

# Mindfulness Meditation in the Treatment of Trauma, Anxiety and Depression

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## *Mindfulness processes*

The consensus in the literature defining mindfulness is that mindful attention requires a deliberate and non-judgemental focus on events experienced from moment to moment. The main purpose of teaching mindfulness skills in the clinical context is to help clients develop a degree of self-awareness, self-acceptance, and a sense of control over emotional reactivity.

Clients begin with a set of breath concentration exercises which require the development of two main attentional skills, focused and sustained attention. They develop the ability to quickly recognise and inhibit their typical response to emerging thoughts to prevent distractibility and refocus on the breath. Clients develop a degree of control over the process of thinking which enables a more accurate understanding that thoughts are just “thoughts”, rather than “truths.”

Clients are then taught to scan their body systematically and develop an ability to feel both salient and more subtle sensations while purposefully inhibiting habitual, learned reactions; often defined as automatic. As they do with their thoughts, clients develop an increasing ability to accept whatever arises in their body from moment to moment while remaining as nonreactive as possible. From a behavioural perspective, this entails a process of systematic desensitisation to internal cues or a deprogramming of established reactive habits in the central nervous system.

Since mindfulness meditation addresses the very core of reinforcement, it has the ability to correct maladaptive behaviour irrespective of the diagnosis. Accordingly, when integrated in Western therapy models, mindfulness helps address the problem of comorbidity (more than one disorder emerging at the same time), which is a major complication for conventional treatments.

In addition, new research in neuroscience provides evidence that mindfulness meditation produces neuroplasticity, which is the ability of the brain to rewire itself according to the task it is required to perform. As the pathways to self-awareness and acceptance in frontal and other regions of the brain become more connected, self-control in the face of problems such as anxiety, depression and traumatic symptoms is made easier. Similarly, people with these conditions can resist the craving for self-medicating substances more easily. Thus, mindfulness meditation can help people with numerous conditions where addiction is a complicating factor in treatment.

## *Method*

The client in this case study was treated with Mindfulness-integrated Cognitive Behaviour Therapy (MiCBT), a sophisticated integration of traditional CBT and mindfulness meditation into a 4-stage generic treatment model which we developed in 2001 to address crisis and prevent relapse a wide range of disorders. It can be flexibly implemented within eight to ten sessions and equally well in individual or group format. In the case described below, the client attended eight treatment sessions over 12 weeks.

### *Client presentation & condition*

The client was a 21-year old female (“Sarah”) referred by her GP for problems associated with a recent traumatic car accident. Sarah was driving fast under the influence of alcohol and lost control of the vehicle, which barrel-rolled and collided against a power pole. Sarah could not recall what had happened just after she lost control of the vehicle, but remembered sitting on the side of the road her head in her hands, sobbing and frightened waiting for help. The police recorded a level of blood alcohol three and half times the 0.05% legal level, though Sarah reported not feeling intoxicated.

Sarah feared to be by herself but her parents were out of the state at the time and for several sessions after the accident, leaving her with some limited support from her sister. One of her concerns was her inability to repay the loan for her (wrecked) car if she remained unable to work. She was also worried about losing her licence again, as driving her car made her feel like “a grown person”. Two years earlier, Sarah had her driver’s licence suspended for six months for the same offence. For the past two years, her very small social network was restricted to a few “drinking friends”, with whom she systematically spent her entire weekends drinking until she would lose consciousness.

Sarah presented with severe symptoms of traumatic stress and chronic depression, including Agoraphobia without history of Panic Disorder, dissociative amnesia, anxiety, hypervigilance to passing vehicles, recurrent nightmares, low mood, and a sense of worthlessness associated with guilt and fear of court appearance. Her presentation met the DSM-IV criteria for Acute Stress Disorder, Alcohol Abuse, Alcohol Dependence and Alcohol-Induced Mood Disorder.

### *Treatment delivery*

In Stage 1 of MiCBT, Sarah received psycho-education related to her condition and began with one session of progressive muscle relaxation to decrease general arousal. She was asked to become acquainted with a home training schedule requiring her to spend 30 minutes twice daily. On session 2, she trained daily in mindfulness skills which required her to examine carefully and accept the nature of her thoughts, how they are impermanence and therefore substanceless. This helped her remain detached from emerging negative thoughts rather than react to (reinforce) them. In sessions 3 and 4, Sarah was instructed to scan their body systematically with an increasing degree of awareness and acceptance of sensations, whatever they may be. Since emotions can only be experienced through body sensations, noticing, accepting and letting go of body sensations enabled Sarah to progressively accept emotions and let them pass in their own right. Her levels of equanimity were beginning to transfer effortlessly to day to day life. At the end of this stage, most clinical symptoms and alcohol dependence had decreased significantly, and self-confidence was greatly improved. However, her recall of the accident was still fragmented. The traumatic features of the memory were reappraised as just thoughts and co-emerging body sensations. Avoidance of these was prevented.

In Stage 2, while continuing with advanced body-scanning methods, Sarah was introduced to exposure techniques targeting avoidance and maladaptive behaviour in sessions 5 and 6. These included contacting the insurance company contesting care reimbursement, addressing her fears of the court process (e.g., the judge shouting to her, as it happened during her first court attendance and the probability of being judged as a repeat offender), experiencing emotions associated with unpleasant memories while delaying alcohol intake, returning to the accident site while neutralising anxiety symptoms, handling the end of her job contract, and seeing her main “drinking friend” in town. Her success on these tasks was enhanced by mindfulness skills. Sarah’s drinking had decreased to one or two standard drinks on the weekend, none during the week. Through mindfulness meditation, she trained herself to accept the experience of craving for what it is; just thoughts and body sensations in a constant state of change.

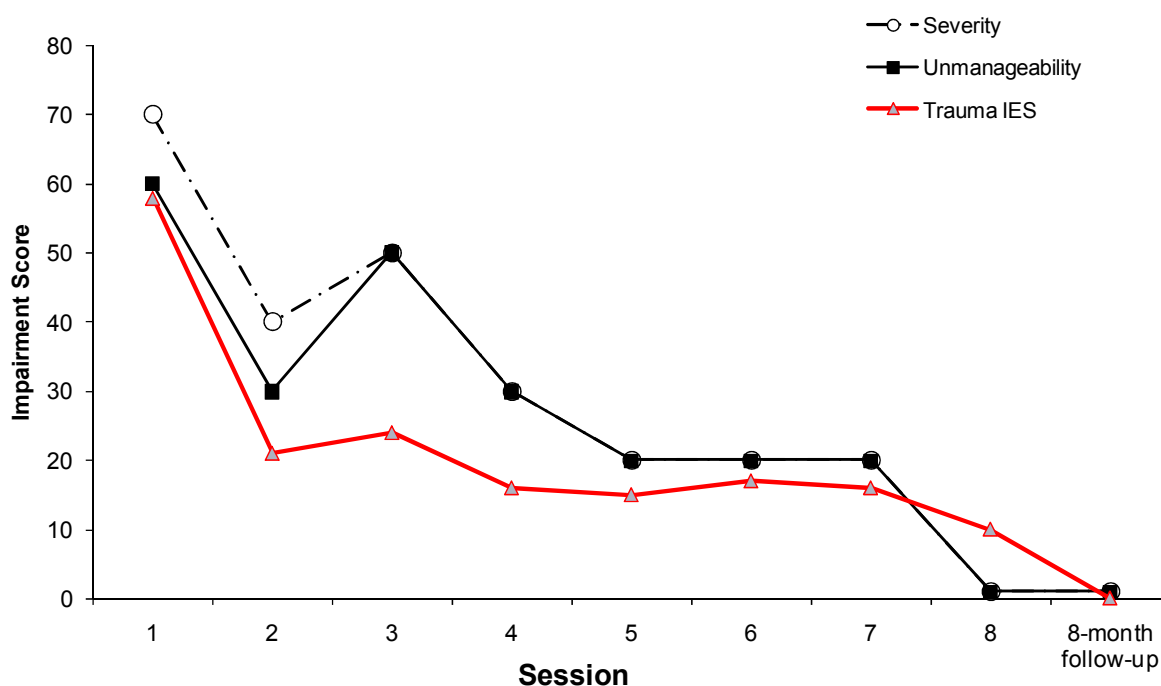
In Stage 3, Sarah was taught to use her exposure skills to address interpersonal issues while continuing to develop her awareness and equanimity with more advanced scanning techniques. She worked on being more assertive with friends who continued to solicit her company for binge-drinking despite the accident. Sarah learned to take full responsibility for her emotions and other experiences while disowning those of others, understanding what others are also going through. It became clear to her that, like these friends, she was depressed and used alcohol in an attempt to self-medicate and meet new people. She could understand her friends' problems but recognised a need for separation from them until they could also accept to make changes. She developed skills and a sense of self-efficacy in social contexts, rather than feeling inadequate, guilty and co-dependent. During this stage, Sarah was also able to contact old friends and create a different social network. She was also able to accept losing her driver's licence—her social activities were not as reliant on her having a car and she was feeling increasingly mature without the need to prove it to herself by driving her own car.

Increased experiential awareness of herself and others led naturally to Stage 4, the empathic stage of MiCBT. In Stage 4, Sarah learned to practise “grounded empathy”, traditionally termed “Loving Kindness” in Eastern teachings. For about 5 to 10 minutes after each meditation practice using advanced body-scanning methods, Sarah learned to formulate positive and kind thoughts and intentions for herself and others while feeling the “free flow” of very pleasant subtle body sensations. By pairing loving thoughts with pleasant sensations emerging as a consequence of advanced (‘sweeping’) methods, Sarah established a sense of forgiveness and compassion for herself and others.

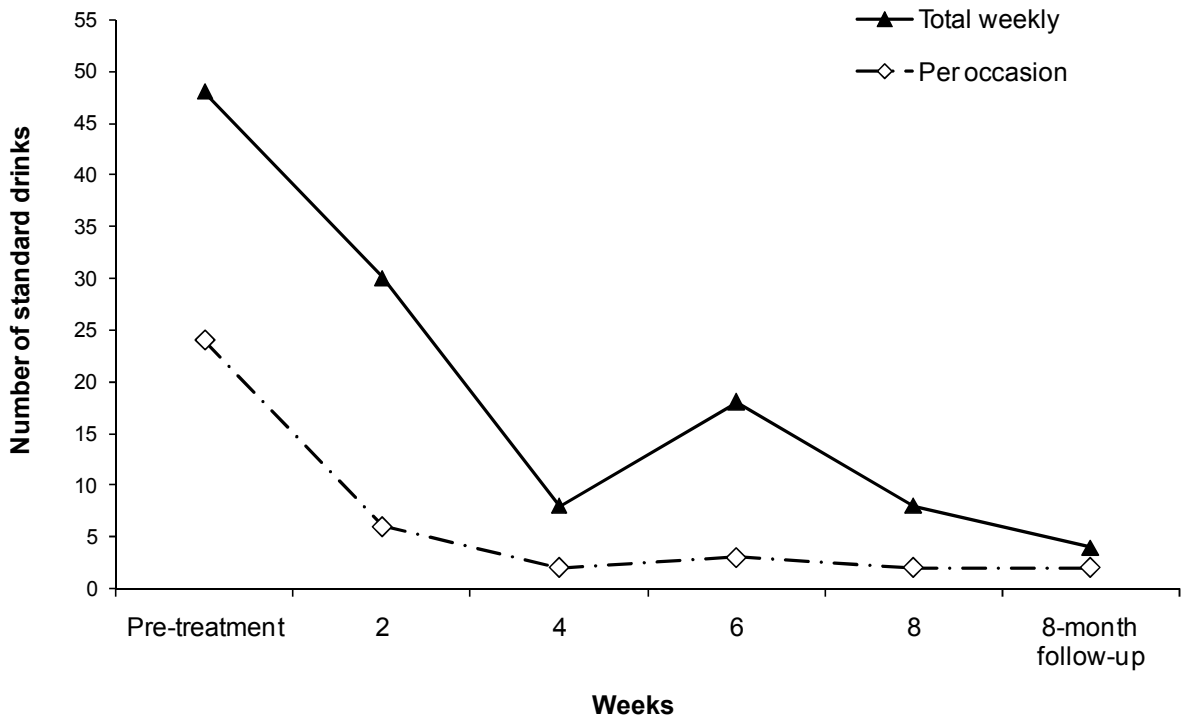
### Results

Following eight sessions of MiCBT within a 12-week period, all clinical symptoms of anxiety, depression and trauma had decreased to normal levels and avoidance behaviour extinguished. The results were maintained at 8-month follow up.

Figure 1 shows the decrease in general impairment scores on the Short Progress Assessment (SPA) and the Impact of Event Scale (IES), which measures the aftermath of traumatic events. Figure 2 shows her decrease in alcohol consumption over the same period.

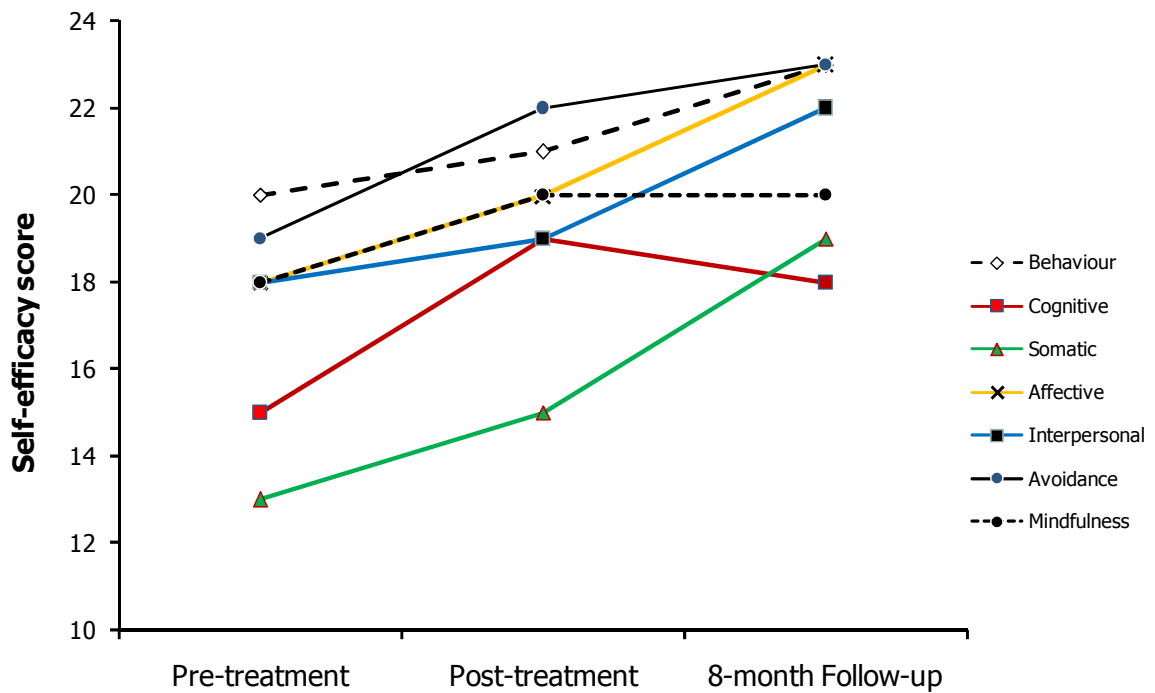


**Figure 1.** Impairment scores on the severity and manageability scales of the Short Progress Assessment, and trauma severity scores on the Impact of Event Scale.



**Figure 1.** Alcohol consumption over the first eight weeks of treatment and at follow-up.

Sarah's sense of self-efficacy with mindfulness training with regards to managing her conditions was assessed with the Mindfulness-based Self Efficacy Scale (MSES).



**Figure 3.** Self-efficacy score on the MSES

Sarah's initial recurrent intrusive (albeit partial) memories of the accident did not return. She also kept a healthy social network, obtained a permanent job in a lawyer's practice and enjoyed a calmer lifestyle. She was given the minimum sentence, a 2-year driving suspension, and to her surprise the judge was sympathetic to her situation. She relocated to the city centre to make transport easier.

### *Conclusion*

When people are clinically depressed or anxious, they tend to feel caught up in negative thoughts and emotions, including making catastrophic predictions of forthcoming situations, or engaging in self-blame. The intoxicating effects of alcohol and other drugs on the frontal lobe disrupts these distressing thoughts and the emotional pains that come with them, making it an attractive alternative for people who are unaware of, or unwilling/unable to seek proper treatment. In the present case, mindfulness meditation helped address the crisis and prevent relapse by training the client to regulate her emotions without the need for external means of control, such as intoxication.

Mindfulness meditation can be used for a wide range of disorders because it targets the craving for pleasant sensations and the avoidance of unpleasant sensations and thoughts, which are at the basis of reinforcement principles. Accordingly, it is likely that mindfulness mediation will be increasingly used in the treatment of conditions such as trauma, anxiety and mood disorders, where comorbidity is a major complication for traditional treatments. The present results further demonstrate that mindfulness meditation integrated in Western therapy can be an effective approach for complex and chronic disorders. More research is needed to examine the benefit of mindfulness in individuals with highly comorbid conditions.