CHAPTER 11

Acceptance through Mindfulness

Despite psychotherapeutic interventions for anxiety, depression, and anger, most patients with moderate to severe acquired brain injuries (ABIs) are unable to recover fully. Thus, they need to find additional ways to cope emotionally with the permanent biopsychosocial ABI sequelae. Coping with a permanent level of disability requires *acceptance*, which is a concept that can be introduced at any point during the treatment process. If the arduous task of acceptance is not directly addressed in therapy, some patients may resort to maladaptive behaviors (e.g., numbing themselves by abusing alcohol or drugs) or maladaptive thoughts (e.g., denial, dissociation, blame, withdrawal). When this occurs, thoughts and behaviors are activated that only add to the patient's suffering. Although all of these reactions are understandable, both Buddhist teachings and Western psychology inform us that our attempts to suppress or avoid painful losses, as a rule, only increase suffering. The initial relief gained by numbing or avoiding does not last but instead sabotages the needed psychological adjustment and leads to greater suffering.

Buddhism arose out of the natural desire to find solutions to suffering. From this tradition grew a strong reliance on both meditation and acceptance. Mindfulness approaches are linked to these methods, which have proven to be effective. It is beyond the scope of this chapter to comprehensively review the mindfulness literature in depth. Nonetheless, a brief summary is provided to show how a mindfulness approach can foster acceptance in patients with ABI.

WHAT IS MINDFULNESS?

> "Notice your breath. Now notice what the bottom of your feet feel like on the floor. What is the temperature like in the room? Are there thoughts that come into your mind? They will do that. Just observe the noise, become aware of it, and gently, softly bring your awareness back to your breath."

These instructions provide a brief introduction to mindfulness, which is best understood in an experiential manner. The therapist may even begin each session in this way, to have the patient touch base with his or her momentary present-time awareness. Being mindful is neither mysterious nor complicated, but it does require focus. It involves being fully present to what is going on in the moment without judging one's own thoughts, expectations, or urges. In sum, mindfulness simply requires a person to observe the present without judgment.

Although grounded in age-old meditative spiritual traditions, the mindfulness approach has gained momentum in recent years as part of a "third wave" of psychotherapeutic interventions. Mindfulness as a "treatment technique" has been used with groups of patients who have chronic medical conditions (e.g., pain, tinnitus, cancer) or emotional difficulties (e.g., depression, anxiety, posttraumatic stress), and it is also starting to gain some attention for use with patients with ABI (Bédard et al., 2003, 2005; Johansson, Bjuhr, & Rönnbäck, 2012, 2013).

COGNITIVE-BEHAVIORAL THERAPY VERSUS MINDFULNESS

Cognitive-behavioral therapy (CBT) and mindfulness-based therapy are, as treatment modalities, at odds. Being truly mindful of thoughts suggests that there is no talking back, no challenging, and no correcting of the thought. As discussed in Chapters 8, 9, and 10, CBT engages patients with ABI to observe their inner mind chatter in order to correct exaggerations, which in turn can reduce their levels of anxiety, depression, or anger. As a psychotherapist wishing to apply both of these divergent treatments approaches, I developed the following decision tree:

■ If psychotherapy or other treatments can reduce or even resolve symptoms, then this is obviously preferable to encourage patients to learn to accept treatable problems. For those patients with ABI who can benefit from cognitive-behavioral interventions to lessen their emotional symptoms, CBT should be the initial treatment. However, when these patients have reached the point when further interventions are unlikely to be of benefit, then mindfulness can foster an approach that allows them to accept their health status.

■ Recent findings have cautioned that cognitive-behavioral approaches have limited utility for more severely impaired patients, due to their difficulties in comprehending the abstract nature of how to catch, check, and challenge thoughts and thus achieve cognitive restructuring (Aeschleman & Imes, 1999; Anson & Ponsford, 2006). For these patients, mindfulness can be beneficial for learning to accept their situation and live in the moment.

■ For individuals with midrange or even mild impairments, who are extremely overwhelmed or in a state of despair, mindfulness-based interventions can serve as the appropriate initial treatment (Bédard et al., 2003, 2005, 2012; Kangas & McDonald, 2011). Asking patients in crisis to listen to elaborate instructions for controlling their mind chatter is often ineffective and can even suggest a lack of understanding and empathy on the psychotherapist's part (e.g., "This therapist has no idea what I am going through . . . these little interventions are like using a bucket of water to extinguish a house engulfed in fire").[1]

For patients who have done their best to address controllable problems using the ABC model of goal setting discussed in Chapter 7, a mindfulness practice can be helpful for learning to accept permanent or progressively worsening limitations. This approach benefits patients with ABI who are stuck in the belief that, if they continue to strive toward eliminating symptoms, eventually they will return to their preinjury, symptom-free status. Other patients are trapped in dysfunctional thought

[1]Mindfulness is not only useful for patients but also for psychotherapists when treating patients with ABI. Communicating with the patient in a nonjudgmental and accepting manner can model mindfulness to him or her. This approach also allows the therapist to express natural feelings of empathy and compassion.

loops because they firmly believe that they must put their life on hold until they are fully restored to their former selves. For example, one of my patients sought treatment after she had completed an intensive course of physical therapy, speech therapy, psychotherapy, and cognitive remediation. She stated that she could not go back to socializing with friends and family until she had restored herself to the person she was before the ABI. She convinced herself that yet another treatment course would set things right. She believed that only after "fixing all [her] problems" could she go back to her previous lifestyle that had been "fun and full." This unrealistic desire led her to block out an awareness of the present moment and thus most ongoing facets of her daily life.

After being informed that it was important for her to better understand her present life, she agreed to practice mindfulness. She first began to experiment with being mindful of her pain, which was followed by noticing her fatigue and eventually even her emotional suffering. Testing whether these symptoms could be a part of her life without the attendant judgmental conclusions of "I'm broken," "I have to get better or my life is over," and "I can't enjoy life until I rid myself of these symptoms" reduced her suffering. After initiating a mindfulness practice, she remarked that her life was not as miserable as she was telling herself it was. This realization led her to return to socializing again with both her family and friends.

TRIGGERING FIGHT OR FLIGHT WITH THOUGHTS

Mindfulness is a method for helping patients to recognize that their thoughts do not always correspond with reality. However, due to past conditioning, our bodies can physically respond to these thoughts as if they were real (when they may not be). Research has shown that thoughts alone can trigger fight-or-flight responses. Within the brain, the amygdala acts as our biological alarm system in response to dangerous environmental cues. However, even in the absence of such cues, this alarm system can be triggered in humans by words that are associated in our imaginations and memories with perceptions of danger. Conversely, research using functional magnetic resonance imaging (fMRI) has shown that the practice of meditation can deactivate the amygdala's alarm system and our fear response (Taylor et al., 2011).

When animals experience the fight-or-flight response to threats in their environment, they return to a state of homeostasis after the predator departs or the attack is thwarted. In contrast to animals, humans can consciously reflect on past traumatic memories—even in the absence of dangerous cues—and thus retrieve memories that trigger fear responses. Focusing on being in the present moment can help prevent such memory-based reactions. As one of my patients stated: "Mindfulness allows me to go to a place where I don't freak out."

GETTING BUY-IN FROM PATIENTS

As an important part of mindfulness training, patients need to understand that thoughts do not consistently reflect the truth. Most often, patients with ABI need time to gradually process and accept this insight. It can be helpful to break this concept down as follows:

- Thoughts are not necessarily true. Thoughts can be overly positive, overly negative, or neutral. Therefore, all thoughts are not necessarily true.
- Similarly, emotions can represent over- or underreactions.
- Current beliefs are also often "not real" but rooted in past beliefs that can be flawed.
- Because many of our beliefs, thoughts, and emotions arise from our past, they do not accurately reflect our present state.
- Therefore, a more accurate awareness of the present state can only emerge if we learn to live more fully in the present moment.

The following mindfulness exercise can help demonstrate how thoughts that seemingly emerge from nowhere can dissipate when one adopts an observer stance.

> "Think of a contractor who tells you that his construction job will be performed perfectly with no flaws. How do you know this is true? You ask for references and he says that he doesn't have any but that you should trust him because his word is true.

The truth is, you do not know, and therefore you can choose to believe him or not.

"The mind operates in very much the same way as the contractor in this example. Our mind will tell us many things, some true, some partially true, and some false, but we will never know what is true until the actual experience occurs.

"Begin by simply noticing your thoughts without automatically accepting them as if they were the truth. Shift your emphasis toward gaining an awareness that is directly linked to your environment and your actual experiences.

"Become more open and accepting of the world according to your lived experiences. At the same time, recognize that your thoughts about life are merely a mixture of true, partially true, and false impressions."

TREATING PATIENTS WHO ARE STUCK IN VARIOUS FORMS OF RUMINATION

The Problem with Thought Suppression

Because the stuckness of rumination is usually depleting, it can reinforce a lack of motivation to change, even if the individual has the brain capacity to make positive changes. One theory behind the origin of ruminative thinking posits that the human mind generates many more alternatives than are necessary (Andrews & Thompson, 2009). Excessive thoughts are particularly prevalent if an individual is attempting to block a thought from occurring. To illustrate this phenomenon, Steven Hayes, a forerunner in the field of acceptance and commitment therapy (ACT), makes use of metaphors and thought experiments to help patients become less fused with what their thoughts tell them. An individual's level of "fusion with thoughts" in this context refers to the extent to which a person is able to view thoughts as just thoughts, rather than seeing thoughts as "the truth" (Hayes, Strosahl, & Wilson, 2012).

To demonstrate this point, Hayes instructs his patients as follows: "Whatever you do, do *not* think about pink elephants." Then, over a 5-minute period, patients are asked to sit quietly with their own thoughts but, in addition, to count the number of times they think about pink elephants. Invariably, and even with explicit instructions *not* to think about

pink elephants, individuals imagine—you guessed it—pink elephants. It goes without saying that, over the course of a typical day, the average person does not think of pink, or even gray, elephants very often. This simple experiment, however, demonstrates how patients who have difficulties accepting their situation can also, paradoxically, become even more focused on exactly that of which they wish to rid themselves (e.g., thoughts such as "Things are horrible," "I'll never get better unless improvement is all I focus on," and "If I don't believe in a full recovery, I'll stop improving"). Although the ability to generate alternative solutions may be useful, it can also cause emotional suffering. The production of so many thoughts in response to an unfixable problem, such as the wish to return to a former state of wellness, can become counterproductive.[2] Though it is useful to incorporate therapeutic tools such as cognitive restructuring and behavioral modification, psychotherapists need to identify when a patient with ABI reaches the point when the mere act of attempting to control that which is out of control leads to greater suffering. A mindfulness approach should be implemented for those patients who are stuck in thinking about their permanent ABI symptoms, especially when traditional treatments leave them feeling more anxious, depressed, or panicked. By asking patients to engage, for example, in the "pink elephant" exercise, they may begin to realize that the effort involved in attempting to suppress a painful memory or worry is actually reinforcing such ruminations. In sum, counterproductive thoughts, which cause a habitual feedback loop, lead to greater suffering.

Language Traps

Even in the absence of fear responses, Hayes et al. (2012) cleverly depicted how simple words can elicit both emotional and even physiological responses. In one study, patients were asked to imagine biting into a lemon; by doing so, salivation was elicited and individuals became aware

[2]Psychotherapists should know that individuals with damage to the prefrontal lobes are particularly prone to repetitive thinking. This so-called *perseverative thinking* is often resistant to treatment. A case example was discussed in Chapter 1 that involved a man who perseverated on crossing the Coronado Bridge in his wheelchair. This brain-based cognitive aberration is most often resistant to treatment and should not be confused with an emotionally based problem with thought suppression.

of the powerful mind–body connection. These same patients were then instructed *not* to salivate when imagining biting into a lemon. Nonetheless, they reported that their body continued to respond by salivating in spite of their best efforts to inhibit this response. Such an exercise illustrates that we have little control over bodily reactions to certain thoughts.

Taking the lemon example one step further, patients were asked to imagine that a nonsense word, *lonen*, had replaced the word *lemon* and that the *lonen* embodied all of the typical characteristics of a lemon: the bitter, sour taste that causes salivation; the yellow color; and the oval shape of the small fruit. Individuals were then asked to imagine biting into a *lonen*; low and behold, they began to salivate in response. Even though they had never even seen a *lonen*, once it became associated with a lemon, it became a powerful physiological trigger. This example demonstrates how we, as humans, can become entangled in words and even biologically respond to them because of classical conditioning.

Exposing language traps is taken even one step further in the following example. How can a common daily event such as a sunset trigger a fear response? For most individuals, a sunset is viewed as a beautiful and life-affirming experience. However, for one individual, seeing a sunset triggered a painful reminder of the loss of his loved one (Hayes, 2012). The *sunset* in this scenario is equivalent to a *lonen*: a neutral stimulus that the human mind can associate with past memories. In this example, memories associated with sunsets triggered sadness and fear because the person was reminded of frequently sharing sunsets with his loved one before she passed.

In sum, adages such as "Don't believe everything you think" and "A thought is just a thought" can be useful, with the caveat that the therapeutic rapport must be strong enough to withstand what might appear to be a somewhat confrontational or invalidating intervention.

Mindfulness Exercise for Use with Patients

One simple way to orient patients with ABI to the practice of mindfulness is to ask them to notice their breath. The following script can be useful:

> "As you are sitting here now, just shift your attention to the room. Notice the chair and how it is holding you up. Maybe take notice of how your feet are resting on the ground. No need to shift or

move, just notice these things as they are, in this moment. Now gently move your focus to your breath. Pay attention to how the air comes in and out gently. Again, no need to change or alter your breath in any way . . . just notice it as it is. If you find that your mind is wandering, that's okay . . . without judgment, gently draw your attention back to your breath. Notice how it is cool entering the body and warmer as it leaves. Also try to detect the exact point of balance, where the air is turning around to leave your body, notice that point of stillness. Thoughts will enter the mind . . . watch them as they leave, letting them leave as easily as they arrive . . . they are just passing through. [Allow the patient to continue doing this exercise for 5 or 10 minutes.] . . . Gently bring your awareness back to the room by wiggling your fingers and toes."

Mindfulness is a learnable skill and requires practice. It can be challenging to achieve moment-by-moment focused awareness. In addition to bringing a focus to the here and now, mindfulness also teaches us to increase acceptance by settling into state of mind that seeks increased objectivity. During meditation, patients with ABI can learn to exert a level of focus that can reduce their suffering. Mindfulness also teaches a number of paradoxical skills: If our aim is to reduce emotional pain, we are taught to sit with our pain. Instead of focusing on avoidance, the focus is on acceptance. Instead of isolation, we are taught to reach out. Practicing mindfulness can provide helpful relief for many patients with ABI.

SUMMARY

Much as with cognitively based therapies, a mindfulness practice also asks the patient to observe his or her cognitions. However, mindfulness departs from the cognitive restructuring approach. Instead of challenging the veracity of thoughts, mindfulness teaches patients to notice what their minds are telling them, without judgment. It asks patients to acknowledge that their minds produce many thoughts, which is a natural human phenomenon. It also asks patients to be wary of believing everything that they think and to understand that a thought is simply a "string of words." Moreover, mindfulness encourages individuals to observe and experience

sensory information more directly. This approach brings with it the opportunity to make room for new input, such as observing a flower or a sunset—afresh, without former overlearned associations. Individuals with ABI thereby learn to explore and accept who they have become, rather than primarily adhering to what their minds are incessantly telling them about their pain, their fatigue, their memory problems, their former level of functioning, and on and on.

The aim of psychotherapy with patients with ABI is to provide them with multiple tools for coping with their biopsychosocial symptoms. As described in previous chapters, this includes assisting patients to cope with anxiety, depression, and anger. In addition, most patients need assistance with accepting the permanent sequelae of their brain injuries. Mindfulness meditation can foster acceptance in patients as they learn to observe their thoughts without judgment. This approach empowers patients to accept who they are at this point in their lives.

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