THE
# HYPNOTHERAPY JOURNAL

nch
with you in mind

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*Your business problems answered. Nick Brunger's new column to help you grow your practice*

*Getting our research act together: Ursula James speaks*

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NATIONAL COUNCIL FOR HYPNOTHERAPY

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# THE NCH COMMITTEE



The National Council for Hypnotherapy, established in 1973 under its former title "The Hypnotherapy Register", represents the practice of Clinical Hypnotherapy as a discrete profession in its own right. Membership is open to those practitioners able to demonstrate appropriate knowledge, evidence of training and clinical experience relevant to the field. The NCH is a member of the UK Confederation of Hypnotherapy Organisations.

# Editorial

If you are new to our profession, I hope that this issue in particular will show you how serious, considered and careful professional hypnotherapists are. This issue, we have a plea for more research from Ursula James, who has been one of the pioneers of training medics in hypnotherapy and knows the importance of showing that we are effective. We welcome a doctor of our own Nick Smith, our new research director, sets out his vision for how we can deliver research which is of a quality which will convince state and other influential bodies to recommend hypnotherapy as a treatment. Then we have an excellent in-depth study of how hypnotherapy can help treat depression by Tom Robertson and a thoughtful overview of hypnosis and mindfulness in treating depression by Carole Wan.

Personalities such as these, constantly developing our profession, show we have the talent and the brains to present a robust case for hypnotherapy. But we need to acknowledge that we are not on a level playing field – there are still too many negative perceptions and stories about hypnotherapy out there. I know when I was considering whether to train as a hypnotherapist I wondered about its image. I had seen its efficacy in the most difficult of circumstances – helping cancer patients; but at the same time there seemed to be such a widespread perception that it was step away from tarot card reading and fortune telling. Was there any protection for vulnerable people, who might seek the help of a hypnotherapist, I wondered. Did I want to be identified with alternative therapies with no evidence base? And I knew for me the answer was no.

For me these worries were quickly put aside when Carole Wan, with whom I eventually trained, invited me to sit in on one of her sessions leading to the HPD qualification. It was not just Carole's wealth of knowledge and experience which impressed me; it was the students in the class.

I especially remember a woman had decided to train as a hypnotherapist as she had seen how hypnotherapy had helped her terminally ill husband. This was serious stuff for serious people. I started training a few months later and have never regretted my decision for a moment.

But, and I am sure I am not alone in this, I still feel I am fighting an uphill battle to be recognised as a serious professional. It is much harder than if I had taken a route into counselling or CBT for example. Certainly things are improving. An ex client of mine who is a local GP put it well: "Hypnotherapy works, and it is cost effective, it will become a no brainer to offer it one day...".

Good positive stuff, but we still need to put clear blue water between us as professionals and some of the nonsense out there. If you look around some of the forums and blogs on the internet you can see people with no training being offered free hypnotherapy scripts to work with clients.

Google hypnotherapy on YouTube and you can find some fantastic things by wonderful therapists. You can also find a lot of lunacy – mass hypnosis, hypnosis to enable sexual assault, street hypnosis where people are injured, people getting stuck in trance. Oh dear! Looking at some of this, if I were a potential client, I'm not sure I would take the risk. That is where we really need to work hard. The NCH is in the lead here. If someone googles hypnotherapy there is a high chance they will come across the NCH site and be given a picture of the best professional practice as well as access to NCH members who are fully qualified hypnotherapists.
If we keep our eyes on the prize we can look forward to the day when hypnotherapy is identified with effective, timely treatments automatically.

Ann Jaloba
journal@hypnotherapists.org.uk

## What do you think?

Join the debate on our discussion forums

http://www.hypnotherapists.org.uk/forum

# View from the Chair

We have just had our 2013 AGM and Extravaganza. Although we had a record number of delegates, I am mindful that the vast majority of our members didn't attend and therefore would not have heard my Chairman's statement which I have set out in full below. Our Extravaganza was a tremendous success; the event ratings completed by delegates were outstanding. We are planning to organise our events with a longer lead time for 2014, so we hope even more people will be able to attend the next event. We will also be keeping you informed of the outcomes of our major new initiatives in later editions of The Journal.

"This statement comments on the financial report for the year ended March 2012, on progress we have made towards and in completion of our corporate goals in the same period and beyond and in our plans and aspirations for the future.

Since my appointment as Chairman in 2008, with the full support of our Board, we commenced a plan of recovery from the somewhat fragile financial situation at that time to the robust financial situation we enjoy now. In my statement at the last AGM, I commented that our Board was satisfied that we had achieved that financial reversal and in fact consolidated our reserves.

The Board decided that with this firm base, despite a continuing hostile economic environment, it was the appropriate time to invest in projects that would bring additional benefits to our members, streamlining our operational and administrative functions, completing our rebranding and accelerating the updating of our systems functionality. In summary, last year we made a commitment to maintain the momentum of change we had initiated and this is exactly what we have done.

The cost of these projects is reflected in the reduction of our retained surplus for the year; however our overall surplus (reserves) have continued to increase; our income has diminished by approximately four per cent whilst our expenditure has increased by 17 per cent; in the main to reflect the projects I have outlined above, in particular IT enhancements, rebranding and the changes in the administration of our members support services.

We continue to participate in the ongoing voluntary regulation process, both independently and through the United Kingdom Confederation of Hypnotherapy Organisations and the Complementary and Natural Healthcare Council, the latter formally representing us with the government's new Professional Standards Authority.

The new Articles of Association agreed at last year's AGM have enabled us to initiate systems-based voting and communication processes which have now dramatically reduced the cost of notification of the AGM and our members' voting intentions. We have in fact used this facility to canvass members' opinions on other issues, including the best CPD courses and comments on the number of clients our members see each week. The Journal, further to the introduction of The Editorial Advisory Board, has been enhanced both by the introduction of a new printer and a more therapy-centred content.

We have introduced a new team of specialist advisors, who will also monitor questions on the wiki section of our website. After a short hiatus, our CPD programme is now re-invigorated with a much increased range of programmes, we have introduced simplified membership criteria with a clearer range of grades, we have introduced a new complaint procedure which complements the new Code of Ethics and updated all our Bye-Laws principally in structure, but incorporating some changes in content.

We have restructured our administration to allow differential pay grades and a dedicated customer service helpline which is staffed during normal business hours. Our new accounting software has resulted in reduced accountancy fees.

Our training schools continue to thrive with a steady stream of graduates completing the HPD, which continues to be the "gold standard" hypnotherapy qualification. We have an increasing number of qualified supervisors graduating from our new externally-accredited course. We have also introduced a new academic membership open to universities, with Southampton University leading the way. Owing to recent

healthcare legislation in the Irish Republic, Hypnotherapy Professional Associations in the Republic have sought affiliations with the NCH to enable their members to access to the HPD.

I have written previously in The Journal about the resignation of Sophie Fletcher from our Board. Sophie has done a dedicated and outstanding job for the NCH, her contribution to our profession in general and the NCH in particular has been outstanding, Sophie found that her NCH volume of work was difficult to reconcile with both her own business and her role as a mother. She had to reassess her priorities and we understand the dilemma. Following a members' suggested motion at last year's AGM regarding the payment of fees to directors and positive comment from other members outside the meeting, the Board decided to look more closely at the historical precedent of only remunerating ex-officio members of the executive. We decided at our most recent board meeting and in compliance with our Articles of Association that remuneration for Board members would be appropriate, the remuneration would only be nominal and paid on the basis of a minimum number of hours worked and on a director fulfilling all the obligations of office. This change will enable the Board to attract and retain directors of the highest calibre and most importantly not to discourage or discriminate against those members who may wish to contribute to the NCH, but through their personal circumstances may feel unable to do so.

The pace of change and the creativity within our Executive is second to none, the dedication of your Executive is undoubted and our commitment to our members continuing development and success is what drives us all, we appreciate and thank you for your continuing support."

Paul White
chairman@hypnotherapists.org.uk

## NCH Focus: Training and accreditation

# Why the HPD is the gold standard

Congratulations to all the HPD completers since the last Journal. I wish you all the very best in your future careers. As usual Stuart and I have been very busy as HPD qualifiers continue to come through and our membership base grows as a result. As always a big thanks to Yvette Lowery, our internal verifier who keeps the show on the road.

A warm welcome to Sian Robinson, our new assessor, who has joined the NCH team recently. She will be a great asset I'm sure. The level of interest in completing the HPD by portfolio continues to grow. There has been a surge of interest in doing the professional discussion/viva and Yvette Lowery as our assessor/ internal verifier is taking a lead on this. It's such a cost-and-time effective way for the NCH and the practitioner to demonstrate competence and gain the HPD.There has been a significant increase in queries regarding training with our accredited schools. I think people are recognising the importance of the "gold standard" the NCH has with the HPD – and that's a good thing! Many other training schools claim to be "accredited" or "validated". All it means often is that someone has rubber stamped the content.

The rigour required by the awarding body, the NCFE, is by no stretch of the imagination a rubber stamp! This sets us apart from all the other hypnotherapy professional associations in terms of offering quality training through our accredited schools and the portfolio route.

A big welcome to Marcia Tillman and her colleagues at the British School of Applied Psychology, who have recently joined us as an accredited school. We look forward to working with you.

There are a number of other schools in the pipeline and if you are interested is setting up as an NCH accredited school, do get in touch. It's a lot more straightforward than you think. Any good quality hypnotherapy training course will cover all the elements required by the awarding body. If you have any queries on any training matters as always feel free to get in touch.

Jill Tonks
training@hypnotherapists.org.uk

# Discount on training now available

I would like to start by thanking all of those members who attended the AGM and voted for me to take up the role of Continuous Professional Development (CPD) director. CPD is close to my heart as I believe it is essential in any professional organisation that its members not only learn new skills but also continuously hone the ones that they already have. In this profession, it is easy to become isolated and allow ourselves to fall into routine. This is bad for us, our practices and our clients. Whilst CPD can cover an almost inexhaustible list of activities it is often the ones that bring us together in groups that add the most value. Supervision, social and networking groups and class-based courses can add much more richness to the experience.

You may remember that at the start of the year, I announced an initiative to encourage more members to take up classroom-based CPD. The scheme offers a subsidy to training schools who offer a range of one-day workshops to members at £50 per day. I also said that I would like to find a way to make more CPD courses available outside of the south-east where many of the larger schools are based. I am pleased to say that the pilot has proved to be of interest to the schools and that there are already three workshops up and running on the CPD page of the NCH site. Interestingly, this also seems to have encouraged some of the schools to offer courses outside of the south east too. We have two offerings in Sheffield and another in West Lothian. Now that the pilot is up and running it now falls to you, the members, to make it a success. I will monitor with the schools how many people are attending the workshops and then later in the year a decision will be made as to whether this is a good use of funds. So please vote with your feet and take this opportunity for some good quality CPD at a knockdown price. Go to http://www.hypnotherapists.org.uk/category/cpd-courses/ For the future, I hope to get a system in place on the NCH site for members to register an interest in a particular course subject in a particular area. Hopefully this will allow schools to gauge where and when it is financially viable for them to put on a class, as well as let them know what courses members are interested in attending. This would be a useful facility for both members and NCH registered schools.

Graham Russell
development@hypnotherapists.org.uk

## Congratulations to our HPD qualifiers

Jake Chambers
Maurice Anslow
Joanne Wallis
Martin Johnson
Elizabeth Allan
Judith Hanson
Peter French
David Rea
Juliette Nolan
Fiona Stobie
Zeenat Ahmed-Peto
Karen Asprey
Iram Awan
Sarah Brazenor
Tony Burkinshaw
Melanie Carter
Michael Cayenne
Edd Curbishley
Helen Day
Lisa Marie Denver
Tina-Jayne Gibbs
Sean Henneghan
Jenney Klose
GeorginaMason
Natalie Mead
Rachel Moore
Siobhan Nell
KhshamaPandey
Natalie Price
Syed AliRezvi
Lou Saucell
Nicole Selwyn
Johanna Simons
Louise Smalley
Joe St Clair
Simon Trow
Chrissie Trow
Victoria Ward
Lesley Williamson
Deborah Williamson

*More qualifiers on page 14*

NCH Focus:

# Our new directors

New directors of research and of member services were elected at our recent Extravaganza. Ann Jaloba talked to them about their plans

## Nick Smith

It's now official. The NCH is the only hypnotherapy organisation in the world with an ex-flying doctor as its Research Director. Nick Smith, our new Research Director, trained as a GP and in a varied career did a stint with the famous flying doctor service in Australia. Wherever he has worked though, Nick says he saw how mental issues, especially depression had a huge effect on general health. This led him to an increasing interest in psychiatry and he trained as a psychiatrist at the famous Maudsley hospital in London. With this specialist knowledge under his belt, he has worked in pharmaceutical and applied research as well as in ethical marketing. The training as a hypnotherapist came about because he was missing patient contact and he now sees clients as a hypnotherapist.

Nick says he is honoured to be voted onto the NCH executive. He believes his background means he is uniquely qualified to deliver a powerful step change in our research agenda. He understands research and is used to working with academics and health professionals.

As a trained and practising hypnotherapist, he is convinced that now is the time for the profession to prove its clinical and cost effectiveness. He notes how other therapies such as cognitive behavioural therapy have got their act together in delivering the sort of quality research which ends up accepted by the government as worthy of funding. We have been left behind, but because hypnotherapy is so effective, Nick believes there is ample opportunity to catch up. He says we must get key opinion formers in health and academia to understand the efficacy of hypnotherapy and combat the myths that hypnotherapy is a strange sideline with no evidence base.

Nick would like to see if we could, relatively quickly, develop some general research matrixes which we can all use in our everyday practice. Can we use some general scale to measure our outcomes, he asks. This would provide a large and powerful body of information to use as a basis of research. He already has some involvement in a major project at King's College London into the efficacy of hypnobirthing and believes that initiatives such as this can be used as beacons to wider research. For Nick the key areas in which we should be pushing hypnotherapy research are where we can show that it is brief, individualised and cost effective. In building up this body of evidence he hopes to work more widely with the CNHC.

If you are involved in any current research projects or you are already using rating scales to measure your clients' outcomes then contact Nick at research@hypnotherapists.org.uk

## Jo Wallis

Jo Wallis, our new Member Services Director, has an interesting, not to say glamorous background in corporate communications in the car industry. She spent many years leading campaigns to launch high-end cars, including Land Rover and Jaguar, onto the market in Australia and the UK.

It was while driving on a transworld rally in Turkey, raising money for breast cancer, that Jo rolled a rally car 50 feet down a ravine. A handily placed rock stopped the car and meant she came out of the terrifying ordeal alive. Such a brush with death made Jo rethink her priorities. She started a family and with small children to look after, she scaled back her career and began to look for a new direction.

# NCH Focus: the new directors

She had always been fascinated with hypnosis and how the mind works. Her mother died when Jo was only 21 and she believes that this launched her lifelong interest into what drives our emotional states.

This remained an interest which informed other areas of her life, until she found herself in a position to make it her profession.

Jo specialises in treating adults with anxiety-related disorders, but her real passion is working with children and this is an area where she plans to expand as she is becoming very well-known locally for her work with children.

As a practising therapist working from home she is very aware of how isolating the profession can be. She sees her main role as Member Services Director as breaking down this isolation and is very keen to use all the channels at the disposal of the NCH to do this.

One of the first things on her radar is the next Extravaganza. She spent a lot of time at this year's recent event talking to members about who they would like to see speaking next year. She plans to have a longer lead in time so the event can be more widely publicised and get even more members attending. She is also very keen to hear your ideas about who you would like to hear speak.

Jo wants to make the most of the technology developments the NCH has recently made to improve communications with the members. She hopes to use our improved email lists to encourage members to visit the NCH website and use its forums to communicate with each other. She believes that by using these channels for regular communications she can better inform everyone of what the NCH, as their professional organisation, is doing.

Even more importantly, she is convinced that our new website, with its forums and wikis, can foster a spirit of community and support among members. If you have any ideas about how the NCH can support you, or a speaker in mind who you would like to see at Extravaganza 2014 then contact Jo on services@hypnotherapists.org.uk

# NCH Focus:
# Another Extravaganza success

One hundred and eighty NCH members gathered in central London last month for the Extravaganza and AGM. Watch the website for the upcoming DVD of the presentations.

# Supervisor spotlight

*One of the benefits of NCH membership is high-quality supervision. We feature a number of our accredited supervisors in each issue. So welcome to some of our supervisors in the south-west.*

## Alison Jones

I qualified as a hypnotherapist in 2006 and as a supervisor in 2011. I trained at the Clifton Practice and am lucky to say that I have worked at the practice for the past seven years. I work with many clients with anxiety issues affecting all aspects of their lives from relationship issues, work/life balance, phobias, weight management and for specific times such as pregnancy and childbirth. I also work with companies giving talks and support to help manage staff wellbeing. During 2013, I have also started lecturing at The Clifton Practice on the latest brain research and how we can use this information within our practice to help our clients.

I am currently offering one-to-one supervision either face to face or over the telephone and am now also extending this to offer group supervision within the Clifton Practice.

I trained and qualified as a supervisor at The Clifton Practice in 2011, this was the first supervision course that had been run at the practice and I jumped at this opportunity, as I remember so clearly the benefits that I had from attending supervision in the early days and the advice and support that supervision continues to give me today. I believe that, whether it is one-to-one or group supervision, having someone and somewhere to turn for this support is crucial to our success and importantly enjoyment of our profession. The supervision I offer is within a safe learning environment where everyone can help each other with the result they build and maintain successful practices. My aim is that supervision is fun and about sharing experiences, finding our inner resources to face challenges and celebrating our success.

I have worked from The Clifton Practice since 2006 and during this time I have gone from combining hypnotherapy with a full-time job as a corporate trainer to being in a position to focus completely on hypnotherapy and I am very proud to be able to say "I am a hypnotherapist". I got into hypnotherapy because of a very good friend who was treated for a phobia of going on buses. Her complete and very rapid recovery was amazing to me and I wanted to find out more. Recently I have also taken on the position as Research Officer for the AFSFH and now also lecture at CPHT on brain research and how we can use the latest research within our practice. I have always worked with people helping their development and now thoroughly enjoy running a successful practice and enjoy sharing my experiences through supervision. Being able to help people transform their lives is a privilege and for me is best job in the world.

Tel: 07730 747772 email: alison@solutionshypnotherapy.co.uk website: www.solutionshypnotherapy.co.uk. Based at The Clifton Practice, 8-10 Whiteladies Road, Clifton, Bristol, BS8 1PD

## Michael Hughes

My name is Michael Hughes and I have been an accredited supervisor since October 2010. I am a HPD graduate of the highly-respected CPHT and I am lucky to be based in a stunning practice in Clifton, Bristol. I offer solution-focused supervision via telephone and email, one-to-one and also group supervision on the third Saturday of every month, currently from a beautiful building in Queen Square in Central Bristol.

I do things very much in my own way and style which is always up to date and innovative. I am incredibly passionate about neuroscience and brain-based therapy. Also, in 2010 I developed a new questioning technique called "The Miracle Wall" which many therapists have found to be an excellent tool to use in the consulting room to get an idea of the client expectations. The same technique can also be used to

NCH Focus:

# Supervisor spotlight

establish the client's perception of how long they feel it will be until their issue will be resolved. I also have a passion for language patterns, metaphor and NLP.

Being consistently busy in my own practice and vastly oversubscribed with a growing waiting list, I know I must be doing all the right things. I like to reflect that working ethos and my passion for hypnotherapy throughout the supervision process and extend this to the support I offer through supervision. To this end I respond very quickly to therapists' calls and emails as I feel it's an integral part of that ongoing support.

The supervision group I supervise has all built up from word of mouth and recommendation and I am pleased to say that I think those hypnotherapists that attend really do genuinely enjoy the supervisions. I know from experience that when I attended my own supervisions that they helped me so much, especially in the early years, to flourish as a practitioner.

I also support graduates who are based all over the UK, not just limited to the south-west. The group is very welcoming, friendly and has a variety of new to experienced practitioners.

I'm a firm believer that if you are truly passionate about hypnotherapy and with a little help that you can step into your confidence as a practitioner that you can do anything. I also firmly believe that hypnotherapists should have hypnotherapy themselves as it just reminds us of why hypnotherapy is such a great profession to be a part of.

All the details: dates, times, location and cost are on my website www.michael-hughes.co.uk and if you click on the supervision tab, you can find all the information you need there.

## Nick Mawer

With five years' experience in running a private practice, I qualified as a supervisor in 2010. I offer supervision to other therapists based on their requirements using a solution-focused approach. Forming a mutually beneficial relationship with other people and helping them to realise their potential is one of my strengths. My own training was with David Newton and I believe in his way of doing things. I have always enjoyed supervision and my own is ongoing: this means I have access to a wealth of experience if the need arises.

Before hypnotherapy I was a police officer which taught me lots of things (and explains why *Catch 22* is my favourite book). I am married to Nicola who is a nurse ("Nick Nic" - heard it before!) and have two grown-up children. My interests outside of work include cycling, swimming and on a really good day getting to the gym.

My special interests are in the areas of anxiety, depression, weight loss and phobias and I offer supervision on a one-to-one or group basis and by Skype or telephone.

Tel: 07954 425548 e-mail: nickmawer@live.com, website: nickmawer.co.uk. Based at: St. Augustine's Medical Centre, 4 Station Road, Keynsham, Bristol BS31 2BN

## Russell Davies

I am currently based in Truro, Cornwall; I qualified as a cognitive hypnotherapist in 2008 and have been in practice since then, also qualifying as an NLP master practitioner in 2009. I have had "3 Principles" training and mentoring with Jack Pransky.

I specialise in fertility and as such I am the NCH fertility specialist advisor and founder of The Fertile Mind (www.thefertilemind.net). I also provide coaching/training in practice building and SEO.

I offer supervision by telephone, Skype, one-to-one in person and for groups (in person and Skype).

Prior to becoming a hypnotherapist I was an IT account manager (turning geek speak to English) for a large corporate. The combination of my business experience and the fact I am a geek who speaks English led me to provide practice building training, coaching and SEO education to hypnotherapists. I am fanatical about practice building and enjoy sharing my experience with others. Having built my practice in

London two years ago I moved down to Cornwall and have re-established my practice there and I now have a busy, full-time practice in rural Cornwall.

My practice is a combination of one-to-one clients, Skype/phone coaching, selling products, training and speaking.

Having had personal experience of infertility, after I qualified, I gradually built a specialism in fertility which as a subject covers a whole range of things such as anxiety, healing and relationship therapy.

I am passionate about supervision as I can look back see how much I benefited from supervision for both my development as a therapist and my practice development.

My supervisees are located all over the country (and further afield) so location need not be a restriction us working together.

I have a couple of spaces available for new supervisees; please feel free to contact me if you would like a chat about supervision.

Tel: 07806 949249 email: russell@russell-davis.co.uk

## Susan Ritson

I work as a supervisor at my clinics in Axbridge and Frome running monthly group sessions in Axbridge. Bi-monthly, I organise talks for the group with the objective of developing new skills to use in practice. I also have supervisees around the country via Skype, phone and email. One-to-one sessions are also always available at any of my clinics and I am available between sessions to provide support if required. An agenda is provided for all sessions, to which the supervisees contribute, this ensures the sessions are structured and tailored to the individual needs of the supervisee.

My previous career was in civil aviation. Fifteen years with British Airways beginning as cabin crew, followed by a mixture of ground operational roles including training ground staff, and finally specialising in common use airport operating systems.

This final role took me all over the world supporting BA staff at airports to integrate these new systems and also to represent BA on a number of industry committees, including being elected chairman of the leading

industry technical committee which supported airlines and industry suppliers globally to standardise computer equipment and systems to make the best use of limited airport space. I left BA in 1998 and worked as a consultant to airports and airlines, supporting them through times of changes of airport equipment and common computer systems.

In 2004 I had a serious fall and fractured my spine, it was as a result of the horrendous pain that I used self hypnosis as a pain management tool and found it so effective, that I went onto train at Clifton Practice Hypnotherapy Training and now work full time as a solution-focused hypnotherapist and supervisor.

Although I work in most areas, I do have particular areas of specialist interest; pain management; weight management (I am also trained in nutrition); fears and phobias; I particularly enjoy working with professional or amateur horse riders either to overcome a fear perhaps after a fall, or to improve their overall confidence and performance.

I can be contacted via tel: 07837 562602, email: susan@ritsonhypnotherapy.co.uk website: www.ritsonhypnotherapy.co.uk

# Supervision

Below is a list of members who have successfully completed the NCH-accredited Supervisors course or have been granted the designation AccHypSup through accredited prior learning.

| | | |
|---|---|---|
| Alison Jones | Bristol | alison@solutionshypnotherapy.co.uk |
| Anita Mitchell | Slough | anita@anitamitchell.co.uk |
| Carole Samuda | Alton | carole@carolesamuda.co.uk |
| Cathy Simmons | London | cathy@cathysimmons.co.uk |
| Chloe Cook | Stafford | chloe@openmindhypnotherapy.co.uk |
| Christine Key | Egham | chriskey1@aol.com |
| Danita Dennington | Thame | dani@denningtons.co.uk |
| Dawn Biggs | Bexhill-on-Sea | dawnbiggs@ukcounsellingservice.com |
| Gillian Wood | Wimbledon | gill_wood@hotmail.com |
| Gloria May | London | gloria.may@chilternstreet.co.uk |
| Heidi Woodgate | Kent | heidi@northkenthypnotherapy.com |
| Jill Tonks | Surrey | jillmtonks@aol.com |
| Joe McAnelly | Newcastle | www.joemc.co.uk |
| Josephine Teague | Cambridge | teague_j@live.co.uk |
| Mary Llewellyn | Doncaster | mairllll@aol.com |
| Michael Cameron | London | michaeljcameron@hotmail.com |
| Michael Hughes | Bristol | info@michael-hughes.co.uk |
| Nicolas Cooke | Birmingham | info@cecch.com |
| Nick Mawer | Bristol | www.nickmawer.co.uk |
| Pat Hoare | Exeter | pat@pathoare.eclipse.co.uk |
| Penelope Ling | Reading | pennyling@talktalk.net |
| Peter Adamson | Warrington | peter@psychotherapy4all.com |
| Russell Davis | Truro | russell@russell-davis.co.uk |
| Sharon Dyke | Taunton | sdhypnotherapy@yahoo.co.uk |
| Stuart Norman | Horley | stuart@mindwise.org |
| Susan Ritson | Axbridge | susan@ritsonhypnotherapy.co.uk |
| Theresa Long | Wimbledon | www.synergy-counsellingandtherapy.co.uk |
| Valerie Hird | York | www.hypnotherapyyork.com |

You can see a full list of NCH-accredited Supervisors by searching in Advanced Options on our 'Find-a-Hypnotherapist' page. If you are an NCH-accredited Supervisor and would like to advertise here, please contact supervision@hypnotherapists.org.uk



# How important are referrals?

## In the first of a regular column, Nick Brunger answers problems which you may have as you build your business

I run a successful, fairly new practice (been going three years now) but feel I am constantly running to stand still to get new clients. I keep reading that it is possible to build a business on referrals only, but I don't see how this can work.

I look at it this way. If I see 200 clients and ten per cent of these send a new client to me then I have 20 new clients, if ten per cent of those send a new client then I have two new clients and then(...)

So how important are referrals, are they being exaggerated or I am missing a trick?

*Nick replies:* I have to say that I share your general scepticism about the power of referrals by clients to build a hypnotherapy practice. The conventional business model says that satisfied clients spread word of the effectiveness of your treatment to others who, in turn, refer new clients to you and so your business grows.

In practise I have found that only works for me with certain client groups, most notably smokers who are happy to pass on the "secret of their success" to family and friends. Apart from them my practice tends to be so diverse and the nature of the problems I work with so personal and complicated that it's often no surprise that satisfied clients do not mention my services to others.

For example, it seems to me highly unlikely that the PR manager dealing with workplace bullying by a senior colleague; the man with a lifelong terror of his own faeces; or the fireman with an oversensitive bladder (all recent clients) would talk to others about their successful treatment because of the highly sensitive nature of their conditions.

However, I do get a healthy number of new referrals from fellow therapists. I work with a long-established and popular natural health centre and find that a high proportion of clients are referred to me by them.

One of the best investments that you can make in terms of time and effort is in offering to exchange treatments with other therapists in your area. This gives them a chance to experience the effectiveness of your therapy and vice versa. The referrals follow and, because they may well network with other colleagues, this is a great way of helping build your practice. Never forget to thank them for each new

*Are you finding a problem in building your business? Nick is here to help. Send your problem to journal@hypnotherapists.org.uk*

# Growing your business: problems answered

client they send your way and make sure that you repay the compliment be sending custom to them in return.

If you work in a clinic setting, make sure that you extend offers of free sessions to the reception staff as well. They are the first point of contact for the public and may suggest your services to customers seeking therapeutic help but unsure of what therapy to access.

You could also look to finding others in your community who may be able to refer others to you because of the influence they have in passing on advice to others: hairdressers, priests, district nurses and so on.

All that said, you may be able to turn your existing clients into a more potent workforce for you by being proactive in seeking their help to bringing in clients.

Try explaining to them that a business like yours thrives on personal recommendation and asking if they would mind helping by recommending your services to others. You might also like to offer them an added incentive. I always tell smokers that I will reward them with an M&S voucher for every new client they send to me who mentions their name.

There is more on using referrals to increase your business in my book *Marketing and Practice Building for Hypnotherapists*.

But while nurturing this area of your marketing, make sure you do not neglect every opportunity you can to attract new clients in these tricky times. Research in the 1980s in the US found that firms who held or increased their advertising spend during a recession grew their business by around 250% over their competitors when measured over a five-year period.

However you market your business, keep the effort up and good luck with expanding your practice in the future.

Copies of *Marketing and Practice Building for Hypnotherapists* are available as a softback book from Nick, as a Kindle publication or as a download. Email Nick at

info@nickbrungerhypnotherapy.co.uk

# Congratulations HPD qualifiers

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An estimated 20% of UK Hypnotherapists practising today have the HPD, with twice that many registered to do it, making it the leading independently-verified UK hypnotherapy qualification. And if you are an experienced hypnotherapist, you can take the new Professional Discussion Route to qualification.

# Time to win the research battle

Hypnotherapist and author, Ursula James is also a visiting teaching fellow at Oxford University and lectures at 11 UK medical schools. Fiona Nicolson spoke to her about the role of research in influencing the perception of hypnotherapy.

### Why hypnotherapy? Where did it all begin for you?

Back in the 1980s, I was employed by the Ministry of Defence (MoD) in Germany, helping to relocate British RAF families from the UK.

I had both counselling and psychotherapy skills but the MoD gave me training in basic hypnotherapy and out of the three sets of skills it was the hypnotherapy that I found really worked and actually made the difference to the families. The families, especially the young ones, could feel very isolated and alone as there was no Skype or mobile phones back then.

All communication was by letter and landline and problems such as addiction and even domestic abuse developed.

It was an old-school and quite authoritarian style hypnotherapy but I was working within an authoritarian environment so it was actually very appropriate. However, to be honest, I was becoming increasingly anti-war and was not comfortable with the contradiction of being involved in a military environment on a therapeutic basis.

So, I returned to the UK and took a variety of interim, people-orientated jobs, all jobs that involved communication, even including bar work! I seemed to be one of those people that people wanted to talk to and I was really interested in the way that people communicate. Communication is a skill that we can take for granted. I decided to train formally at the London College of Clinical Hypnotherapy (LCCH) and particularly enjoyed the self-hypnosis which was an initial part of the course. I continued to support myself whilst training and went on to be Vice Principal of the LCCH for several years as well as Vice Principal of the British Society of Clinical Hypnosis.

### You were the first person to teach hypnotherapy as part of the medical syllabus at Oxford University. How did you make that happen?

A common frustration among many of my peers was the fact that hypnotherapists were not taken seriously by the medical profession. There are usually two routes to deal with that kind of situation – you can either wait for someone else to do it or you can act to change it.

So I did some research and discovered that the BMA (British Medical Association) had set out an edict in the 1950s that all medical students should be taught hypnotherapy. Armed with that knowledge, I became the first person to actually knock on the door of Oxford University and ask them if they would like to be the first university in the county to actually fulfil their obligation.

That was 11 years ago. I persuaded them to let me in, they were a bit stuffy initially as they only gave me one year to make it work, but the course was soon really over-subscribed by the medical students. There were 20 students in each class, which is a huge class size for Oxford University, who normally only have four to six students in a class.

Hypnotherapy is highly useful for childbirth and also phobias, things

that were already supported by a good level of research. Being Oxford, the medical students would check up on the research and would then really embrace the course when they realised that it was already legitimately within the framework that they understood.

The final hypnotherapy evaluation for the students was a practical test so I got them to hypnotise the students in the year below. The upcoming students were really enthralled by being hypnotised and were very keen to be taught to do it themselves. The demand increased and this course has been running ever since and is now taught in 11 medical schools across the UK.

### How did you involve the other medical schools?

Once you have opened that door a little chink, and when that little chink is Oxford University, it then allows you to go to the other medical schools and say "Oxford is doing this (...) when are you going to start?"

The courses run at set times throughout year with the team running specific modules. What the students learn depends on the module with some courses being up to six weeks long. The students learn about hypnotherapy, what it does, how it can be used and recognition of what conditions it can be used to treat. They also learn self-hypnosis for personal use. The model works and we are now collecting data from the students to carry out longitudinal studies (repeated observations of the same variables over long periods of time) to see if it changes their attitude. Data are everything.

### How have the courses helped to change the perception of hypnotherapy within the medical profession?

We have not reached all of the medical profession, but on the basis that the doctors who were taught hypnotherapy on our courses can, at the very least, use self-hypnosis on themselves, it follows that those doctors will be open minded enough to refer patients for hypnotherapy. I am proud of my legacy; that I have taught over 1,000 doctors to be more open minded and to spread the hypnotherapy word, and I know from the feedback I get that they do spread the word. I now undertake research projects with some of the doctors I taught originally.

# Time to win the research battle

### How do most of the medical profession perceive hypnotherapy?

There are some doctors who embrace hypnotherapy because they understand the framework or practice it themselves, but there are others who would not touch it with a bargepole because hypnotherapy does not tick the National Institution for Health and Clinical Excellence (NICE) guidelines. I think this is beginning to change, both because more doctors are being taught hypnotherapy at medical school and also because of the financial implications.

Using self-hypnosis to increase levels of calm in mothers for birth can lead to a calmer birth and ultimately calmer child which then leads throughout childhood and beyond. This is the study of epigenetics which is really big at the moment.

### How can we work more closely with the medical profession to further influence how our industry is perceived?

I believe it is down to research and yet more research but the recent financial and economic situation has meant that there has been far less research funding. For example, there has been so much nationwide publicity about the successful use of hypnotherapy for Irritable Bowel Syndrome (IBS) and Professor Whorwell, who is known for his leading research into this, has a two-year waiting list for his clinic. Even he cannot get any more funding to expand and meet the demand, there is just no more funding.

Having said that, the more that we as hypnotherapists can carry out research, the more likely it will be that hypnotherapy will be accepted under the (NICE) guidelines.

That is how cognitive behavioural therapy (CBT) was accepted under the NICE guidelines, through conducting peer-reviewed controlled tests. The research does not have to be highly specialised, there just has to be lots of it. I would encourage anyone who is involved in hypnotherapy to keep up to date with what relevant research is out there. Not everyone has time so it is important that people are aware of how they can easily get access to information on research through for example e-zines and Google alerts.

### How easy is it for individuals to set up their own hypnotherapy research projects?

It is easy for someone to set up their own research project, but it can be difficult to actually run it successfully unless they understand the fundamental parameters of research. The hard bit is having it accepted by a peer-reviewed journal but without peer review the research is not credible, this is the gold standard.

If you as a hypnotherapist wish to undertake a research project, you really need to have a doctor on the proposal, even if they don't actually do anything. Academic doctors, who have to produce research papers, might especially be interested in being involved.

You would do the actual work and pull everything together and the doctor would put their name on the paper with you. But at the end of the day I think that research really should be approached from a group point of view. It would be much easier if it was a collective effort across all the hypnotherapy schools with them co-ordinating the research.

### If not individual projects, then how should it be approached collectively?

I know that several of the hypnotherapy schools are carrying out their own individual research which is great, but it is not about personalities, it is about getting things done. As I said before, it should be approached from a collective across all the hypnotherapy schools. It will not work if all the different bodies are trying to do a little bit by themselves. If I had a magic wand I would ask every training organisation to encourage their graduates to review their last year's statistics and, for example, how many clients they saw for each type of issue and submit them in a formulaic way. If this was collated nationwide then we could start to know how many people had gone to a hypnotherapist for say, a phobia.

You cannot start a research project just with a good idea – it has to be based on some existing statistics to show what question you are proposing to answer. So if an analysis of practitioners' records, which everyone should be keeping, was to show how many people saw a hypnotherapist last year for a phobia that would be extremely interesting. We would not even need to define if the therapy worked or not. If we could get those numbers and present to the National Health Service (NHS) that, for example, 5,000 people visited hypnotherapists last year then we could start to be able to secure funding for further research. Five thousand is a huge number and is statistically significant.

### What kind of analysis could be done and how could the findings be used?

I did not set out to be a researcher as I initially thought that all the research information would already be there and I just became fed up with people saying "someone should do this". But it cannot ever be driven by just one person.

The hypnotherapy organisations need to work collaboratively if they want to be taken seriously by the NHS and work towards get NICE guidelines, the same way as CBT did. If everyone pulled together there is no reason why raw, retrospective data couldn't be collated in three months.

It could take the format of five simple questions. For example, "How many patients did you see with this condition?", "How many sessions did you see this client?" and "How long did you leave between sessions?" Make research the simplest and easiest thing to do so people are likely to respond. A retrospective study of how many people consulted hypnotherapists in the last three years could be ideal because suddenly you have a large body of evidence that could even get onto the national news.

It is about gathering enough retrospective data to say that there is a question here that needs to be answered. The next stage is to review the financial implications. For example, if one per cent of all smoking cessation clients actually stopped then what are the financial implications for the NHS? How much would the NHS save? If we consider the potential impact then this is an impact study. Then we can start to say we have a question to answer and how can we take it a stage further.

*It emerged that there was little or no high-quality research for any of the complementary and alternative medicines. Since then other complementary practices such as CBT got their act together and CBT is now recognised by NICE.*

If the objective is to get hypnotherapy to a more mainstream environment then you have to play by the mainstream rules and work within the given system. You just need studies showing statistical significance in favour of hypnotherapy versus a control.

Now is the time it needs to be done. There was a House of Lords report that came out in 2001 reviewing complementary medicine. It emerged that there was little or no high-quality research for any of the complementary and alternative medicines. Since then other complementary practices such as CBT have got their act together and CBT is now recognised by NICE.

There is a window of opportunity to grow the credibility of hypnotherapy through research. This needs to be done sooner rather than later as the perception of other therapies, such as CBT as a recognised therapy, is continuing to grow wider.

### What other aspects of research can help us grow in influence?

Going back to a key point, there are strong financial implications for using hypnotherapy and this can be a strong influence. In summary, research is the key way forward to influence the medical profession and one aspect of that is how much the NHS can potentially save through the use of hypnotherapy for specific cases and specific treatments.

It is one thing becoming a hypnotherapist, but you have to at least be aware of the requirement for research out there and even if you are unable to do it yourself at least recognise that this is what is holding the profession back.

If you are prepared to and able to make some contribution to research then you will be able to help drive the profession forward, but it not ever just about one person doing it.

*As well as seeing private clients, lecturing and writing both textbooks and novels, Ursula is currently carrying out PhD research into the effect of altered states on cognition and the bio-medical markers of stress. She is a Patron of Anxiety UK and the National Centre for Domestic Violence (NCDV). She has appeared on This Morning and Woman's Hour on BBC Radio 4. She also presented the Channel 5 TV show – Sex Lies and Hypnosis*

# Applying a Simple Mind Body Connection Model to Support the Understanding and Treatment of Depression

By Tom Robertson

Summary

This paper describes a simple 'Mind Body Connection' model and how it can be used to support the treatment of depression. By helping the client to understand and accept they are "at cause" for their emotional state, it empowers them to make positive change in their life. It does this by changing the client's perception of their condition and reframing it from a debilitating mental disease to a physical/chemical condition that they have the power to change by the way they think and act.

The paper also presents a model for change which is derived from the mind body connection model to support therapeutic intervention. This model, which might be familiar in different guises to some readers, suggests that both the client's physical (physiological) and mental processes be considered in equal measures during therapy. A summary of how both of these components can be integrated into existing therapeutic practices is provided.

The paper does not provide a prescriptive approach for dealing with depression.

## 2 Background

Over the years, as I learned more and more about the mind body connection, I developed simple models to help me understand the processes involved in creating depression and to help me to explain it to clients. That understanding helped me to put together more informed treatment strategies for depression, anxiety and stress, around the traditional approaches used in hypnotherapy.

I began to selectively introduce the models and explanations to clients before and during therapy. At the back of my mind I had a feeling that if the client could understand their condition from a different perspective it could motivate them to change. My reasoning was that many clients felt that they had no control over their condition, labelled as a disease of the mind. Once clients accept the label of depression it sticks and often they have difficulty dissociating themselves from the label. In their minds, that is who they are!

Often, after I explain the mind body effect model to clients, I can almost sense some relief from most, while a few have a 'eureka' moment. This was particularly true for David (not his real name) who suffered from anxiety and depression for years, was being treated by his GP and a psychiatrist. He was on antidepressant drugs and had previously attended CBT, without making great progress. Excitedly, after I had explained the model, he said: "No one has explained my condition in this way before. This is great news". During therapy, he wholeheartedly threw himself into the treatments, so much so, that a major change took place after only one session. (Note: It is important to seek the GP's approval while working with clients diagnosed with depression.) The models helped David to understand that he was "at cause" for his depression and

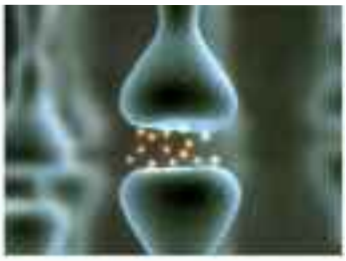
therefore must take responsibility for his own improvement. He was in the driver's seat, not me! This was a breakthrough for him.

For many depressed people, the model provides a powerful reframe of their condition. It can shift the client's perception of their condition from a mental one to a physical/chemical one. Clients can often feel helpless and immobilised by a mental state problem but they might feel more ready to deal with a physical state problem. A simple demonstration involving the client making a few changes to their physiology and noting the resulting changes to their emotions, is often enough to convince them of the potency of the reframe. The demonstration, simple as it is, helps the client to re-engage with positive mental and physical processes that may have eluded them for some time. An example of the demonstration is described in section 3, entitled 'What is the Mind Body Connection', which the reader is invited to try out.

The simple models presented within this paper have not only improved my communication with clients but also resulted in modifying my approach by integrating some of the concepts suggested by the model into existing treatment strategies for depression. By sharing them in this paper, I hope that those less familiar with the mind body connection will find similar benefits when treating their clients for depression and other related mental conditions.

## 3 What is the mind body connection?

In the context of this paper, I define the mind body connection very simply as the effect that the mind in action (via thoughts) has on the body's kinesthetic state (via chemicals) and the effect the body's kinesthetic state has on the mind. To aid comprehension of the models presented I have, as much as possible, avoided the use of complex scientific jargon and detailed explanation of neuro-biological processes. There is much written on the subject. However for those interested there are three excellent books that I particularly used as references for this paper. They are *Evolve Your Brain* by Dr J Dispenza, *The Biology of Beliefs* by Dr Bruce H. Lipton and *The New Neuroscience of Psychotherapy, Therapeutic Hypnosis & Rehabilitation: A Creative Dialogue with our Genes* by Drs E Rossi and K Rossi.



Figures 1 and 2: the synaptic gap

Quite simply, consider the brain to be comprised of nerve cells or neurons. It is estimated that there are approximately 100 billion neurons in our brain. It is outside the scope of this paper to describe the neurons in detail. However we can imagine a neuron as having a tree-like structure with many leafless branches that can reach out and connect to branches in other neurons.

The neurons do not physically touch at the point of connection. They are separated by a small gap, known as the synaptic gap. This is illustrated in figures 1 and 2.

When neurons connect to each other in three-dimensional patterns within our brain, they form neural networks. Neural networks are created every time we have a thought, learn something new or have an experience. Neural networks are created and develop by a process of association (which connects similar neurons or networks related to that specific thought, thereby increasing knowledge) and by repetition of the same thoughts.

Thoughts that run through our minds create the equivalent of powerful electrical impulses that vary in frequency and electrical charge across the synaptic gaps of our neural networks. These impulses generate chemical messengers called neurotransmitters which pass on information to other neurons across the synaptic gap. Once they reach the other side of the gap, they are transformed back into electrical impulses to continue their journey, in the same way, through the network.

Neurotransmitters give rise to our fluctuating moods and emotions that we experience throughout our day. Different thoughts produce different moods or feelings by producing different neurotransmitters, i.e. the neurotransmitter for a happy thought has a different chemical structure to one for a depressing thought, for example. Specific examples of common neuro-transmitters include serotonin,

# Depression - mind body connection

glutamate, dopamine and melatonin.

As well as neurotransmitters, each thought generates other chemicals including peptides (manufactured by the hypothalamus) and hormones manufactured by our organs that cascade down into our bodies and cells. The structure of these chemicals depends on the emotion behind the thoughts. For example, dopamine is produced when the thoughts are pleasant and relaxed and adrenaline and cortisol are produced when thoughts are fearful and stressed (via the flight and fight mechanism). The different molecular structures of the chemicals generate a range of responses in the body giving rise to different physical feelings and symptoms.

Via the nervous system, the body is connected to the brain and the brain to the body. The nervous system is just an extension of the brain and connects the environment to the body via the sensory organs (skin, eyes, ears, nose and tongue). Their beliefs about the environment influence how different people perceive it. Perceptions shape our thoughts and memories of an experience. As we replay our memories in our mind, we effectively recreate that experience over again with all of the associated emotions that accompanied it.

It is easy to imagine how a person who believes that the world is a dangerous place, will live and behave, compared to a person who believes that the world is a pleasant and safe place. An optimist perceives the environment differently from a pessimist. Continually being pessimistic or continually living in a state of anxiety and fear can lead to depression, especially if there is constant replaying of unpleasant memories! (See section 4.4 'A Model of Depression').

Thinking the same thoughts or repeating the same experiences over and over again has two implications:

## 3.1 Creation of Neural Networks

A single thought will involve a number of neurons firing together to produce the effect of that thought in the mind and body. If the single thought is new and not often repeated, the neurons will remain connected during the lifecycle of the thought. However, if the same thought is repeated over and over again, the neurons eventually join together to create a neural network. This process is defined by a neurological principle, known as Hebb's Law, which can be expressed as "Neurons that fire together wire together!"

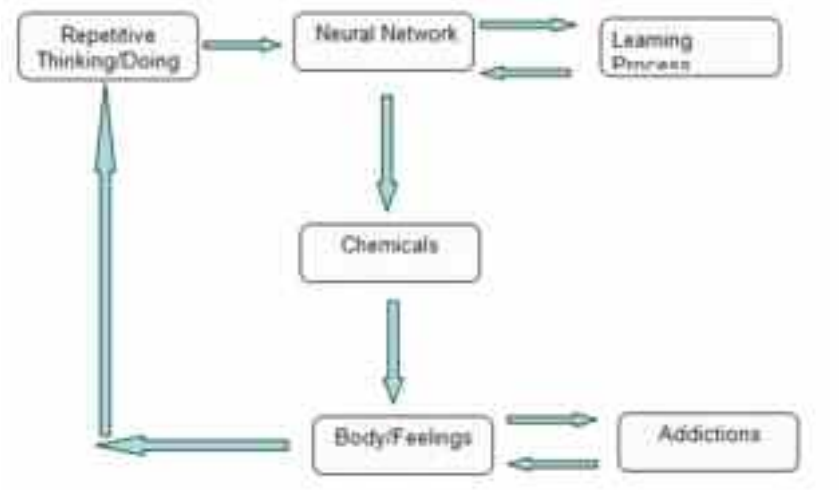



Figure 3: the mind body connection

At one time, it was thought that our brains were hardwired and could not be changed. However recent research supports the existence of this wiring and re-wiring process, known as neuroplasticity. It is this neuroplasticity that helps us to learn and grow.

The creation and development of neural networks forms the basis of learning. As the neural network develops, so does our learning. We go through several stages of learning from (a) unconscious incompetence, (b) conscious incompetence, (c) conscious competence and (d) unconscious competence. I also like to add a final stage (e) personal mastery. You can easily link the stages to your own experience of learning to drive a car or ride a bicycle. All of our behaviours, including negative ones, are learned in this fashion.

The neural networks become programmes that reside in our brain, by which a thought, decision or action can automatically trigger the whole learned behaviour without having to go back through the whole learning process. For example, as an experienced driver, when you go into a car you automatically know how to drive it. However, if the experiences we continually repeat are negative, we effectively

learn to be anxious or depressed! People with phobias have had powerful one-off learning experiences as a result of a traumatic event, i.e they learned very quickly!

### 3.2 Creating Chemical Addiction

Neurochemicals eventually find their way into the body's complex cell structure and the cells adjust to absorb the chemicals and process them. To do this, they develop receptors on the surface of the cell that are unique to each chemical or molecular structure. Once a receptor receives its specific chemical, it operates as a key which allow the cells to absorb and process the chemicals.

As we repeat the same thoughts and experiences, in the same way that permanent neural networks develop, permanent receptor sites also develop for the specific chemical structure associated with the thoughts. As thoughts intensify and become more frequent, the receptors start to look out for and demand more chemicals to replace those already processed by the cell. In other words the cells and hence the body become addicted to the chemicals. This addiction results in the body starting to run the mind by telling the mind to go on producing more chemicals. This process, which I define as the mind body connection for the purpose of this paper, is illustrated schematically in figure 3.

Thoughts are an internal representation of the client's reality i.e. their perception of the environment. They are represented in the mind by images and self talk (internal voices). Thoughts give rise to emotions which are interpreted by the body through the chemical processes resulting in physical

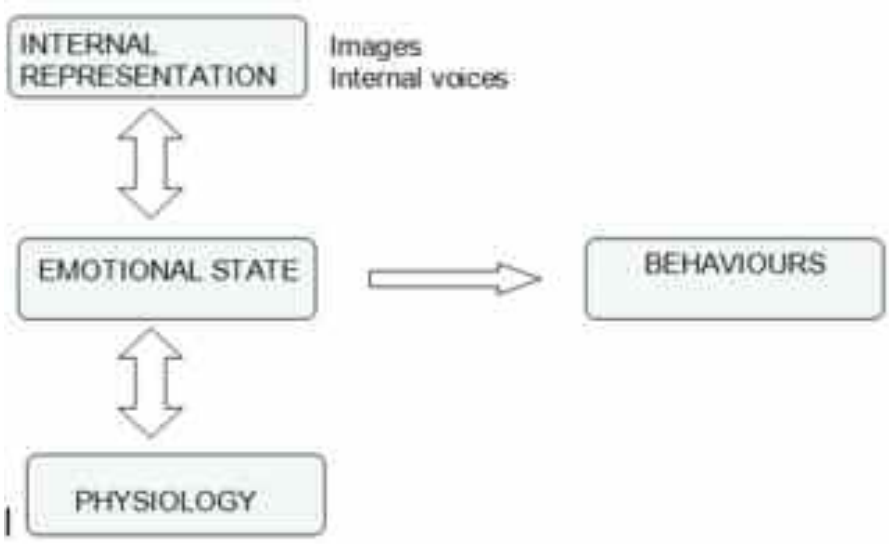



Figure 4: model for change

(kinesthetic) feelings and changes in physiology. Emotional changes affect physiology and likewise changes in physiology can affect emotions, creating a cybernetic loop. It is emotions that drive behaviour.

This relationship between thoughts (internal representation), physiology, emotions and behaviour means that we can reconfigure the mind body connection model as a model for change as shown in figure 4.

This model links the processes going on in the client's mind and body to emotions and behaviour. Therefore, it highlights two key components to change a client's emotional state and behaviour during therapy, i.e. their internal representation and physiology. (Internal representation: images; internal voices). Before considering the implications of the model for change, it is necessary to review the nature of depression and to construct a model of it.

### 4. A Model of Depression

The symptoms of depression are well documented. They are a combination of physical and 'mental' states including, for example:

*Feeling sad or empty*
*Lack of interest or pleasure*
*Tiredness*
*Feelings of hopelessness*
*Feelings of worthlessness or guilt*
*Inability to think clearly*
*Self-persecution/self-pity ('Why does it always happen to me?')*
*Insomnia*
*Weight loss or gain*
*Body agitation or slowing down*
*Thoughts of death*

Depression can affect the physical health of people by lowering lymphocyte responsiveness and immunoglobulin blood levels, which reduces the effectiveness of the immune system. This makes depressed people more prone to illness than non-depressed people.

Depressed people typically believe that they cannot change or should not change. In response to their perception or beliefs about the environment, they may develop a permanent pervasive style of thinking, which can be considered as learned pessimism.

However life is cyclical, consisting of positive and negative experiences for everyone, as shown in figure 5. How we deal with these variations

# Depression - mind body connection

depends on our attitude and personality. Typically optimists view life positively and pessimists view life negatively, as depicted in figures 6a and 6b, respectively.

Now if we add the cycles of life's experiences on top of these views, we can see how it is possible that even in the negative cycles, the optimist retains some of their positive state and that in the positive cycles, the pessimist retains some of their negative state. These are depicted in figures 7a and 7b, respectively.

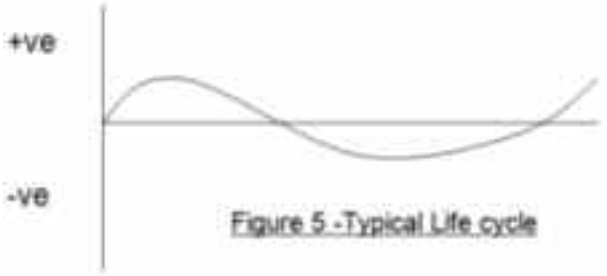


Figure 5 -Typical Life cycle

Of course, depressed people often have some periods in their life, where life is really painful due to: phobic or traumatic events such as rape and serious accidents for example; stressful and sad events such as bereavements, for example; and persistent or repetitive unpleasant events such as bullying, sexual or physical abuse for example. All of these events contribute to an ongoing negative thinking process.

This leads us to a useful definition, which I believe was defined by Michael Yapko, that depression is a painful life plus a pervasive style of thinking. Figure 7b is a useful schematic representation of this definition. Once they engage in this pervasive style of thinking, depressed people often focus on past negative events that caused their problems, always looking over their shoulders. Sometimes the actions of looking or moving forward are just too frightening or challenging for them and they may prefer the status quo. This is their comfort zone, dictated by the chemical addiction and corresponding neural networks, previously described.

One challenge for the therapist is to take the client out of this comfort zone!

## 5 Using the Model to Generate Change

### 5.1. Client "at cause"

A good starting point to move the client out of their comfort zone is to get them to accept they are at cause for their present state. By simply presenting and explaining figures 1 and 2, without a lot of technical detail, is often sufficient to elicit positive responses from clients.

First, the mind body connection model provides a powerful reframe of the client's condition, i.e. their condition is due to their bodies becoming addicted to chemicals as a result of neurological processes, over which they can take control, rather than an untreatable pathological mental disease, over which they have no control.

Secondly, the reframe helps the client to accept that their own repetitive negative thinking and actions created the chemical "addiction" and hence caused their condition. If the client accepts they are at cause, it empowers them to take responsibility for their own improvement by enabling them to change how they think and act.

If the client does accept being at cause, change will not happen easily. It takes an act of will to make the change, which can only come from within the client. If the client always sees themselves as the poor victim, (saying, for example: "why does this always happen to me?"), it is extremely disempowering and limits the possibility of the client taking any action to change.

To prove that changing the way they think and act can alter their mood or state, the client is invited to make some simple changes to their physiology and thoughts and observe how it changes their feelings. The approach used is similar to the following example, which I suggest you try out for yourself.

Sit as you would imagine a depressed person would sit, i.e. breathing shallow, head and eyes down, unhappy expression on your face and shoulders slumped forward. Now, take note of your feelings and any pictures or thoughts that come into your mind. Once you have done this, change your physiology to that of a happy or joyous person, i.e. shoulders back, breathing deeper, head up, eyes forward and a smile on your face or laugh heartily. Now notice the difference in your feelings, thoughts, pictures and internal dialogue.

Enhance your state by remembering a time and place when you were really relaxed. Next, stand up and take a proud confident posture and while snapping your fingers, say the

word "YES"continuously in progressively more positive or aggressive tones. How are you feeling now? Building on the above actions, it is but a small further step to have the client imagine and describe some changes to their life as a result of maintaining the positive state. This adds further momentum to the change process already begun during the demonstration.

The demonstration of change fits in nicely with a useful definition of change, coined by Dr Joe Dispenza: "Change is to act and think differently in the same environment." The challenge is to make the change permanent!

### 5.2. Changing the way clients think and act

The model suggests that one way to address the chemical imbalance between the brain and body is to change the way we think and act. This is achieved by changing the client's negative thinking and actions to positive thinking and actions. This is the challenge for therapy!

Dealing with thoughts, perceptions and emotions is the traditional territory for hypnotherapists. The model depicted in figure 2 suggests that the territory could be expanded to include both physiological and mental change processes. The model puts a strong focus on the role of physiology in treating depression.

Depressed people's thoughts can be focused on past events or impending doom, with the client acting out negative scenarios over and over again, in their minds. Clients are usually (but not always) associated in these internal images. Sometimes they are victims of their own internal voices which ruminate over their worst experiences of life, typically telling them how useless or worthless they are. In extreme cases these voices might even tell them to commit suicide. (NOTE: If the client suggests or appears to be suicidal, they should be referred back to their GP or mental health professional immediately).

People with depression often experience kinaesthetic shutdown by deliberately avoiding exercise. The effect of this is to increase tiredness, resulting in further reduction of exercise. In extreme cases the shutdown of psychomotor response can physically immobilise the client. They typically display a negative physiology i.e. sitting in a crouched or closed position with shallow breathing, with head and eyes down and shoulders rounded and detached from the world, lost in their negative memories. This combination of negative internal thinking and negative physiology operates as a cybernetic loop in which one reinforces the other!

Taking a detailed history from the client might reveal the circumstances or events that made the client depressed, including significant emotional events such as trauma or phobias. Each client is different, with his or her own issues and perceptions, which contribute to different degrees of depression. Therefore any therapy intervention should be tailored to suit the client's needs. Bearing in mind that the therapy has to take the client out of their comfort zone, the pace of change has to be carefully assessed so that it does not put it out of the client's reach.

Traditional strategies for dealing with depression are already well established and documented, so will not be described in detail in this paper. However, using the client-centric models, suggestions to support or enhance existing strategies are provided in four key areas: 1. Putting the client at cause 2. Changing internal representation.
3. Creating a positive physiology.
4. Creating an action plan.

Optimist Mental State
Figure 6a

Pessimist Mental State
Figure 6b

Optimist + Life Cycle
Figure 7a

Pessimist + Life Cycle
Figure 7b

#### 5.2.1 Putting the client at cause.

At the risk of going on *ad nauseam*, this is a critical first step in the change process. Clients need to put themselves at cause to make any change-work effective. The reframing potential of the model to support this is well

documented in section 5.1 so will not be further explained here.

### 5.2.2 Changing internal representations

Thoughts are represented by the client's internal images and internal voice(s). These images can be represented in black and white or colour.

The images can take on different spatial positions in the mind's eye (left, right middle or up, down and straight ahead). They can be near or far, framed or panoramic, and can be seen as movies playing in their minds or a still photograph. The client may experience themselves in the movie (associated) or be looking at themselves in the movie (dissociated). All of these image characteristics are known as sub-modalities in Neuro Linguistic Programming terminology. Likewise voices can take on different characteristics, including loudness, tone, mono or stereo and so on.

To demonstrate the power of submodalities, think of a pleasurable scene and notice how it is represented in your mind's eye. Now change the submodalities of the image, by moving it to a different spatial location, make the image bigger or smaller, or brighter or black and white and so on. Associate or dissociate in the image. Notice how your feelings change as you play around with them. Similarly, we can play around with voice. Try to hear an irritating or very serious internal voice. Now, change it to sound like Donald Duck and notice how it lessens the intensity of the emotion, associated with it. One client who was hearing internal voices asking her to harm herself, controlled and eventually eliminated them by giving them a squeaky pathetic tone, which loosened their authority and sincerity.

Many hypnotherapy and NLP patterns, used in therapy, already take advantage of these characteristics or sub-modalities to bring about change. It is outside the scope of this paper to describe them all in detail or to provide hypnosis scripts to cover all possibilities. The following list includes a number of examples that are regularly used. (Note that the list includes Emotional Freedom Technique (EFT), a very powerful and invaluable technique for dealing with a wide range of negative emotional issues). The list is far from being exhaustive:

- Dealing with significant emotional events such as trauma and phobias is often the first stage of an intervention. Techniques for doing this include timeline work, EFT and NLP Fast Phobia (Double Dissociation) Cure, for example.
- Using the scramble/reverse movie technique (dissociation) to deal with unpleasant events or memories.
- Associating the client into pleasurable memories and images and dissociating from painful ones. (Association and dissociation techniques are often used in systematic desensitisation for clients suffering anxiety.)
- Challenging and changing internal voices to loosen the emotional intensity of nagging or unpleasant voices.
- Creating positive resource states, such as happiness, confidence and relaxation and anchoring them.
- Creating positive future state images supported by solution focussed dialogue.
- Using relaxation techniques.
- Reframing the client's negative experiences and perceptions into positive ones.
- Using parts integration to deal with multiple parts that cause internal conflict.
- Using EFT to remove negative emotions from unpleasant memories.
- Changing values and beliefs and eliminating limiting decisions.
- Using metaphors to facilitate change.

Many of the techniques are within the client's capability to use by themselves. It is recommended to train the client to use a number of them to build into their personal action plan (see section 5.2.4).

### 5.2.3 Creating a positive physiology

I now place a lot of emphasis on supporting the client to change and manage their physiology, which I tended to ignore in my early years of practice. In this context, physiology includes physical activity. The demonstration of changing their physiology, described previously, is a great convincer for the client to become more involved in doing more activity.

Research published in the *Journal of Sports Medicine* by F Dimeo *et al* in 2001 concludes that physical exercise may be more effective than drugs for treating mild to moderate depression. The purpose of changing their physiology is to get the client moving again, i.e. to change their emotion. Exercise stimulates the neurotransmitters to produce serotonin and endorphins, which improves how they feel.

Changing physiology can range from simple postural changes to full exercise programmes carried out in a

gym. However, the changes have to be within the client's capability to change.

For example, one client I worked with was a very keen cyclist prior to his depressive episodes that virtually turned him into a couch potato. As part of his treatment, I suggested that he should cycle everyday for at least 30 minutes. The next time I saw the client he said he felt a failure because he did not have the energy or the motivation to do this. I had set the bar too high and he nearly lost his faith in me, as a result. We subsequently adjusted the programme, to be within his capability, to help turn him around!

It helps to ask the client what they might enjoy doing or what they once enjoyed doing, to include in their programme. Regardless of the magnitude or type of activity, the programme should be structured so that the client can experience achievement and success, no matter how small the task.

Examples of some activities include:

- Adopting positive postures including deep breathing, head and eyes up and smiling or laughing heartily.
- Moving rhythmically. This could be as simple as walking on the spot for a few minutes to gentle jogging or cycling. I encourage the client to make positive affirmations while doing the exercise.
- Adopting the postures of role models or prominent successful people and anchoring the states elicited by them. Showing pictures of people in various positive emotional states and getting the client to copy or model them is useful.
- Keep fit workout (unless the therapist is also a keep fit coach, the client should only do this under the supervision of a qualified keep fit coach). The client can be encouraged to join a gym. This has the additional advantage of improving the client's social interaction.
- Participating in dance classes.
- Listening to or playing relaxing music.
- Taking up art.
- Reconnecting with family and friends.
- Helping with family chores once again, for example, helping to tidy a room.

### 5.2.4 Creating an action plan

Ensure the client takes responsibly for their own progress by encouraging them to become involved in preparing their action plan.

The action plan should be structured to provide a good balance of activities designed to change both internal representation and physiology, depending on the client needs. A typical action plan might include some of the following activities:

- Setting goals with varying degrees of stimulation and difficulty.
- Listening to their hypnotherapy CD for relaxation and change.
- Daily mental programme including:

*a) Setting/reinforcing positive anchors for confidence, relaxation, happiness, empowerment and motivation.*
*b) Cleaning up the previous day's negative emotional events using the scramble or reverse movie technique and EFT.*
*c) Rehearsal of how they would like their day ahead to unfold, using visualisation techniques.*
*d) Stating/writing down three things they are looking forward to that day.*

- Daily physical programme including:

*a) Postural/physiology changes.*
*b) Rhythmic movement and exercise programme.*
*c) Doing household chores.*
*d) Meeting people.*
*e) Indulging in a hobby.*

- Maintaining a log/praise book logging their daily progress and achievements, no matter how small, as success breeds success!

## 6. Conclusion

Experience suggests that by explaining the simple mind body connection model and model for change to clients, it can result in a positive shift of their perceptions of depression and its treatment, through their reframing and motivational potential. The reframe enables the client to understand how they are at cause for their condition and encourages and empowers them to change.The models also suggest that treatment of depression can be enhanced by utilising processes that modify the client's internal representation and physiology in equal measures. They are included in a four-step process model that can be integrated into or utilised in traditional treatment strategies. The four steps are:

1. Putting the client at cause.
2. Changing internal representation.
3. Changing physiology.
4. Creating an action plan.

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# Hypnosis and mindfulness in the treatment of depression

## Carole Wan says hypnotherapy can reach depressed people in a way CBT alone cannot

On 17 December 2012, I attended the Royal College of Medicine for a series of presentations on depression. One presenter, Michael Yapko, gave a talk via video link on the above theme. I first trained with Yapko in the early 1990s. Since then, I have attended many of his training courses, particularly in the use of hypnosis for pain management and for treating depression. Our own three-day masterclass in depressive disorders, partly based on the work of Yapko, has recently been updated to include information on the efficacy of mindfulness, so this topic was of particular interest.

The United Kingdom currently loses revenue of half a billion pounds per annum due to depressive disorders and the effects of this illness. Over 46 million prescriptions were issued for anti-depressant medication in 2011. One individual in seven in Scotland is now taking antidepressants. Although it is now over 20 years ago since the publication of Michael Yapko's first books on hypnosis and depression (1 & 2) hypnotherapy is still often overlooked as a possible treatment for this illness. As Yapko said, "(..) hypnosis is still the crazy cousin that no one wants to invite to the family picnic". That is, relaxation and mindfulness are somehow seen as the 'more acceptable' face of therapy for depressive illness, despite the fact that hypnosis can be so effective. He argues that mindfulness is so similar to hypnosis (certainly self hypnosis) that the two are sometimes interchangeable.

There are many causes of depression but generally a serotonin imbalance or genetic causes are not featured. Kenneth Kendall, professor of psychiatry and genetics at Medical College, Virginia quotes, "the strongest predictor of depression is still your life experience. There aren't any genes that make you depressed. There are genes that make you vulnerable to depression." What is evident is that there is a trans-generational risk of transmission of the likelihood of depression caused, partly, by family values. These may be built on passivity, the "why bother" approach. Passive therapy therefore is not helpful, as ruminative responses do not help. These include catastrophising, analysing how things may become even worse and journalling. The constant rumination and analytical approach that may be a common feature of depressive illness just causes the sufferer to spiral down.

This was illustrated by two clients that presented to me on the same day a couple of years ago. Both had been diagnosed with depression. Both were male and both were in stable relationships. The first client I saw was in his 40s. His long-term depression had caused him to ask, and be granted, reduced hours of work. He worked two days a week at home and had reduced his travelling time to work by working the remaining days on a flexitime basis, therefore avoiding the stressful rush hour. As this was the third bout of depression he had suffered in his life, he already knew what to do. However this time he chose not to take antidepressants. Instead, he was

attending cookery classes and had started to learn t'ai chi. Hypnosis was another piece of the jigsaw that he hoped would help him to finally beat this illness. During the course of treatment, which lasted approximately four months, this gentleman conquered his depression by using a combination of exercise, learning new skills, reducing work-related stress (he held an executive post in a large company) and practising skills that he could use on a daily basis.

The second client was a little younger and his wife was expecting their second child. He was already taking antidepressants when he attended therapy and was anxious to get "back to normal" as soon as possible. He ruminated constantly and had abandoned the course of CBT proposed by his GP. Despite this, he kept a daily record of how he was feeling and often attended appointments with books and charts that were a legacy from his CBT sessions. "I've had two bad days and nine good days since I last saw you," he would say: "I'm really not happy with that." He expected every day to be a good day. In many ways, the CBT had made matters worse. My first client, on the other hand, responded very well to my approach of hypnotherapy combined with cognitive therapy. Client number two was in therapy for much longer. He resisted hypnosis as he felt it "wouldn't work." He was convinced that CBT was the best way to go, despite the fact that it did not seem to have helped him. He didn't want hypnotherapy, even though he had attended my consulting room on recommendation from a friend. It was only when I suggested that learning some breathing techniques may help him to relax that he experienced relaxation. Not surprisingly, he responded to the "breathing techniques" exceedingly well and once he understood what hypnotherapy entailed he enjoyed sessions of hypnosis. We also used a solution-focused approach to his treatment and this, coupled with some metaphorical hypnosis work and learning self-hypnosis, was the turning point.

Although he found it frustrating as he gradually cut down on his antidepressants, with the help of his doctor and myself, he finally reached the stage where he began to recognise his negative thinking processes and his "type A" behaviour patterns and find some strategies to help with this catastrophising and his tendency to react by analysing every situation. He realised that he had, in fact, experienced a number of quite serious life events during a very short period of time. He became aware that previous optimism had given way to a fear of "what if". He was not born with depression and there was no reason why he would ever encounter it again.

The highest relapse rate for any medication occurs in the use of antidepressants. One important issue that Yapko discussed was the fact that some therapists may disempower their clients by either labelling them ("a depressive") or focusing too much on the history of their depressive illness. Hypnosis is empowering and too much thinking can be disempowering. Certainly, I find that looking at positive life experiences and achievements during the initial interview is an important part of the therapeutic process. Homework, I believe, is always valuable; particularly so when treating depression whatever method is used, whether brief solution-focused hypnotherapy, cognitive therapy, Ericksonian hypnotherapy, counselling or mindfulness makes very little difference. None of these "cure" depression.

The one thing that lifts depression is the associations that people build, a feeling of empowerment, learning new skills, sorting out sleep problems (often a part of depression), learning to be more resourceful. CBT can, I believe, be an effective part of the treatment plan. However CBT does have its limitations by the very fact that it is cognitive rather than experiential. With the use of hypnosis we can instil positive cognitions once we've identified the negative ones and dealt with them. Hypnosis by itself, as we know, can be used for ego strengthening. It empowers people and makes the resource will. It builds expectancy and flexibility and intensifies a useful subjective experience. It helps individuals tolerate ambiguity and can be used on a metaphorical level to help people overcome any blocks.

For those of you familiar with the work of Erickson, his story on the

# Hypnosis and Mindfulness in the treatment of depression

African violet lady neatly illustrates this in a solution-focused way. The story is in the box below.

The treatment of depression should therefore be active i.e. treatment is better if the client is actively involved in their own treatment. Useful tools are self-hypnosis and positive psychology (3). These both operate on the simple premise that change is an internal experience that we need to create in order to deal with the unstable attributional style that is common feature of depression. One of Yapko's books on depression is called *Hand-me-down Blues.* Whenever I discuss this book and its contents with clients presenting with depressive disorders, I have yet to encounter anyone who disagrees. In fact, human relationships can either increase or decrease vulnerability to depression. For example, we know that our brain will actually change depending on the relationship that we may be part of. Just as we have all experienced sadness and grief we have also experienced elation and love.

Feelings of loneliness and isolation are on the rise and these can only increase further as technology develops. A word that many of you may be familiar with - epigenetics - is also becoming more important as there is overwhelming evidence that a depressed mother, for example, may give birth to a child who is more vulnerable to depression (due to her lack of attention and interaction from the mother). As this child grows, her own negative attributional styles may then lead her to develop depression at some time in her adult life. However, relaxation can be seen to actually change our genetic expression.

Research carried out at Harvard University has found that regular relaxation will change our genes in order to increase immunity. This experiment, led by Herbert Benson, went one stage further. The control

A favourite aunt of one of Erickson's colleagues was living in Milwaukee and had become quite seriously depressed. When Erickson gave a lecture there, the colleague asked him to visit the aunt and see if he could help her.

The woman had inherited a fortune and lived in the family mansion. But she lived all alone, never having married, and by now had lost most of her close relatives. She was in her 60s and had medical problems that put her in a wheelchair and severely curtailed her social activities. She had begun to hint to her nephew that she was thinking of suicide.

After Erickson finished his lecture, he took a taxi to the aunt's house. She was expecting him, having been told by her nephew that he was coming. She met Erickson at the door and gave him a tour of the large house. She had had the house remodelled to allow wheelchair access, but other than that, it appeared as if nothing had been changed since the 1890s. The furniture and household decorations showed a faded glory, smelling of must. Erickson was struck by the fact that all the curtains were kept closed, making the house a depressing place indeed. The aunt saved the very best for last, however, and finally ushered Erickson into the greenhouse nursery attached to the house. This was her pride and joy; she had a green thumb and spent many happy hours working with the plants. She proudly showed him her latest project taking cuttings from her African violets and starting new plants.

In the discussion that followed, Erickson found out that the woman was very isolated. She had previously been quite active in her local church, but since her confinement to a wheelchair she attended church only on Sundays. Because there was no wheelchair access to the church, she hired her handyman to give her a ride to church and lift her into the building after services had started, so she wouldn't disrupt the flow of foot traffic into the church. She also left before services had ended, again so she wouldn't block traffic.

After hearing her story, Erickson told her that her nephew was worried about how depressed she had become. She admitted that it had become quite serious. But Erickson told her that he thought depression was not really the problem. It was clear to him that her problem was that she was not being a very good Christian. She was taken aback by this and began to bristle, until he explained. "Here you are with all this money, time on your hands, and a green thumb. And it's all going to waste. What I recommend is that you get a copy of your church membership list and then look in the latest church bulletin. You'll find

group, who had not been involved in any relaxation methods, was asked to practice daily relaxation. After just two months, genes identified as those that helped fight inflammation and fight cancer, were actually switched on. And the more people practised relaxation, the healthier they became.

So what about mindfulness? Yapko argued that mindfulness and hypnosis are almost same thing. There are certainly many features of mindfulness that are evident in hypnosis. For example, dissociating from the outside world by going inside, focusing on the breath, focusing on the current experience (rather than the past or the future), separating the conscious from the subconscious. Suggesting therefore that a client focuses on each breath whilst, at the same time, thinks feelings of acceptance and compassion means that the individual is not thinking about themselves. Imagining thoughts drifting to the sky as if they were clouds floating away is a common hypnotic suggestion for separating intrusive thoughts from the relaxed mind, although it is also utilised in mindfulness. Both mindfulness and positive psychology (see the work of Martin Seligman) strive to generate an unconscious response although neither called are hypnosis. What they do have in common with hypnosis, however, is that all three of these approaches will create a greater internal locus of control, more self-awareness and self-acceptance and a degree of emotional self-regulation.

Mindfulness is known to establish a positive expectancy about life, as does hypnosis, which employs positive suggestion and ego strengthening. Mindfulness involves a degree of disassociation, which is of course one of the main features of the trance state. It is believed that mindfulness encourages an unstable attributional style and will involve pattern interrupts and reframing– something that any of us skilled in both hypnosis and NLP are familiar with. Regardless of what we call the treatment, the utilization of hypnosis within a treatment plan for depression, may only strengthen the efficacy of any psychotherapeutic approach.

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announcements of births, illnesses, graduations, engagements, and marriages in there—all the happy and sad events in the life of people in the congregation. Make a number of African violet cuttings and get them well established. Then repot them in gift pots and have your handyman drive you to the homes of people who are affected by these happy or sad events. Bring them a plant and your congratulations or condolences and comfort, whichever is appropriate to the situation."

Hearing this, the woman agreed that perhaps she had fallen down in her Christian duty and agreed to do more.

Twenty years later, as I was sitting in Erickson's office, he pulled out one of his scrapbooks and showed me an article from the Milwaukee Journal (or whatever the local paper was called). It was a feature article with a large headline that read, "African Violet Queen of Milwaukee Dies, Mourned by Thousands." The article detailed the life of this incredibly caring woman who had become famous for her trademark flowers and her charitable work with people in the community for the ten years preceding her death.

From O'Hanlon, B; *Do One Thing Different* William Morrow pp 6-8

# Unconscious art

## Cathy Preston explains how it works

It would be easy to assume that unconscious art is just art therapy with a catchy name, but that isn't the case. In fact it can barely be defined as therapy at all, though is therapeutic in a range of ways. Nor is hypnosis necessary to practise it, though the closer the connection between your conscious and unconscious, the easier it is to achieve without interference from the conscious mind, so if you're either a hypnotherapy practitioner or have been a client of one it's likely you too will find it much easier than the man or woman on the street. But some seem to have an innate ability to tap into their unconscious so it can be hard to predict.

*My demons: Much more recent, after an extended period of external difficulty. I'd lost much connection with my ability to express in this way. It was very reassuring to discover my darker side and my deeper workings were so good humoured. Pastels on dark background.*

### The Basics

1 This method is as possible for anyone with a high level of experience or training in painting and drawing as it is for those who have none at all. It can prove easier for those who have none because letting go of expectations and techniques can be difficult, but those who have no training may also consider themselves bad at art, so that too can be a barrier. If you have any skills they will come into play once you allow the image to begin to manifest, and if you don't, you may discover talents you had no idea you possessed, but either way, the main point is not to produce a piece of great technical merit, but to allow what you contain to be expressed.

2 Usually, most artistic creations come from observation, of a desire to recreate elements of the physical world on canvas or paper. Unconscious Art requires you to turn and face the other way, to look within. However you may not even be aware of what you're drawing while you're drawing it, until a certain point when it becomes apparent. Then, while your natural skills may come into play, it's helpful to prevent your sense of control and desire to produce a work of merit from taking over. There are several reasons for this. Firstly, because it's preferable to allow the work to manifest as it needs, sometimes with seeming flaws and lack of artfulness, and secondly because sometimes you may find gifts and skills you didn't know you had by allowing it.

3 Doing Unconscious art can produce some quite unexpected effects and results because, not only does it come from parts of yourself you may have no conscious knowledge of, but also because these differing aspects can produce work of varying skill levels. I have produced works which look like they've been drawn by a not very artistic five-year old and ones which I could not produce consciously if I tried, due to being far above my conscious skill level. This in itself can be enlightening. But also you can learn from your deeper self and discover how to apply these inner skills to your more conscious works, and whatever you produce can be fascinating.

### Execution

There are various starting points and ways to do this:

a) Start drawing or painting without the faintest idea of what will manifest. Do not think or consider in any way. Allow yourself free rein irrespective of whether something recognisable begins to appear or not.
b) Sit quietly and wait for the beginnings of an image to appear in your mind. Start drawing or painting that. Allow yourself to do this in whatever way feels right at the time rather than conforming to your normal style.
c) Put whatever colours on paper or

canvas you feel drawn to, blend and merge them in ways which appeal. Sit and look at those colours and see if you can see any images in them, as you might look for images in a fire. Once you do, begin to paint or draw them in place. It doesn't matter if the end result is a complete picture or a series of apparently unrelated objects. It can feel a little like you're projecting the inside of your mind onto the paper.

d) Doodle: allow yourself far freer expression than you might normally when doodling.

e) Sit for a few moments considering what you're feeling (even about the thought of attempting this) and then try and depict that pictorially in whatever way suits you best.

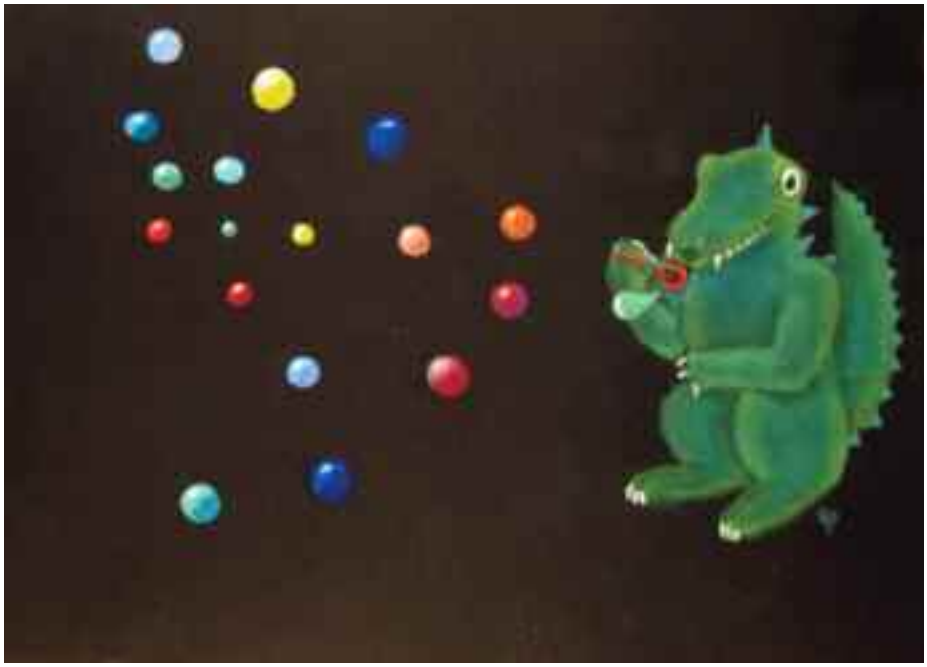
f) Consider a concept or experience that's been on your mind or has affected you recently. Imagine ways of depicting that symbolically and do so using whatever visual methods appeal.

g) You will see from my images there can be a level of sophistication or real innocence revealed. It can be hard when you expect yourself to produce something mature and a childlike image manifests, or when you initially imagine an image portraying one thing, yet something other is revealed. Trust that whatever comes is what's needed, try not to control it or have expectations.

h) Enjoy the process. There's no one right way to do this and no correct outcome, what works for you and the images you produce will be unique to you. That's in many ways the antithesis of what we're taught (not just about art) but it's what will create the most satisfying and rewarding outcome and image, even if you may initially struggle to let go enough to produce anything at all.

i) If you can, it's helpful to do this on a black background (though not vital) because it's easier to draw these kind of images and concepts from emptiness than bright blankness. This means it lends itself to certain types of mediums and not others. Pastels and acrylics for example can work very well, whereas watercolours or pencils will not.

What matters most however is that you choose a background which pleases you, not in an intellectual way, but in a more 'sensing' one, which may well depend upon your situation or mood at the time.



*Bubble dragon: Produced one night when the electricity went out and I wanted something to do, so created under the light of an oil lamp. What this strange creature might mean is anyone's guess. I have no idea, but it's a good example of what curiosities can appear. Pastels on card.*

*Third Eye: The background was done on this first, the colours expressing the mood. The faces appeared out of it, I just filled them in, as if my unconscious were projecting itself onto the paper.*

# Unconscious art

### Side Effects

You may find:

1 An increase in artistic ability.
2 A greater pleasure in creating images (with or without the above).
3 An increasing insight into your inner workings.
4 A developing self-love and acceptance, quite often associated with:
5 A sense of infatuation with the image being created at the time, as both an outpouring of your self and a birthing of the image.
6 An appreciation of art and the created image in a whole new way.
7 A deeper insight into the metaphors our unconscious contains (since many of them are common and universal, irrespective of cultural norms) which can be applied in both personal and professional ways.
8 A greater natural understanding of symbols and imagery.
9 Finding yourself in the seam of a creative activity, which can be a lifelong journey.
10 The ability to work more closely and in tandem with your unconscious and emotions.
11 A greater insight into dreams and visions.

### Contraindications

There are some who may not only find doing this difficult but detrimental. As one should not use hypnotherapy on those with a psychosis due to differing and unpredictable brain chemistry, so Unconscious art can lead anyone of such a nature into delusional and/or unhelpful places, and should be avoided.

To find out more:
www.immortalart.co.uk Or contact Cathy at cathy@immortalart.co.uk or call: 01566 86402

## Members' feedback

# What's new and reviews

*Love Birds*

Published by Hodder £13.99

Trevor Silvester

*Reviewed by Fiona Nicolson*


The new book by Trevor Silvester, *Love Birds*, is aimed at helping couples improve their lives together through understanding that the differences between them can be used positively. It is a book written for a wider audience but the principles it uses can be incorporated and utilised by therapists working through relationship issues both with couples and individuals.

Trevor originally had the idea for *Love Birds* through his extensive work with couples. He disagreed with the premise of the book by John Grey, *Men Are From Mars, Women Are From Venus,* that the most common relationship problems between men and women are as a result of the fundamental differences between the genders. Through his work with gay couples, Trevor had noticed that the problems and differences gay couples were experiencing were the same as anyone else.

Trevor was using Myers Brigg Personality Inventory and Neuro Linguistic Programming (NLP) representational systems as an integrated part of his overall therapeutic approach. Myers Brigg Personality Inventory is a means of measuring psychological preferences in how people perceive the world and make decisions, and aspects of Myers Brigg had become integrated into NLP metaprogram. NLP representational systems similarly, is a way of grouping and describing how individuals operate in, and make sense of, their world.

Through his use of Myers Brigg and NLP representational systems, Trevor pinpointed the key differences of behavioural characteristics of the couples and individuals with whom he was working. Most people think that everyone else sees the world

just like them, but by highlighting and explaining these key differences to the couples themselves, they were able to gain insight and start to recognise that the differences between them were not necessarily negative. It was just that they each had a different way of seeing the world. Trevor describes it as "about taking a relationship back to how two people are relating." These are the principles he still uses as a relationship coach and is the basis for *Love Birds*.

When asked about the use of birds as a metaphor for the adaptation of Myers Briggs and NLP terminology for a mainstream reader, Trevor said he had wanted to write a light-hearted book about a serious subject. "I wanted to make people smile at the things that they are having great difficulty with - if I stuck with the language of NLP and Myers Brigg then it would have been a barrier. I knew that if I could turn it into something cute and cuddly then people could sit opposite each other with a glass of wine and start to laugh about things that previously they would have been shouting about."

The book is written in a fun and approachable style with the reader being initially introduced to the rationale for the book and also to a level of expectation of what the book anticipates both the individual and couple will achieve from the process. The next section covers the science behind why we fall in love and the motivation for relationships, followed by an explanation of the methodology of the book.

The book takes the format of two quizzes that individuals complete. The first of which segments them into one of two groupings which are named Ground Birds and Sky Birds.

This is where the fun starts – my partner and I completed the quiz together and I read out our respective groups to much head nodding and shaking in equal quantities and a good amount of laughter. A second and more in-depth quiz (it only takes a few minutes – lots more knowing nodding, and a tiny bit of sighing) further segments the participants into one of eight possible groupings of preferences which have bird names from Owl through to Nightingale. This is followed by profile explanations of each bird type and then an analysis of the inter-relationships of various combinations of the different bird types.

Trevor commented that men and women are in a different place from 20 years ago, "They are ready now for something more sophisticated than generalising into two groups of people – that being said I made it eight groups of people and it is still only a model. I have to trust that the reader will recognise that I cannot fit everyone precisely into any label I give them, but there will be enough things making them nod, that they will look sideways from the specific type I have given them. This will allow them to find even more things relevant to themselves. I don't want them to read it as paint by numbers book but more of a way of opening a dialogue with their partners."

The book is also full of stories about Trevor and his wife which brings the

# What's new and reviews

book to life and highlights that it has a real application in everyday relationships and is not just theoretical. Trevor explains that he is an Owl and his wife is a Swan and are therefore opposites, "We use this stuff on a weekly basis because we are opposites and it gives us a language and understanding of how to value the differences between us."

The fact that the book is now on the shelves of mainstream bookstores and that Penguin have bought the rights for the United States highlights the belief that this will definitely appeal to a wider audience. But how useful is it as a tool for therapists working with relationship issues? I do not work specifically with relationship

problems but I have several clients who whilst progressing

through layers of their own issues have realised that they find a part of their relationship or even an element of their partner's behaviour to be detrimental or negative in some respect. On my suggestion, they have worked their way through the relevant sections of the book, either individually or as a couple, and the insights gathered from that process and the ensuing discussions have helped them to understand things from a different and ultimately more positive perspective.

I think that utilising the Myers Brig and NLP representational systems processes could be an effective

element of a therapist's toolkit, not just from the insights it brings for individuals and couples collectively, but also from a perspective of joint tasking between sessions. The book allows clients to engage in a quite complex process in an approachable way – the bird metaphor makes it simple to understand and easy for the relationship coach to explain and discuss. My only suggestion would be that the full questionnaires should be available online for therapists to download and I understand that this will be the case in the near future. It would be beneficial for therapists wanting to send the questionnaires to clients in advance to be able to access them easily.

Definitely worth a read – both on a personal basis and with a therapists hat on as well. After all, most of us could benefit from some further insights into our own relationships whether as a partner or friend which we can then further utilise in the therapy room.

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thoughts and reflections: a poem

## Spare a Thought for the Therapist

*By Joe McAnelly*

I work endlessly to help those who come across my path and that is so fulfilling and the days fly by like clouds that frequent the sky and time just seems to lend itself to my craft. But things are not always what they seem and life recently has not been like that.

I got a call one day from Mr C who had designs on taking care of me and consulted a doctor who cut him off and disconnected the line for all time, and, just for good measure, give some pills and said "they may make you ill but statistics show they will make you better". Well, I took those pills and they did make me ill and consoled myself with thought that I am not a statistic but a human being with a brain and the power of suggestion and I can do better.

As I recover from the ills of that dread disease a nightmare did descend around a metaphor that I did use so often with so much ease. It was about a train that was laden with carriages of excess emotion and the need to "let them go". I was the driver of the train and carriages did leave and seem to gain astride my pain an advantage of unparalleled proportion. As the carriages seem to pass the clientele did shout and scream about their misfortune.

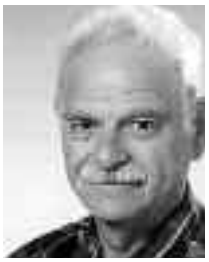
"Just one last thing" they shout just in case there is some doubt of the engine failing to reach its destination and dying ...with frenzied adulation they cry "can we

see you one last time so that we can be fine just down the line". It would seem that they are so wrapped up in their own plight and have little insight into how the engine and it's driver are recovering from the malfunction at the junction and how much energy the drive has expended in the fight. A subtle dawning at this junction comes across the driver of the train who has endured so much pain and resolved so much gain for those that have been on the train. It's time to take some time and a well-earned rest and devote some attention to other people who in the past have rarely got a mention in the hectic world pseudo redemption. And at close I hear a voice echoing from the hills shouting for statistical data and I am reminded of those pills and the thought of all those ills and that no human is a statistic they have a brain, the gift of life and can do better.

*Joe had colon cancer May 2012 but now recovered and back to practising therapy.*

Rubin Battino

# On the Importance of Inclusivity



Clients come to see us because they are stuck, that is, they know only one interpretation for a particular stimulus in their life, and that interpretation leads to one response. Although this is a rather simplistic model of psychotherapy, it seems to fit the facts. This means that our main task as therapists is to help clients discover choices in interpretation and choices in responses. Then, they are not stuck!

Also, both we and our clients tend to think about what is troubling them is in an either/or fashion. They are depressed, panicked, anxious, obsessive, sad, grieving, unhappy, desperate, blocked, and limited *or* they are not.

Bill O'Hanlon (1) found a fascinating way to deal with this stuck state of affairs. He calls it "inclusivity" which gets into the realm of both/and. This is an oxymoronic confusion or scrambling meaning technique. This is best illustrated by the following statements, generally prefaced by "I wonder how it would be or feel to be(...)"happily depressed, depressedly happy; compulsively spontaneous, spontaneously compulsive; obsessively casual, casually obsessive; sadly delighted, delightedly or happily sad; desperately free, freely desperate; actively blocked, blocked actively; grievingly full of warm memories, warmly grieving; calmly panicked, panicked calmly; anxiously at peace, peacefully or calmly anxious; stressedly calm, calmly stressed; openly protective, protectively open; freely dependent, dependently free.

Please note that these are all oxymorons like a "down escalator" or "jumbo shrimp".

Recently, in the support group I facilitate, one of the members was talking about being depressed. This was first normalized by another group member talking about how depressed she had been and is still occasionally depressed about having cancer.

I pointed out that almost everyone I know who has been diagnosed with a life-challenging disease goes through depression at one time or another. Then, I said: "I wonder what it would be like to be happily depressed." The confusion that appeared in his face was a wonder to behold. Others in the group got the idea and added many both/and comments. (I leave this to your imagination.) He began to smile with the novelty of these new ideas. How could he be depressedly alive and active? What would it be like to be energetically slothful?

Inclusive statements scramble thinking and provide interesting choices to what had hitherto been restricted. I hope that the more you think about the transformation involved in going from either/or to both/and will provide you with choices in your own life and also choices for your clients. You might even become effectively ineffective, for example!

*Reference*

*1) O'Hanlon, B. (2003). A guide to inclusive therapy. 26 methods of respectful resistance-dissolving therapy. New York: W.W. Norton and Company.*

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