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Foreword



Mindfulness: The Heart of Rehabilitation

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This volume presents the work and insights of many prominent and dedicated proponents of complementary and alternative therapeutic approaches in rehabilitation medicine, as well as their visions of the future in this rapidly growing field. It is in large measure a product of the abiding vision and passion of the editor, Dr. Eric Leskowitz. Dr. Leskowitz and I have had numerous conversations about developmental trends in this field, and I am delighted to have been asked to write the foreword to this seminal text, which appears at a critical moment in the emergence of the medicine of the twenty-first century.

Dr. Leskowitz and I share a passion for the origins of words. He encouraged me to base this foreword on some of my own investigations and experiences regarding the very words we use to name the work we

do, and how such an inquiry might expand the boundaries of our understanding of the scope of the possible in rehabilitation medicine.

In my experience, it can be illuminating to ponder the origins of those words that name our professional fields of endeavor and calling. Doing so sometimes reveals novel dimensions of meaning and potentially relevant interconnections that may ordinarily go unnoticed or unexamined. For instance, in the nascent field of mind/body medicine, I find it intriguing that the words *meditation* and *medicine*, which are clearly related by superficial inspection, share the same root meaning of "right inward measure" or "wholeness."¹ From this perspective, medicine is the attempt to restore right inward measure when it is disturbed or compromised, and meditation can be thought of as the direct

perception or realization of right inward measure. In seeing such a link, new avenues of thought and investigation may open up that can give rise to novel insights and practical clinical and teaching applications, as well as to fresh ways of reconceptualizing the growing edges of a rapidly changing field.

Thus it was natural to pursue the origin of the word "rehabilitation" some years ago when Dr. Leskowitz invited me to speak at a symposium he organized at the Spaulding Rehabilitation Hospital on CAM in rehabilitation. I consulted the Appendix of *Indo-European Roots*² in the *American Heritage Dictionary of the English Language* in part to follow up on a hunch that the word seemed to contain two French verbs: "habiter" (to live in, to inhabit, to dwell) and "habilitier" (to qualify, to enable). As it turns out, there is an interesting and telling association that may be of considerable relevance to those of us who work in rehabilitation.

The first meaning of *rehabilitation* is given as: "to restore to good health or useful life, as through therapy and education." This is the meaning we all commonly think of and the usage we conventionally employ in our discourse, based on the Latin "re" + "habilitare," to enable, thus to re-enable, make well again, to restore to a former state or capacity.

If, however, one probes a little deeper, following the suggestion to "*see HABILITATE*," one notices immediately that this word is situated among a bevy of words: *habile*, *habilitment*, *habit*, *habitable*, *habitant*, *habitat*, *habitation* that all derive from the deep Indo-European root, *ghabh-e*, and its core meaning: to give or receive. Here, we discover that the English words *able* and *inhabit*, among many others, are indeed linked. Rehabilitation carries deep in its core not only the meaning "to re-enable" but also (and tellingly) "to re-inhabit." Rehabilitation is thus a process of learning how to reinhabit one's life and body, a process that can be furthered by various therapies, as well as education, as noted in the first definition, but which is ultimately one of interior ^{1,2} ~~space~~ felt, lived, and embodied experience.^{3,4} After all, we grow into a dwelling and it grows on us over time, like our clothes, which is another meaning (*habillier*) from the same root.

And this is where the giving and receiving comes in.* One cannot truly inhabit a space without *giving* one's self over to it—to the light, shadows, colors,

sounds, layout of the rooms, texture of the space, to what the Chinese call its "feng shui"—touching it through our senses and through our awareness and in this way, *receiving* its unique qualities. It takes time for us to "feel" our way into a new home, to sense its energies and how they might be worked with and modulated. That happens through just such a reciprocal process of giving and receiving, of dwelling in and honoring our senses and sense impressions.⁵

The revelation of "to learn to live or dwell inside again" reminds us that rehabilitation from injury, trauma, disease, or insult of any kind involves a kind of learning, a "moving in" to, a taking up residence in dimensions of one's life, one's body, and one's being, dimensions that may—whether we like it or not, or wanted it or not—now need to be rediscovered or perhaps, in some cases, encountered for the first time if one hopes to heal and recover optimally. We feel our way, working at the edges of how we find things in this moment, exploring our boundaries, giving ourselves over to our attempts, and listening carefully for and receiving the feedback from foot, or leg, or hip, or heart, or lungs, or mind. We learn as we go, by seeing how our efforts and expectations (predictions) accord with the feedback the body (and mind) give us and by then making appropriate adjustments in our efforts and attitudes and beginning again. Out of this often slow and sometimes painful process comes the re-enabling, the recovery of whatever degree of capacity might be realizable, moving toward a limit that usually remains unknown and mysterious.

Rehab professionals are continually surprised at what people are capable of and by how the body and mind can sometimes respond to a strong determination to take up residence again and to work with self-compassion and gentleness at the boundaries of what one can and cannot do at any given moment, even in the face of what may sometimes seem like insurmountable obstacles or challenges. This interface is where the learning takes place, and the growing into oneself, as one feels one's way into what will be inevitably and to a large degree a new territory within one's own interior landscape of being.

Note that the root meaning of "to learn to live inside again" carries a strong energy of agency. It is the person himself or herself who is taking up residence again and going through the learning process, not the physician or the therapist. The terrain of this learning process is the inner landscape of the body and the

*I am indebted to Barbara Gates, editor of *Inquiring Mind*, Berkeley, Calif, for this insight.

mind, one's entire sense of self, and thus includes whatever we mean when we speak of heart and soul, and spirit, the reflections of our completeness and interconnectedness as a human being, as a person, our *right inward measure*.

This sense of personal agency and interiority on the part of the patient is not so much in evidence in the more conventional definition of *rehabilitation*, which emphasizes the perspective of the support system that is assisting in the re-enabling by providing the therapies and the context in which the work and the learning can unfold. Yet we all know that both outer and inner agency are vital for true and full rehabilitation to take place. The person who is patient needs the help of a very special holding environment, a setting in which well-chosen and well-monitored treatment programs and therapies can take place, and in which the staff can provide technical expertise, ongoing emotional support, counseling, and encouragement. Such an environment serves as the crucible in which the outer and inner work and the learning can begin and then unfold over time. But optimal rehabilitation also clearly requires the full engagement of the patient as a participant in the process of this intimate giving and receiving. It is after all the person himself or herself who is moving in and who will have to engage directly with whatever heat is generated in the crucible in the slow and sometimes long-term process of taking up residence once again in one's body, as it is in any given moment and in one's life.

The richness of meaning embedded within the word *rehabilitation* invites us to be exquisitely sensitive to both the outer and the inner domains in which the work of rehabilitation unfolds, their intimate reciprocal interconnectedness, and to the various roles that health professionals and patients are called to in furthering that work and optimizing potential outcomes. "Learning to live inside again" necessitates a high degree of focused and sustained attention and awareness rooted in the present moment, as well as a high degree of sensitivity to boundaries and limits and a willingness to dwell at them, *inhabit them*, in inner stillness, beyond the reactivity of thought and judgment but with great discernment and intentionality. This embodied attention, this consciousness *in* the body, this willingness to work at the boundaries of what one finds in this moment when one looks and then makes an intentional effort to be with, accept, and work with things as they are is a condition of body and mind known as *mindfulness*.⁶

If rehabilitation is above all a participatory process that involves mobilizing the full repertoire of inner and outer resources of the individual patient for the learning, growing, healing, and transformation, that, over time, comprise the experience of "giving and receiving" and "living inside again," then mindfulness and its embodiment from moment to moment might be said to constitute the heart of rehabilitation. By the same token, the process of rehabilitation also requires a high degree of mindfulness on the part of rehabilitation professionals in the sense of a continual keeping in mind what the interior and exterior contexts of the therapies involve, a sensitivity to the sacred trust of the relationship with the patient (who is often in a state of high vulnerability), and a continual titrating of the treatment protocol to the changing status of the patient.⁷ And what is that relationship if not a compassionate and embodied engagement in giving and receiving on the part of rehabilitation professionals?

To frame mindfulness as a participatory process in more concrete terms, consider the ways it has been integrated into medicine at the University of Massachusetts Medical School. The medical patients who participate in the Department of Medicine's Stress Reduction Clinic are all engaged in learning, to one degree or another, to inhabit their lives and their bodies anew, whether they are traditionally classified as rehabilitation patients (i.e., suffering from chronic pain conditions, heart conditions, lung conditions, and so on) or not. In this case, the rehabilitation is catalyzed through intensive training in and practice of formal and informal mindfulness meditation (including mindful hatha yoga, which is a rich and gentle meditative discipline of mind/body interiority and exploration) and their applications to the situations and circumstances in which the patients find themselves in their daily lives.^{8,9,10} Mindfulness practices have been integrated to varying degrees into the standard cardiac and pulmonary rehabilitation programs in our hospital as well. From the perspective of the consciousness disciplines,¹¹ such as meditation, tai chi, qigong, and yoga, we may all—patients and professionals alike—suffer from a lack of intimacy with our experience of the present moment and would stand to benefit significantly from learning to live inside again. A rough but accurate paraphrasing of a line in James Joyce's *Dubliners* makes the point and seems sadly to have quasi-universal applicability: "Mr. Duffy lived a short distance from his body."

With a recalibrated perspective on rehabilitation from our etymological exploration, it becomes clear than there may be many valid pathways to effect the learning to live inside again. These pathways include those that emphasize what the patient can do for himself or herself (with appropriate and on-going support, training, and classes), such as meditation, exercise, yoga, tai chi, physical therapy, occupational therapy, biofeedback, stress reduction, and those that require direct treatment (and/or prescription) from skilled therapists and physicians, such as chiropractic, massage, craniosacral therapy, acupuncture, or naturopathy.

This book addresses a major need on the part of practitioners, patients, and students alike to have together in one place comprehensive expertise on the vast range of so-called complementary and alternative practices and approaches currently finding their way into use and investigation in the field of rehabilitation. It appears at a time in which all of medicine is experiencing a rising tide of consumer and physician interest in alternative approaches and its massive economic implications for health care.^{12,13} Ultimately, as has been observed many times in recent years,^{14,15} the terms *complementary* and *alternative* are likely to dissolve in the face of new research results and clinical experience, and we will have a larger, evidence-based *integrative rehabilitation*, part of the larger phenomenon of an expanded-modality, evidence-based *integrative medicine* that is currently developing. Beyond that, we may be able at some point to drop the term *integrative* and just have these approaches be an intimate and common-sense part of medicine, *good medicine*, and of rehabilitation, *good rehabilitation*.

This unique volume in the series, *Medical Guides to Complementary & Alternative Medicine*, is likely to be an important catalyst in that unfolding. The visionary editorial leadership of Dr. Leskowitz has gathered together an impressive array of experts across a broad spectrum of disciplines, many of which are not commonly integrated within mainstream medicine and rehabilitation at this particular moment in time. The result is a forward-looking and valuable resource for evaluating what is known about specific interventions and therapies and how

they might be utilized when appropriate to meet the profound and multidimensional needs of the specific individual rehabilitation patient and further his or her returning to a fuller, healthier life. Many people, professionals and patients alike, for years to come, will be the beneficiaries of this pioneering contribution.

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