INTERNATIONAL JOURNAL OF SOCIAL SCIENCES BULLETIN
ISSN: (E) 3007-1917 (P) 3007-1909
Volume 4, Issue 3, 2026

EVALUATING FEASIBILITY AND PSYCHOLOGICAL SAFETY OF SHIFT INTEGRATION MODEL (SIM): AN ORIENTATION-PHASE PILOT STUDY

Adam Kamran Kureshi[*1], Shamsa Batool[2]

[*1]*MSCP, MSHMI, Independent Researcher, Lahore, Pakistan*
[2]*MSCP, Head of Department, Applied Psychology, Al-Razi Institute, Lahore, Pakistan*

[*1]adamkureshi.hr@gmail.com, [2]shamsabatool007@gmail.com

Corresponding Author: *
Adam Kamran Kureshi

DOI: http://doi.org/10.5281/zenodo.19625727

Received	Accepted	Published
01 February 2026	17 March 2026	31 March 2026

ABSTRACT

Background: *As psychological and behavior-change frameworks increasingly migrate into non-clinical settings, such as universities and professional environments, concerns have emerged regarding premature depth activation, boundary ambiguity, and unstructured sequencing. Many well-being interventions introduce awareness, reframing, and action demands without explicitly operationalizing containment, readiness, or ethical staging.*

Objective: *This study introduces the Shift Integration Model (SIM) as a staged behavioral self-containment framework designed to govern sequencing and psychological depth in non-clinical contexts. The present paper reports Phase-1 feasibility testing of the Orientation phase of Behavior Shift Communication (BSC-O), operationalized through the ARRI loop (Awareness; Regulation; Reframing; Integration).*

Methods: *A four-session structured primer was delivered to faculty and student participants (N = 23) within an academic setting. Complete analyzable feedback data were available for 18 participants and formed the primary analytic sample. The study employed a process-focused pilot feasibility design prioritizing psychological safety, containment integrity, framing clarity, and institutional manageability over outcome testing. Real-time session indicators, anonymous qualitative feedback, and exploratory pre- and post-measures, including the Emotional Regulation Questionnaire (ERQ-R reappraisal) & Brief Resilience Scale (BRS), were analyzed descriptively using descriptive statistics.*

Results: *All 23 participants completed the four-session sequence (100% intervention retention), with 16 of the 18 participants in the primary analytic sample completing delayed follow-up (88.9%). Across sessions, participants reported high psychological safety, clarity of scope, and manageable engagement demands. No escalation events, depth breaches, or adverse psychological effects were observed. Qualitative feedback indicated increased awareness and reflective flexibility without therapeutic expectations and behavioral pressure. Exploratory quantitative analyses showed small, directional increases in cognitive reappraisal (d = 0.15) and resilience (d = 0.21), with confidence intervals that crossed zero, consistent with the model's orientation-level scope.*

Conclusions: *Findings support the feasibility and ethical containment of BSC-O as a bounded, non-clinical orientation framework. The results reinforce the proposition that orientation constitutes a legitimate intervention phase distinct from behavioral execution. By formalizing sequencing and depth caps as design variables, SIM offers a principled architecture for staging psychological processes in institutional wellbeing initiatives. Subsequent research is required to evaluate execution-phase processes and long-term outcomes within the full SIM framework.*

Keywords: *Behavioral, framework, psychological, regulation*

INTRODUCTION

The Need for Staged, Non-Clinical Wellbeing Frameworks

In recent years, psychological and behavioral interventions have increasingly expanded beyond clinical settings into universities, workplaces, and professional training environments. This shift reflects the growing influence of process-based and transdiagnostic frameworks, which emphasize underlying psychological mechanisms, such as awareness, self-regulation, cognitive flexibility, and behavioral consistency, rather than disorder-specific treatments (Hofmann & Hayes, 2019; Hayes et al., 2020).

While this expansion has enabled psychological knowledge to support prevention, education, and organizational well-being, it has also introduced design challenges. Interventions delivered outside clinical care frequently draw on therapeutic constructs without the structural safeguards that guide clinical practice, including clear sequencing, contextual boundaries, and defined professional roles (Craig et al., 2008; Kazdin, 2007; Welfel, 2016). Consequently, programs intended to enhance well-being may inadvertently activate emotional or cognitive processes without adequate attention to timing, containment, or participant readiness.

Evidence from intervention science suggests that exposure to internal psychological processes without appropriate sequencing may increase distress, disengagement, or misinterpretation of intent, particularly in group contexts where facilitators are not clinicians, and participants have not sought therapeutic support (Yalom & Leszcz, 2005; Dimidjian & Segal, 2015). These concerns highlight the importance of frameworks that explicitly treat sequencing, containment, and contextual boundaries as core design principles rather than implicit assumptions.

Limitations of Existing Approaches in Non-Clinical Contexts

Existing psychological, coaching, mindfulness-based, and behavior-change frameworks offer valuable conceptual tools for understanding human behavior. However, when adapted for non-clinical group delivery, several recurring limitations emerge in the literature.

First, psychological depth is often left implicit rather than operationalized. Emotional exploration, meaning-making, or reflective sharing may be encouraged without clear boundaries regarding disclosure or processing. Group psychotherapy research has long documented the risks of unbounded emotional exposure in group contexts, particularly when facilitation authority and responsibility are ambiguous (Yalom & Leszcz, 2005). In non-clinical settings, this ambiguity can generate discomfort or vulnerability that facilitators are neither trained nor positioned to manage.

Second, sequencing is frequently assumed rather than designed. Processes, such as awareness, regulation, reframing, and action, are often presented as interchangeable or simultaneous, despite evidence that premature reframing or action demands can function as avoidance rather than integration (Hayes et al., 1999). Behavior-change research similarly emphasizes that readiness for action varies across individuals and contexts, and that mismatches between intervention demands and participant readiness can undermine engagement and sustainability (Prochaska & Velicer, 1997).

Third, outcome expectations are often misaligned with the scope of intervention. Participants may infer therapeutic or transformational intent even when programs are framed as introductory or preventive. This places unspoken pressure on both facilitators and participants to demonstrate insight, change, or resolution regardless of whether such outcomes are appropriate or achievable within the format. When programs imply transformational or therapeutic outcomes beyond their stated scope, expectation drift can introduce ethical ambiguity and unintended harm, particularly in preventive or non-clinical settings (Lilienfeld, 2007; Dimidjian & Segal, 2015; Welfel, 2016). Taken together, these limitations highlight the need for frameworks that explicitly distinguish between orientation and execution; capacity-building and behavior change; and process exposure and outcome evaluation; particularly in early-stage or preventive interventions.

The Shift Integration Model (SIM)

The Shift Integration Model (SIM) was developed in response to these challenges as a staged framework for ethically sequencing psychological processes in non-clinical contexts. SIM is not a therapeutic model, nor does it prescribe treatment pathways or clinical outcomes. Instead, it functions as a governing architecture that specifies the order in which psychological processes are introduced, the depth at which those processes are engaged, the facilitation stance appropriate to each stage, and the transition points between internal orientation and external behavioral change.

SIM is grounded in the premise, well supported in intervention science, that psychological processes are not universally appropriate across all contexts or stages (Kazdin, 2007). Behavioral execution without prior orientation may increase instability rather than effectiveness, particularly in group-based or preventive formats. Accordingly, SIM formalizes sequencing and containment as first-order design principles rather than secondary implementation considerations.

Behavior Shift Communication (BSC) Within SIM

Within the SIM framework, behavior change is organized through a Behavior Shift Communication (BSC) architecture that conceptualizes change as iterative rather than linear. BSC draws on established principles from behavior change communication and self-regulation research, which emphasize that behavior emerges from ongoing feedback loops rather than isolated insight or instruction (Bandura, 1997; Carver & Scheier, 1998; Michie et al., 2011).

Crucially, SIM distinguishes between two phases that differ in intent, depth, and ethical requirements: BSC-O (Orientation), which focuses on internal capacity-building without behavioral demand, and BSC-E (Execution), which focuses on translating capacity into intentional action and reinforcement.

Each phase is operationalized through a distinct process loop. BSC-O employs the ARRI loop (Awareness; Regulation; Reframing; Integration), while BSC-E employs the ARAR loop (Awareness; Reframing; Action; Reinforcement).

The present paper focuses exclusively on BSC-O. This phase is designed to introduce awareness, self-regulatory capacity, and meaning flexibility without requiring behavior change. Maintaining this distinction is critical for ethical clarity and methodological precision, particularly in early-stage or group-based interventions.

Purpose and Scope of the Present Study

This study reports the development and Phase-1 feasibility evaluation of SIM, using a four-session primer to operationalize BSC-O within the ARRI loop. The primary aim was not to assess behavioral outcomes, emotional resolution, or therapeutic benefit, but to evaluate whether a staged orientation framework could be delivered safely, coherently, and acceptably within a non-clinical academic setting. Consistent with best-practice guidance for complex intervention development, the study prioritized feasibility, safety, and fidelity over outcome testing (Craig et al., 2008; Bowen et al., 2009).

Contribution of This Paper

This paper makes three primary contributions. First, it introduces SIM as a structured framework for staging psychological processes in non-clinical wellbeing interventions. Second, it articulates BSC-O as a distinct, testable phase within that framework. Third, it provides empirical feasibility and safety evidence from a structured multi-session pilot aligned with established standards for early-phase intervention research (Eldridge et al., 2016).

THEORETICAL BACKGROUND AND MODEL DEVELOPMENT

From Protocol-Based to Process-Oriented Frameworks

Over the past two decades, psychological and behavioral sciences have undergone a marked shift from protocol-based intervention models toward process-oriented approaches. Rather than evaluating whether a specific technique or manualized protocol “works”, contemporary research increasingly focuses on how change occurs, while examining mechanisms, contextual conditions, and interactions between processes that give rise to observable outcomes (Kazdin, 2007; Hayes et al., 2020).

This perspective has been particularly influential in research on self-regulation, cognitive flexibility, and behavior change, where outcomes are understood to emerge from dynamic feedback systems rather than isolated techniques (Carver & Scheier, 1998; Kashdan & Rottenberg, 2010). As a result, psychological science has become more portable across settings, informing interventions in education, organizational development, and public health prevention.

However, translation into non-clinical group delivery has been uneven. Many applied programs adopt process-based language while continuing to rely on protocol-based delivery structures. As a result, multiple mechanisms are often introduced simultaneously without clear guidance regarding sequence, depth, or ethical boundaries (Dimidjian & Segal, 2015). This creates a disconnection between theoretical intent and applied design, particularly where facilitators are not clinicians, and participants have not sought therapeutic care.

The Problem of Sequencing and Psychological Depth in Non-Clinical Interventions

A persistent limitation across non-clinical wellbeing and behavior-change interventions is the absence of explicit sequencing logic. Awareness, regulation, cognitive reframing, and action-oriented strategies are frequently presented as interchangeable components, despite strong evidence that the timing and sequencing of these processes meaningfully influence participant experience and outcomes (Kazdin, 2007).

Behavior-change research has consistently shown that readiness for change varies across individuals, and that prematurely demanding action may weaken engagement and the sustainability of behavioral change (Prochaska & Velicer, 1997). Likewise, within behavioral and contextual psychological frameworks, the early use of reframing or coping strategies may inadvertently serve as experiential avoidance rather than genuine integration, particularly when individuals lack sufficient regulatory capacity to remain present with distressing internal experiences (Hayes et al., 1999).

These risks are amplified in group-based and preventive contexts. Research on group interventions indicates that participants differ widely in tolerance for ambiguity, emotional exposure, and reflective depth, and that poorly structured or sequenced interventions may inadvertently heighten vulnerability or disengagement (Yalom & Leszcz, 2005). When delivered outside clinical settings, facilitators may lack the mandate or training to manage emotional escalation or boundary confusion, increasing ethical risk.

Psychological depth represents a further challenge. In many applied programs, it is treated as an emergent property rather than a design variable, allowing emotional material to surface without clear boundaries for disclosure, processing, or containment. Evidence from mindfulness-based and reflective interventions cautions that depth without contextual fit or adequate facilitator capacity may lead to adverse effects, misinterpretation, or unmet expectations (Dimidjian & Segal, 2015). These findings highlight the need to explicitly structure sequencing and depth in non-clinical interventions rather than relying on participant choice or facilitator intuition.

The Shift Integration Model (SIM): Governing Sequence and Containment

SIM as a model was developed to address these limitations by functioning as a governing framework rather than a technique-based intervention. SIM does not prescribe specific exercises, therapeutic strategies, or behavioral targets. Instead, it specifies the structural conditions under which psychological processes may be ethically introduced and transitioned.

This approach aligns with intervention science, which stresses that mechanisms must be evaluated within appropriate contextual and temporal boundaries (Kazdin, 2007). SIM operationalizes this principle by positioning sequencing, depth limits, and transition rules as core design elements rather than implementation details.

SIM is grounded in four assumptions. First, psychological processes are not interchangeable and carry different activation risks depending on timing and context. Second, behavioral execution introduced without prior orientation may increase instability rather than effectiveness. Third, non-clinical settings require explicit containment

mechanisms to prevent boundary drift and unintended therapeutic exposure. Fourth, integration unfolds over time and should not be forced within early-stage or group-based formats.

By codifying these assumptions into a replicable architecture, SIM provides a scaffold within which diverse applied formats, workshops, trainings, digital tools, or hybrid programs can be ethically governed without collapsing into therapy or superficial skills training.

Behavior Shift Communication as Behavioral Engine within SIM

Within SIM framework, behavior change is structured through BSC, which conceptualizes change as an iterative process mediated by internal and external communication loops. BSC draws on established principles from behavior change communication and self-regulation research, which emphasize feedback, meaning attribution, and reinforcement over persuasion or instruction (Bandura, 1997; Carver & Scheier, 1998; Michie et al., 2011).

Unlike traditional behavior change communication models, which often focus on messaging, persuasion, or environmental cues, BSC centers on internal communication, how individuals interpret internal signals, regulate responses, and attribute meaning to experience. This emphasis aligns with contemporary views of behavior as an emergent property of ongoing self-regulatory processes rather than discrete decisions.

Critically, BSC is not treated as a single undifferentiated cycle. SIM distinguishes between two BSC phases that differ in intent, depth, and ethical requirements: Orientation and Execution. This distinction directly addresses a common conflation in applied interventions, where exposure to internal processes is implicitly treated as sufficient preparation for behavioral change.

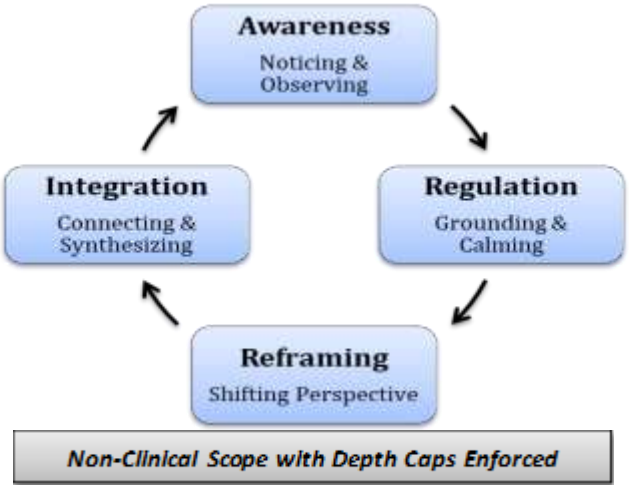
BSC-O and the ARRI Loop: Orientation without Behavioral Demand

BSC-O is designed to build internal capacity and flexibility without placing demands on behavior change. Its function is preparatory rather than corrective, establishing the conditions under which later execution may become possible.

BSC-O is operationalized through the ARRI loop: Awareness, Regulation, Reframing, and Integration. Each component serves a distinct function, and their sequence is intentional. Within ARRI, awareness involves noticing internal responses without immediate interpretation or correction. Regulation emphasizes remaining present with mild discomfort without escalation or attempts to control the experience. Reframing introduces recognition that multiple meanings may be possible without selecting or privileging a preferred interpretation. Integration then allows these processes to settle without closure, action, or resolution.

Figure 1

The ARRI Process Loop Underlying SIM Orientation (BSC-O)



This sequencing reflects empirical and theoretical work on psychological flexibility and tolerance of ambiguity, which suggests that the ability to hold multiple meanings without premature closure is a marker of adaptive functioning (Budner, 1962; Kashdan & Rottenberg, 2010). Importantly, ARRI does not culminate in action. Within BSC-O, integration refers to orientation-level settling rather than behavioral execution, preserving a clear ethical boundary between capacity-building and change.

BSC-E and the ARAR Loop: Execution after Orientation

In contrast, BSC-E governs the translation of internal capacity into behavior. It is operationalized through the ARAR loop: Awareness, Reframing, Action, and Reinforcement.

BSC-E assumes that foundational regulatory capacity has already been established and that meaningful flexibility is accessible without avoidance. Action and reinforcement are therefore introduced only after orientation has occurred and readiness criteria are met, consistent with behavior-change research emphasizing the role of capability and opportunity alongside motivation (Michie et al., 2011). Although BSC-E is not evaluated in the present study, its articulation is necessary to situate BSC-O within the full SIM architecture and to prevent misinterpretation of the primer as a complete or outcome-oriented intervention.

Differentiation from Existing Models

SIM and BSC are intentionally positioned as integrative and bounded rather than competitive with existing frameworks. Unlike therapeutic models, SIM does not engage in diagnosis, emotional processing, and symptom change. Unlike coaching and skills-training models, it does not assume readiness for action. Unlike generic behavior change communication approaches, BSC emphasizes internal communication and meaning flexibility rather than persuasion or messaging.

The novelty of SIM lies not in introducing new psychological constructs, but in structuring their ethical deployment across stages, contexts, and levels of depth. By explicitly distinguishing orientation from execution, SIM addresses a structural gap that spans clinical, educational, and organizational intervention literature.

Implications for Model Validation and Phased Research

By formalizing the distinction between orientation and execution, SIM enables phased validation consistent with best-practice guidance for complex interventions (Craig et al., 2008; Bowen et al., 2009). BSC-O can be evaluated independently for safety, feasibility, and coherence before any claims are made regarding behavioral outcomes.

This staged approach reduces ethical risk, prevents premature outcome pressure, and supports methodological clarity. Subsequent phases can then evaluate execution, reinforcement, and longer-term outcomes under conditions where readiness and scope are explicitly defined (Eldridge et al., 2016).

Literature Gap and Positioning

The literature reviewed above provides robust theoretical foundations for understanding psychological mechanisms, readiness for change, self-regulatory feedback processes, group dynamics, and ethical boundary considerations. Process-based therapy clarifies how change occurs (Hofmann & Hayes, 2019; Hayes et al., 2020). Behavior change science delineates readiness and capability conditions (Prochaska & Velicer, 1997; Michie et al., 2011). Mechanism research emphasizes contextual sensitivity (Kazdin, 2007). Group intervention literature and broader ethical analyses highlight the importance of containment structures and contextual safeguards when introducing psychologically activating processes outside therapeutic settings (Yalom & Leszcz, 2005; Kazdin, 2007; Lilienfeld, 2007). Complex intervention guidance outlines phased validation pathways (Craig et al., 2008; Bowen et al., 2009).

What remains under-specified across these domains is not the identification of mechanisms, but the architectural governance of their introduction in non-clinical institutional contexts. Existing models describe processes; fewer specify the structural conditions under which those processes should be staged, bounded, and

transitioned outside therapeutic care. In applied settings, mechanisms are frequently assembled additively rather than sequenced architecturally.

The Shift Integration Model (SIM) is positioned at this architectural level. Rather than proposing new psychological constructs, it formalizes design governance, sequencing logic, depth parameters, transition criteria, and facilitation stance, as explicit structural variables. In doing so, SIM operates as a meta-framework: it organizes established mechanisms within a staged containment structure suitable for institutional well-being initiatives.

The present study represents an empirical test of that structural premise. Specifically, it examines whether the Orientation phase can function as a coherent, bounded intervention layer when evaluated independently of claims about execution and outcomes. By isolating orientation for feasibility testing, the study advances the literature from theoretical integration toward architectural validation.

METHODS

Study Design and Rationale

This study employed a process-focused pilot feasibility design to evaluate the Orientation phase of SIM, operationalized as the BSC-O. The primary objective was to assess feasibility, acceptability, psychological safety, and procedural integrity rather than behavioral effectiveness, symptom change, and therapeutic outcomes.

The design aligns with established guidance for early-phase evaluation of complex interventions, which emphasizes the need to establish feasibility, fidelity, and ethical safety before outcome testing (Craig et al., 2008; Bowen et al., 2009; Eldridge et al., 2016). In such studies, descriptive and process-level data are considered appropriate and sufficient, particularly when the intervention introduces novel sequencing, delivery architecture, or boundary safeguards.

Consistent with SIM's theoretical position, the intervention was not intended to produce emotional resolution, behavioral change, and sustained clinical impact. Instead, the study examined whether a tightly structured, staged orientation framework could be delivered as intended, tolerated by participants, and understood without generating escalation, dependency, or unintended therapeutic expectations.

Group size was determined based on feasibility and small-group intervention guidance rather than statistical power considerations. Early-phase pilot research prioritizes implementation integrity and acceptability over hypothesis testing (Bowen et al., 2009; Eldridge et al., 2016). Methodological literature on group-based research commonly recommends 6-12 participants to balance interactional diversity with manageability and containment (Morgan, 1997; Yalom & Leszcz, 2005). Cohort sizes were therefore selected to align with feasibility norms and group-dynamic principles consistent with SIM's containment-oriented design.

Participants

The final sample comprised 23 adult volunteers across two cohorts: 15 students and 8 faculty members of both genders were recruited from a university setting. Recruitment materials framed the program explicitly as a non-clinical wellbeing orientation rather than therapy, counseling, and skills training. This framing was reiterated verbally at program initiation and reinforced throughout.

Inclusion criteria required participants to be aged 18 years or older, able to attend all four sessions, and willing to provide anonymous session-level feedback. No exclusion criteria were applied based on psychological symptoms, diagnoses, and prior intervention exposure. No diagnostic screening was conducted, consistent with the feasibility focus and non-diagnostic orientation of SIM.

Table 1

Participant Demographics by Cohort (N = 23)

Variable	Faculty (n = 8)	Students (n = 15)	Total (N = 23)
Gender			
Female	6	7	13
Male	2	8	10
Age Range			
18–20	0	9	9
21–24	4	6	10
25–34	4	0	4

Note: *Primary process analyses were based on the subset of 18 participants who provided complete voluntary feedback data. Additionally age and gender were recorded descriptively and were not used for subgroup comparisons, consistent with the feasibility-focused design.*

The SIM Primer (BSC-O) consisted of four consecutive in-person group sessions (75–90 minutes each), delivered between January 19 and January 22. Each session corresponded to one phase of the ARRI loop: Awareness, Regulation, Reframing, and Integration Orientation, introduced sequentially across the four-day structure.

Each session followed a standardized internal architecture designed to preserve procedural consistency and bounded depth. Sessions began with an opening orientation that clarified intent, scope, and non-clinical boundaries. This was followed by structured experiential and reflective exercises aligned with the focal ARRI component of the day. A time-limited group reflection phase was then conducted under explicit containment rules, after which the session concluded with a closing orientation reinforcing non-resolution and non-action.

This staged sequencing reflects SIM's premise that psychological processes should be introduced incrementally and within clearly defined limits in non-clinical group contexts (Kazdin, 2007; Dimidjian & Segal, 2015). Throughout the program, explicit statements clarified that sessions would not involve emotional processing, therapeutic interpretation, problem-solving, and behavioral planning. This boundary framing was designed to reduce expectation drift, maintain procedural clarity, and preserve contextual scope, consistent with ethical guidance for psychological interventions delivered outside formal treatment settings (Welfel, 2016; Craig et al., 2008).

Facilitator Transparency

Sessions were facilitated by two trained SIM facilitators; one was the developer of the SIM framework, and the second was the co-author of the present study. To mitigate expectancy effects, feedback was collected anonymously, facilitation adhered to a standardized script with predefined depth caps, and no evaluative judgments were provided. The second facilitator did not participate in data analysis. Following each session, facilitators completed a structured fidelity checklist documenting adherence to sequence, depth limits, and facilitation stance (Bowen et al., 2009).

Setting and Contingency Protocol

Sessions were conducted in an enclosed university library seminar room arranged in a round-table format to facilitate visibility and containment. A whiteboard was positioned behind the facilitators for structured orientation prompts. Facilitators were seated at one end of the table, with participants seated around the table to maintain shared visual engagement and process oversight.

Although the intervention excluded emotional processing, a contingency protocol was established a priori. Participants were informed they could pause or withdraw at any time. If sustained distress occurred, facilitators were prepared to suspend discussion and provide referral information for the university counseling center or licensed mental health professionals. No depth breaches requiring referral occurred.

Data Collection Procedures

Attendance was recorded at each session to assess the feasibility of delivery and completion across the consecutive-session format. Participation in structured exercises and group discussions was voluntary throughout, and observation without verbal contribution was explicitly normalized to preserve psychological safety and participant autonomy.

Immediate session-level feedback was collected at the conclusion of each session (January 19-22). A delayed follow-up reflection form was administered on February 13, approximately three weeks after program completion, to assess sustained interpretive impressions without reintroducing intervention content or extending exposure. This interval was selected to allow reflective distance while maintaining temporal proximity to the original experience.

Session-level rating items assessed perceived psychological safety, manageability of session demands, clarity of SIM framework, tolerance of discomfort, and perceived flexibility in meaning-making. All items were measured using 5-point Likert-scales with plain-language anchors. Consistent with feasibility study guidance, measures were intentionally brief and non-diagnostic, prioritizing participant burden reduction and process monitoring over psychometric validation (Bowen et al., 2009).

Participants were also invited to provide optional open-ended written feedback using broad, non-directive prompts. Qualitative responses were analyzed in their original language form, with minimal editing limited to clarifying unintelligible wording, in order to preserve participant voice and contextual nuance.

Analytical Strategy

Quantitative data were analyzed descriptively to examine patterns across sessions and between cohorts. Session-level indicators were summarized using frequencies, means, and distribution patterns. Entries marked "Extra" or "Missing" were treated as non-responses and excluded from quantitative summaries.

Exploratory pre-post measures were analyzed to generate secondary directional signals. Estimation statistics (mean differences, standard deviations of difference scores, effect size estimates, and confidence intervals) were calculated descriptively. No formal hypothesis testing was conducted, consistent with feasibility study guidance emphasizing estimation over inferential conclusions (Eldridge et al., 2016).

Qualitative responses were analyzed using a structured analytic matrix documenting original wording, interpreted meaning, and predefined interpretation rules. Interpretations were constrained to observable language and avoided diagnostic inference. Because feedback was anonymous, qualitative data were analyzed at the group level rather than linked longitudinally. Quantitative analyses were conducted using Microsoft Excel (Microsoft Corp., Redmond, WA, USA). Descriptive statistics and estimation metrics were computed using standard spreadsheet functions.

Ethical and Methodological Safeguards

Several safeguards were implemented to maintain ethical integrity and methodological clarity throughout the pilot. The intervention was explicitly framed as non-diagnostic, and participants were repeatedly reminded that sessions were not intended to constitute therapy, counseling, and skills-based treatment. Emotional processing and behavioral planning were deliberately excluded to preserve the orientation-level scope of the model and prevent drift into therapeutic territory. Predefined depth caps were enforced across all sessions to ensure that reflection remained structured and contained.

In addition, clear criteria for a "depth breach" were established a priori. A depth breach was operationally defined as sustained emotional escalation requiring individual intervention, interpretive processing that extended beyond the defined orientation scope, or explicit participant expectations of therapeutic resolution. Structured fidelity monitoring procedures were used following each session to document adherence to sequencing, depth limits, and facilitation stance. Together, these safeguards were designed to uphold professional boundary standards, minimize unintended psychological risk, and ensure that the intervention remained within its stated non-clinical parameters.

Ethical Approval and Consent

Ethical approval was obtained from the IRB committee of Al-Razi Institute, Lahore. The study was classified as minimal-risk behavioral research conducted within an educational context. All participants provided informed consent before participation and were informed that withdrawal was permitted at any time without consequence. Data were anonymized at the point of collection.

RESULTS

Participant Flow and Retention

A total of 23 participants enrolled in and attended the pilot intervention, comprising both faculty and student cohorts within the four-day SIM orientation program. All 23 participants completed the full four-day sequence, resulting in a 100% completion rate for the structured intervention phase. This full retention across consecutive sessions indicates strong short-term engagement and supports the operational feasibility of delivering the intervention within the institutional setting.

Of the total attendees, 18 participants provided complete voluntary feedback data, which constituted the primary feasibility analytic sample for process-level analyses. End-of-day feedback forms administered during the intervention phase were completed anonymously and were therefore analyzed at the group level rather than linked longitudinally to individual participants.

At delayed follow-up, 16 participants submitted reflection responses, representing an 88.9% retention rate relative to the primary analytic sample (16/18). Two participants from the analytic baseline cohort did not complete the delayed reflection form. The retained follow-up sample continued to include both faculty and student participants, suggesting that the orientation format remained acceptable across cohorts and sustained participant engagement beyond the immediate intervention period.

Process Indicators

The primary feasibility dataset consisted of structured end-of-day feedback collected across the four sessions. These data were designed to monitor emotional containment, psychological safety, clarity of framing, and perceived manageability in real time.

On Days 1 and 2, participants rated their immediate emotional state using a five-point Likert scale ranging from very steady to very unsettled. Ratings clustered predominantly in the lower-to-mid range of the scale, with most responses indicating moderate steadiness and only occasional reports of elevated unsettledness. There was no pattern of escalating distress across sessions, and no participant required additional containment or referral. The distribution of ratings suggests that emotional activation occurred within manageable bounds and did not exceed the intended depth cap of the BSC-O model.

Clarity ratings collected on Day-1 indicated that the majority of participants experienced the session as clear or very clear. Similar clarity patterns were observed on Day-4 when participants were asked about the overall clarity of the SIM approach. These findings suggest that the program's conceptual framing was consistently understood and that participants were able to cognitively engage with the material without confusion regarding scope or intention.

Day-2 included a measure assessing perceived capacity to remain with discomfort. Most participants endorsed moderate to strong capacity levels. This is particularly relevant to the regulation phase of BSC-O, as ratings suggested that the group-level experience of discomfort tolerance remained within manageable bounds. The ability to remain with discomfort without escalation supports the ethical containment premise embedded within the model's architecture.

Day-3 assessed perceived flexibility in meaning-making and psychological safety during the reframing component of the orientation. Participants largely endorsed high levels of psychological safety alongside moderate-to-high levels of cognitive flexibility. The concurrent presence of safety and flexibility is noteworthy, as it indicates that cognitive expansion did not occur at the expense of emotional containment. Most participants also reported that the session felt mentally manageable, further reinforcing the stability of the process.

On the final day, participants rated overall psychological safety within the program. Ratings were consistently high, with the majority indicating that they felt safe or very safe. In addition, most participants expressed willingness to engage with SIM again in the future and indicated that they would recommend the orientation if offered again in their institution. These indicators collectively support the acceptability and perceived safety of the BSC-O framework when delivered in a structured, non-clinical format.

Institutional Fit & Framing

Qualitative feedback across the four sessions revealed recurring themes of increased self-awareness, improved understanding of emotional regulation, enhanced reflective capacity, and a sense of calm or mental clarity. Importantly, critical feedback centered mainly on logistical and environmental factors, such as room temperature, noise interruptions, seating comfort, language preferences, and scheduling coordination. No qualitative responses indicated psychological destabilization, unmet therapeutic expectations, and misinterpretation of the program as clinical therapy. Taken together, the end-of-day data provide strong evidence that the orientation operated within safe and bounded parameters consistent with the design principles of BSC-O.

Feasibility was also reflected in operational fit and framing integrity. Participants were asked to reflect on the manageability of the four-day consecutive format within their academic and professional responsibilities. Most described the format as mostly manageable or fully manageable. Only isolated responses referenced scheduling strain related to external obligations rather than the program burden itself.

Notably, no participant withdrew during the structured sequence, and attendance remained stable across both faculty and student cohorts. The absence of systematic attendance barriers suggests that the BSC-O orientation can be embedded within institutional calendars without causing substantial operational disruption. Environmental feedback indicated minor logistical adjustments that could further optimize delivery in future iterations.

A central ethical component of SIM is the explicit distinction between orientation-level reflective engagement and clinical therapy. Participants were therefore asked whether the program felt aligned with its description as a non-clinical orientation rather than a therapeutic or skills-based intervention. The majority endorsed that the program was clearly or mostly aligned with its stated framing. Very few expressed uncertainty, and none reported feeling misled.

These responses indicate that clarity of scope was preserved throughout delivery. It suggests that the BSC-O model can be introduced within institutional contexts without creating therapeutic expectations or blurring ethical boundaries. The clarity of scope appears to have been preserved throughout delivery.

Delayed Follow-Up

At delayed follow-up, participants were asked whether they had experienced distress related to the sessions after program completion. Most reported no distress. Where distress was endorsed, it was described as mild and manageable. No participant reported severe reactions or unmet psychological needs attributable to the orientation.

Participants also described ongoing changes in how they related to internal experiences such as stress, thoughts, and discomfort. Reported themes included greater differentiation of stress responses, increased awareness of emotional triggers, more deliberate cognitive reframing, and improved tolerance of discomfort. These reflections were articulated in non-clinical language and did not reflect claims of symptom remission or therapeutic transformation. The data suggest sustained orientation-level reflective engagement without destabilization.

Exploratory Quantitative Signals

Exploratory pre-post analyses were conducted to examine preliminary directional signals consistent with the theoretical scope of BSC-O. These analyses were not designed to test efficacy, and no hypothesis testing was conducted. Estimation outputs are reported descriptively to characterize magnitude and uncertainty.

Emotion regulation, assessed using the ERQ-R reappraisal subscale, increased modestly from

baseline (M = 4.59) to post-intervention (M = 4.81), yielding a mean difference of 0.22. The standard deviation of the difference scores was 1.47, corresponding to a small within-person effect size (Cohen's d = 0.15). The 95% confidence interval ranged from −0.51 to 0.95, crossing zero and indicating statistical uncertainty consistent with the pilot sample size. The modest directional increase aligns conceptually with the orientation phase's emphasis on cognitive flexibility without behavioral execution.

Brief resilience scores similarly showed a modest increase from baseline (M = 3.00) to post-intervention (M = 3.10), yielding a mean difference of 0.10. The standard deviation of the difference scores was 0.48, corresponding to a small effect size (Cohen's d = 0.21). The 95% confidence interval ranged from −0.13 to 0.34 and also crossed zero. These findings are interpreted as exploratory and non-confirmatory, providing directional consistency rather than outcome validation.

Importantly, the magnitude and uncertainty of these signals are consistent with the intended scope of BSC-O as an orientation phase focused on internal flexibility rather than behavioral change or symptom reduction.

Integrated Interpretation

This feasibility pilot demonstrated that the Behavior Shift Communication-Orientation (BSC-O) can be delivered as a psychologically safe, ethically contained, and institutionally manageable reflective framework. Across four sessions, real-time process indicators showed stable emotional containment, high clarity of framing, and sustained psychological safety, with no escalation events, depth breaches, or adverse effects reported. Participants described the format as clear, structured, and compatible with their institutional roles, and delayed reflections suggested ongoing engagement without destabilization or therapeutic dependency. Although not powered to assess efficacy, exploratory quantitative measures indicated small directional shifts in cognitive reappraisal and resilience aligned with the conceptual aims of BSC-O. Taken together, these findings support the model's scalability as a bounded orientation-level intervention capable of fostering reflective flexibility within clearly defined ethical and institutional parameters.

DISCUSSION

Feasibility and Containment Integrity

This pilot examined whether the Orientation phase of SIM, operationalized through the BSC-O, could be delivered safely, coherently, and manageably within an institutional setting. The primary aim was feasibility evaluation rather than outcome testing.

Across the four-day sequence, the program demonstrated full completion, high perceived psychological safety, strong alignment with non-clinical framing, and absence of adverse events. End-of-day indicators suggest that reflective engagement occurred within manageable parameters, and no escalation beyond the defined depth cap was observed. Collectively, these data reinforce the structural coherence of BSC-O.

A key theoretical concern underlying SIM is the risk of premature depth activation in non-clinical group settings. Many reflective or well-being programs inadvertently encourage emotional exposure without sufficient containment structures. BSC-O was explicitly designed to prevent such escalation through pacing, sequencing, and clarity of scope.

Process-level data suggest that this containment function operated as intended. While mild discomfort and cognitive activation were reported, these responses were described as manageable and developmentally appropriate rather than destabilizing. No participant required referral or reported adverse outcomes. Anonymous real-time feedback may have reduced social desirability pressure and supported more candid reporting of comfort and logistical barriers. This supports the proposition that orientation-level awareness and reframing can be introduced without breaching psychological safety when depth caps are operationalized clearly.

Institutional Fit Under Pilot Conditions

The four-day consecutive format was largely described as manageable within academic schedules. Environmental concerns (e.g., room

temperature, noise, seating comfort) emerged, but these reflected logistical rather than conceptual strain.

These observations suggest that BSC-O can be embedded within institutional calendars under pilot conditions without substantial operational disruption. However, generalizability across diverse institutional contexts remains to be empirically established. Importantly, participants consistently endorsed that the program aligned with its description as a non-clinical orientation process rather than therapy or skills training. This clarity of framing is central to SIM's ethical positioning and appears to have been successfully communicated.

Short-Term Reflective Carryover

Delayed qualitative responses indicated that some participants reported modest shifts in how they related to stress, thoughts, and internal experiences. These reflections were described in terms of awareness, differentiation, and cognitive flexibility rather than emotional processing or behavioral transformation.

Given the brief follow-up interval and absence of structured longitudinal measurement, these findings should be interpreted as short-term reflective carryover signals rather than evidence of sustained change. They nevertheless provide preliminary support for the proposition that orientation-level engagement may extend beyond the immediate session context without requiring execution-phase processes.

Exploratory Quantitative Signals

Exploratory analyses of emotion regulation (ERQ-R reappraisal) and resilience (BRS) showed small directional increases from baseline to post-intervention, with small effect sizes and confidence intervals crossing zero. These findings are therefore descriptive rather than confirmatory. The modest signal is consistent with the scope of BSC-O, which introduces awareness and reframing without engaging action, reinforcement, or behavioral execution processes, supporting its role as a preparatory rather than outcome-driven intervention.

Implications for Staged Behavioral Frameworks

The present findings contribute to conceptual discussions within prevention and well-being literature regarding sequencing. Many institutional initiatives conflate orientation, execution, and outcome evaluation within compressed timeframes. SIM proposes that orientation constitutes a legitimate intervention phase in its own right.

This pilot provides preliminary empirical support for that proposition. Orientation, when treated as a distinct and bounded phase, can be delivered safely and coherently. However, it is not positioned here as sufficient for behavioral change, nor as a replacement for execution-phase work. Maintaining this conceptual boundary remains critical to both ethical clarity and theoretical precision.

Positioning Within the SIM Trajectory

This study evaluated only BSC-O and did not test the BSC-E, the ARAR loop, or full-cycle SIM implementation. The findings should therefore be understood as validating the feasibility of Phase 1 within a staged architecture. Subsequent research will be required to examine transitions into execution-oriented processes and to evaluate outcome-level effects over longer intervals and across varied populations.

LIMITATIONS AND FUTURE RESEARCH

Design and Scope Limitations

When interpreting the study's results, a number of limitations should be taken into account. First, rather than using an outcome-evaluation framework, the study used a pilot feasibility design. For instance, claims about behavioral change, emotional improvement, symptom reduction, or long-term impact are not supported by the data. This restriction is deliberate and in line with accepted recommendations for early-phase assessment of complex interventions, which prioritize fidelity, safety, and feasibility over efficacy testing. (Craig et al., 2008; Bowen et al., 2009).

Second, the study relied on self-reported session-level measures and optional qualitative feedback. While appropriate for monitoring psychological

safety, manageability, and conceptual coherence, these measures are inherently limited by response bias and do not capture longer-term integration or behavioral translation. No long-term outcome follow-up was conducted beyond the brief delayed reflection check-in.

Third, the pilot was conducted within academic and training settings, involving faculty members and students. These populations may be more accustomed to reflective or structured group formats than other groups. Although the intervention was explicitly non-clinical, findings may not generalize directly to populations with different occupational demands, cultural expectations, or levels of psychological vulnerability.

Finally, the absence of a comparison or control condition limits the ability to contextualize observed feasibility and safety patterns relative to alternative formats, such as single-session workshops, skills-based programs, or unstructured wellbeing sessions. This limitation highlights the need for comparative designs in subsequent research phases.

Measurement and Interpretive Constraints

The study did not make outcome evaluation a primary aim and deliberately avoided symptom-focused or clinical outcome measures. The primary dataset consisted of session-level process indicators assessing psychological safety, clarity, and manageability.

Exploratory pre-post self-report scales, such as Brief Resilience Scale (BRS) (Smith et al., 2008), and Emotional Regulation Questionnaire (ERQ-R reappraisal) (Gross & John, 2003), were included solely as secondary descriptive signals to examine directional consistency with the theoretical orientation phase. These measures were not used to test efficacy, and estimation outputs were interpreted cautiously in light of the small sample size and feasibility design.

This restrained measurement approach was methodologically and ethically driven. Introducing performance- or improvement-oriented outcome framing during the Orientation phase would have risked shifting participant expectations toward change, resolution, or therapeutic progress contrary to the intended scope of BSC-O.

While this approach strengthens ethical containment and preserves architectural integrity, it necessarily limits inferential scope. Future research will need to balance measurement depth with SIM's core sequencing principle that orientation precedes execution and outcome evaluation, particularly when working with high-stress or professionally vulnerable populations.

Additionally, although attendance was monitored across sessions, the study did not examine dose-response relationships or cumulative exposure effects. These remain important questions for subsequent research phases.

Conceptual Boundary Conditions

This study evaluated only the Orientation phase, i.e., BSC-O, of Behavior Shift Communication within the Shift Integration Model. Findings should therefore not be extended to the Execution phase, i.e., BSC-E, the ARAR loop, or full-cycle SIM implementations.

Importantly, the results should not be interpreted as evidence that SIM produces behavioral change in the absence of execution-oriented processes, nor that BSC-O alone is sufficient for sustained outcomes. Rather, the data support BSC-O as a ***necessary but not sufficient*** preparatory phase within a staged behavioral framework.

Maintaining this distinction is critical to preserving both ethical clarity and methodological precision, particularly given the risks associated with premature action demands highlighted in behavior-change and contextual psychology literature (Hayes et al., 1999; Prochaska & Velicer, 1997).

Directions for Phase 2 and Phase 3 Research

The findings of this pilot provide a foundation for ***Phase 2 research***, which may evaluate the transition from BSC-O to partial or full BSC-E within a longer-format protocol. Such studies could involve four- to six-week programs that preserve SIM's sequencing logic while introducing carefully bounded action and reinforcement components.

Healthcare professionals and other high-demand occupational groups represent particularly relevant populations for subsequent phases, given

their exposure to chronic stress, frequent demands for rapid action, and documented risks associated with premature coping or emotional suppression.

Phase 2 studies may incorporate validated pre–post measures of regulation capacity, psychological flexibility, or burnout-related constructs, alongside behavioral indicators aligned with ARAR processes. Mixed-methods designs integrating process data with exploratory outcome signals would further strengthen model validation.

Phase 3 research could extend validation longitudinally and across delivery modalities, including digital or hybrid formats. Such work would be essential before making claims regarding scalability, automation, or population-level impact.

Summary of Limitations and Research Trajectory

In summary, this study should be understood as a ***foundational validation step*** rather than a test of efficacy. Its primary contribution lies in demonstrating that a staged behavioral self-containment framework can be delivered safely, that orientation can be treated as a legitimate intervention phase, and that ethical sequencing can be operationalized in real-world group settings.

Subsequent research is required to evaluate execution, reinforcement, and long-term outcomes. However, the present findings provide a defensible and necessary starting point for that trajectory.

CONCLUSION

This paper introduced the SIM framework as a staged behavioral self-containment framework designed to ethically sequence internal capacity-building and behavioral change in non-clinical wellbeing contexts. Responding to persistent challenges in prevention and wellbeing literature, particularly the risks of premature action, emotional overexposure, and outcome-driven pressure, SIM offers a structured alternative grounded in containment, pacing, and readiness.

Through a four-session pilot evaluating the Orientation phase of BSC-O, operationalized via the ARRI loop, the study demonstrated that awareness, regulation tolerance, and meaning flexibility can be introduced without triggering escalation, dependency, or therapeutic framing. Across faculty and student cohorts, participants reported consistent psychological safety, conceptual clarity, and engagement, alongside qualitative indicators of tolerance-building and meaning flexibility without evidence of emotional processing or premature behavioral demand.

The contribution of this study is not an efficacy claim but a conceptual and methodological one. The findings support the proposition that orientation constitutes a legitimate and necessary phase within behavioral change frameworks, rather than merely a prelude to action. By empirically demonstrating that BSC-O can be delivered safely and coherently as a standalone phase, this work strengthens the theoretical foundations of SIM and provides a defensible basis for subsequent execution-focused research.

More broadly, the paper articulates a layered internal architecture for staged change: SIM as the governing framework, Behavior Shift Communication as the behavioral engine, and ARRI/ARAR as operational loops governing orientation and execution, respectively. This structure enables both academic testing and applied deployment while preserving ethical boundaries around depth, demand, and responsibility.

In contexts where wellbeing initiatives are increasingly expected to be scalable, measurable, and non-clinical, SIM offers a principled framework for doing less early and doing it well. By restoring sequencing, containment, and choice to the center of behavioral change efforts, the Shift Integration Model contributes a timely and ethically grounded addition to contemporary behavioral science and applied psychology.

Funding and Institutional Disclosure

This research was conducted independently and was not funded, endorsed, or supported by any employer or affiliated institution

REFERENCES

Bandura, A. (1997). *Self-efficacy: The exercise of control* (Vol. 11). Freeman.

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C. P., Squiers, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine, 36*(5), 452–457. https://doi.org/10.1016/j.amepre.2009.02.002

Budner, S. (1962). Intolerance of ambiguity as a personality variable. *Journal of Personality, 30*(1), 29–50. https://doi.org/10.1111/j.1467-6494.1962.tb02303.x

Carver, C. S., & Scheier, M. F. (1998). *On the self-regulation of behavior*. Cambridge University Press.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: The new Medical Research Council guidance. *BMJ, 337*, a1655. https://doi.org/10.1136/bmj.a1655

Dimidjian, S., & Segal, Z. V. (2015). Prospects for a clinical science of mindfulness-based intervention. *American Psychologist, 70*(7), 593–620. https://doi.org/10.1037/a0039589

Eldridge, S. M., Chan, C. L., Campbell, M. J., Bond, C. M., Hopewell, S., Thabane, L., & Lancaster, G. A. (2016). CONSORT 2010 statement: Extension to randomised pilot and feasibility trials. *BMJ, 355*, i5239. https://doi.org/10.1136/bmj.i5239

Hayes, S. C., & Pierson, H. (1999). Acceptance and commitment therapy. In W. O'Donohue & J. E. Fisher (Eds.), *Encyclopedia of cognitive behavior therapy* (pp. 1–4). Springer.

Hayes, S. C., Hofmann, S. G., & Ciarrochi, J. (2020). A process-based approach to psychological diagnosis and treatment: The conceptual and treatment utility of an extended evolutionary meta-model. *Clinical Psychology Review*, 82, 101908.

Hofmann, S. G., & Hayes, S. C. (2019). The future of intervention science: Process-based therapy. *Clinical Psychological Science, 7*(1), 37–50. https://doi.org/10.1177/2167702618772296

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility is a fundamental aspect of health. *Clinical Psychology Review, 30*(7), 865–878. https://doi.org/10.1016/j.cpr.2010.03.001

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1–27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Knapp, S. J. (Ed.-in-Chief), Gottlieb, M. C., Handelsman, M. M., & VandeCreek, L. D. (Assoc. Eds.). (2012). APA handbook of ethics in psychology (Vol. 1). *Moral foundations and common themes*. American Psychological Association.

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2*(1), 53–70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science, 6*, 42. https://doi.org/10.1186/1748-5908-6-42

Morgan, D. L. (1997). *Focus groups as qualitative research* (2nd ed.). Sage.

Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. *American Journal of Health Promotion, 12*(1), 38–48. https://doi.org/10.4278/0890-1171-12.1.38

Welfel, E. R. (2006). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues*. Thomson Brooks/Cole Publishing Co.

Yalom, I. D., & Leszcz, M. (Collaborator). (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books/Hachette Book Group.