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Commentary 2

Keep Your Friends Close and Your Enemies Closer: How Thinking Negative Thoughts *and* Doing Positive Things Are Both Necessary to Facilitate Mourning After Brain Injury

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> "It is only as I understand the feelings and thoughts which seem so horrible to you, or so weak, or so sentimental, or so bizarre—it is only as I see them as you see them, and accept them and you, that you feel really free to explore all the hidden nooks and frightening crannies of your inner and often buried experience."
>
> Carl Rogers (1961)

Introduction: some general ideas on the relationship between psychoanalytic and humanistic views of the mind

When I finished reading Segal's paper two memories came into my mind. The first one was that of a dear teacher I had during my undergraduate years. His name was Jorge Gissi. Gissi was an "old-style"' professor—I realised that years after, when I encountered the "scientific" academia. He knew the classics by heart; he could talk about Freud, Jung, Rogers, Maslow, Sartre, and many others for hours with astonishing easiness and no notes. Gissi was not interested in a scientific approach to the human mind, but rather on how different views of the mind (and the soul) lead clinicians to understand emotional suffering and psychological help in so many different ways. Some classmates, those that expected clear answers and recipes, found Gissi unsystematic and disappointing. I loved him. I loved him because he convinced me, without me being much aware of it at that time, that all psychological theories were incomplete. One day, he begun a lecture saying:

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"psychological theories can be divided in two main schools of thought, those that see human beings as motivated by conflict, and those that see human beings driven by self-actualisation". This simple idea has stayed with me till today, working as a signpost to remind myself that the main question is not which of these two views of the mind is true, but rather from which side of the road am I looking at my patients. Segal's paper resuscitates this problem, but in a different context: if psychodynamic (conflict-based) and humanistic (self-actualisation-based) views of the mind represent partial truths, and in consequence are both necessary, how *can we* articulate them when working with neurological patients?

A second memory, also connected to my undergraduate self, took me to the readings of Ken Wilber. Probably because of Gissi's influence in the development of my way of thinking, I did not feel that psychoanalytic and humanistic perspectives were incompatible then. At that time (end of the 1990s) Wilber was a very influential figure in transpersonal psychology, and I particularly liked his ideas on the evolution of consciousness. Wilber proposed that disparities among psychological schools could be explained as a simple reflection of their focus on different evolutive moments in the history of consciousness (Wilber, 1973). Psychoanalysis, for example, was considered as an ego-therapy, since its main goal was to address the problems that emerged in the constitution of a healthy ego. Humanistic psychologies, in contrast, were considered as existential-therapies, since they focused on the whole organism and the struggles that emerged when attempting to actualise its potentialities. The important point here was that, according to Wilber, the constitution of a healthy ego was a pre-requisite in order to evolve towards "existential" levels of consciousness. In other words, we cannot reach self-actualisation if we are dominated by neurotic conflicts, which are the result of a poor ego developmental process—there is a nested hierarchy. I believe that Wilber's ideas offer some interesting vantage points to consider Segal's paper and her discussion on the compatibility of psychoanalysis and positive psychology when working with neurological patients.

I believe that, by clarifying these two points—that psychoanalysis and positive psychology are incomplete on their own, and that self-actualisation can only exist when a relatively stable and harmonic ego has been developed—many unnecessary arguments can be avoided. However, and more importantly, I strongly believe that by adopting this complementary-nested approach, we have a better chance to build a theoretical model that can be useful in offering psychological support to neurological patients.

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Negative and positive thinking: Segal's ideas on how to facilitate mourning

There are very few psychodynamic articles that directly address the problem of mourning in neurological populations, and even fewer using ideas from Kleinian psychoanalysis. This is why I would like to summarise Segal's main points first, in order to discuss some of them later. According to her:

(a) Positive thinking *may* have a defensive function during mourning. By voluntarily avoiding thinking negative thoughts related to losses (suppress them), and focusing only in positive ideas, patients can attempt to defend themselves from depressive feelings or overwhelming fear and anxiety.
(b) Rejecting negative thoughts related to loss has an *impoverishing effect* in the way we relate to the world and to ourselves. This, because negative thoughts, even when denied, keep influencing the way our mind works. Since rejected negative thoughts cannot be properly symbolised—represented, put into words—they trigger a vicious cycle where negative affect is not regulated and regulatory functions (thinking) become less efficient. As a consequence our capacity to think about the world from different angles becomes constricted, and we can only see parts, and predominantly the bad parts of the world and ourselves–its persecutory version.
(c) This defensive function is mainly motivated by *fantasies*; no realistic fantasies but persecutory fantasies. This is extremely important, because it points at the fact that losses acquire meaning based on the particular psychohistory of each individual. In other words, humans are not "objective" when attributing meaning to events. We do not only mourn the "real" consequence of a loss but, most importantly, its "fantasised" consequences. A patient that highly valued his intellect throughout life may signify his lost executive abilities according to inferiority feelings (a persecutory fantasy), which he has kept at bay by actively demonstrating that he is super-smart.
(d) When negative thoughts, or persecutory fantasies related to loss, are kept away, they are stored in their unmodified form. As a consequence, *unrealistic associations* of what has been lost compromise the perception of reality, or the perception of a version of reality that facilitates the process of mourning.
(e) The therapist can experience these negative thoughts, once the patient has suppressed them. This is because patient and therapist's minds work as a *functional unit*, where information is exchanged in conscious and unconscious levels. So if the therapist experiences a frightening feeling, what is he/she supposed to do? He/she can

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defend from it, and push it away, or he/she can present it to the patient as an object of shared exploration.

(f) *Shared and safe exploration* of negative thoughts promotes thinking. Thinking helps metabolising negative feelings making losses more realistic and bearable.

(g) When negative thoughts can be experienced without overwhelming negative affect, negative and positive aspects of reality can be considered together. In other words, *true—non-defensive—positive thoughts*, which are firmly rooted in reality, can emerge.

I have attempted to summarise what, in my opinion, are Segal's main points. Even though she proposed these ideas in relation to her work with multiple sclerosis patients, I believe these are points also worth considering for non-progressive forms of brain damage, such as stroke or traumatic brain injury (TBI).

The first remark that I would like to make regarding Segal's ideas is that they strongly resonate with other non-Kleinian psychodynamic authors that have addressed the problem of mourning after acquired brain injury. Mainly in relation to the key role that psychohistory has on attaching meaning to losses, as well as in the use of defence mechanisms in order to manage painful feelings or overwhelming anxiety (Klonoff, 2010; Prigatano, 1986, 2008; Prigatano & Klonoff, 1988; Salas & Turnbull, 2010). However, Segal's paper also has novelty. In my opinion, its contribution to the literature is that it emphasises the relevance of thinking, as a regulatory process, when facilitating mourning:

> What I found . . . was that both client and I could actually bear these thoughts, and that thinking them through did change them. It became clear that an extremely frightening fantasy, scenario, memory, or thought can remain unchanged when the person cannot bear to think it through. However, when the thinking process is restarted, other aspects of the memory or thought surface and the extreme fear reduces.

The relevance of thinking, or symbolising, to psychological change has a long tradition in psychoanalysis. Freud (1911b), for example, suggested that it is through thinking, or the "secondary process", that automatic tendencies are inhibited and its energy used for adaptive purposes. Later on, Wilfred Bion (1984), a post-Kleinian psychoanalyst, also placed thinking at the heart of the therapeutic enterprise, by suggesting that the therapist's role was to help patients metabolise somatic and unrepresented experiences. I do believe that Segal's paper, somehow, follows this line of thought, by proposing that only through thinking negative thoughts, and its associated negative feelings, they can be regulated. I would even go further here, by saying that it is not so much about thinking positive or thinking negative at all, but finally about preserving

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thinking while in the midst of a traumatic situation. In other words, to help patients sustain their symbolic function, to keep *thinking about*. Trauma or psychic pain can compromise symbolisation, in some cases generating what has been called *desymbolisation*:

> Desymbolization is concrete and repetitive, with an insistence not only on the sameness of things and situations, but also on the sameness of the self and of others. Defensively, this mode of mentalization is based on profound disavowal, implementing the wish not to know . . . Psychic space can be said to be frozen. One finds a serious inability to use experience, external, situational, and internal, to create complex and varied meanings. Only single, unwavering perceptions of experience are used and they are treated as concretized facts, rather than being understood as a construction, that is, as one of many possible interpretations (Lasky, 2002)

I believe this idea is extremely relevant when working with brain-injured survivors. First, because as any human being facing a traumatic event, survivors need to cope with intense negative feelings triggered by multiple physical, cognitive, and social losses, which tend to impair symbolisation. Second, because in many cases the "thinking" machinery itself is impaired due to damage to the frontal lobes and impairment of executive functions, thus compromising the main regulatory tool. So, at least for brain-injured patients, this is a key theoretical and technical problem. How to facilitate mourning, via "meaning making", when the same machinery that is needed for the process is damaged? The easy way out is simply to say that brain-injured patients are not suitable candidates for psychological work. But that is, in my opinion, profoundly unethical. Brain damage often impairs the tools that humans use to manage and cope with feelings, but does not abolish the capacity to experience emotions. Brain injured patients may be slower or less abstract, but they preserve what defines them as human beings: sentience.

Segal's paper places a challenge to everyone interested in facilitating emotional adjustment after brain damage. If mourning requires thinking about negative thoughts, how can we facilitate such process when the thinking machinery is damaged? This is not the place to address this theoretical and technical problem in detail. However, it is necessary to raise awareness of the relevance of such issue. With several colleagues we have attempted to answer this question, particularly in relation to the problem of concreteness after traumatic brain injury. We have developed a model to understand concreteness in the context of psychotherapy, suggesting some theoretical and technical modifications that can help when working with this population (Salas & Coetzer, 2015; Salas et al., 2013). I hope the reader can consider this line of work as an example that can be replicated with other brain injured sub-populations.

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I would like to close this section with a last comment regarding Segal's ideas, particularly one that is of special relevance when working with brain injured patients: the regulatory role of the mind of the therapist. Segal notes that in her work she can become aware of thoughts or feelings that the patient has not mentioned or is unaware. In psychodynamic jargon, this phenomenon is known as countertransference (for a review of this concept in brain injury see Lewis, 1999). I believe that pointing at the usefulness of this concept when working with neurological patients is important. If brain injured patients are often impaired in their thinking, they may often struggle linking thoughts with words, identifying and understanding what they are feeling, connecting feelings with events, or simply putting different ideas together in order to see the big picture. If we look at these problems from a cognitive stance, this is a huge issue, since a necessary step for many cognitive therapies is that the patient himself articulates a problem that needs to be addressed. Psychoanalytic models of the mind can bypass this limitation, since knowledge about the subjective state of patients can be experienced indirectly by the therapist, and then offered to the patient as something that can be jointly observed and reflected upon. The use of countertransferential feelings is perhaps the golden key to work with patients that present thinking impairments. Interestingly, a very similar idea is largely accepted in neuropsychological rehabilitation: cognitive impaired functions need to be scaffolded from outside. I am simply extending this principle by suggesting that regulatory functions—such as the capacity to think about feelings—can also be scaffolded from outside (Salas, 2012).

How can positive psychology contribute to mourning? Some notes on Evans' paper and positive everyday routines

As I said in the introduction, psychoanalytic and humanistic (positive psychology) views of the human being are incomplete on their own. In consequence, when working with brain-injured patients, the principles that underlie both frameworks need to be articulated. Following Wilber's work, I proposed that self-actualisation requires some level of ego integrity first. The relevance of these ideas when working with brain-injured survivors is this: we cannot ignore what is wrong and only focus on what is strong—paraphrasing Seligman's quote. Doing this would be somehow naïve and would neglect the real complexity of human beings. Here I rather agree with Segal's position that in order to have true positive thoughts sometimes you need to be able to think about negative thoughts. In other words, emotional conflict is unavoidable, and we can

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only mourn our losses going through them. My position is that it is only from a less conflicted experience of ourselves, and the world, that we can really pursue self-actualisation. It is true that in neuropsychological rehabilitation there are impairments that cannot be fixed, and in consequence interventions must aim at potentiating remaining skills—what is strong. However, this analogy does not really apply to patient's emotional experience, since it is exactly that which cannot be fixed, the source of suffering. We also know that in many cases patients prefer to focus on what is preserved, as a defensive move to avoid thinking about that which cannot be fixed.

I need to clarify that I am not against the relevance and usefulness of positive psychology. I simply believe that we cannot ignore the intrinsic conflictive nature of human beings. Brain injured patients do not spontaneously experience personal growth after their accidents. On the contrary, in most cases, such growth is the product of a painful period of transition, where old and new versions of the self need to be rearranged.

So what is the potential role of positive psychology in facilitating mourning after brain injury? I do believe that positive psychology brings a couple of valuable principles. The first, and most obvious one, is a focus on self-actualisation. As George Prigatano used to say, brain damage does not modify our *need* to love, work, or play, but only the means, or the tools, by which we accomplish such goals (Prigatano, 1989). Positive psychology, in its many forms, brings self-actualisation to the forefront again.

The second powerful idea proposed by positive psychology is related to the value of doing things. Mourning can be facilitated, and well-being can be fostered, not only by thinking about things, but also via engaging in positive activities. As far as I know, this principle was first proposed by Ylvisaker and Feeney (1988) in neuropsychological rehabilitation. They suggested that helping individuals with brain damage in establishing positive everyday routines was key in order to facilitate their emotional adjustment. By setting positive routines, survivors experience fewer discrepancies between what they can do and what the environment demands them to do. Additionally, due to the fact that survivors are successful in such activities, and experience some sense of renewed mastery, positive feelings are experienced and motivation to stay engaged is strengthened.

Neurophilosophycally speaking, *thinking*, as a process, corresponds to what has been called the extended-self, while *doing* is more closely related to the core self or nuclear self (Damasio, 1999). Individuals with TBI, for example, often present dramatic changes in their extended self, since their capacity to reflect upon others and themselves, as well as thinking about past and future events is commonly impaired. Strikingly,

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the nuclear or core self, which allows a moment-to-moment emotional relation to the environment is largely preserved (Salas et al., 2013). Risking an oversimplification, it is possible to say that the extended-self is a *thinker*, while the core-self is a *doer*. If you are not convinced of this argument, think about how these concepts apply to development, and particularly how children evolve from doers to thinkers. However, the main point here is that, because of changes in the extended self, individuals with TBI can benefit from doing things as a way of accessing to positive self-states. By doing things survivors can re-engage in meaningful and positive activities, thus experiencing less discrepancies between the old and new me—a central goal of mourning after brain injury. Positive psychology, as described by Evans (2011), offers a wide range of tools that are potentially useful engaging patients in activities that can trigger positive self-states.

I would like to close this commentary by simply re-stating my main thesis. After brain damage, mourning can be facilitated via *thinking* negative thoughts—thus elaborating conflicts—and also via *doing* positive things—thus helping in accessing to positive self-states. In the best scenario, when survivors' thinking is relatively preserved both strategies must be used. In cases of more severe brain damage, when the thinking machinery is largely impaired, facilitating the engagement in positive activities may be the best choice. However, a word of warning, do not take this prescription rigidly. Even in cases of severe brain damage, meaning making may be necessary. Perhaps not in the form of counselling or psychological support, but simply as statements that can be regularly offered by professionals to patients, in order to assist them in making sense out of what happens inside them or around them.

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