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The Application of Mindfulness in Coping With Intrusive Thoughts

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Across a variety of disorders, clients present with clinically significant intrusive thoughts. These thoughts can be problematic in their own right, with many clients reporting difficulty focusing on other therapeutic interventions due to problems with attention and increased distress that often accompany the experience of intrusive thoughts. Thus, cognitive-behavioral therapists can find value in learning thought management strategies that can be used with a variety of clients. Despite the increase in attention within the scientific literature and popular media on mindfulness-based interventions, many clinicians are unaware that it is possible to bring these skills into therapy as an adjunct to ongoing cognitive behavioral therapy (CBT). Thus, we provide an overview of how to teach brief mindfulness skills (5–10 minute trainings). Video segments will teach how to introduce these skills to clients, as well as highlight three skills that have been found to be particularly useful for coping with intrusive thoughts: observation of thoughts; nonjudgment of thoughts; and being larger than your thoughts. The benefits and challenges of using these skills will also be discussed.

Intrusive thoughts, which are common across a variety of disorders, can be defined as "... *any distinct, identifiable cognitive event that is unwanted, unintended, and recurrent. It interrupts the flow of thought, interferes in task performance, is associated with negative affect, and is difficult to control*" (Clark, 2005). Specifically, these thoughts are typically short sensory flashes (most commonly visual), and are experienced with a sense of "now-ness" or happening in the present (although the individual usually does not lose awareness of other aspects of the present, as in a flashback; Hackman, Ehlers, Speckens, & Clark, 2004). These distressing cognitive events are a normative response to stressors, and are common in both nonclinical (Brewin, Dalgleish, & Joseph, 1996; Purdon & Clark, 1993) and clinical samples. Indeed, intrusive thoughts have been observed and studied in depression (Hall et al., 1997; Wenzlaff, 2002; Wenzlaff, Wegner, & Roper, 1988), anxiety disorders (Gross & Eifert, 1990; Ladouceur et al., 2000; Wells & Carter, 2001), insomnia (Harvey & Payne, 2002; Wicklow & Espie, 2000), and general medical conditions such as breast cancer and cardiac populations (Bennett & Brooke, 1999; Johnson Vickburg, Bovbjerg, DuHamel, Currie, & Redd, 2010; Ladwig et al., 1999; Lewis et al., 2001).While most cognitive-behavioral treatment programs are diagnosis-specific and teach clients skills to manage symptoms, it is possible that transdiagnostic skills can also provide benefit across a wide range of presenting complaints (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012). Learning effective strategies for coping with intrusive thoughts is one such skill.

Although intrusive thoughts are both expected and normative across varied populations, those experiencing intrusive thoughts often report that the thoughts are disturbing, and they fear "going crazy" (Shipherd, Beck, Hamblen, & Freeman, 2000). When an intrusive thought occurs, it can create emotional distress, physiological arousal, and interference with concentration or task completion lasting anywhere from minutes to hours. Intrusive thoughts can be future-oriented, as with anxious or worry-related thoughts, or they can be past-oriented, as with depressive rumination. There are a multitude of strategies to assist in coping with intrusive thoughts, some that are designed to work in the short-term and some that are more effective in the long run. Short-term strategies including avoidance-based strategies such as distraction (engaging in activities), denial, suppressing overt emotion (e.g., trying not to cry), and suppressing the unwanted intrusive thoughts themselves (Lapp et al., 2010; Wheeler & Torres Stone, 2010) are quite common and can be effective for brief periods. Indeed, short-term coping is an important part of coping effectively and can be beneficial in reducing distress associated with

[1] Video patients/clients are portrayed by actors.

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intrusive thoughts. The negative reinforcement associated with avoidance-based coping makes it a tempting strategy to overutilize. However, suppression as a long-term coping strategy can be problematic (e.g., Purdon, 1999; Purdon & Clark, 2000; Shipherd & Beck, 1999; Shipherd & Beck, 2005). Conversely, supplementing avoidance-based coping (short-term technique) with approach-based coping, including cognitive behavioral interventions, mindfulness, and acceptance-based interventions, are more helpful to long-term functioning (Shipherd & Salters-Pedneault, 2008) and are an important aspect of many empirically supported treatments.

Fortunately, clinicians can help clients target intrusive thoughts—and the coping mechanisms that are commonly used to deal with them—and can teach clients resilient coping skills (Marcks & Woods, 2005). One potential approach-based strategy to target intrusive thoughts and their resultant symptoms is the use of mindfulness training, which has been shown to be effective at mitigating a variety of symptoms and has a rich foundation in the literature (e.g., Kabat-Zinn, 2005). Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 2005) has been utilized across a wide variety of populations, both clinical and nonclinical, with positive results in a host of domains including depression, anxiety, chronic pain, alcohol misuse, and physical complaints (Hofmann, Sawyer, Witt, & Oh, 2010; Morone, Greco, & Weiner, 2008; Rosenzweig et al., 2010; Smith et al., 2011). MBSR is also used as a general stress reduction technique in nonclinical samples (Shapiro, Brown, & Biegel, 2007; Shapiro, Schwartz, & Bonner, 1998). While traditional MBSR requires in-depth practitioner training and is typically delivered over the course of 12 weeks, it has been shown that mindfulness skills can be taught via brief 2- to 20-minute trainings. In these studies, brief education and metaphors delivered by novices resulted in decreased avoidance and struggles with intrusive thoughts or increased acceptance (Eifert & Heffner, 2003; Gutierrez, Luciano, Rodriguez, & Fink, 2004; Hayes et al., 1999; Keogh, Bond, Hanmer, & Tilston, 2005; Levitt, Brown, Orsillo, & Barlow, 2004; Masedo & Rosa Esteve, 2007). Thus, it is clear that brief training in acceptance and mindfulness-based skills can drastically alter clients' interpretations of thoughts and emotions, and can reduce symptoms.

Metaphors and guided experiential exercises, the foundation of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), allow the individual to observe their thoughts from a more detached perspective rather than being fused with the thoughts and accompanying distress (Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004). Yet, in the absence of extensive training on experiential exercises, many clinicians are unclear about how to utilize these strategies as part of ongoing treatment. We argue that the exercises and metaphors can be a useful adjunct to other treatments, as they help the client see the thoughts as they are—just thoughts. CBT therapists may find familiar ground in talking to clients who believe that thoughts are facts and have difficulty disengaging from the associated physical and emotional sequelae that accompany believing that negative thoughts about the self, others, and the future are factual (rather than just thoughts). Moreover, given the nature of intrusive thoughts (unwanted and distressing), they can pull attention away to past events (as with depressive thoughts about past mistakes) or to the future (as with anxious thoughts). In each case, the intrusive thoughts demand attention that could be allocated toward the tasks in the present moment. Mindfulness practice, by definition, promotes an awareness of the present moment and facilitates an ability to choose where attention is directed. Additionally, an ongoing sense of self (self-perspective) is established with these techniques so that the individual can view him/herself as a "thinker" of thoughts. From this perspective, a context can be built wherein thoughts can be experienced without any need to suppress or avoid, but rather it becomes possible to observe the thoughts as they come and go. This process encourages meta-cognition rather than overinvolvement with the maladaptive intrusive thoughts and their painful sequelae. Clearly this approach, which emphasizes increasing adaptive behaviors rather than focusing on problems, can be valuable across treatment of a wide variety of clinical presentations and is applicable in both group and individual treatment modalities.

Within this framework, we developed and tested ACT-based mindfulness skills in an active duty Army population (more detail about this program can be found in Fordiani & Shipherd, 2011; Shipherd & Fordiani, 2012). These skills were packaged into a 50-minute, trainer-led PowerPoint-based presentation (the RESET training), which was designed to be consistent with the format and duration of mandated Army-wide training modules. The training is mentioned here as it is an example of a skill-building intervention that was designed to be applied to a broad audience of active duty soldiers. Specifically, the RESET training focused on psychoeducation about intrusive thoughts and skills to cope with them, presented in an easy to remember acronym:

Remember it is normal to have intrusive thoughts.
Ease up on efforts to control: It doesn't always work well with thoughts.
See and accept your thoughts: You are more than just your thoughts.
Experience thoughts as they happen: Don't judge them.
Train your skills: Practice is important!

We introduce the RESET acronym here as it may be helpful for some clients who find this assists in remembering concepts. Many CBT interventions utilize acronyms, such as the Dialectical Behavior Therapy (DBT) example of DEAR MAN skills (Describe, Express, Assert, Reinforce, Mindfully, Appear confident, Negotiate) and some clients find them