward valued states of being, but is likely to be a useful pathway toward approaching them.

CALM-MO Combined

The interrelatedness of CALM-MO elements is an advantage of the approach for targeting neurotic loops in which individuals find themselves reactive to their own reactivity. Adverse events occur in an individual's environment, which trigger negative emotional responses tied to individuals' perceptions of those adverse events. However, the neurotic loop is formed when they habitually react to those negative emotional

messages in maladaptive ways, often through avoidance, self-criticism, or other forms of harmful self-correction or soothing. A recent conversation with a client provided a relatable example, in which the individual described a tendency to "stress eat" combined with a goal of losing weight. Normal life stresses would provoke the strategy of eating to self-sooth, but this would be followed by self-judgement for eating. This self-judgement produced additional stress that resulted in further eating to self-soothe.

One can imagine the neurotic loop as a wheel, supported by an array of spokes which each represent maintaining factors in the wheel's self-completing cycle. Left alone, such a pattern is stable over time and may escalate in intensity as it continues to spin under its own momentum. However, each individual spoke represents an opportunity for intervention to weaken and disrupt the cycle, and each spoke will more likely than not be responsive to at least one, and likely more, elements of CALM-MO.

The Emotional Sweet Spot

The Unified Theory suggests a growth-oriented alternative to the reactivity of the neurotic loop that involves the balancing of two adaptive processes relative to emotion: attunement and regulation. Many individuals tend to invest energy in one side of this dialectic or the other. This may be expressed through over-regulation of emotion, often through avoidance, leading individuals to neglect essential information about the self and its needs. Individuals who find themselves over-regulating negative emotion are likely to believe such experiences would be intolerable, uncontrollable, or socially detrimental. Others may tend toward under-regulation, characterized by difficulty managing negative emotion, overwhelm, and over-identification with their emotional experience. Individuals enacting this approach are more likely to appear impulsive, disproportionately reactive,

and swept along by their feelings. Attunement and regulation are not a dichotomy, and these strategies are often displayed by the same individual in different situations or across time. Over-regulation is a short-term solution, and negative emotions are not resolved by an individual's avoidance of experiencing them. Most often, over-regulated feelings leak out into an individual's behavior, transforming into more tolerable expressions of emotion (e.g., anger rather than fear or hurt) or erupting in an uncontrolled fashion. What follows is self-judgement not for failing to address feelings, but for losing control of them and for the consequences of doing so, which can often be represented as threatening to relational value. The intolerability of once again feeling out of control of feelings, coupled with the inner critic narrative, serve to renew the need for control as the only acceptable response to distressing feelings.

CALM-MO seeks to resolve the tension between attunement to and regulation of negative emotion through establishing what Henriques (2015) calls the *emotional sweet spot*. In doing so, an individual balances their ability to openly access and experience negative emotions as they come with their ability to regulate those emotions in concordance with their values, sense of identity, and long-term goals. Therapists often describe this balanced action as the processing of negative emotion, but a more apt term might be to describe clients in the emotional sweet spot as metabolizing their emotions by tuning into the messages they bring, placing those messages in the context of current experience, values, and goals, responding to the revealed need, and evaluating the results of their action with respect to their continually constructed experience and identity.

Chapter 10: An Integrative Therapy Tool for Learners

The field of Psychology has historically been home to numerous impactful but competing and seemingly irreconcilable theoretical paradigms of human functioning and development. the Unified Theory attempts to unite the field by placing those existing theoretical paradigms in a metatheoretical framework that allows for the contextualization of multiple perspectives in relation to each other and psychology as a whole. The Unified Theory provides a broad language for describing human behavior, and cognitive, psychodynamic, humanistic, behavioral, and other perspectives can be represented as "dialects" that have emerged from different "regions" of psychological thought. Each dialect remains relevant, with its own unique and essential insights into human behavior as well as applicability that is localized to the contexts of its theoretical development.

Psychological practitioners tend to have "accents" that indicate how they conceptualize and intervene in clinical contexts based on which theoretical paradigms, or combinations thereof, they subscribe to. While most clinicians continue to identify with one theoretical orientation or another, a growing number of psychotherapists identify as integrated, with therapists more likely to do so the longer they have been active as clinicians (Norcross, 2005). These therapists often cite the limitations of individual perspectives and the strengths offered by others as motivating factors toward integration. Following analysis of the autobiographies of 22 integrative therapists, Rihacek and Danelova (2016) developed a 3-stage developmental model that described the transition of experienced clinicians from single-orientation emphases to integrative practice. The authors suggested that the tendency of therapists to adopt more integrative approaches as

they gained experience may illustrate a natural component of psychotherapist development.

Norcross (2005) detailed several strategies of theoretical integration. *Technical eclecticism*, being the least theoretically bound, is represented by clinicians who employ techniques from across theoretical paradigms based on efficacy and practicality for particular purposes, rather than theoretical foundation. *Assimilative integration* describes the process of grounding oneself in a particular "home" orientation while sampling from other perspectives insofar as their elements can be reconciled with the home theory. *Theoretical integration* is the approach of clinicians who seek to harmonize two or more theoretical perspectives into a single coherent framework rather than favoring a single paradigm. Finally, the *common factors* approach represents a de-emphasis of theoretical perspective, and instead makes use of principles common to virtually all orientations that have been demonstrated to be predictive of therapeutic outcome (e.g., therapeutic alliance, opportunities for catharsis). As an expression of a more recent fifth option, *unification*, CALM-MO is a tool that tends to defy the above categories of integration. However, it holds significant overlap with the common factors approach, in that it emphasizes universal therapeutic principles that are time-honored and research-backed predictors of successful psychological intervention. These qualities make CALM-MO a potentially valuable tool not just for intervention, but also for training beginning clinicians in integrative therapeutic principles.

Training in Psychology

As of 2008, about 14% of practicing psychotherapists self-identified as integrated in a survey conducted by the APA (APA, 2009). Time in the field appears to be a

predictor of integration, with more experienced clinicians more likely to endorse an integrated therapeutic approach than beginning clinicians (Norcross, 2005). Psychologists who self-identify as integrated often cite the limitations of a paradigm in which they were initially trained, exposure to research supporting the efficacy of integrated approaches, and being drawn to new and different perspectives of human functioning as the main influences of adopting an integrated approach. This suggests that gaining experience in the field, both in direct clinical contact and in depth of understanding and application of theory, is the main pathway to integrative psychotherapy practice. However, it does not necessarily follow that beginning clinicians would not benefit from exposure to integrative tools and principles in the earlier days of their training.

The majority of clinical psychology training programs emphasize a particular theoretical orientation in the training of budding psychologists, though more recently many have begun to diversify theoretical exposure or even explicitly promote integration as a viable pathway to clinical practice (Boswell et al., 2010). Research into training programs' theoretical leanings are sparse, and what is available paints a complex picture of theoretical emphasis, resulting differences in instruction, and their impacts on trainees and new practitioners. For example, a national survey of instructors of initial psychotherapy courses in APA accredited programs found that differences in theoretical orientation did not predict differential instruction on two out of three factors: professional behaviors and skills (e.g., conveying empathy, listening effectively, withholding judgement) and problem-focused skills (e.g., accurately identifying client problems and appropriate intervention selection). Only the third factor, dynamic constructs (e.g., conceptualizing the therapist's role, family of origin issues, interpretive techniques)

differed based on instructors' theoretical preference (Stevens, Dinoff, & Donnenworth, 1998).

Still, a grounding theoretical framework is considered to be essential for learning to conceptualize and intervene in clinical contexts, and programs do differ in theoretical emphasis. According to Norcross, Evans, and Ellis (2010), 43% of faculty in APA accredited training programs identified with a cognitive-behavioral orientation, 28% endorsed a humanistic perspective, 21% utilized systemic frameworks, 19% self-identified as psychodynamic, and 3% reported a behavioral approach. This distribution appears to be stable over time, with a longitudinal study by Norcross and colleagues (2021) indicating a distribution of 45% CBT, 30% humanistic, 22% systems, and 20% psychodynamic-oriented faculty in over 200 psychology doctoral programs. Clinical psychology programs tended even more toward cognitive orientations, while humanistic and psychodynamic-oriented faculty were more likely to be found in counselling psychology programs.

It is important to acknowledge that the theoretical emphasis of a trainee's program is one of many influences on their self-identified theoretical orientation as practicing clinicians. In a study of 142 psychology trainees in the U.K., Buckman and Barker (2010) found that personality factors were a strong predictor of theoretical orientation, especially for individuals who self-identified with a cognitive-behavioral approach. Interestingly, the same study indicated that for individuals self-identifying as psychodynamic, training factors (e.g., program emphasis) was a stronger predictor than person-based factors. For individuals who identified with a systemic approach, both factors were equally powerful. Similarly, Murdock and colleagues (1998) found that an individual's philosophical

assumptions were the strongest predictor of theoretical orientation across a sample of Master's and Doctoral level trainees. However,while these studies may suggest that personal factors are more powerful than training factors in the development of a clinician's initial theoretical orientation, it is crucial to recognize that programs do not recruit random samples of trainees. Instead, many training programs are made up of self-selected individuals who respond to those programs' descriptions of theoretical emphasis during the application process, and programs are also likely to disproportionately admit students whose philosophical positions are already a good fit with their perspectives on the nature and role of psychologists.

There is also evidence that beginning clinician orientations are already trending toward preferences for integrative practice. According to Boswell, Castonguay, and Pincus (2009), while a psychodynamic approach was the most common single theoretical perspective endorsed among a sample of 46 doctoral graduates across 4 clinical and counseling psychology programs, the proportion of graduates who self-identified as eclectic or integrated was even greater. According to Rihacek and Roubal (2017), it may be more helpful to conceptualize theoretical orientation development as that of an individual therapist's "personal approach," rather than as an expression of broader categories of theory.

While years of clinical experience seems to have been the primary pathway to many therapists' integrative practice, it does not seem that this is the only pathway to the development of an integrative approach. Indeed, the tendency toward integration now appears to be best reflected through a bimodal distribution based on a clinician's time in the field. As this pattern continues to unfold, there will likely be a gap between beginning

clinicians' hunger for integrative training and how their programs will respond. What better reason to provide trainee therapists with a metatheoretically grounded and practically familiar psychotherapeutic tool that can serve as an expression of integrative therapeutic principles and is digestible by beginning clinicians?

Psychotherapeutic Principles

As previously described, the major target of CALM-MO is the triple-negative neurotic loop, which describes characteristic patterns of negative reactions to negative feelings that are themselves prompted by negative situations. According to Henriques (2021), this process is the key maladaptive process underpinning the internalizing disorders (e.g., depression, anxiety), which are the most frequently cited "presenting problems" in clinical practice. Throughout this work, the integrative nature of CALM-MO has been illustrated by its relationship to varying theoretical approaches and its consistent and grounded application of techniques from across the theoretical spectrum. However, it may offer additional clarity to further illustrate how various theoretical dialects express their differing perspectives in describing the same internalizing patterns and to show how each represents an entry point for the application of CALM-MO. To do so, this work will utilize Character Adaptation Systems Theory (CAST), the fifth key idea of the Unified Theory. CAST is an integrative system of conceptualizing behavioral adjustment processes by dividing and describing them in five domains. These are the *habit system*, corresponding to a behaviorist view of functioning, the *experiential system*, consistent with emotion-focused therapy (EFT), the *defensive* and *relational systems*, corresponding to variations in psychodynamic theory, and the *justification system* which is reflective of cognitive explanations of functioning.

In an article describing connections between CAST and major theoretical approaches (e.g., cognitive, psychodynamic), Mays and Henriques (2018) introduced the case of "Caroline" in order to illustrate how CAST allows for trans-theoretical clinical conceptualization through incorporation of the major insights of established theoretical paradigms:

> Caroline is a 19-year-old single, Caucasian female, currently in her sophomore year of college. When Caroline first entered the clinic, she avoided eye contact and kept her head low as she struggled to find the words to express her presenting concerns. She was apologetic throughout the session and spoke vaguely of her problems with inattention, confused thoughts, low self-esteem, anxiety, and depression. She spoke about her overall sense of inferiority that frequently resulted in harsh self-criticism when she perceived herself to have failed in some way, Her affect was generally mildly negative, and she reported certain times when her thoughts and feelings became overwhelmingly negative. When this happens, Caroline cannot interrupt her negative thought patterns and has experienced passive death ideation thinking, "It would be easier if I wasn't here." Her main way of coping with these feelings is to seek out contact with other people and trying to tell herself that everything is fine.
>
> Caroline described her childhood as "OK," but that she always felt a bit vulnerable. She reported that her parents were there for her, but she was not sure that they really knew her and that she had many thoughts and feelings that she did not share with anyone (let alone her parents). She recounted a history of conflicted relationships, both with peers and romantic partners, with major themes being a fear of being rejected, a sense of not being good enough, a feeling that she was being taken advantage of, and, on occasion, periods when she "blew up" and became extremely upset. At her initial presentation, a detailed assessment revealed Caroline met criteria for Major Depressive Disorder, with Anxious Distress.

The Habit System

The habit system is primarily concerned with the acquisition and maintenance of behavior through conditioning processes. This involves inherent fixed-action patterns, the impact of reinforcement and punishment, and procedural memory, all of which tend to act beneath conscious awareness. As Mays and Henriques (2018) illustrate, the

behavioral perspective would emphasize Caroline's avoidance of anxiety-provoking situations as part of a feedback loop in which social withdrawal is negatively reinforced by the removal of the stress and anxiety they provoke. For Caroline, this behavioral avoidance is expressed not only by physical withdrawal from social situations, but by her approach to those interactions she does participate in, which tends toward passiveness and submission. While these strategies are reinforced because they remove Caroline from anxiety-provoking situations (e.g., conflict), in the end her passivity and withdrawal contribute to her needs remaining unmet, and also deny her opportunities to have more positive social experiences and to develop important social skills.

A behaviorism-oriented clinician would find a CALM-MO approach to Caroline's predicament to be mostly familiar territory. Targeting her reactivity to negative emotional states, Caroline's CALM-MO would build mindful awareness of the situation and her internal experience, and she could engage in intentional exposure to feared stimuli with the goal of experientially decoupling them from reactive and distressing feelings. Caroline would practice not only relaxation techniques to systematically reduce maladaptive reactivity, but she would also gain insight into her functioning and a sense of curiosity toward her own process that will allow her to better recognize and respond to behavioral contingencies on her own. In doing so, CALM-MO would seek to make learning processes, which usually take place below the level of conscious awareness, explicit in the narrative shared by Caroline and her therapist. Learning processes would continue to take place behind the scenes, but directed by intentional adherence to personal values.

The Experiential System

Consistent with how emotion-focused therapy (EFT) conceptualizes human functioning, the experiential system consists of perceptual experience, drives, and emotional states that make up much of conscious awareness. The experiential system is a constant process of weaving perceptual continuity and providing the building blocks of meaning-making. EFT identifies emotions that are naturally congruent with a given situation as those that are adaptive, with maladaptive emotions being the opposite. Secondary emotions are those experienced in response to an unacceptable primary one, such as the anger that overcomes pain or fear for many. Emotions can also be instrumental in that they can be habitually utilized to manipulate others into behavior that meets the individual's perceived needs. From this view, Caroline's depressive feelings are likely secondary emotions that arise in response to more painful feelings like loneliness, fears of rejection, and perceived inferiority. Her anger, too, is likely a secondary emotional reaction that distances her from the above unacceptable or intolerable emotions but may lead to intense shame, either in self-evaluation following an interpersonal outburst or through a just as damaging self-critical process. Some of Caroline's withdrawal-motivating emotions may also be instrumental, as the natural response to sadness tends to be caregiving and this may have been the most reliable avenue Caroline has had for meeting her need for nurturance.

Caroline's MO would allow her tolerable access to even painful emotions, making them available to be metabolized into value-congruent action (e.g., assertiveness) rather than necessitating their avoidance and dismissing essential information about her moment-to-moment experience and needs. Caroline would benefit from the opportunity to safely and fully feel these emotions, not just talk about and intellectually understand

them. In doing so, Caroline will have the opportunity to understand with both head and heart that she can be her genuine emotional self and not find herself overwhelmed or lost in her negative feelings. Moreover, she can learn to do this in the context of a strong therapeutic relationship without the danger of being rejected or abandoned. A compassionate MO would connect her pain to the suffering of others and help her to understand that it does not make her alone nor inadequate in comparison.

The Relational System

Henriques (2017) describes the relational system as an extension of the experiential system that is specifically adapted for social functioning. It includes social motivations and feeling states, as well as learned schemas of self in relation to others that develop initially in the context of parent-child interactions (i.e., attachment theory) but are nevertheless responsive to social learning throughout the lifespan. As previously discussed, the Influence Matrix can be used to illustrate how such development occurs in the context of an individual's efforts to maximize relational value. Such efforts, as expressed through patterns of interpersonal behavior, can be based upon ineffective internal working models of the self in relation to others, often producing self-fulfilling prophesies such as feelings of inadequacy that prompt an individual to push others away and therefore increase loneliness and feelings of inadequacy. As a frame for conceptualization, the relational system coincides with modern offshoots of psychodynamic theory such as Interpersonal Psychotherapy (IPT), which involves intervention into the way an individual approaches social interaction in order to strengthen their relational bonds as a pathway to distress reduction. While IPT does not

seek to address fundamental patterns of self-and-other relating arising out of attachment, other psychotherapeutic approaches which focus primarily on the relational system do.

While CALM-MO's focus on increasing insight through self-observation is not a primary goal of IPT, practitioners of the latter would likely recognize interventions seeking to contextualize Caroline's social functioning as interactional with available supports (Mays & Henriques, 2018). Clarification of Caroline's relational needs and values would aid her in identifying discrepancies with her interpersonal approach, and bolster motivation for her to learn and apply new social skills that are congruent with those needs and values. An effective therapist would be attuned to how Caroline's characteristic interpersonal patterns are expressed within the therapeutic relationship, and sensitive to the ways in which varying social contexts are likely to place differing demands on her.

Additionally, an understanding of Caroline's attachment style and process could be deeply beneficial as she continues to navigate social relationships. As Mays and Henriques (2018) point out, if Caroline's original attachment figures were unable to or inconsistent in attending to her emotional needs while effectively managing their own, she is likely to have developed adaptive patterns of protecting herself from any resulting anxiety. However, those self-protective strategies are unlikely to be well-suited to navigating current relationships and may be activated at the first sign of relational threat, triggering further disharmony and relational turmoil. A CALM-MO approach would advocate for navigating these patterns as they arise in the room and training her MO to adopt the role of the therapist in gently and warmly evaluating how her development impacts her current relational process.

The Justification System

The justification system consists of linguistically based and expressed beliefs and values regarding the self and the world, symbolic and verbal meaning making, and attributional biases. It is primarily concerned with evaluating and expressing the legitimacy of behavior and developing a meaningful framework regarding continuity of the self and of how the world works. The justification system describes aspects of functioning that are emphasized by cognitive approaches, which conceptualize dysfunction in terms of beliefs, systematic biases, and schemas. According to cognitive theory, these structures organize perceptual experience and mediate the relationship between stimuli and emotional response. From this perspective, maladaptive beliefs, expectations, and styles of thinking (e.g., overgeneralizing, jumping to conclusions) lead Caroline to misinterpret situations and respond to those interpretations rather than the situation itself. In describing Caroline's functioning, Mays and Henriques (2018) posit that she may be operating with an other-oriented schema, or a working model of relationships that emphasizes a need to meet the needs of others before her own in order to maintain those connections and avoid rejection or abandonment. She is also likely to derive her sense of self-value from the evaluations of others, leaving her hypervigilant and hypersensitive to perceived criticism. Such vigilance and sensitivity are likely to impact her perceptions of even ambiguous social situations as disproportionately threatening.

A CALM-MO approach would seek to help Caroline construct a narrative of how her perceptions and expectations impact her emotional experience, as well as how she learned to see things the way that she does. A compassionate frame would aid her in

seeing her process as a natural consequence of her development, rather than a result of some deep flaw in her as a person. Taking a CALM stance, her MO would aid her in warmly attending to the ways she interprets social stimuli, and highlight alternatives grounded in compassionately derived goals and values. Skills in accepting, rather than avoiding, her internal experience would be essential to her ability to tolerate this process and metabolize her feelings into value-congruent action.

The Defensive System

Significantly overlapping with a neo-Freudian psychodynamic view of human functioning, the defensive system is primarily concerned with how individuals manage conscious attention of their behavior and internal experiences in relation to various forms of threat (Henriques, 2017). Individuals accomplish this through the classically defined defense mechanisms (e.g., denial, projection) that are themselves unconscious but act to direct awareness away from unacceptable stimuli in order to reduce discomfort or anxiety. Such anxiety is seen by psychodynamic approaches as arising from the tension between an individual's conflicting drives and needs. Henriques identifies five domains of human experience that individuals are typically defended against: death and the idea thereof, threats to the individual's worldview and meaning-making systems, threats to important relationships between self and other, threats to self-concept, and painful or unacceptable feelings and memories. In Caroline's case, it is highly likely that she is defended against her genuine emotions surrounding relationships with others and would therefore benefit from gaining access to those feelings that are most directly tied to her needs.

A CALM-MO works to reduce the need for maladaptive defenses by reducing reactivity to internal events such as the anxiety that arises from discrepant values and behavior. Psychodynamically trained clinicians are likely to recognize CALM-MO's potential as a tool for gently making unconscious processes like needs and drives, as well as their conflicts, available for conscious experience and intentional action. For Caroline, this process may involve intentionally giving voice to both her fears of rejection and her longing for connection, and taking intentional action toward balancing them. Caroline's MO would help her to adaptively evaluate her fears as they become more tolerable and available to conscious experience and interpersonal expression.

CALM-MO is the Right Tool for the Job

Clinicians in training, whether primarily studying cognitive, behavioral, psychodynamic, or other traditional theoretical orientations, would recognize key elements of a CALM-MO approach and be able to apply it with relatively little adjustment. This is partially because, as the description of the case of Caroline above illustrates, each perspective seems to be using its own language to describe the same set of human developmental and functional processes. In contextualizing these perspectives, the Unified Theory sets out a meta-theoretical framework for describing the "elephant" of human behavior. Arising from this meta-theory, CALM-MO is an excellent tool for bridging traditional theoretical paradigms' linguistic differences by connecting trans-theoretical therapeutic principles to trans-theoretical conceptualizations of individual functioning. CALM-MO brings together intervention techniques to promote growth and change not merely based on their apparent efficacy (i.e., as in technical eclecticism) but

on their grounding in that metatheoretical framework and the contextualization of their parent theoretical perspectives in relation to each other.

Furthermore, not only would a clinician trained in a single approach be able to apply CALM-MO through familiarity with shared basic principles, that clinician would also be exposed to the essential insights of other approaches in the context of the applied problems therapists face in helping clients improve their well-being. Therapists will have the opportunity to encounter when their "home language" does not have the vocabulary or grammar to adequately represent a client's experience, and they will already be embedded in an approach that offers alternative ways of describing and responding to client presentations.

CALM-MO can be included in clinician training at the level of clinical supervision or included in coursework emphasizing integrative approaches to psychotherapy. In addition, it can provide ideal structure for an introductory psychotherapy course within a graduate program. The therapeutic principles embedded in CALM-MO can provide ideal jumping-off points for learning and discussion of how various strategies of intervention arose from traditional theoretical paradigms, as well as how these perspectives have evolved over time. Ideally, students will begin to see these paradigms as fundamentally related and complementary frames of reference for understanding human functioning.

Beginning clinicians who are trained in a CALM-MO approach will start their careers with a map of the field of psychology that would allow them the flexibility to avoid becoming bogged down in particular ways of conceptualizing or intervening. In the therapy room, they will have a set of meta-theoretically grounded and empirically

validated strategies for recognizing and promoting growth-oriented change. Even if they choose not to adopt it more broadly, training in a CALM-MO approach would provide a foundation for integrative psychotherapeutic principles, as well as an appreciation for how the various theoretical paradigms, once considered to be mutually exclusive, can be seen as different languages striving to describe the same common experience of being human.

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