

INTEGRATING MINDFULNESS INTO PSYCHOTHERAPY PRACTICE

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Abstract

Although mindfulness practice is in its relative infancy in the psychotherapy field, a growing body of research indicates that mindfulness-based psychotherapies are effective in treating a number of clinical disorders. The goal of this paper is to outline the key components of mindfulness for clinicians with limited exposure to the concept, and to describe the application of mindfulness-based approaches to the treatment of various disorders. Training issues and future directions for mindfulness-based psychotherapy are also addressed.

Integrating Mindfulness into Psychotherapy Practice

Over the past several years, the psychotherapy literature has witnessed a growing number of articles and books devoted to the topic of mindfulness (e.g., Baer, 2003; Germer, Siegel, Fulton, 2005; Hayes, Follette, & Linehan, 2004). Given the preliminary evidence suggesting the usefulness of incorporating mindfulness into psychotherapy, the primary goal of this paper is to introduce mindfulness to clinicians who are interested in learning more about this therapeutic approach. Additionally, tangible ways in which clinicians can integrate mindfulness into their everyday clinical practice are addressed, as well as information about avenues through which to gain training in mindfulness.

Mindfulness Defined

Three core components are inherent to most definitions of mindfulness: (1) bringing attention to one's experience in the present moment; (2) an awareness that emerges through paying attention on purpose; and (3) a nonjudgmental attitude or acceptance of the ongoing stream of internal and external stimuli as they arise (e.g., Baer, 2003, Bishop et al., 2004; Kabat-Zinn, 2003). The 3 distinct parts in this definition are irreducibly intertwined in the experience of mindfulness and serves as a useful reminder to return to for clinicians beginning to incorporate mindfulness into their therapy practice.

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Basic Principles for Integrating Mindfulness into Psychotherapy

The 3 components of mindfulness are quite unique in psychotherapy practice and it is imperative that clinicians address all three parts with their clients. More specifically, helping clients to develop a detached awareness of thoughts and feelings, placing an emphasis on staying in the present moment, and fostering an acceptance of moment-to-moment experience may be a novel or perhaps even a counterintuitive approach to psychotherapy for many clinicians. Thus, the therapeutic rationale behind each of these concepts is addressed below, and the origins of mindfulness practice are briefly explored as well.

Thoughts are Thoughts, Feelings are Feelings, and neither are Facts

Mindfulness is a metacognitive approach in which the content of thoughts and feelings is given much less emphasis than how clients hold or relate to their thoughts or feelings. This involves teaching clients to observe and become aware of (without an active attempt to change) their thoughts and feelings as they arise, with the ability to take a detached, spectator role. By not judging our experience, we are more likely to see it as it is. Jon Kabat-Zinn, the founder of the mindfulness-based stress reduction (MBSR) program and one of the pioneers of integrating mindfulness into psychotherapy perhaps put it best in noting: "It is remarkable how liberating it feels to be able to see that your thoughts are just thoughts and that they are not 'you' or 'reality.' . . . The simple act of recognizing your thoughts as thoughts can free you from the distorted reality they often create and allow for more clear-sightedness and a greater sense of manageability in your life" (Kabat-Zinn, 1990, p. 69-70).

The Answer Lies in the Present (and not the Past or the Future)

Mindfulness also involves remembering, but not dwelling in memories. The Sanskrit word for mindfulness, *smriti*, translates into the English *remember*. Mindfulness is remembering to bring awareness and attention back to the present moment (Hanh, 1998). When we are mindful, we non-judgmentally accept whatever is occurring in the here and now. We have everything we need to make the present moment the happiest in our life, even if we have a cold or a headache – we don't have to wait until we get over our cold to be happy, having a cold is a part of life (Hanh, 1998).

Acceptance Precedes Change

In mindfulness-based psychotherapy, interventions are designed to increase acceptance of moment-to-moment experience rather than to change it. Acceptance refers to a willingness to let things be just as they are the moment we become aware of them – accepting pleasurable and painful experiences as they arise. Sanderson and Linehan (1999) note that the Middle English root for the word *accept* is *kap*, meaning to take, seize, or capture – definitively an action verb, not implying passivity or resignation, as is often mistakenly supposed. Rather, acceptance allows change and growth by actively acknowledging that avoidance of unpleasant emotions does not result in "feeling better." A mindfulness-based clinician encourages clients to let go of the idea that all problems might, with enough effort, be "fixed" or "changed." Mindfulness-based psychotherapy is explicit about the risk that endless attempts at fixing or controlling one's experience might have. Chief amongst these is the possibility that such efforts merely reinforce the attitude that unpleasant thoughts, feelings, or bodily sensations are the "enemy," and that once they are eliminated, life will substantially improve (Segal, Teasdale, &

Williams, 2004). The problem with this stance is that it only encourages further attempts to solve problems by ruminating on or worrying about them, and these attempts often keep persons trapped in the state from which they are trying to escape (Segal et al., 2004).

Context of Buddhism

Although relatively new to psychotherapy, mindfulness practice is an inherent component to Buddhism, and its origins date back over 2500 years. Through a process of trial and error, the Buddha devised a way of living which allowed for the alleviation of psychological suffering and utilized logico-empirical (e.g., mindfulness) methods to discover ways of alleviating human suffering. The issue of Buddhism is addressed here to allow the reader to see the historical context in which mindfulness developed. To become *aware of present experience* with *acceptance*, one obviously need not be a Buddhist. This is an important point to convey to clients who may have misgivings about being involved in psychotherapy in which they may be asked to participate in meditation and other more traditionally Eastern practices.

Mindfulness-based Approaches for Treatment of Specific Disorders

Mindfulness-based interventions have demonstrated effectiveness in treating chronic pain (Kabat-Zinn, Lipworth, & Burney, 1985; Kabat-Zinn, Lipworth, Burney, & Sellers, 1987), anxiety (Kabat-Zinn et al., 1992; Roemer, Salters, & Raffa, 2005), eating disorders (Kristeller & Hallett, 1999; Wilson, 1996), recurrent major depression (Ma & Teasdale, 2004; Teasdale et al., 2000), borderline personality disorder (Linehan, 1993a), substance dependence (Hayes et al., in press; Marlatt et al., 2004) couple distress (Christensen, Sevier, Simpson, & Gattis, 2004; Jacobson, Christensen, Prince, Cordova, &

Eldridge, 2000), psychosis (Bach & Hayes, 2002; Gaudiano & Herbert, in press), and trichotillomania (Twohig & Woods, 2004). Given the frequency with which depression, anxiety, borderline personality, substance dependence, couple distress, and psychosis are seen in clinical practice, the focus below is on using mindfulness-based interventions in treating these six clinical issues. Training issues and qualifications for utilizing mindfulness in psychotherapy are also addressed.

Recurrent major depression

Even though the vast majority of clients recover from an episode of depression, research estimates are that 85% of clients with unipolar depression are likely to experience recurrences (Keller & Boland, 1998). Residual ruminative thinking and its association to depressed moods is believed to be a primary causal factor underlying high rates of relapse (Persons & Miranda, 1992). Teasdale, Segal, and Williams (1995) proposed that the skills of attentional control taught in mindfulness meditation could be crucial to inhibiting the deleterious effects of ruminative thinking and subsequent relapse of major depressive episodes. Their information-processing theory of depressive relapse posits that individuals who have experienced major depressive episodes are vulnerable to recurrences whenever mild dysphoric states are encountered, because the states may reactivate the depressive thinking patterns present during the previous episode, or episodes, thus precipitating a new episode.

Mindfulness-based cognitive therapy (MBCT) is a manualized (Segal, Williams, & Teasdale, 2002) 8-week group intervention that integrates elements of cognitive therapy (CT) for depression and Kabat-Zinn's (1990) MBSR program. Unlike CT, there is little emphasis on changing the content of the thoughts; rather, the

emphasis is on changing awareness of and relationship to thoughts, feelings, and bodily sensations. Aspects of CT included in MBCT are primarily those designed to facilitate a detached or decentered view such as “thoughts are not facts” and “I am not my thoughts.” Unlike MBSR, which is a generic program applicable to a variety of problems, MBCT is specifically designed for clients who are in remission from recurrent unipolar major depression. Increased mindfulness allows early detection of relapse-related patterns of negative thinking, feelings, and bodily sensations, thus allowing them to be “nipped in the bud” at a stage when this may be much easier than if such warning signs were not noticed or ignored (Segal et al., 2004, p. 56). Similar to MBSR, clients are introduced to mindfulness experientially rather than didactically, and this begins with the mindful eating of a raisin. In this exercise, the therapist teaches the client to bring full nonjudgmental awareness to the raisin as a tangible way to introduce the practice of attentional control. This progresses on to nonjudgmental awareness of bodily sensations (i.e., body scans) and eventually to the primary target – thoughts and emotions (see Segal et al., 2002 for full protocol).

Borderline Personality Disorder

Clinicians generally agree that clients with a diagnosis of borderline personality disorder (BPD) are challenging and difficult to treat. Chronic emotional dysregulation is a core BPD symptom that has proven to be particularly resistant to treatment when using conventional (e.g., psychodynamic, cognitive, etc.) psychotherapy (Linehan, Cochran, & Kehrer, 2002). Dialectical behavior therapy (DBT) is a mindfulness-based treatment that incorporates behavioral science, dialectical philosophy, and Zen practice to effectively treat emotional dysregulation and related BPD symptoms. DBT is based on a dialectical worldview, which postulates that reality consists of opposing forces. The synthesis of these

forces leads to a new reality, which in turn consists of opposing forces, in a continual process of change. In DBT, the primary dialectic is the relationship between acceptance of what is and efforts to change what is. Akin to Buddhist Psychology, therapists advocate and model a Middle Way by encouraging clients to accept themselves, their histories, and their current situation (i.e., radical acceptance), while directing an intense behavioral and environmental change in order to build a better life (Linehan, 1993a).

DBT is an intensive treatment in which clients attend a year-long weekly skills group, as well as individual therapy to work on applying these skills to their everyday lives (Linehan, 1993a, 1993b). Mindfulness (in addition to interpersonal effectiveness, emotion regulation, and distress tolerance) is taught and practiced in the weekly skills group. Mindfulness is key to DBT because it is the primary vehicle through which clients learn to regulate emotion by tolerating and accepting present experience instead of continually using ineffective coping (e.g., cutting, illicit drugs, etc.) to try to “force” away negative affect states. The specific mindfulness skills taught in DBT are similar to other approaches (e.g., MBSR), however, Linehan (1993a, 1993b) utilizes the distinction between “what” skills (observe, describe, participate) and “how” skills (non-judgmentally, one-mindfully, effectively) to enhance their comprehensibility. In the individual therapy sessions, clinicians structure each by session by assessing for current dysfunction in the following areas, in order of clinical importance: suicidal and parasuicidal behavior, therapy interfering behavior, and quality of life issues. In adhering to the core dialectic, DBT therapists shift back and forth in session between a nurturing acceptance (or validation) of the client’s experience and more forceful change (or problem-solving) strategies.

Linehan (1994) notes that some severely impaired clients may be unable or unwilling to

formally meditate as extensively as other mindfulness-based treatments recommend. Most mindfulness skills used in DBT emphasize less formal, sitting meditative practice, and instead focus on skills more easily integrated into everyday activity (some adapted from Hanh, 1976). For example, clients are encouraged to mindfully (following “what” and “how” skills) make tea, wash dishes, take a bath, or go for a walk. Several variations on observing the breath are also taught, including following the breath in and out, counting breaths, coordinating breathing with footsteps while walking, and following the breath while listening to music. These practices are all taught to help clients begin to develop the ability to become nonjudgmentally aware of present experience, and this practice is then gradually applied to more internal, abstract cognitive and emotional experiences.

Substance Abuse/Dependence

Relapse prevention (RP; Marlatt & Gordon, 1985) is a treatment package that combines behavioral coping skills training with specific cognitive interventions and global self-management strategies designed to prevent or limit the occurrence of relapse episodes. In traditional RP, clients are taught to identify and modify coping skills deficits, the role of self-efficacy, the abstinence violation effect, and the importance of challenging positive outcome expectancies. Through the ongoing evolution of RP with a growing emphasis on mindfulness-based techniques, Marlatt and colleagues (Marlatt, 2002; Witkiewitz, Marlatt, & Walker, 2004) have recently developed a treatment approach entitled mindfulness-based relapse prevention (MBRP). Unlike traditional RP and cognitive-behavioral interventions, which are focused on challenging and changing the content of maladaptive thoughts, MBRP focuses on changing one’s relationship to thoughts. The goal of MBRP is to develop awareness of thoughts, feelings, and sensations

(including urges or cravings) by developing mindfulness skills that can be applied in high-risk situations for relapse. Clients are taught specific RP strategies (enhancing self-efficacy, behavioral activation and coping, education about positive outcome expectancies, and the abstinence violation effect) to be used in conjunction with mindfulness practice. Clients learn, through mindfulness techniques, that arising thoughts and cravings are just that; they are mental events that come and go. It is the attachment or aversion to the thoughts or sensations that causes suffering or discomfort that may potentially lead to relapse. The mindfulness techniques in MBRP teach clients to recognize these thoughts and cravings, and to accept them and let them pass, without necessarily reacting to them.

“Urge surfing” is a core MBRP technique that teaches clients to visualize their urge as ocean waves that grow gradually until they crest and subside (Marlatt, 1994). As the urge wave grows in strength, clients are instructed to surf the urge by allowing it to pass without being “wiped out” by giving into it. The wave metaphor gives clients an experience-based exercise (i.e., most of us have been to the beach) through which they can begin to internalize the ebb and flow nature of craving, as well as a specific skill to help reinforce acceptance and self-efficacy. Although Marlatt (1985, 1994) has detailed the role of mindfulness practice in RP in earlier writings, he more recently makes the distinction between the central role mindfulness now plays in the MBRP (Witkiewitz, Marlatt, & Walker, 2004) relative to its more adjunctive place in RP.

Couple Distress

Akin to other therapies reviewed in this paper, integrative behavioral couple therapy (IBCT) emphasizes mindfulness and acceptance, but it is the lone therapy that explicitly does so within the context of an intimate relationship. IBCT was

derived directly from observed shortcomings of its predecessor – traditional behavioral couple therapy (TBCT; Stuart, 1969). Despite a history of efficacy (e.g., Jacobson, 1984), more recent outcome research revealed that TBCT was generally not effective with couples who are older, more emotionally disengaged, more polarized on basic issues, and more severely distressed (Jacobson & Christensen, 1996). Each of these factors is likely to be associated with long-standing, deeply entrenched behavioral patterns. Thus, the strictly change-oriented techniques of TBCT were unlikely to be successful with these “unchangeable” couples (Wheeler, Christensen, & Jacobson, 2002, p. 611), and the need for a more mindfulness-based approach to treatment emerged.

Developed by Christensen and Jacobson (Christensen & Jacobson, 2000; Jacobson & Christensen, 1996), at its most fundamental level, IBCT promotes acceptance of the following ideas: each partner has feelings that are understandable, has a story that makes sense, has hold of some truth about the relationship, and has a position on the problem worthy of consideration and attention. When there is little or no acceptance, a partner's feelings may seem outrageous and their “story” may not make sense – it may seem to contain no truth, and the position itself may inspire ridicule. Out of this fundamental acceptance and the conversations that ensue from it, acceptance of more specific negative behaviors may emerge, such as greater acceptance of a partner's anger, or a greater acceptance of a partner's shyness about initiating sex (Christensen et al., 2004). To this end, IBCT employs three specific strategies to promote acceptance: empathic joining around the problem, unified detachment from the problem, and tolerance building (Christensen & Jacobson, 2000). Unlike more directive acceptance-based therapies, IBCT does not tell clients that they should be more accepting or what they should accept. Rather, it tries to create conditions under

which partners will naturally increase in their emotional acceptance of one another.

In using empathic joining, the therapist suggests or elicits feelings associated with the couple's problem that are not commonly expressed. These feelings may be unexpressed because they are embarrassing or vulnerable, or because the partner is only vaguely aware of them. These emotions, once voiced by one partner, may then elicit more constructive and sympathetic responses in the other. In this way, IBCT therapists attempt to generate an empathic connection between partners around the very issues that drive them apart. In contrast to the emotional focus of empathic joining, the emphasis in unified detachment is on creating objective, intellectual distance from the problem. In empathic joining, IBCT therapists alter an ongoing battle between partners by getting them to notice and attend to each other's wounds. In unified detachment, therapists ask couples to detach or decenter from the charged situation – “to move to a better vantage point, use their binoculars, and observe the ongoing battle” (Christensen et al., 2004, p. 301). Finally, tolerance building in IBCT begins with the assumption that many important differences between couples, and the subsequent problems, will never be completely erased. Therefore, IBCT emphasizes the management of problems rather than their elimination, as well as recovery from problems rather than their prevention. Enacting negative behavior and searching for the positive benefits of the couple's differences are commonly used tolerance building interventions that communicate to the couple that their problem will reappear, but can be managed.

Psychosis

Even with psychotropic medication compliance, hallucinations and delusions may persist for clients with a psychotic disorder. This is believed to be one of the primary factors

contributing to repeated hospitalizations in this population (Lehman & Steinwachs, 1998). Accordingly, psychosocial interventions have generally focused on building coping skills to help reduce the frequency and intensity of positive schizophrenia symptoms (e.g., Wykes, Paar, & Landau, 1999). The potential gains from these treatments may be undermined, however, if clients use suppression and avoidance as a method of regulating experiential content (Bach & Hayes, 2002), as thought suppression can actually lead to increased frequency and intensity of unwanted thoughts (Salkovskis & Campbell, 1994). Alternatively, acceptance and commitment therapy (ACT; Hayes et al., 1999) teaches clients acceptance and mindfulness to defuse (i.e., take less literally) from unwanted internal sources of distress. From an ACT perspective, psychological inflexibility is the underlying cause of most psychopathology. Consequently, the goal of ACT is to create psychological flexibility; “to support clients in feeling and thinking what they directly feel and think already, as it *is*, not as what it *says it is*, and to help clients move in a valued direction, *with* all of their history and automatic directions” (Hayes, 2004, p. 17). ACT is a mindfulness-based treatment with demonstrated efficacy in treating a variety of disorders (see Hayes, 2004 for a review), including psychosis, for which the adapted treatment manual is outlined below.

Bach and Hayes (2002) developed a 4-session, individually-administered treatment for clients currently hospitalized with psychotic symptoms (i.e., hallucinations and/or delusions) with the goal of decreasing rates of rehospitalization among participants. The first treatment session focuses on assessing clients’ past efforts to deal with the positive symptoms of psychosis and the possibility of just noticing thoughts and perceptions rather than believing and acting on them. The second session addresses the notion of accepting one’s symptoms even though one may not like them. The third session

focuses on accomplishing valued goals and examining the context in which given responses may be more or less workable. In the fourth and final session the therapist reviews the concepts described in the first three sessions. In the Bach and Hayes (2002) study, the therapist used specific ACT metaphors and paradoxes modified for this population to enhance continuity of treatment (see Hayes, Strosahl, & Wilson, 1999 for more detail and examples). Results revealed that ACT treatment reduced the rate of hospitalization over a 4-month period by 50%, and although ACT clients reported similar symptom frequency and distress as clients who received treatment as usual, ACT clients reported significantly lower believability of their symptoms.

Generalized anxiety disorder

Orsillo, Roemer, and colleagues (Orsillo, Roemer, Block Lerner, & Tull, 2004; Roemer & Orsillo, 2002) developed an acceptance-based behavioral treatment model for generalized anxiety disorder (GAD), derived largely from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), which was described above. A core assumption of this treatment model is that experiential avoidance, or attempts to change the form or frequency of internal events such as thoughts, feelings, bodily sensations, or memories, contributes to the development and maintenance of psychological distress (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). From this perspective, anxiety disorders are thought to develop when individuals are unwilling to experience the anxiety (including associated images, thoughts, bodily sensations, etc.) with which they are struggling, and these attempts at avoidance only serve to perpetuate distress (Orsillo et al., 2004). Therefore, the primary goal of treatment is to develop experiential acceptance, that is, a willingness to experience internal events in order to participate in present-focused experiences that are deemed important and meaningful. The initial

step in acceptance-based behavioral therapy is to increase actions and behaviors in the client's life that are consistent with his or her values and/or desires (e.g., being intimately connected with others, engaging in challenging and meaningful work, education, or recreational activities). The underlying proposed mechanism of change is the development of a cognitive stance from which internal events are viewed as natural, universal, transient responses that arise from our interactions with the environment that need not direct behavior. Instead behavior is shaped through increased contact with naturally reinforcing contingencies for valued behavior (Roemer & Orsillo, 2002).

In practice, the treatment model addresses the cardinal symptom of GAD – worry – by targeting inherent worry features (i.e., worry is future focused; worry and GAD are characterized by rigid, habitual responses; worry serves an experientially avoidant function, and; worry may inhibit action in valued directions) via psychoeducation, fostering acceptance, and initiating valued (or mindful) action (Orsillo et al., 2004). The introduction to treatment includes psychoeducation on the nature of worry and anxiety, the concept of mindfulness and mindfulness skills, the function of emotions (e.g., emotions provide important information to ourselves and others), and the problems associated with efforts at experiential control, along with the potential solution of willingness to have one's internal experience. Acceptance is fostered via the introduction of multiple aspects of mindfulness (e.g., awareness, nonjudgmental observation, beginner's mind, staying in the moment, acceptance/letting go) and cultivated through formal (e.g., sitting meditation) and informal (e.g., drinking a cup of tea using mindful awareness) mindfulness skills practiced in and out of session. Additionally, the concept of values, or a life worth living, is introduced in the beginning stages of treatment, and once clearly defined, these values guide treatment by assisting clinician

and client in choosing actions for the upcoming week, and help in identifying potential obstacles while reviewing actions and obstacles from actions selected in the previous session.

Mindfulness Training and Qualifications

Many opinions exist regarding the level of training and experience one must have before beginning to integrate mindfulness into psychotherapy practice. Segal, Williams, and Teasdale (2002), for example, assert the critical importance of a therapist's personal formal meditation practice for the competent practice of MBCT. In contrast, Hayes (2004) contends that personal mindfulness practice is not necessary for one to employ ACT methods in treatment. Linehan (1993) bridges the gap between the two by noting that DBT therapists are not required to have a personal formal meditation practice, but are required to both practice mindfulness in their daily lives and be members of a clinical consultation team that practices formal mindfulness at the beginning of each meeting.

Consonant with Linehan's position, Germer (2005) believes it is crucial for clinicians to have experienced what they teach. To incorporate mindfulness into all aspects of the therapeutic approach – to shape understanding, demeanor, words, and recommendations – it is advised that the therapist devote a great deal of time to formal meditation practice with a skilled teacher to develop great faith in using mindfulness with any experience. Alternatively, therapists seeking to introduce more informal mindfulness techniques into therapy, such as watching the breath or bringing attention to present experience, need only to have had suitable instruction and supervision and to have tried these techniques in their daily lives (Germer, 2005). A good starting point for clinicians interested in incorporating mindfulness into their clinical practice is to become more familiar with the manuals/books/articles detailing

the mindfulness approaches presented above, and to adhere to the recommendations espoused by each particular type of treatment. Additionally, introductory workshops and other trainings are offered annually at the Association for Advancement of Behavioral Therapy (AABT: www.AABT.org) convention.

Conclusions

The use of mindfulness in clinical practice is growing rapidly, and preliminary research indicates that a number of psychological disorders can be effectively treated using these techniques. Clinicians wanting to incorporate mindfulness into their practice must begin by seeking out the requisite texts, training, supervision, and personal practice (relevant to the particular type of mindfulness-based psychotherapy) before engaging in such practice. In addition to training issues, as mindfulness-based psychotherapy continues to evolve and grow, component analysis research of multicomponent treatments will also help to advance this promising field. A wide range of putative mechanisms of change for the observed effects of mindfulness therapies have been proposed, including exposure, cognitive change, self-management, relaxation, and acceptance (Bear, 2003). However, the relationship between each specific mindfulness technique and hypothesized underlying mechanism of change has remained largely unexplored. The vast majority of mindfulness-based psychotherapies utilize a variety of mindfulness techniques, and although most are efficacious as a treatment package, little is known about the efficacy of each technique in isolation. More research is needed to parcel out these effects. Until then, in clinical practice, the most sensible approach may be to tailor the treatment to the needs of the client. Although all three mindfulness components are essential to its practice, a prudent strategy may be to place an emphasis on the component that best suits the client's diagnosis and stage of progress in treatment. For example, a client with OCD might benefit more from

“disentangling from thought” than from “choiceless awareness” practice, and a client who is self-injurious may benefit more from “attention regulation” than from “exposure” treatment. Similarly, a client with borderline personality disorder who grew up in an invalidating environment may require a great deal of “self-acceptance” to become more mindful of strong emotions. Essentially, a process-based understanding of mindfulness (i.e., awareness, of present experience, with acceptance) may be the most helpful clinical guide in matching a mindfulness-based technique to a particular client.

References

- Bach, P., & Hayes, S. C. (2002). “The use of acceptance and commitment therapy to prevent the re-hospitalization of psychotic patients: A randomized controlled trial”. *Journal of Consulting and Clinical Psychology, 70*, 1129-1139.
- Baer, R. A. (2003). “Mindfulness training as a clinical intervention: A conceptual and clinical review”. *Clinical Psychology: Science and Practice, 10*, 125-143.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., et al. (2004). “Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*”, *11*, 230-241.
- Block, J. A. (2002). *Acceptance or change of private experiences: A comparative analysis in college students with public speaking anxiety*. Doctoral dissertation, University of Albany, State University of New York.
- Christensen, A., & Jacobson, N. S. (2000). *Reconcilable differences*. New York: Guilford.

- Christensen, A., Sevier, M., Simpson, L. E., & Gattis, K. S. (2004). "Acceptance, mindfulness, and change in couple therapy". In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 288-309). New York: Guilford.
- Dimidjian, S., & Linehan, M. M. (2003). "Defining an agenda for future research on the clinical application of mindfulness practice". *Clinical Psychology: Science and Practice*, 10, 166-171.
- Gaudiano, B. A., & Herbert, J. D., (in press). "Acute treatment of inpatients with psychotic symptoms using acceptance and commitment therapy". *Behaviour Research and Therapy*.
- Germer, C. K. (2005). "Mindfulness: What is it? What does it matter?" In C. K. Germer, R. D. Siegel, & P. R. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 3-27). New York: Guilford.
- Germer, C. K., Siegel, R. D., Fulton, P. R. (Eds.). (2005). *Mindfulness and psychotherapy*. New York: Guilford.
- Hanh, T. N. (1998). *The heart of the Buddha's teachings: Transforming suffering into peace, joy, and liberation*. New York: Broadway.
- Hanh, T. N. (1976). *The miracle of mindfulness*. Boston: Beacon.
- Hayes, S. C. (2004). "Acceptance and commitment therapy and the new behavior therapies: Mindfulness, acceptance, and relationship". In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 288-309). New York: Guilford.
- Hayes, S. C., Wilson, K. G., Gifford, E. V., Bissett, R., Piasecki, M., Batten, S. V., et al. (in press). "A randomized controlled trial of twelve-step facilitation and acceptance and commitment therapy with polysubstance abusing methadone maintained opiate addicts". *Behavior Therapy*.
- Hayes, S. C., Follette, V. M., & Linehan, M. M. (Eds.). (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition*. New York: Guilford.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.
- Jacobson, N. S. (1984). "A component analysis of behavioral marital therapy: The relative effectiveness of behavior exchange and problem-solving training". *Journal of Consulting and Clinical Psychology*, 52, 295-305.
- Jacobson, N. S., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: Norton.
- Jacobson, N. S., Christensen, A., Prince, S. E., Cordova, J., & Eldridge, K. (2000). "Integrative Behavioral Couple Therapy: An acceptance-based, promising new treatment for couple discord". *Journal of Consulting and Clinical Psychology*, 68, 351-355.
- Kabat-Zinn, J. (1990). *Full catastrophes living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte.

- Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). "The clinical use of mindfulness meditation for the self regulation of chronic pain". *Journal of Behavioral Medicine*, 8, 163-190.
- Kabat-Zinn, J., Lipworth, L., Burney, R., & Sellers, W. (1987). "Four-year follow-up of a meditation-based program for the self-regulation of chronic pain: Treatment outcomes and compliance". *Clinical Journal of Pain*, 2, 159-173.
- Kabat-Zinn, J., Massion, M. D., Kristeller, J., Peterson, L. G., Fletcher, K. E., Pbert, L., et al. (1992). "The effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders". *American Journal of Psychiatry*, 149, 936-943.
- Kabat-Zinn, J. (2003). "Mindfulness-based interventions in context: Past, present, and future". *Clinical Psychology: Science and Practice*, 10, 144-156.
- Keller, M. B., & Boland, R. J. (1998). "Implications of failing to achieve successful long-term maintenance treatment of recurrent unipolar major depression". *Biological Psychiatry*, 44, 348-360.
- Kristeller, J. L., & Hallett, C. B. (1999). "An exploratory study of a meditation-based intervention for binge eating disorder". *Journal of Health Psychology*, 4, 357-363.
- Kumar, S. M. (2002). "An introduction to Buddhism for the cognitive-behavioral therapist". *Cognitive and Behavioral Practice*, 9, 40-43.
- Lehman, A. F., & Steinwachs, D. M. (1998). "Patterns for usual care for schizophrenia: Initial results from the schizophrenia Patient Outcomes Research Team (PORT) client survey". *Schizophrenia Bulletin*, 24, 11-20.
- Levitt, J. T., Brown, T. A., Orsillo, S. M., & Barlow, D. H. (2004). "The effects of acceptance versus suppression of emotions on subjective and psychophysiological response to carbon dioxide challenge in patients with panic disorder". *Behavior Therapy*, 35, 747-766.
- Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.
- Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford.
- Linehan, M. M. (1994). "Acceptance and change: the central dialectic in psychotherapy". In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context and psychotherapy* (pp. 73-86). Reno, NV: Context.
- Linehan, M. M., Cochran, B. N., & Kehrer, C. A. (2002). "Dialectical behavior therapy for borderline personality disorder". In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (3rd ed.). New York: Guilford.
- Ma, S. H., & Teasdale, J. D. (2004). "Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects". *Journal of Consulting and Clinical Psychology*, 72, 31-40.
- Marlatt, G. A. (1994). "Addiction, mindfulness, and acceptance". In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher

- (Eds.), *Acceptance and change: Content and context and psychotherapy* (pp. 175-197). Reno, NV: Context.
- Marlatt, G. A. (2002). "Buddhist psychology and the treatment of addictive strategies in the treatment of addictive behaviors." *New York: Guilford.*
- Marlatt, G. A., Witkiewitz, K., Dillworth, T. M., Bowen, S. W., Parks, G. A., Macpherson, L. M., et al. (2004). "Vipassana meditation as a treatment for alcohol and drug use disorders". In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 261-287). New York: Guilford.
- Orsillo, S. M., Roemer, L., Block Lerner, J., & Tull, M. T. (2004). "Acceptance, mindfulness, and cognitive behavioral therapy: Comparisons, contrasts, and application to anxiety". In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 66-95). New York: Guilford.
- Persons, J. B., & Miranda, J. (1992). "Cognitive theories of vulnerability to depression: Reconciling negative evidence". *Cognitive Therapy and Research, 16*, 485-502.
- Roemer, L., Salters, K., Raffa, S. D. (2005). "Fear and avoidance of internal experiences in GAD: Preliminary tests of a conceptual model". *Cognitive Therapy & Research, 29*, 71-88.
- Roemer, L., & Orsillo, S. M. (2002). "Expanding our conceptualization of and treatment for generalized anxiety disorder: Integrating mindfulness/acceptance-based approaches with existing cognitive-behavioral models". *Clinical psychology: Science and Practice, 9*, 54-68.
- Salkovskis, P. M., & Campbell, P. (1994). "Thought suppression induces intrusion in naturally occurring negative intrusive thoughts". *Behaviour Research and Therapy, 32*, 1-8.
- Sanderson, C., & Linehan, M. M. (1999). "Acceptance and forgiveness". In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 199-216). Washington, DC: American Psychological Association.
- Segal, Z. V., Teasdale, J. D., & Williams, J. M. G. (2004). "Mindfulness-based cognitive therapy: Theoretical rationale and empirical status". In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 45-65). New York: Guilford.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive theory therapy for depression: A new approach to preventing relapse*. New York: Guilford.
- Stuart, R. B. (1969). "Operant interpersonal treatment for marital discord". *Journal of Consulting and Clinical Psychology, 33*, 675-682.
- Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (1995). "How does cognitive therapy prevent depressive relapse, and why should attentional control (mindfulness) training help?" *Behaviour Research and Therapy, 33*, 25-39.

Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. K. (2000). "Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy". *Journal of Consulting and Clinical Psychology, 68*, 615-623.

Twohig, M., & Woods, D. (2004). "A preliminary investigation of acceptance and commitment therapy and habit reversal as a treatment for trichotillomania". *Behavior Therapy, 35*, 803-820.

Wheeler, J. G., Christensen, A., & Jacobson, N. S. (2002). "Couple distress". In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (3rd ed.) (pp. 609-630). New York: Guilford.

Wilson, G. T. (1996). "Acceptance and change in the treatment of eating disorders and obesity". *Behavior Therapy, 27*, 417-439.

Witkiewitz, K., Marlatt, G. A., & Walker, D. E. (2004). "Mindfulness-based relapse prevention for alcohol and substance use disorders: The meditative tortoise wins the race". *Journal of Cognitive Psychotherapy, 23*, 67-98.

Wykes, T., Parr, A., & Landau, S. (1999). "Group treatment of auditory hallucinations". *British Journal of Psychiatry, 175*, 180-185.