MINDFULNESS AND THE MINDFUL THERAPIST: POSSIBLE CONTRIBUTIONS TO HYPNOSIS

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Abstract

Mindfulness, an old Buddhist practice, has gained an importance in psychotherapy such as in Hakomi, cognitive therapy or in ‘Mindfulness-Based Stress Reduction’.

Mindfulness is described as being composed of four essential components: (1) attention, concentration, meta-awareness, (2) the internal observer and disidentification, (3) attention to the present moment and beginner’s mind, (4) acceptance, equanimity and nonjudging. Hypnosis and mindfulness relate to each other in a complementary way in many dimensions and create spectrums between: (1) absorption – open awareness, (2) dissociation – disidentification, (3) suggestibility – consensus consciousness – awakening, (4) goal- and change-orientation – exploration – equanimity and acceptance, (5) lack of consciousness – hidden observer – internal observer, (6) regression – progression – experiencing the present moment, (7) top-down-interventions – bottom-up-interventions, (8) doing-mode – being-mode. In hypnosis these full spectrums can be used. Moreover, in the dimension of the therapeutic relationship, a mindful therapist can be beneficial for the therapeutic process, for example to support mindfulness and the internal observer and acceptance in the client and for the creation of corrective experiences. Aspects of interpersonal neurobiology of mindfulness and difficulties in making a comparison between hypnosis and mindfulness at the neurophysiological level are discussed. Copyright © 2009 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key terms: disidentification, hypnosis, internal observer, loving presence, mindful therapist, mindfulness

Introduction

More than 2500 years ago, Buddha presented mindfulness as the very heart of the path towards liberation from suffering. In the 1970s the Hakomi-Method (Kurtz, 1990) introduced mindfulness explicitly into psychotherapy. In the last decades mindfulness has gained in importance (Baer, 2006; Johanson, 2006; Brown, Ryan and Creswell, 2007), most influentially in Mindfulness-Based Stress Reduction – MBSR (Kabat-Zinn, 1990, 2005; Grossman, Niemann, Schmidt and Walach, 2004). Mindfulness-based methods have been created, and the concept of mindfulness is influencing methods such as behavioural therapy; psychoanalysis (Germer, Siegel and Fulton, 2005); problem-specified therapies such as Dialectical Behavioral Therapy – DBT (Linehan, 1993a, 1993b) for borderline patients; Mindfulness-Based Cognitive Therapy – MBCT (Segal, Williams and Teasdale, 2002) for depression; ‘sensorimotor psychotherapy’ for
So the following questions arise: could hypnosis also benefit from the concept of mindfulness, and according to the dimension of the therapeutic relationship, how could it be beneficial for the hypnotherapeutic process if the therapist is able to be in a mindful state?

What is mindfulness?

The way we focus attention influences how we see or even construct our worlds, and shapes the mind and even the brain. Mindfulness means paying attention to the here-and-now experience in an accepting and nonjudgmental way and at the same time being aware of aspects of the mind itself. The basic instruction for formal mindfulness meditation (Vipassana) is: ‘...sit quietly, don’t move and then simply pay open-minded attention to whatever is, moment-by-moment, with equanimity, with no attachment or aversion to whatever comes up and no attempt to manipulate whatever comes up’ (Tart, 2001b: 68).

The word mindfulness is used for specific states but also for traits. In mindfulness trainings, mindful states are induced repeatedly over time with the aim of the cultivation of mindful traits, a mindful attitude.

Four components of mindfulness

1. Awareness of attentional processes, concentration, meta-awareness, labelling

Mindfulness seeks to deautomatize attentional processes by being aware of the moment-to-moment focus of attention. The focus can be narrow or broad, wide and open. The technique of labelling of what is going on helps to achieve meta-awareness, the awareness of awareness. One can label e.g. seeing, hearing, touching (outside); imaging, thinking, feeling (inside).

2. Observing (the ‘internal observer’) leading to disidentification, pure awareness

Four domains of experience create a phenomenon to which the word ‘self’ applies. Corresponding to these domains Deikman (1982: 92) distinguishes between the ‘thinking self’, the ‘emotional self’, the ‘functional self’ with the body as chief organ and the ‘observing self’. The observing self is a phenomenon of a different order; it is the most personal of all, prior to thought, feeling, and action and body, for it experiences these functions. The most important fact about the observing self is that it is incapable of being objectified. Whatever we can notice or conceptualize is already an object of awareness, not awareness itself (Deikman, 1982: 94).

To practise mindfulness means to increase awareness of what is being experienced. Simultaneously the activity of the observing self, or more exactly the process of observing, is trained. In the literature about mindfulness the term ‘internal observer’ is used for this observing self. Mindfulness means being in a receptive state of observing the unfolding experience in the inner and outer world, being aware of the objects which are observed, but at the same time being aware of the awareness. During advanced mindfulness training the focus shifts from the objects of awareness towards objectless observation, to awareness of awareness itself, to ‘pure awareness’. This way leads to the
transpersonal dimensions of mindfulness, which cannot be discussed here. One of the mechanisms of the effects of mindfulness is disidentification. That means that this conscious observing of experience helps to disidentify from thoughts, feelings or states we go through. A thought is understood as a thought, not more and not less. In Mindfulness-Based Cognitive Therapy (Segal et al., 2002) this change of perspective is called ‘decentering’ and is probably the central ingredient in the effectiveness in preventing relapse of depression. Non-attachment and non-identification with what we take to be real can be seen as the basis of mindfulness-based approaches. Observing the coming and going of different (ego-)states helps to disidentify ourselves from the states. The construct of the ‘internal observer’ being responsible for this observation process is helpful for disidentification, as we can identify more and more with this internal observer.

3 Present moment, presence; beginner’s mind
Mindfulness means paying attention to the experience from moment to moment, not being entangled with memories of the past or future expectations. With beginner’s mind (Suzuki, 1970) one meets each moment innocent of preconceptions and expectations, judgements and prejudices. Beginner’s mind is able to explore and observe and see ‘things as they are’. Beginner’s mind faces life as a child does, full of curiosity, wonder and amazement. The focus of attention on the present moment facilitates a quality of presence being centred and embodied, also in being together with other human beings.

4 Acceptance, equanimity and nonjudging of experience
Mindful observing means seeing all objects of experience as they are with equanimity (Young, 2004), which means without aversion or attraction. Mindful awareness means accepting things as they are, nonjudging, not wanting them to be different, without desire for change, just as a benevolent grandfather or grandmother sees their grandchild as they are. This giving up of aversion makes it possible to approach situations which have hitherto been avoided, thus enabling a corrective experience.

Hypnosis and mindfulness: possible contributions emerging from a complementary or dialectical relationship
Many aspects of mindfulness and hypnosis relate to the same area, which creates a complementary relationship, both being located on a continuous spectrum. Three major aspects define hypnotic states: (1) absorption, (2) dissociation and (3) suggestibility. Furthermore hypnosis is (4) mostly goal-oriented and aimed at changing, in hypnotic states (5) the ‘hidden observer’ (Hilgard, Morgan and MacDonald, 1975) can be present, hypnosis works (6) with regression and progression. Hypnosis mainly works (7) with bottom-down activation, and hypnosis is an active process, the hypnotist (8) does something, especially in the phase of induction.

1 The spectrum from absorption to open awareness (mindfulness)
In hypnosis, absorption – e.g. in imagination – means focusing and the full engagement of attention while excluding other perceptions. Normally in hypnotic states, the surroundings are not perceived by the patient. Hypnotized individuals seem to lack metaconsciousness. The capacity to observe oneself is suspended in the narrow focus of hypnotic absorption. Mindfulness leads to the opposite of absorption: crucial points are the presence of the internal observer, the awareness of being aware and the widening of
attention to an inclusive ‘open awareness’. For patients it can be helpful to gain meta-
awareness and to become aware of their automatically-functioning attentional processes.
Mindfulness training can help to reach the ability to focus on what is important and
‘wholesome’ – a term of Buddhist psychology. Widening the attention or intentionally
changing the focus of attention helps to come out of automatically-triggered problemati-
cal trances.

2 The polarity between dissociation and (embodied) mindful disidentification
Overwhelming experiences lead to spontaneous and automatic dissociative phenomena,
to depersonalization, to feelings of being detached from one’s own body or mental pro-
cesses, being nowhere. This can be a life-saving mechanism to avoid pain and feelings
and to escape from reality. In hypnotic states phenomena of dissociation are sometimes
induced intentionally, e.g. in trauma therapy it is helpful to induce dissociation or dis-
embodiment e.g. through the screen-technique.

Mindfulness means observing, participating but disidentified, staying embodied in
the here and now, ‘watching’ memories arising with the connected feelings coming and
going, not identifying with them but at the same time not being dissociated. A strong
negative correlation between the severity of dissociation or depersonalization and mind-
fulness has been found (Michal, Beutel, Jordan, Zimmermann, Wolters and Heidenreich,
2007). Mindful observation helps to face reality and therefore it can lead to the integra-
tion of the observed elements. The construct of ‘embodiment’ is an essential character-
istic of mindfulness (Maze, 2008: 45). Presence in a lively body could be an aim for
patients; mindfulness is a way to reach cautiously more integration of body and mind.

3 The spectrum from suggestibility to consensus consciousness and
to awakening
Absorption in a distinct state leads to intense perception of parts of the inner or outer
world and to repression of other parts. The perception is taken as the only reality and
therefore we tend to believe what we see, think and feel. Mostly we are identified with
thoughts and feelings associated with the different states, e.g. in a pathological way with
a depressive or anxious state.

Hypnotic suggestions coming from the outside lead in the same direction, namely
taking the suggested as reality. Mindfulness aims at ‘perceiving the world as it is’ and
is thus the opposite of suggestibility. Mindfulness aims at questioning the concepts and
prejudices of ‘Consensus Consciousness’ (Tart, 2001a). Hypnosis aims at coming out of
‘problematical trances’ and states into ‘solution-trances’ to resourceful states. Mindful-
ness is solution of second order and so points to the next level, leading out of states into
the observation of states coming and going, to disidentification from the different states
but also from all other phenomena such as thoughts, feelings, images and sensations.

4 The spectrum from goal-orientation and change to exploration with
acceptance and equanimity
As part of contemporary western society, psychotherapy has to be efficient concerning
time and costs. Manualized solution- and symptom-oriented short-time psychotherapies
have developed out of this trend. Sometimes people expect rapid changes and this without
their own contribution, especially in hypnosis. These expectations are unattainable in
many cases. If psychotherapy is not able to alleviate symptoms, problems or outer reali-
ties the change in attitude towards the problems helps the patient to cope with them.
Additionally, to stop fighting against something paradoxically often leads to change.
Mindfulness is a way of attaining a new perspective on reality. In Buddhist terms it is at the heart of the way of liberation from suffering. One of the mechanisms is letting go of aversion and avoidance and cultivating acceptance and ‘loving-kindness’. Mindfully looking at objects and therefore seeing them as they really are leads to insights which help with accepting things as they are or even more to love them.

5 The spectrum from lack of consciousness, the ‘hidden observer’ to a conscious ‘Internal Observer’

Insight-oriented psychotherapies make reference to ‘the observing function of the ego’; Sterba (1934) calls it a therapeutic split, a ‘dissociation within the ego’. In hypnosis Hilgard et al. (1975) experimented with hypnotic induction of analgesia. Even in those subjects claiming to feel no pain, a ‘hidden observer’ could be elicited, who was able to report the experimentally induced pain. Hilgard’s neodissociation hierarchical model includes an executive ego or central control structure which has monitoring functions (i.e. hidden observer) and executive functions. The emergence of the hidden observer can be understood as the result of Hilgard’s instruction, which hinders total absorption by focusing on the pain perception itself and simultaneously focusing on the competing hypnotic metaphor of tingling numbness or warmth (Spiegel, 1990: 136).

The ‘internal observer’ is a constituent component of mindfulness emerging through awareness of the observation itself and the awareness of awareness.

6 Focusing on the timeline: regression, progression and awareness of experiencing the present moment

Looking at hypnosis under the aspect of the timeline, spontaneous or intended regression happens, and working in child-states offers the possibility of corrective emotional experiences. In solution-oriented techniques imagination of times in the future is induced, in which the goal has already been attained. Mindfulness-centered therapies use the power of now, for mindful exploration in and of the therapeutic situation or to teach patients to awaken them to the present by being mindful. Actualized negative memories of the past or anxieties thinking of the future dissolve in the light of mindfulness.

7 The oscillation between top-down and bottom-up interventions

Like many traditional models of psychotherapy, hypnosis is based primarily on the idea that change occurs in a ‘top-down’ manner. The entry point is the story the patient tells. The assumption is that significant change in the patient’s narratives, cognitions, beliefs and imagination effect change in the physical or embodied experience of the patient. In addition to the helpful top-down approaches, a ‘bottom-up’ approach could be complementary, using the body as entry point. By the (assisted) mindful observation of sensations, arousal, movement and emotions a bottom-up processing can occur and help in integration. This can lead to symptom reduction and promote change in the cognitions, emotions, belief systems and capacity for relatedness, especially in the traumatized client (Ogden et al., 2006). An example for an already used bottom-up approach in hypnotherapy is the affect bridge (Watkins, 1971), where the bodily amplified emotion is used as a bridge, evoking memories of the past connected with a distinct present emotion.

8 The spectrum from the doing-mode to the non-doing and being-mode

Goal orientation can lead to a ‘doing-mode’ in the therapist and to the idea that the therapist and the patient must work hard to find and do the right thing. In mindfulness there are no ideas as to how the world should be. Instead, it studies and listens to reality in
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order to see and understand it more clearly. Real mindfulness is very radical. There is absolutely nothing to strive for. It is an expression of eastern ‘non-doing’, though it is not the same as western ‘doing nothing’ (Weiss, 2009). It is a ‘being-mode’, a special quality of being, or more exactly of ‘being with’, with relational aspects.

Mindfulness in the therapeutic relationship

In the most widespread mindfulness-based methods (MBSR, MBCT, DBT), patients are instructed to practise mindfulness in group settings or alone. Mindful states are induced to cultivate mindful traits. A totally different approach is using mindfulness during a one-to-one psychotherapy session in Mindfulness-Centered-Therapies (Cole and Ladas-Gaskin, 2007). The therapist and the client do their best to be mindful. The therapist intends to be in an attuned presence; the client intends to use mindfulness to study and to relate to his own inner experience. In the late 1970s the Hakomi-Method (Kurtz, 1990) was developed, in which mindfulness is used in this way for a ‘Mindfulness-Based Assisted Self-Discovery’.

The mindful therapist

It has become clear how mindfulness as a quality is helpful for the patient, in that they learn this skill and attitude. For the patient to experience a mindful therapist opens a further dimension. What can the development of mindfulness in the therapist contribute to such beneficial effects? According to Fulton (2005), these can be summarized as follows:

1 Attention: Mindfulness is an antidote to a wandering mind; one can practise ‘presence’, generate interest in the smallest details of the moment-to-moment experience and pay wholehearted and utterly undistracted attention – a new and corrective experience for many patients.
2 Affect tolerance: We can be prepared to face our feelings in the deep knowledge that all emotions are transitory and thus can be encountered without fear.
3 Acceptance: Mindfulness means acceptance; in observing that we judge, the judgement loses its sting. The safety of genuine acceptance is spontaneously extended to our patients and may provide some patients with their first trustworthy relationship.
4 Empathy and compassion: Our relationship to suffering can be transformed by surrendering our need to reject it, and thus becoming more open-hearted. This attitude of empathy, compassion and acceptance by the therapist can be internalized by the patient and so help in the development of self-empathy, self-compassion and self-acceptance.
5 Equanimity and the limits of helpfulness: The quality of compassion developed in the practice of mindfulness is balanced by the cultivation of equanimity i.e. an attitude of non-discrimination and open receptivity in which all experience is welcomed. Simultaneously, the real limits to what we can do to help are recognized and thus our own limitations are accepted. Equanimity allows us to stop trying to repair things for long enough so that we can see what is really present.
6 Learning to see: Through mindfulness we gain insight into the ways we construct our world and we see how patients engage in the same process of construction. We become more acute in our ability to see their minds.
7 Learning not to know: Mindfulness helps to differentiate between life as it is and our ideas about it. We surrender our wish to know and control, and allow ourselves not to know. An open and attuned mind can be more responsive to the demands of the moment.

8 The possibility of happiness: The practice of mindfulness helps to cultivate a calm joy, which is not easily disturbed by changing conditions.

These qualities help to create a state in the therapist, which in the mindfulness-centered Hakomi-Therapy is called ‘loving-presence’. It is characterized by:

(1) an alert presence, focused on present; (2) unshakeable acceptance; (3) openness for all psychological elements without discrimination; (4) patience, caring, accuracy; (5) focusing on self-organization of the inner world at the present moment and not on the solution of problems; (6) the constant support of the inner observer in the client; (7) participating, empathic curiosity which permits an experimental attitude; (8) inner centeredness and equanimity (Weiss, Harrer and Dietz, 2010).

It has been shown that promoting mindfulness in psychotherapists in training could positively influence the therapeutic course and treatment results in their patients (Grepmair et al., 2007).

Interpersonal neurobiology and mindfulness

According to ‘Interpersonal Neurobiology’ (Siegel, 1999; Fishbane, 2007) ‘the brain is an organ of adaptation that builds its structures through interactions with others…. There are no single brains’ (Cozolino, 2006: 6). Secure attachment is built on the attunement of the parent to the infant. With parental empathy the child ‘feels felt’ and develops a confidence in his or her own experience. Parallels can be drawn between the parent-baby relationship and psychotherapy: attunement between therapist and patient can be seen as the heart of therapeutic change. Mindful shared attention initiates this attunement (Siegel, 2007: 290).

The states of the patient and the therapist are the result of an ongoing interpersonal exchange. Empathic resonance is the result of dyadic attunement and induces the synchronicity of activities in the right brain-hemispheres of the therapeutic dyad (Schore, 2003).

Neurobiological aspects of hypnosis and mindfulness

Hypnosis and mindfulness can be investigated and compared at a neurobiological level (Holroyd, 2003; Halsband, 2008). The results of a growing number of studies are summarized by Winter and Halsband (2008: 178): ‘The neurophysiological approach revealed that meditation and hypnosis share common components, but there is also evidence for distinct neural correlates’.

In the research into meditation there are many variables which contribute to inconsistent results. It could be shown that different forms of meditation evoke different states. There are different patterns of activation in the brain if a person is concentrating on a mantra or an image, or is in mindfulness-meditation, or labelling affects (Creswell, Way, Eisenberger and Lieberman, 2007), or in a state of loving-kindness or compassion (Lutz, Brefczynski-Lewis, Johnstone and Davidson, 2008).

There are, however, not only studies which try to discover the physiological substrate of states of meditation; enduring alterations which accompany mindfulness traits have
also been investigated. It has been shown that the brains of long-term meditators display EEG-patterns of synchronicity unknown in untrained subjects (Lutz, Greischar, Rawlings, Ricard and Davidson, 2004) or differences in the thickness of the cortex in several regions (Lazar, Kerr, Wasserman, Gray, Greve, Treadway, McGarvey, Quinn, Dusek, Benson, Rauch, Moore and Fischl, 2005). Even 8 weeks of mindfulness-training lead to measurable differences in the EEG (Davidson, Kabat-Zinn, Schumacher, Rosenkranz, Muller, Santorelli, Urbanowski, Harrington, Bonus and Sheridan, 2003). Some of the inconsistencies seen are perhaps due to differences between the subjects and in the duration and intensity of their meditation-training.

With the increasing application of the technologies of neurosciences, changes in brain activity following the induction of hypnosis have become an important focus of attention. In this context, one of the most important and influential theoretical perspectives is that of frontal inhibition. As well as the investigation into states, there is research comparing individuals with high and low susceptibility (Gruzelier, 1988; Gruzelier, 2006; Wagstaff, Cole and Wagstaff, 2007). Further studies will bring new insights into the regulation of attention and frontal functions, and thus help us to understand more about hypnosis and mindfulness.

**Conclusion**

By considering the eight dimensions of the ‘hypnosis-mindfulness-spectrums’ described earlier, the therapist can ask him/herself the following questions while planning therapy:

1. When to narrow and to focus attention in order to induce absorption, and when to lead the patient to a more open awareness or even to teach mindfulness?
2. When to use dissociation-techniques? When to lead patients out of dissociated states using mindfulness? When to facilitate mindful disidentified embodiment?
3. When to use suggestibility in ‘traditional trances’? When to use mindfulness for a new look at reality?
4. When to work for change and to search for solutions and when to have a more exploring attitude to gain insights, to facilitate the acceptance of the unchangeable? When to invite the ‘miracle of mindfulness’ (Thich Nhat Hanh, 1975) to happen in patients, therapists and in-between?
5. When to use disidentification as a key? When to introduce the ‘internal observer’ as a technical term into psychotherapy, both in the therapeutic process itself and in reflection?
6. When to induce regression, when to induce progression and when to focus consciously on the present moment?
7. How to balance between top-down processing and bottom-up processing with the aim of integration?
8. When to emphasize ‘being’ rather than ‘doing’?

Lynn, Surya Das, Hallquist and Williams (2006: 143):

propose that hypnosis and mindfulness-based approaches can be used in tandem to create adaptive response sets and to deautomatize maladaptive response sets. . . . They also suggest that mindfulness can serve as a template for generating an array of suggestions that provides cognitive strategies to contend with problems in living and to ameliorate stress and negative affect more generally.
In the other direction, hypnosis can facilitate mindfulness, hypnotic suggestion can be given to achieve detachment, to attend mindfully and to separate a particular stimulus from an intense affect (Lynn et al., 2006).

By way of conclusion, hypnosis and mindfulness display some similarities, but are complementary in other dimensions and can be seen as being in a dialectical relationship. There are many ways in which the therapist can integrate the ‘mindfulness-pole’ of the whole spectrum of mindfulness-based techniques and attitudes. Mindfulness in the therapist opens further dimensions for the patient experiencing the therapeutic relationship, which can also be understood at a neurobiological level, as leading to new states and traits.

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References


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