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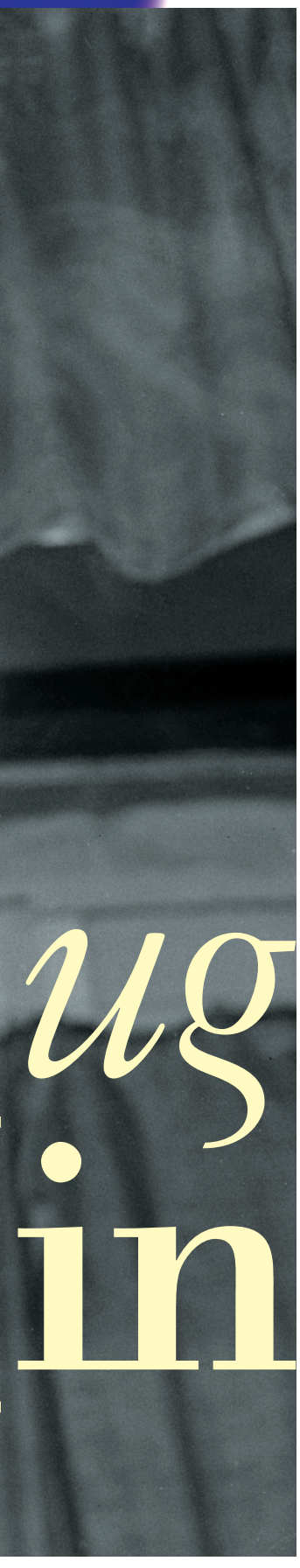

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by

MICHAEL YAPKO

IF YOU TALK TO MINDFULNESS practitioners about the similarities between guided mindfulness meditation and hypnosis, they tend to react with various degrees of indignation, if not downright revulsion, as if to say, "Don't get that icky hypnosis all over my nice mindfulness!" Mindfulness practice, they aver, is rooted in the ancient wisdom traditions of the East, dedicated to developing self-understanding, serene acceptance of life's trials, and spiritual growth. Free of religious dogma or orthodoxy, presumably it imposes nothing, but simply elicits an inner "awakening" of people's "true selves" and helps them "cultivate compassion," "awaken from the trance of unworthiness," and, of course, "attain enlightenment." Who *wouldn't* want to experience these lofty states of mind? ■ Hypnosis, by contrast, is commonly

AWAKENING THE HYPNOTIST WITHIN

considered a crass theatrical stunt—an occasion for a hypnotist to exert mind control over a passive subject. In this distorted view, hypnotists impose their will on easily led people, as epitomized in a cheesy Las Vegas stage show where the slick, manipulative hypnotist makes a row of volunteers believe and act as if they were playing musical instruments or pantomime over-the-top lascivious behavior. If mindfulness is symbolized by the Buddha, his soft gaze turned down in serene contemplation, hypnosis is too often represented by Svengali, *his* fierce eyes fixed on his prey.

But a closer look at the processes, goals, and outcomes of both mindfulness and hypnotism reveals that they share fundamental similarities of purpose and practical knowledge. Within the framework of a trusting therapeutic relationship, attuned therapists now regularly employ Guided Mindfulness Meditation (GMM) in the same way I was trained to use clinical hypnosis. Today's mindfulness-oriented therapists, like clinicians practicing hypnosis, teach clients self-regulation strategies, such as how to use their breath and employ guided imagery to shift attention and experience the deep power of accepting what's unchangeable or inevitable.

As mindfulness methods have come to assume a more prominent role in mainstream clinical practice, the common mechanisms that underlie the efficacy of both GMM and hypnosis have become more apparent. To begin with, both involve two people: a guide, teacher, or therapist, who uses suggestion to focus then alter the awareness—cognitive, sensory, relational, and emotional—of a client or student, thereby promoting experiential learning. These alterations in awareness may give rise to dramatic and seemingly spontaneous shifts in perspective and even profound personal transformation as one's self-definition expands. They may also yield what pioneering hypnosis researchers Theodore Sarbin and Ernest Hilgard called "believed-in imagination." In fact, the science of clinical hypnosis is highly relevant to understanding how the methods of mindfulness may have even greater impact when used in a psychotherapeutic context.

GMM practitioners could significantly improve their clinical work and produce more focused and effective interventions if they drew upon the findings reported in thousands of studies already done by hypnosis researchers about the many complex personal and interpersonal factors influencing people's ability to respond meaningfully to suggestion. But to do so, they first need to strip away the philosophical abstractions, Eastern mystical spirituality, and romantic exoticism that currently infuses the entire discussion of mindfulness. They'd be advised to start by considering some basic clinical questions they generally don't yet ask: What differences are there between mindfulness employed primarily as a spiritual quest and that applied for therapeutic purposes? What role do the therapeutic alliance, client expectations, and therapist's suggestions play in conducting GMM? How do we determine who's most and least likely to benefit from such experiential methods? How can we best adapt mindfulness methods to meet the needs of specific clients?

Spiritual Practice *Isn't* Clinical Intervention

It seems likely that, barring a few spiritual geniuses (Buddha being one), almost nobody really learns mindfulness alone, in a vacuum. Mindfulness requires a *teacher*, to provide explicit instruction, encouragement, and leadership, within the context of a trusting relationship. The failure to see the fundamental similarities between GMM and hypnosis stems from the tendency to regard all mindfulness practice—guided or otherwise—as entirely a solitary spiritual practice, undertaken by one person meditating alone, seeking capital-T Truth. In contrast, hypnosis is seen as a kind of indoctrination—an induction into mindlessness too often carried out by quacks with control issues.

Of course, most therapy clients don't learn mindfulness because they desire spiritual transcendence. Instead, they find themselves trying meditation for more immediate reasons: freedom from pain, depression, crippling phobias, or addictions. Would client X *ever* have gone to an integrative medicine center to learn how to meditate if he

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hadn't been diagnosed with cancer, suffered great pain, and become desperate enough to try almost anything? Would client Y be practicing mindfulness if she'd been able to resolve her eating disorder or depression through ordinary therapy, medications, or any other mainstream solution? It follows that since the two typical reasons for learning mindfulness—as a spiritual pursuit or a clinical treatment—are different, the intentions for using them and methodology followed also should be different. These differences should be well understood by the clinician and clearly articulated to the client.

Therapists who view mindfulness as a private pursuit of deeper awareness tend to remove themselves from the equation, considering themselves "only" guides, as if they were doing nothing more than handing out an instruction sheet. But, what, exactly, does it mean to be a guide, and how does guidance in the form of GMMs in therapy influence the client's phenomenology and associated clinical outcomes? If mindfulness is to progress as a clinical tool, we need to better understand how it works: how the guide structures and delivers the words to cause meaningful subjective but nonvolitional experiences, such as acceptance and compassion. To do that means acknowledging the powerful role of suggestion in encouraging attention and stimulating (priming) unconscious processes. This is the domain of clinical hypnosis, and the research and methods found there warrant every clinician's serious study.

Like students of mindfulness who may meditate and spontaneously "cultivate equanimity" or have profound feelings of spiritual transcendence, people in hypnosis routinely experience dramatic suggested effects that defy logic: being able to stem bleeding from the site of a wound, having a "felt sense" of being with someone long deceased (whether a relative or the Buddha), feeling a vital connection to "the inner sage." Such remarkable experiences illustrate clearly the measurable shifts in physiology, relationship, cognition, affect, and spirit that can arise through hypnotic experiences. These dramatic effects are far better understood in social-psychological terms as the products of suggestion within a shared perceptual framework than as the spontaneous bubbling up of spiritual "truths" in therapy.

When a clinician conducts a GMM, it's self-deception to believe he or she isn't the one conducting the session and serving as the catalyst for what transpires. It's deceitful to suggest to clients that it's entirely up to them how many steps along the "path to enlightenment" (or "wellness") they take, as if the clinician's guidance and the quality of their therapeutic alliance weren't vital to what happens. Therapy is a shared, goal-oriented process, and both clinicians and clients inevitably contribute to the outcome.

The Power of Suggestion

Nevertheless, the very idea that GMM, just like hypnosis, incorporates active, directed suggestion to a client by the therapist strikes many mindfulness practitioners as tantamount to heresy, a betrayal of the "purity" of the practice itself. Mindfulness is typically introduced in the context of a therapeutic relationship by a clinician convinced of its merits, who directly says to the distressed client that "this will help," and then begins the experience by conducting a guided mindfulness meditation. The GMM attempts to engage the client's attention and help him or her focus on certain suggested experiences, whether they involve breathing, scanning the body, meditating on acceptance, awakening to the truth, or cultivating compassion. Finally, the point is made, either implicitly or explicitly, that this experience will have some lasting impact on the client's well-being and that repeated practice will facilitate the desired effects. Is there any part of this process that does *not* rely on the use of suggestion to attain therapeutic results?

To acknowledge the inevitable role of suggestion in mindfulness is to acknowledge the principles and methods of clinical hypnosis. Hypnosis encompasses the study of how to compose and deliver suggestions that engage the client's attention, foster a deep experiential absorption, and "spontaneously" elicit different kinds of empowering subjective experiences, such as analgesia or anesthesia for pain management or increased bodily and sensory awareness. Hypnosis, like mindfulness, encourages awareness and acceptance, especially an awareness of the personal resources one can bring to bear on a situation. Virtually all of the modern neuroscience of clinical hypnosis, like that of mindfulness, focuses on attentional processes and directing focused attention in clinically useful ways. When a mindfulness practitioner talks about "attention without intention" and tells the client to "let go of goals" and "stop being a human *doing* and instead be a human *being*," he or she is paradoxically suggesting a new goal of having no goals. Whatever the client's experience from either GMM or hypnosis, the therapist's actively directed suggestions lead the way. If mindfulness-oriented clinicians want to be effective in the work they do, it's important that they strive to better understand how their methods—their suggestions—are structured and delivered, and discover what role the quality of their suggestions plays in the clinical results they obtain.

Clinicians also need to ask tougher questions. What, actually, are the differences, if any, between mindfulness and clinical hypnosis? We know that the neuroscience of mindfulness and hypnosis is parallel, causing changes in brain activation of the same magnitude. Both feature cortical inhibition as revealed by slowed EEG theta waves, and both show higher levels of activity in areas where theta is prominent, such as the frontal cortex and especially the anterior cingulated cortex. But it's still too early to draw many conclusions about the meaning of such neural activities.

To highlight impressive brain changes presumably justifying mindfulness meditation, some neuroscientists identify a much-touted thickening of the cortex following repeated meditation. But what's the evidence that a thicker cortex actually makes for a smarter, happier, better, more effective human being? None yet! What does it indicate that some research suggests a thicker cortex may be associated with autism? The fact that experience, including

meditative and self-hypnotic experience, changes brains in measurable ways is fascinating, but it raises far more questions than answers about the psychological impact of these changes.

More important to the understanding of mindfulness and hypnosis, though, is the evidence that what a brain scan reveals depends on what the client is being asked to do. GMMs typically have different focal points associated with them than do hypnosis sessions. In fact, it may be that all that differs between GMM and hypnosis is what the person focuses on and how that focused mind-state is used. The effects of suggesting global and spiritual experiences to people—feelings of acceptance, forgiveness, or overall serenity—will be quite different to those of providing clients with specific ways to accomplish a particular goal, such as overcoming depression or anxiety. Clinical hypnosis is openly and unapologetically goal-oriented, while GMM is equally goal-oriented, but its practitioners are still uncomfortable defining themselves as such.

The similarities of clinical hypnosis and GMM are stronger by far than their differences. The methods of both stimulate unconscious processes that produce automatic or nonvoluntary, but meaningful and helpful, responses—even though GMM practitioners may not use this language to describe what they do. How are these "spontaneous transformations" accomplished? Mindfulness practitioners will typically respond with a global answer of an "awakening" or a spiritual answer of "enlightenment." However, a more realistic answer is to be found in the neuroscience of attention and, more specifically, in the capacity to influence unconscious processes in dissociated states.

Dissociation: The Driving Force

Both GMM and clinical hypnosis use suggestive methods to elicit beneficial, nonvoluntary responses—suspension or amelioration of pain, "spontaneous" feelings of compassion, acceptance, or transcendence, and so on—that can't simply be willed. During a course of meditation, a wide range of responses can seem to arise as if from nowhere.

For example, a mindfulness practitioner has the client focus on her breath by suggesting that she "become aware of the breath, the rise and fall of the chest, the warm or cool temperature of the air," and the client's breathing may slow down, even though the practitioner hasn't suggested that she slow her breathing down. The client says it "just happened." Similarly, a person undergoing GMM reports an "amazing transformation of my anger to forgiveness" or proclaims "my self-hatred turned to self-love." These aren't responses you can consciously generate on demand. They're nonvolitional but subjectively powerful. It's not surprising that a client will have the feeling that something "magical" just happened.

What may seem magical to people who haven't analyzed this phenomenon in depth is actually one of the most intensively studied aspects of clinical hypnosis. People can have dramatic sessions in a wide variety of ways, and these can have powerful enduring effects. One of the most common observations documented in the hypnosis literature is how a new perceptual or behavioral response can be readily absorbed and then repeatedly acted upon for a time span ranging from a short while to an entire life—even on the basis of a *single* hypnotic experience.

Even more intriguing, during hypnosis, people are typically fully aware

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of the suggestions being given them and their responses to the suggestions. But they're not aware of how they're able to respond nonvolitionally—how they're able to develop pain-relieving numbness in a limb, for instance. Understandably, this gives many the feeling that something remarkable "touched their soul," outside the context of the hypnotic relationship. The same thing happens with GMM, during which people may be aware of and respond powerfully to suggestions for "loving-kindness," for instance, but have no idea *how* they did so. So, they feel that "something amazing happened!" It's curious and puzzling to observe such responses; it's hard to try to explain them. What about the unconscious allows automaticity of responses—responses that seemingly "just happen" involuntarily, outside of or beyond our willed control, as a result of well-crafted suggestions from the therapist or guide?

A key to how this may occur can be found in the phenomenon of dissociation, which, simply defined, involves breaking a global, multifaceted emotional, sensory, and/or cognitive experience into its component parts. As soon as you suggest to someone that she focus on some specific stimulus, or experience a sense of detachment from some thought or feeling, you're directly and indirectly suggesting dissociation—drawing her attention to this aspect of the experience, functionally separating it from the rest. When people speak about "parts" of themselves, as when someone says, "My head tells me this, but my heart tells me that," or "Part of me cares, and the rest of me couldn't care less," they're using the language—and suggested subjective reality—of dissociation.

During the experience of hypnosis, dissociation becomes especially evident when people respond nonvolitionally, that is, without conscious effort, to a suggestion. For example, a clinician might suggest a feeling of lightness or warmth in the client's body, and that the client allow this experience to develop. Without being aware of expending any effort to respond, the client readily experiences lightness or warmth that seems to "just happen." Typically, the first time a client has this kind of dissociative experience, he or she is truly amazed. Beyond suggestions for automatic or nonvolitional sensory experiences, one can just as readily suggest emotional experiences, a procedure in hypnosis known as the "induction of affect." In this way, hypnosis commonly connects people to feelings of love or compassion, forgiveness or equanimity, hopefulness or firm resolve, and curiosity or resourcefulness, which seem genuine and spontaneous to the subject. While identifying these emotional experiences as effects of suggestion and dissociation rather than signs of profound awakening may remove the aura of spirituality, the beneficial therapeutic impact is the same.

In GMM, dissociation similarly becomes evident when people can separate themselves from their usual frames of reference. When someone drifts off into serenity through a narrowed focus on just the physical experience of breathing, the accompanying sense of depersonalization can be a beneficial dissociative response. The ability to detach oneself from one's thoughts—externalizing angry or self-destructive thoughts by seeing them, for example, simply as "clouds passing in the sky"—has great therapeutic potential as a critical step in building impulse control, frustration tolerance, and reality-testing skills.

Which of the many elements of experience we pay attention to at any given time—whether during a party, for example, we focus on our curiosity about other people, rather than on what we believe is our social awkwardness—can make an enormous difference in the quality of the overall experience and the lessons we draw from it. In both GMM and clinical hypnosis sessions, we deliberately shift the quality and direction of focus from self-limiting to expansive elements of experience to relieve emotional or physical pain. A client burdened with multiple anxieties can't solve all his problems in a day, or even in a year. Worrying about solving problems just exacerbates the anxiety, but if that client can just focus on his breathing, and thereby discover an ever-present means of emotional self-regulation, chances are his overriding sense of dread and doom will lift and he'll get some relief. Similarly, suggesting to a highly self-critical perfectionist that she focus on a message of loving-kindness to herself may, over time, help her recognize she's much more than just her imperfections, and thereby expand her harsh self-definition to be able to accept herself and find more comfort in her own skin.

Hypnosis by Any Other Name

The point is that whether these states of what we might call therapeutic dissociation and depersonalization result from clinical hypnosis or GMM, they're achieved via similar, if not identical, consciousness-shaping mechanisms and procedures. Since, as clinicians, we're supposed to do more than just stumble blindly forward with our clients on instinct alone, it behooves us to *know* what we're doing and why—what mechanisms and procedures we use to get what effects. The wording of suggestions and the range and quality of their impact on subjective experiences like insight and "transcendence" have been studied and distilled for decades in the well-established literature of clinical hypnosis. We don't have to attribute therapeutic gains to abstract awakenings when we can credibly predict them from the nature of our suggestions and the social psychology of the interaction.

As an example of this suggestive structure, let's consider the guided meditation conducted by Jon Kabat-Zinn, famous for helping bring mindfulness into the mainstream of Western medicine and society, during a 2007 presentation he gave at Google. (The entire presentation, guided meditation included, is easily accessed on YouTube: www.youtube.com.)

Stage 1: Preparing the Client

In his psychoeducational preface about the benefits of meditation, Kabat-Zinn told the audience that we have a "Stone Age mind in a digital world," which "works against creativity." Since this language was sure to appeal to Google employees, who are dedicated to becoming more creative in the digital world, he suggested a strong motivation

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to the audience for taking up mindfulness meditation. He prepared them for the experience by saying, "So, let's see if we can tune in to now for no other reason than just for fun, . . . not to get anywhere, [or] to be more relaxed, [or] to become a great meditator, [or] to break through some problems that you're having, . . . but to see if you can hold this moment in awareness."

Stage 2: Orienting the Client

Kabat-Zinn introduced the term *proprioception*—defined as the unconscious perception of movement and spatial orientation arising from stimuli within the body itself—as a scientific frame for the automaticity of perception and bodily functions like breathing. This oriented his audience to the credible idea that important bodily responses can arise effortlessly, without conscious involvement. He said, "If breathing depended upon the conscious mind, . . . we'd all be dead already—'Well, I got busy, forgot, oh yeah, I'm supposed to breathe.' Luckily . . . the design of the nervous system is much too clever to leave that to conscious control. . . . What's being suggested is, [let's] see if we can drop in on the sensations of breathing without fiddling with the breathing at all. It knows how to do it really well, much better than you."

Stage 3: Focusing Attention

The focus then shifted from the general orientation and rationale for the session to a narrowing of attention on the breath. Selective attention gives rise to dissociation and is essential to activating any experiential processes. He directly suggested how to sit and then employed metaphor when he said, "So see if you can just feel yourself breathing. . . . Sit [in an] elevated and erect position that embodies dignity . . . [to] meet this moment in its fullness with alertness. . . . Let's see if we can feel the breath, not think about the breath . . . moving in and out of the body as if we were approaching a shy animal sunning itself on a tree stump in a clearing in a forest. We want to approach [it] gently."

Stage 4: Building a Response Set

The purpose of the response set is to increase responsiveness as the experiential process unfolds over time. In this phase, suggestions are offered to intensify focus and deepen absorption in the process. For this purpose, Kabat-Zinn said, "If you'd like to concentrate more, focus on the abdomen or wherever the sensations are most vivid, I invite you to close your eyes if you care to . . . and just ride; surf the feeling, the sensations of the breath moving in and out of your body, moment by moment by moment, . . . and let everything else going on in the mind, in the room—sounds, everything—just be in the wings."

Stage 5: Offering Therapeutic Suggestions

Kabat-Zinn reassuringly suggested that for meditation beginners, or even for practitioners of 50 years or more, the mind will naturally wander; the goal is to come "back to the breath over and over again." He explicitly stated that the goal of the session was to teach the value of awareness in the moment and the importance of holding on to that awareness across life experiences. "It's not like you'll make a bad meditator because your mind is unruly. This is the nature of the mind. . . . It's just like the Pacific Ocean at its most tumultuous. . . . If you learn to drop down 20, 30 feet under the water, there's just gentle calmness, . . . and it's the same with the mind. The surface of the mind can be very agitated, embroiled in thought and emotion, but awareness itself is like the depths."

Stage 6: Generalization

The goal at this stage is to help make the response available in other life contexts. At this point in the process, Kabat-Zinn had already encouraged a focused awareness on breathing, an appreciation for the inevitability of mindlessness and the value of mindfulness, an orientation toward finding comfort in the depth of oneself, and a sense of gentle compassion toward the self. How did he use suggestion to encourage people to integrate these new awarenesses into their lives? He said, "If [the mind] wanders 10,000 times, you know what's on your mind 10,000 times, and without judging condemning, forcing, blaming, just come back to this moment, this breath . . . with a certain kind of tenderness as a radical act of love and kindness just toward yourself . . . wherever you are. . . . And the meditation practice winds up doing *you* much more than you're doing the meditation practice, and the world and everybody and everything becomes your teacher."

Stage 7: Ending the Experiential Session

In this last stage of the process, Kabat-Zinn used permissive suggestions to bring people back to a more externally oriented awareness of themselves and the immediacy of the context. He said that the formal experience might be over, but striving for awareness could be a lifelong commitment. He rang a meditation bell and continued, "Now I'd like to invite you, if your eyes are closed, to allow your eyes to open . . . while maintaining the same quality of awareness, . . . even as you turn your head or shift your body or stretch. . . . So although the formal meditation practice in some sense comes to an end, and has to, the real meditation practice never comes to an end; it's your life. . . . It's no more at an end than your breathing."

In conducting this GMM, Kabat-Zinn offered many different suggestions about how attendees could think of themselves and their experience, starting with how to sit and ending with when to open their eyes. When he suggested different levels of experience, specifically the surface of the mind versus the depths of awareness, building on the earlier notion that the conscious mind is quite limited, he referred, of course, to the relevant attributes of the unconscious. These include the abilities to process information on multiple levels, develop new awarenesses and behavioral responses automatically, and respond to familiar challenges in new and creative ways. All in all, I'd have to say that although Jon Kabat-Zinn may not yet know it, he's already a skilled practitioner of clinical hypnosis!

Unintentional Intentions

When someone uses suggestion without realizing it, how can the suggestion be focused yet flexible enough to be adapted by different individuals who each have differing capacities for attention and response? When one uses suggestive strategies to elicit highly subjective experiences that necessarily involve dissociation and other hypnotic phenomena (such as *time distortion* in order to "hold this moment in awareness" or "sense the timelessness of this moment," *sensory alteration* in order to "just ride; surf the feeling the sensations of the breath," or positive *hallucination* in order to see and experience a "shy animal sunning itself on a tree stump"), how can these techniques be used deliberately and skillfully if one isn't even aware of employing them? In Kabat-Zinn's guided meditation, his suggestions for eliciting these phenomena were general in nature, direct in structure, and given permissively in style. Might his suggestions have had greater impact if they were offered in other structures and another style? Could the responses have been fuller if he'd known what responses he was suggesting instead of suggesting them unintentionally? The hypnosis literature says yes.

The field of clinical hypnosis has studied intensively individuals' abilities to become absorbed in and responsive to the guidance (suggestions) of another. The findings are unequivocal: people differ widely in their capacities to focus attention and generate nonvolitional responses. How then does a mindfulness practitioner determine who is and who isn't likely to respond well to such experiential processes? Should it just be assumed that everyone is capable to the same extent? Is telling people to "just practice harder" enough to enhance responsiveness? The research in hypnosis addresses this subject in depth and offers many insights into the nature of hypnotic responsiveness and the variable effects of practice over time. Studying the gifted meditators and discovering their presumably desirable thicker cortices offers no evidence that nongifted meditators, or those whose meditations are limited in time and frequency, will achieve anything close to the same.

Successfully adapting the delivery of hypnosis or guided meditations to the uniqueness of the particular client requires many skills, including the ability to observe and accurately determine someone's information-processing style and tailor the wording of the message or suggestion to fit that style. To be more effective, you must throw away the script, acknowledge in experiential terms the uniqueness of your client, and adapt your methods to those individual differences. No matter how many times you conduct a scripted GMM body scan or an awareness exercise, you'll always be conducting a standardized procedure on people who respond idiosyncratically.

The field of hypnosis has examined the role of dissociation in generating nonvolitional responses, such as those that spontaneously arise during the course of a guided meditation. These are the hypnotic phenomena of *age regression* (the experiential utilization of memory), *age progression* (the experiential utilization of expectancy), *analgesia* (the capacity to reduce sensation selectively), *catalepsy* (the inhibition of voluntary movement), *positive and negative hallucinations* (having sensory experiences with no external cause, or not having sensory experiences despite the presence of a stimulus), *time distortion* (the constriction or expansion of one's subjective sense of time), and other marked perceptual shifts that highlight how malleable subjective perceptions can be. These capacities for transforming perception are amplified during experiences of mindfulness and hypnosis, making it necessary to be exceptionally clear about what one is suggesting and why. Global explanations of "an awakening" or "becoming mindful" seem poor substitutes for an in-depth knowledge of the interface between receptive, dissociative, focused states and suggestions—for hypnotic phenomena disguised as "sacred meditations."

When people don't understand the mechanism behind something that seems extraordinary, they can too easily conclude it's magic or divinely inspired. Even those practitioners of hypnosis who aren't well grounded in the science of hypnosis can resort to global philosophies such as "trust your unconscious to know the meaning of the metaphor" or "trust your unconscious to know what to do when the time is right." When people don't recognize their participation in co-creating some experience, they may conclude it's the "inner sage" or "the Buddha within," and have little or no insight about the role suggestion played in eliciting the hypnotic phenomenon that seemed so unexpected.

Clinicians who use guided mindful meditations need to become more aware of what they're doing, how and why these experiential processes work, and how they can improve their own practice of these powerful methods. The field of clinical hypnosis has gone far in explaining the key structural factors underlying GMM and hypnosis: the skilled application of suggestions to a client who is in an attentive and receptive dissociated state. Understanding this can benefit not only mindfulness practitioners, but therapists and even other health care professionals. After all, every therapeutic intervention you can name, whether medical or psychological, will necessarily involve some degree of skilled—and suggestive—communication with an individual within the context of a therapeutic alliance.

Key points to remember regarding the process of suggestion are:

- Dissociation is critical to developing positive automatic responses that foster greater self-trust and greater emotional regulation. As neuroscientists focus on the nature of attention, they commonly describe different but related attentional subsystems in the brain. The most salient point is that attention isn't a singular mechanism—it's comprised of multiple, interactive conscious and unconscious processes. Different qualities of attention will be elicited by different qualities of suggestion. It's interesting, but hardly surprising, to discover from neuroscience that different areas of the brain regulate the different types of attention. Thus, it's predictable that there are differences in brain activity across different types of suggestive experiences.
- When you conduct experiential processes, you can't avoid giving suggestions.

This means that whatever comes up for a person during a session is, at least in part, your co-creation. The study of hypnosis indicates that what generates an effect isn't only what you say: it's also what you imply. Your influence on the client is inevitable. The science and art of suggestion, or hypnosis, is found in learning to use that influence skillfully and benevolently.

■ All people are different, and not equally capable of focused attention, dissociation, and mindfulness. If you wish to enhance your effectiveness with a broader range of clients, you can't use the same techniques and wording with everyone. Many people who find it hard to "focus on the breath" or do a "body scan" might do well with another approach tailored to their personal style.

Years ago, when psychologist Neil Jacobson asked, "What is it about cognitive-behavioral therapy (CBT) that works?" his research suggested it was much less correcting cognitive distortions than *behavioral activation*—the action-orientation of CBT interventions—that helps mobilize the immobile. The fact that mindfulness works isn't in question today. But does it work in the way advocates have suggested?

There's a popular television commercial for an automobile in which a young boy dressed as Darth Vader walks through his house with arms outstretched trying to muster The Force in order to get an exercise bike to turn on, his resting dog to stand, the washing machine to turn on, a doll to speak, and a sandwich plate to slide over to him. Naturally, he fails in each instance. Then, when his father pulls into the driveway in the new car, he rushes outside to channel The Force into starting the car. Much to his surprise, the car turns on! His mother and father are quite amused watching his amazement, because Dad used his new car's remote to turn the car on from inside the house.

In its own way, mindfulness also posits something like The Force—a mysterious, hidden, often spiritual source of energy; a kind of otherworldly magic that can grant profound gifts to those who are successful at eliciting it from the hoary depths. In fact, we'd understand mindfulness phenomena much better if we'd study the empirically demonstrated mechanisms of clinical hypnosis—a quite this-worldly form of "remote control." ■

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