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Gil Boyne: Interview With The Master

NATIONAL COUNCIL FOR HYPNOTHERAPY
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CONTENTS

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

Writing the editorial for the Winter edition is always fun, because I get a chance to reflect on the year and wish you all a Happy Christmas and New Year.

The tricky part is future pacing myself from Halloween, when I usually write this, to Christmas. Luckily, the early snow is making it much easier to get into the Christmas spirit.

2008 has been a year of much change, and despite the background of doom and gloom in the world economy, I find myself feeling excited and inspired as I reflect on the year.

Part of that excitement has to do with the front cover, which not only marks a milestone in the continued evolution of the Journal, but also a highlight in my career.

That's because, since I last wrote to you all, I've had the very great pleasure of training with one of our profession's longest serving and most colourful characters: the legend that is NCH Fellow, Gil Boyne.

Spending time in the company of a wonderful spirit like Gil, with his insight, his passion for the work, and his deep love of people made a lasting impression on me: I hope my interview with him in this edition will do the same for you.

Gil's Masterclass was assisted by another hero of mine: Dr. John Butler, who many of you will recognise from Channel 4's "Hypno-Surgery Live" programme.

John is an inspiration, not only because he understands Gil's work inside out, but also because he is someone who has "walked the walk" by using self-hypnosis for his own hernia repair operation. There were quite a few impressed faces in the room when he showed that film, I can tell you.

The NCH has been through many changes this year, not least in the inevitable turnover in committee. I say inevitable because, as a members co-operative, it falls to individual members to commit their time and plenty of goodwill for the benefit of us all.

Looking at the current committee, I see a group of committed individuals with a single purpose - making sure the NCH continues to represent YOU effectively as well as meeting YOUR needs - and as you'll read later on in the Committee News, they are keen to find out what YOU think.

I would also like to extend my heart-felt thanks to each and every one of you who has contributed to the Journal this year.

I know that some of you have had to wait for several editions to get your contribution published, but please keep them coming in. Having a good selection of material to choose from not only helps me ensure each edition contains a good balance of articles, but it also means the Journal reflects the interests of each and every one of you most effectively.

So what is it that inspires and excites me most about all the people I have mentioned? Quite simply, it is their willingness to take action.

Gil Boyne, who shows us that taking action can shape our destiny; Dr. John Butler, who leads by example; the people on the NCH committee, who have stepped up for the good of us all; the contributors who make this Journal what it is.

All of them taking action.

Before I wrap up, there are four other people taking action who I want to make special mention of. I don't want to say too much and steal John Lawrence's thunder, so be sure to read the UKCHO update in Committee News, but there are four individuals bravely putting aside past differences to find a way forward for Voluntary Self Regulation. Fingers crossed.

I have no idea what the New Year will hold, but I remain optimistic as long as there are inspiring and passionate people out there who are willing to take action.

May your own actions guide you to a very happy and prosperous New Year and I look forward to talking with you again in the Spring.

Enjoy the read.

Rob Woodgate

Committee News and AGM

View From The Chair

Many of you will be aware that prior to taking up the position of Chairman I was (briefly) the Ethics Director and prior to that, the Public Protection Officer.

I was more than a little surprised when the Chair became vacant so shortly after Fiona's resignation, but welcomed the opportunity of putting my name forward for consideration and was delighted when my fellow members of the Executive demonstrated their support by voting for my appointment as Chairman.

I firmly believe that change in any organisation is a force for good if handled appropriately, however I also think 'experience' is one of the best ways of avoiding the 'mistakes' of the past. My first priority has been to strengthen the organisation: by inviting Fiona Biddle to continue in her role as a member of the accreditation committee; by inviting Paul Howard, our former highly successful Marketing Director to return to the Executive in that role.

Rob Woodgate, who you will know as our Journal Editor, is taking on additional responsibility as Director of Technology with a special brief to improve our web functionality/interactivity and the automation of our admin. functions, and last but by no means least I have invited Trevor Silvester back to the Executive as our Ethics Director. With this enhanced Executive I'm sure we can meet the needs of our members.

Which leads me to the next step - what are the needs of our members?

In the past we have done surveys with very limited response; we have asked Conference delegates to complete surveys, which they have done with much enthusiasm, but Conference delegates represent less that 10% of our members. So, we really need to know what "you" think and what you want from our organisation.

With this in mind, your Executive Committee have been allocated a list of contact details and members' names, who they will speak to over the coming months. Our objective is simple: 'that a member of your Executive will speak to each and every member by the end of the first quarter next year'.

If you can't wait that long or feel we might have missed you, don't wait, give us a call - our contact details are at the front of the journal or on the website. We want to hear from you!

Paul White

Research News

As I write this it is mid-October, and it is a warm, sunny autumn day – yes, we do get them occasionally, even in the North of Scotland. Hard to believe that by the time you receive this it will be Christmas, or even the New Year. Even more so because, miracle of miracles, for once there are no Christmas decorations in the shops yet. Nor are we being subjected to endless rounds of Jingle Bells in the arcades. So it does feel a bit strange right now to be wishing you all a very Happy Christmas and a successful 2009!

Here is a confession - I have always had a bit of a soft spot for Dr. Anton Mesmer. Yes, he was misguided in some of his beliefs and some of his techniques, if used today, would no doubt result in a series of lawsuits! But he had such very good intentions, and did achieve remarkable results with many of his patients. So imagine my delight at a medical article that I came across recently in the Daily Telegraph concerning the use of magnets.

The article described how a car crash victim who had been in a coma for more than a year had been brought back to full consciousness using a 'pioneering magnetic treatment'. Doctors had considered that there was nothing further that could be done to help the patient but, as a very last resort, they decided to try treating him by placing powerful magnets close to his head to stimulate the underlying brain tissue. Initially there was little change, but following 15 of such sessions there were signs of improvement. Now not only is the patient conscious and able to speak simple words, but also is well enough

The James Braid Society

The society is non-profit making and offers an open invitation to therapists to come along to one of its monthly meetings, whether members or not.

Annual subscription is a one-off payment of £30. Visitors are welcome to come and "try out" the club before joining by just paying £7 entrance fee.

Meetings are held in Central London, upstairs at "The Carpenters Arms", 12 Seymour Place, W1H 7NE. Nearest tube station Marble Arch.

Talks cover a range of subjects of interest to anyone involved in clinical hypnosis. Expert speakers are always welcome.

The meetings begin at 7.15pm and end at 9pm on Thursdays.

Dates for 2009:

Jan 22nd
Feb 19th
Mar 19th
Apr 16th
May 21st
Jun 18th
Jul 23rd
Sep 17th
Oct 15th
Nov 19th

Chairman, Leila Hart
0207 4024311
Secretary, Fiaz Ayub
0207 2864107
Membership, Margaret Sinclair 0208 3956766

www.jamesbraidsociety.com

to be cared for in his own home.

It is the first time that this technique, known as Transcranial Magnetic Stimulation (TMS) has been used to treat patients suffering from severe brain trauma. However, researchers are also investigating its effectiveness in the treatment of patients who have suffered a stroke and for sufferers of Parkinson's Disease.

I have no doubt that TMS is far more scientific than Animal Magnetism. But wouldn't Mesmer, who was so discredited in his time, be delighted to know that he was on the right lines.

This will be my last Research News as I will be standing down in the New Year. It has been an exciting three years for me, and it has been a great privilege to be a member of such an excellent and dedicated team. At the time of writing my successor has not been selected. However, I wish him/her all the very best in this very interesting position.

Jo Goss

Marketing News

Over the next quarter you can expect a call from one of the committee members to discuss with you how your practice is going, what sort of level of business you are doing, and asking for ideas from you about what benefits you would like to get from the NCH. We feel that this contact with you is crucial so that we can get an idea of what you need. Please help us get this information. We are not doing this for our health, we are doing it for the benefit and the growth of the NCH and all its members. It's a big task, with each committee member having to call over a hundred members. A big way you could help is by making sure that your contact details on the NCH website are correct. Out of the first 7 members I phoned, 3 had incorrect numbers. This of course is not only bad for your business but also reflects badly on the NCH and may well put off a potential hypnotherapy client. So PLEASE make sure that your contact details are current.

The so called "credit crunch" – how do you survive?

There is so much doom and gloom out there at the moment, it could almost make me depressed, but then I remember that I am a therapist and the last thing I should be is depressed because my job is to make clients feel good. How can I do that if I go around saying "woe is me, we're all doomed". The first thing I can tell you, and something you should all know, is that if you expect business to be bad, IT WILL BE!

So how can you guarantee that your practice will not only survive but flourish in the coming year? Well quite simply, and I've told you before, you need to apply those two words, "MASSIVE ACTION". Ask yourself: what have you done in the last quarter to ensure you get more clients? What steps have you taken to make it that much easier to find you than your competitors? What have you done that gives something to your potential clients that has real value? What extra steps have you taken to make sure that what you offer is the best you can? What is your target market and what can you do to get to more of them? These are just a few things I can think of that you should be asking. If you don't get a satisfactory answer from yourself, give yourself a kick up the backside and take "MASSIVE ACTION" to rectify the situation.

Paul Howard

Training & Accreditation News

The NCH has now been awarded 'Direct Claim Status' (DCS) for the Hypnotherapy Practitioner Diploma (HPD). This is a tremendous achievement as I can now sign off the certificate claim forms for the HPD portfolios without having to wait for our External Moderator to visit. The DCS was given to the NCH because we achieved an 'Excellent' or 'Above Average' grade in all the sections of the External Verification Report. This has been helped by the professionalism and dedication of all of the NCH Accredited Training Schools, so thank you and well done!

Verification Dates

Because the NCH now has 'Direct Claim Status' all HPD certificates can now be claimed at the point of 'Internal Verification' (IV). I will continue to set IV dates, however, instead of just 3 times per year they will be every two months. This will mean that training schools can still set their students realistic and manageable targets to complete the HPD portfolios.

IV Dates: The last day of each of the following months: February, April, June, August, October, and December.

John Harrington

Secretary's News

There is much myth and misinformation circulating in the big wide world about what the Data Protection Act requires, and what various individuals and bodies responsibilities are. To clarify this and help us all tread safely through this apparent minefield, the Exec Committee has decided to draw up a policy that can be incorporated into the Bye Laws. So I am at present writing a Policy on Data Protection for the Council and I intend that it will be in plain English.

Many of you will by now have heard of CRB checks and probably have been through the process several times. Well, this is all changing. CRBs are being replaced by the Independent Safeguarding Agency and a National Register of Persons Suitable to Work with Young and Vulnerable Persons. This is the final stage in the implementation of the recommendations made by the Bichard Report. The ISA was due to roll out the registration process to new volunteers and professionals in October 2008 – this has been delayed. We will keep you up to date with their progress and tell you what to do when the time comes.

Hope every member has a very happy Christmas and with or without a recession, a prosperous New Year.

Martin Armstrong-Prior

UKCHO News

I finished my last UKCHO piece with the words... 'watch this space'.

Well I am delighted to inform all you space watchers... that things have indeed moved on.

On Wednesday 22 October 2008, I attended an UKCHO meeting at the Royal Society of Medicine in Wimpole Street, London. As well as the routine agenda matters we were delighted to welcome Ian Cambray-Smith of the Prince's Foundation for Integrated Health. Ian addressed our meeting in order to update the UKCHO group on progress.

He intimated that he had contacted the Working Group on Hypnotherapy on various occasions to arrange a meeting between them and UKCHO to bring the Regulation process forwards. At the time of the meeting they had yet to respond.

Ian further intimated that by 3 January 2009 the Regulatory Process for Hypnotherapy will have commenced. All interested professional bodies will be able to participate in the process. As the participating professional bodies within UKCHO remain interested and in active pursuance of this objective, the NCH will be involved.

It goes without saying that progress on this within a unified profession would be a very good thing.

So I am delighted to report that on Tuesday 9th December 2008 Peter Matthews and I from UKCHO will meet with Chris Forster and William Broom representing the Hypnotherapy Working Group at the Prince's Foundation Headquarters in London in a meeting chaired by Ian Cambray-Smith. It is my sincere wish that at this meeting all hatchets, old scores etc. can be left at the entry door and meaningful progress can be made. I would then be more than delighted to inform you of that progress in the next Journal.

Let us all hope that 2009 brings a fruitful and progressive year for the profession of hypnotherapy as a whole. I would like to think that as your NCH representative that the NCH involvement within UKCHO has done much over the last ten years to live up to the strap statement that features on every issue of your Journal cover, namely "moving therapy forward".

John Lawrence

Minutes of the Annual General Meeting Held at Staverton Park, Daventry On 20th June 2008

The Meeting commenced at 16.30

Matters Arising

Minutes of the previous AGM had been printed in the Hypnotherapy Journal and there were no matters arising.

Proposed by Fiona Biddle, Seconded by Paul White, and agreed by meeting attendees with three abstentions.

Chair's Report

A copy of the report was published in the last edition of the Journal.

Secretary's Report

Profits and losses:
There has been a steady increase in our primary source of income, membership fees, and this has been supplemented by a substantial improvement in admin efficiency, that has provided a reduction in costs.

There will be a change in admin costs this coming financial year, as the Admin role has been split and extended. This has been done to improve service levels to both members and the public.

We will be carrying forward a substantial buffer, to help even out the costs.

I feel that Trading, profit and loss account shows the robustness of our organisation and provides us with a sound platform on which to build our plans for the future.

Obvious Points:
Some elements of the accounts need a little clarification.

1. Supervision and NCFE training, this element consists only of expenses incurred in the running of the NCFE/HPD scheme.

2. CPD events are regularly run at a loss, as we price them to encourage new and existing members to attend. This is a members' service which we are looking at developing further.

3. Conference costs increase year on year, as may be expected, and overlap as the next years planning and deposits fall into the current financial year.

4. The marketing costs were down this year, primarily due to the PR & Marketing officer's period of poor health and the fact that the costs from the ASDA promotion fell in the previous financial year.

5. Fees and journals have increased, due to a one off payment to help the development of the UKCHO register and the cost of research journals for our research officer.

6. Professional fees were for Legal Opinion sought in respect of a complaint process. We felt that the precedent this provided was of value to the general membership, as well of the member concerned in the process. We felt that it was important to have confirmation that our procedure was sound.

Policy Development:
Almost all policies are developed from the Strategic Plan and are designed to enable us to reach our goals. They all have to be approved by the Executive and can be challenged by members at an AGM.

Election Statements

Each Executive Council member up for re-election had an opportunity to make their election statements and their status of election.

- Jo Goss for Research (RE-ELECTED)
- Richard Nicholls for Development (RE-ELECTED)
- Su Ricks for Executive Director (RE-ELECTED)
- Paul White for Public Protection Officer (ELECTED)
- Kevin Still for Ethics – not in attendance (NOT RE-ELECTED)

Motion 1; Training School Advertising and Publicity:

Add the following:
The advertising of courses shall be restricted to factual material. All claims regarding standards, outcomes and facilities available must be accurate and verifiable. There shall be no claims as to potential career opportunities, e.g. instant expansion of practice, ability to command higher fees. This shall apply regardless of the media used. All advertising must comply with current Advertising Standards rules.

Proposed by Fiona Biddle, Seconded by Paul Howard

Motion agreed.

Motion 2; Add membership type Associate

Associate members are practising hypnotherapists who have trained with an organization which is not an NCH accredited training school. Associate members are required to upgrade to full membership within 2 years by completing the Hypnotherapy Practitioners Diploma.

Proposed by Fiona Biddle, Seconded by Nick Cooke

Motion agreed.

Motion 3; Amend Other Designations:

This grade may be applied for by Accredited members, Fellows or Senior Clinicians who have a formal Supervision qualification to the level of the Cert.Hyp.Sup or higher. There is a CPD requirement of 1 day per year on a subject related to supervision.

Proposed by Su Ricks, Seconded by Nick Cooke

Motion agreed.

Motion 4; Equivalence to HPD – Amend the following:

Bye Law 5: Training:

a) Courses, Criteria for Accreditation:
To apply for Accreditation for a Course in the training of Hypnotherapy a Course provider must produce evidence that the course provided will meet the following requirements:

Establishments must:

a. accept that the NCH will inspect their course facilities, administrative offices and a class in progress with due notice given.

b. run training course(s) of not less than 450 hours, made up of interpersonal interactive tuition (minimum of 120 hours), supervised practice, home study and assessment preparation, that prepare students to the NOS minimum level.

c. have at least two suitably qualified and experienced trainers. (See notes).

Schools must offer the HPD or a qualification of an equivalent or higher level than the HPD, which is externally validated by an appropriate body as their qualification to practice.

3) LICENTIATE MEMBER (Lic.)
To become a licentiate member the following requirements would need to be met:

Either a)
Complete an accredited training course to a satisfactory level.

Or b)
Have completed the Hypnotherapy Practitioners Diploma.

Or c)
Have completed a qualification to an equivalent or higher level than the HPD, which is externally validated by an appropriate body.

The onus is on the applicant to show to the satisfaction of the NCH that they have sufficient knowledge, skills and understanding to be a competent, ethical and caring professional hypnotherapist.

All applicants at this level must also:

- Provide two references (if applying on the basis of a above, one referee would be expected to be the course tutor)
- Show a commitment to on-going professional development
- Give details of an established system of supervision with a suitably qualified supervisor. A report from the supervisor(s) may be required
- Undertake to adhere to the Code of Ethics and Practice
- Undertake to remain fully and appropriately insured throughout their membership of the NCH
- Be prepared to discuss their application with a member nominated by the committee
- Give details of any disciplinary action that has been taken against them
- Accept that the committee's decision is final.

4) REGISTERED MEMBER (REG.)
To become a registered member the following requirements would need to be met:

Either a)
Have been a licentiate member of the council

AND Have been in practice for a minimum of one year
AND Have completed a minimum of 100 client hours
AND Submit two cases studies of 1500 words
AND Submit a statement of progress made within the first year of practice of 500-1000 words.

Or b)
Have completed an accredited Course of Training

AND Have been in supervised practice for a minimum of one year
AND Have completed a minimum of 100 client hours
AND Have completed a minimum of 15 hours CPD

Or c)
Show evidence of formal training in hypnotherapy

AND have completed the Hypnotherapy Practitioner Diploma. Members registered on this basis would be expected to complete the HPD within 6 months of joining.
AND Have been in supervised practice for a minimum of one year
AND Have completed a minimum of 100 client hours
AND Have completed a minimum of 15 hours CPD

Or d)
Have completed a qualification to an equivalent or higher level than the HPD, which is externally validated by an appropriate body

AND Have been in supervised practice for a minimum of one year
AND Have completed a minimum of 100 client hours
AND Have completed a minimum of 15 hours CPD

All applicants at this level must also:

- Provide two references, at least one of which must be from a fellow hypnotherapist or hypnotherapy trainer
- Show a commitment to on-going professional development
- Give details of supervision/an established system of peer-support and of supervision undertaken since qualification. A report from your supervisor may be requested.
- Undertake to adhere to the Code of Ethics and Practice
- Undertake to remain fully and appropriately insured throughout their membership of the NCH
- Be prepared to discuss their application with a member nominated by the committee
- Give details of any disciplinary action that has been taken against them
- Accept that the committee's decision is final.

5) ACCREDITED MEMBER (ACC.)
To become an accredited member the following requirements would need to be met:

Either a)
Have been a registered member of the council

AND Have been in practice for a minimum of five years
AND Have completed a minimum of 500 client hours
AND Demonstrate a commitment to personal and professional development through attendance at seminars, further training etc.
AND Submit a statement of personal and professional philosophy showing development since qualification of 1000 words.

Or b)
Have completed an Accredited Course of Training

AND Have been in practice for a minimum of five years
And Have completed a minimum of 500 client hours
AND Have completed a minimum of 15 hours CPD each year of practice, since qualification

Or c)
Show evidence of formal training in hypnotherapy

AND Have completed Hypnotherapy Practitioner Diploma. Members registered on this basis would be expected to complete the HPD within 6 months of joining
AND Have been in practice for a minimum of five years
And Have completed a minimum of 500 client hours
AND Have completed a minimum of 15 hours CPD each year of practice, since qualification

Or d)
Have completed a qualification to an equivalent or higher level than the HPD, which is externally validated by an appropriate body

AND Have been in supervised practice for a minimum of one year
AND Have completed a minimum of 500 client hours
AND Have completed a minimum of 15 hours CPD

All applicants at this level must also:

- Give details of an established system of peer-support or supervision.
- Undertake to adhere to the Code of Ethics and Practice
- Undertake to remain fully and appropriately insured throughout their membership of the NCH.
- Be prepared to discuss their application with a member nominated by the committee
- Give details of any successful disciplinary action that has been taken against them
- Accept that the committee's decision is final.

Proposed by John Harrington, Seconded by Jo Goss

Motion agreed.

Motion 4B. Revise Byelaw 1 to include ethics and conduct of Officers of the Council

Byelaw 1: Code of Ethics and Conduct of Members and Officers of the Council:

a) Members Elected and Appointed to the Management Committee as Directors shall also conform to the following rules:

1) Registration of Business Interests
All directors will register all Business Activities from which they draw any pecuniary reward, whether linked to another Member of the Council or from outside the Council.

2) Suspension of Directors
Any Director subject of the Council's Grievance and Public Protection Process at level 1 shall be suspended from all Director's rights and any duties of their office, pending the resolution of the Process.

Any Director subject of Criminal or Civil Proceedings will likewise be suspended pending the outcome of those hearings. Failure to notify such process is a breach of b)2 of this Byelaw.

3) Motions of No Confidence
Any Director or Officer of the Council who is the subject of a valid motion of 'No Confidence', shall be suspended pending the resolution of that question, by a vote at a quorate meeting. All such motions must have a proposer and a second. The meeting that decides such a question shall be deemed quorate if half the elected directors plus 1 are present. This number can include the Company Secretary, who has a statutory vote, but excludes ex-officio officers who have nominal voting rights.

4) Expenses
Directors may claim expenses at rates agreed by the Committee during its proceedings. Any such claim shall only be met on the presentation of the relevant receipted bill/invoice. Expenses will only be met for approved Council Business.

5) Additional Lawful Duties
Directors shall be subject of any other duty that applies as a result of Companies Law, in addition to any duties arising from the Memorandum and Articles of Association of the Company and Company Policies.

6) Misuse of Office
Directors may not use their title of Office for pecuniary gain. Title of Office may be quoted in any bio or C.V. as a fact of experience or when acting in an Official capacity, e.g. representing the Council at an external event.

Motion agreed.

Proposal to amend the NCH byelaws to allow the use of testimonials – as proposed by Lysette Offley

Speaking for Lysette Offley's Proposal was Penny Rattle. Seconded by Tam Munro.

Speaking against was Executive Committee member Paul White and Su Ricks.

Vote went to paper with show of hands in room in the majority vote against.

Motion agreed with 83 vote for, 345 votes against, and 10 abstention.

Any Other Business

None.

The meeting adjourned at 18:15

Letters to the Editor

Stress Buster

Dear Rob,

I was sent the following item some time ago; I don't know the author.

The latest Stress Management Technique - and apparently it is really effective after only a single session:

1. Picture yourself near a stream.

2. Birds are softly chirping in the cool mountain air.

3. No one but you knows this secret place.

4. You are in total seclusion from the hectic place called "the World".

5. The soothing sound of a gentle waterfall fills the air with cascading serenity.

6. The water is crystal clear.

7. You can easily make out the face of the person you are holding underwater...

Alan Grieveson

Editors Reply - Thanks for sharing that very useful technique...

Progressive Pause

Dear Rob,

I was forwarded a very interesting piece of research carried out by Charlie Curtis BCH on the use of progressive pauses and inducing trance states. The material comes in the form of two booklets plus a couple of voice CDs.

Charlie Curtis has very kindly given consent for the NCH to add the booklets and the audio tracks in their entirety to our resources area for members' use.

Would you please let members know this is available in the members area of the NCH website.

Jo Goss

Editors Reply - Consider it done. Many thanks to Charlie for his generosity.

Got something to say?

Whatever your view, email your letters to me at:

journal@hypnotherapists.org.uk

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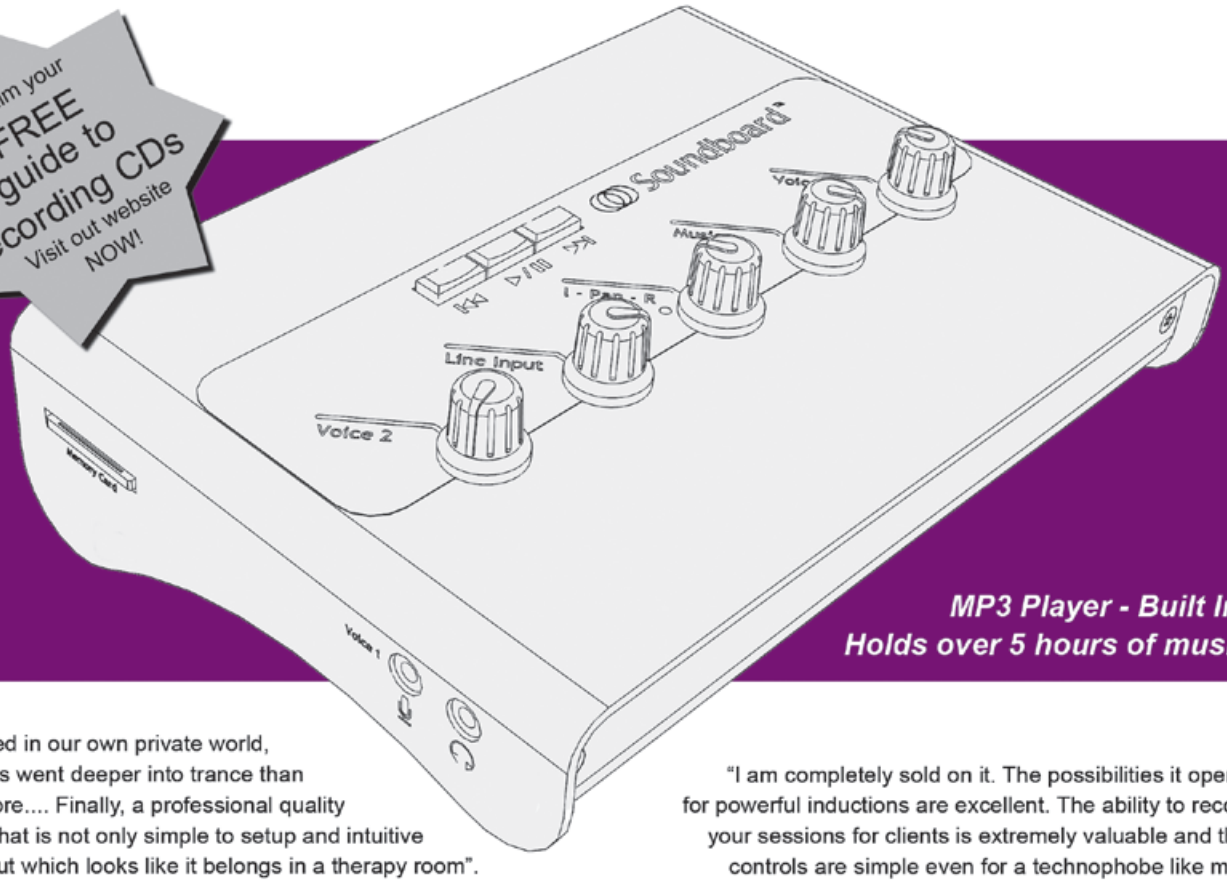

MP3 Player - Built In!
Holds over 5 hours of music

"Immersed in our own private world, my clients went deeper into trance than ever before.... Finally, a professional quality product that is not only simple to setup and intuitive to use, but which looks like it belongs in a therapy room".
Rob Woodgate, Editor of the NCH Hypnotherapy Journal, UK

"I am completely sold on it. The possibilities it opens for powerful inductions are excellent. The ability to record your sessions for clients is extremely valuable and the controls are simple even for a technophobe like me"
Gloria Hammett. Founding partner of The Romney Centre, UK.

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Gil Boyne: Interview With The Master

By Rob Woodgate

RW: Gil, you've enjoyed an amazing career spanning over 50 years, were recently named "man of the century", and are hailed as a pioneer of modern hypnotherapy along with Erickson and Elman. How did it all start for you?

GB: My great uncle was a famous magician and stage hypnotist, and when I was 11 years old he was playing at a theatre in our city. He came over for Sunday dinner and I saw him hypnotise my mother and father. I was amazed by what I saw, and I began to look for some information.

But at that time – 1935 – there was no information on hypnosis apart from a paragraph in the encyclopaedia Britannica. So, I imitated what my uncle had done and eventually managed to hypnotise some schoolmates; that was really the beginning.

RW: When did you decide to take it further?

GB: I went in the Navy at 18 and served almost 4 years in the Pacific area. At one point, I took an injury to my knee in an explosion on Okinawa, and while I was in the hospital, I started hypnotising some of the other patients. The doctor saw this and he asked me to make the rounds with him to hypnotise certain patients.

We were doing well and suddenly an order came from higher up: 'stop the hypnosis'. So they shipped me out, back to my ship.

Gil Boyne: 84 and Going Strong

But the war and my time in the combat area really changed me. I had an outgoing personality as a youngster, but my war experience changed that. I grew a Van-Dyke beard, moustache, wore dark glasses and ended up on a 10% disability pension with a diagnosis of 'psychoneurosis: mixed types'. Whatever that means.

The psychiatrist told me to look in the newspaper ads and find a job selling door to door. I ended up selling magazines, and after 6 weeks without making a sale it started to come together for me.

From there, I went on to sell cookware sets, encyclopaedia and all sorts of other things. It was very good training, because it taught me to speak to people and taught me the art of persuasion.

And after all, that is essentially what hypnotism is all about – persuasion.

RW: So your sales training helped you recapture what you had and set you up for your career in hypnotherapy.

GB: Yes. Working in direct sales at that time was commission only. When you make sales, you make commission; no sales-no commission. As a crew manager, my income was in some way affected by the performance of my crew, so as new men came in for training I would work with them. Each day I would take them one by one and hypnotise them in the car.

Soon my reputation grew, because those men were producing – and eventually I became a sales manager, and then a sales motivator. Other companies began contacting me to motivate their sales force and soon that was all that I did.

RW: So you were increasing their self-confidence and their belief in their ability to make sales.

GB: Yes. The biggest problem for sales people is they want approval. They fear disapproval. And you have got to risk disapproval. You've got to be really tough, even though you disguise it.

Five years later, I decided I wanted to do hypnotism for a living and I thought California was probably the best place. At that time (1954) there were very few hypnotists, in Southern California and when I went to their free lectures, I decided that I could do it better than they did.

So I moved, took a job in direct selling to raise some money, rented a little apartment, put a small ad in the classified section of the L.A. Times and waited for the phone to ring.

RW: How did your career take off

from there? What was your biggest break?

GB: I was selling for a housewares company - still door to door - and there was a big drug store on the corner that had a fountain where they served coffee and doughnuts.

One morning I went in with some of the other salesmen to get a cup of coffee and there was an elderly woman behind the counter.

I said, "How are you today?", and she said, "I've had this terrible headache for 4 days. I can't get rid of it and I'm so worried. The pharmacist fixed up several things for me to take but none of them had any effect."

Remember, I was very young, in my 30's. I said, "I can get rid of that headache right now". She looked at me and said, "Are you kidding me?" I reached over the counter, put my hand on the back of her neck, pulled her forward and shouted 'sleep'. I gave her some good suggestions then brought her up. She said, "Oh my god, it's a miracle, my headache's gone, my headache's gone."

She ran out back to the pharmacist and said, "This man, he cured my headache, he cured my headache."

The next day, as we got in the car to go out to the territory, a new man asked if I was the fellow who is interested in hypnotism. I said yes.

"Well", he said. "A funny thing happened last night. I was listening to Ben Hunter's all night radio show about 1am, and this woman called in. She said she had this terrible headache until this man came in and hypnotised her. She said it was very sudden and dramatic and the host, Ben Hunter, has been asking for the hypnotist to come in for an interview."

So that night at 11pm, I went up to the radio station. I went in and there was a switchboard operator and receptionist.

I told her, "Ben Hunter has been broadcasting that he wants me to come in for an interview – I'm the hypnotist."

She said, "What?" I said, "I can hypnotise people in a split second." She said, "Can you hypnotise me?" I said, "Of course." So I reached over, pulled her forward and she fell across her switchboard.

The studio door opened, and Al Poska stepped out. He was the presenter on a show called 'Conversation Please' and he had just finished interviewing two brothers who were pop singers. As he walked up, the phone lines were buzzing, she was lying there and he said, "My God, what happened? Did she have a heart attack or what?"

I walked over, looked up and said, "No, she's hypnotised". He said, "What do you mean she's hypnotised?" I said, "I just put her under." He said, "For God's sake, get her out."

When I did, he said to her, "What happened?" She said, "I don't know, he was talking to me and suddenly I went blank."

I reached over the counter, put my hand on the back of her neck, pulled her forward and shouted 'sleep'.

The two brothers, who were famous singers, were standing there, and one said, "Can you do it to me?" So I said, "Of course I could – stand up straight". I used the instant induction; he went down on the floor. Then I turned to the other fellow, and said, "Look into my eyes", and he fell to the floor too.

So Al Poska, the host, said, "I want to interview you on my show". And I said "Well, Ben Hunter gets his interview first." I knew Ben Hunter had an all night show – Al Poska only had a half hour show.

And he said, "Well, I'll interview you a week or so after Ben does". I replied, "Too late, I'm leaving town shortly."

Ben Hunter came in shortly afterwards and I went into the studio with him. He said, "I'm booked up for the next 10 days or so, I can book your interview after that." I said, "Too late, I'm leaving town." I wasn't of course, but he didn't know that.

So he picked up the phone and told his secretary to cancel his guests for that night and reschedule them. And for the next two hours, I was on the biggest station in LA.

Now Ben Hunter was so popular that he had developed his own travel agency. He would advertise on his show and take people on tours. But his wife had an aeroplane phobia, and wouldn't go on any tours with him.

When I hypnotised her, I found out what it was – her son had developed an ailment that leads to the loss of his hearing, and she had flown to specialists in the USA and Europe to find a cure. And all the time she was on these planes, she was as tight as a drum with the disappointment from treatments that didn't work and the fear that there was no cure.

Her friends and relatives kept telling her that she had to relax – soon the word 'relax' became linked to her extreme hypertension. On the couch, the more I told her to relax, the tighter she got. I realised this, and finally, I just dropped the word relax completely, and used words like 'letting go', 'loose and limp' and we had great success.

Now the stage is set for the real explosion of my career. Ben was so happy with the result that he gave me a special number to get into the talk show; his direct line.

Once a month, he would appear in a different city for the 'Night Owl Roost', and I became the featured speaker for several months. He would advertise these meetings on the show and when callers asked questions about the mind, psychology or hypnosis, he would say, "Gil Boyne will be on tomorrow night and we'll ask him."

The station was 50,000 watts and on a good night, after midnight, the show reached into 24 states. That started my career.

Some might say I got a lucky break. No, I created good fortune! I hypnotised the woman with the headache!

RW: That is such an important point. Many hypnotherapists have an incredible desire to help people, but they see it as a vocation, not a business. But if you don't promote yourself, how are people ever going to find you to get the help you can give? You've got to make your own luck. And you did that by marching yourself down to the studio.

GB: You are absolutely right. Every action has a consequence.

When I was a regular on that show, I had three hypnotists working for me full time, and we were working from first appointment at 8 in the morning, until 9pm at night. And I was getting free publicity worth hundreds of thousands of dollars.

At that time, I had an overwhelming enthusiasm. I was like an electrical storm.

RW: It is one of the things you promote as a key attribute for a hypnotherapist.

GB: You need the passion – greater than the passion you ever had for a woman, for gambling, for an addiction, or anything. A deep passion to help people.

Gil Being Interviewed by Ben Hunter

Of course, in the beginning there was a tremendous amount of ego in what I was doing. As the years go by, the ego subsided and I recognise my part, and the client's part in the therapy.

RW: Absolutely. I think it is a universal experience amongst therapists that sometimes, when you feel you have done your best work, the client is not ready to change, and sometimes what you think of as your worst clients end up being the ones who recommend you to all their friends.

GB: Clients must accept the responsibility. It's the denial of the responsibility that created the problem in the first place. I remember once, in front of a class, this very soft-spoken woman told her story and it became obvious that her mother was the source of her problem. So I had her create a dialogue with her mother, and I said, "Say to your mother, 'I hate you'."

She said, "I could never say that." So now we know where she is stuck. Her mother is not sitting there, it's all in her mind. So I repeated the request, and again she said she couldn't do it. So I said, "Look at me and say, 'I won't say that.'" She did. "Now tell me 'I won't say that because…'" She said, "I won't say that because you can't talk to your mother that way". I said, "No – *children* can't talk to their mothers that way. Adults are free to do so."

A lot of people don't understand my work. Sometimes I get very tough, sometimes I may even shout. And students ask, "Don't clients resent you for that?" My answer is, "Well, they always love me in the end, and I know I'm going to get to the end". They know I'm not going to pat them on the back and say, "There, there, darling; it'll be all right. Give it some time and everything will work perfectly." Their subconscious says, "Here is somebody who is not going to take 'no' for an answer."

RW: What do you say to those hypnotherapists who still rely solely on suggestion therapy and scripts?

GB: In the beginning, before I knew better, I was hurling suggestions at clients with a lot of enthusiasm and energy but that is not the royal road. It works in some cases and it has short-term benefits for some. It paves the way for some who are really ready for change.

For example, you may get a person who has really made up their mind to stop smoking at an emotional level. And their wife has said they can no longer smoke in the house. The children are on their back. They come for one session and they stop smoking. They would have stopped if they didn't have the session.

Over the years, I've come to understand the two levels of the mind, and I believe that suggestion alone often doesn't do the job.

The true dynamics of change are:

- The client has to reach the point of readiness to change. That happens before they get to you.

- The relationship with the therapist, much of which is at the unconscious level.

As a therapist, you can only influence the relationship. A therapist once told me that clients must think of him like he is their father. And I replied – "Poor therapy".

You have no idea who or what the unconscious connection with the father is, nor how positive or negative it may be – and how that can be projected on you if you insist on them thinking of you as the father.

RW: Yes, a negative transference could really damage the relationship and interfere with therapy. As part of your work, you have a novel way of dealing with transference – can tell us about that.

GB: Many students wonder why I ask clients who I remind them of at the end of each session, before I bring them out of hypnosis. I want to find out:- are they projecting the image of their father, or their uncle who titillated them sexually when they were 4 or 5 years old. Or is it a beneficial, positive connection.

Usually by the 3rd or 4th session I ask them and they say, "No one – you are Gil Boyne." And I say, "That's wonderful, for that's who I am. Separate, distinct, from anyone you ever knew." No one had ever thought of that before.

Psychoanalysts talk about transference and counter-transference, but no one has ever thought about how to clear it. I just ask them - "Who do I remind you of?" - while they are still hypnotised.

RW: You also use other techniques as part of 'Transforming Therapy', such as spelling out the word – is that to stop people thinking consciously?

GB: It is a technique I originated. In order to get to the word, you have to get to the feeling. And you get to the feeling through the initial interview, which can last up to an hour. And somewhere in their narration, you'll get their feeling – usually they feel unloved - but there are many expressions of it, such as sibling rivalry, mother's rejection, father's rejection, unfortunate love affairs, and feelings of inferiority.

So I feed that back to establish an Affect Bridge that will carry them to the word. And once they get the word, I have them use it in a sentence, and when I have the sentence, then I do the regression.

RW: Your faith is also very evident in your work. Compared with the USA, the UK seems a bit of a heathen bunch, so if you were in practice over here, would you introduce these concepts in your work as strongly as you have done in the USA?

GB: Absolutely. I have a mission. I believe that people's lives can be improved if they come to the realisation that there is something outside of us and we are a creation of a larger force.

I believe it is most helpful to know that there is a force outside ourself, larger than ourself, and that we have been given divine gifts.

And it doesn't matter what name you give it, whether it's Jesus Christ or Muhammad or the Great Pumpkin in the Sky. You have to know that there is something larger than you, and connected to you.

We have been given many divine gifts, and the foremost of those is the ability to create. No other animal can literally create. All other animals can only procreate and function out of instinct and training. Everything around us is the creation of mankind. I believe it is most helpful to know that there is a force outside ourself, larger than ourself, and that we have been given divine gifts. I'll help you to recognise them and use them.

Creation is a divine gift. I believe that's what is truly meant when we are told that man is made in the image of God, the ultimate creator.

RW: You have been enormously successful as a therapist. Can you tell us a little about how you ran your sessions – for example, did you used to actively solicit feedback from your clients?

GB: Usually, way back, depending on the problem, I would book them for 6 or 8 sessions. I never booked for one session at a time. When I finished on the first session I'd say – "well we can get a lot of good work done in about 6 sessions, and the cost will be..."

I then made an effort to collect it all from them in advance. And I'd tell them that if we get the job done sooner than that, I'd refund the difference. That kept me from having no-shows.

Then, lets say they had agreed to 6 sessions. On the 5th session, I'd say, "Now we agreed for 6 sessions, and next time is the 6th. Next week, I want you to bring me a written report of what your progress has been. If you feel that 6 sessions have been sufficient– that's wonderful – if you feel you need additional sessions. I'm available for you."

And on the 6th session, as we are finishing up, I'd say – "I want you to know, if you need further help, I will find a place to book you in ahead of

new clients." I'd let them know I had a special interest in them. I have had clients span 3 generations and I have had clients who would call me with different problems - 25 years later!

And they tell me, "I always come back to you because you get the job done."

RW: Many hypnotherapists, it seems, are just making ends meet. If you had one piece of advice, what would it be?

GB: I would say between 60-75% aren't earning an adequate income. Adequate to maintain a lifestyle that is suitable for a self employed, self-directed person working in therapy. If you are not earning at least £50k, then you don't have a full time occupation or your goal may not be a monetary one.

there is a myth that persists, which is the deeper the trance, the better the suggestions will be accepted

But money has no significance. In man's history, money has been pieces of rock, a stone with a hole in it, pieces of metal, women, cattle, and pieces of paper. None of it means anything. If money is meaningless, what has meaning? Money is the payment for the service you give.

So how can you increase your supply of money? You can increase the form and the quality of your service. And when you do that, the money will come.

RW: You increased your own service by starting Westwood Publishing and bringing Dave Elman back to print. Can you tell us a bit more about that?

GB: Well, there is a story to that. When Dave was a boy, his father was dying of cancer and in terrible pain. He read of a hypnotist appearing in a nearby city and sent his wife to fetch him. He hypnotised Dave's dad and relieved his pain. And so the boy was able to go in and be with his father in his final days.

It made an indelible impression on his mind. And so, he became an amateur hypnotist, and as a teenager he put on many hypnotism shows.

Eventually, when he was a young man, a doctor saw him perform and asked him, if he got a small group together, would he be willing to give them instruction. And that was the beginning. Before that, his main income came from radio network production and marketing.

RW: So he was a marketer too!

GB: He had a show, called "Hobby Lobby". But his avocational work was hypnotism. Now, the only other person teaching hypnotism was Milton Erickson, and several psychiatrists that taught with him, and hypnotherapy wasn't very well accepted by the medical profession.

At the time there was no such thing as lay hypnotism, and Elman's book was available only to doctors who had taken his classes.

But I had a copy of the Elman book, and I knew it was exciting and could become a classic textbook. Soon after he had died, I contacted his widow and she told me that several people had wanted to republish the book, but no one had wanted to pay advance royalties.

She also had a cellar full of LP recordings of his course. I gave her the advance she wanted and I acquired the LPs and exclusive worldwide distribution rights for all of Elman's works, written and spoken. In the years since then, his book has become the best selling hypnotherapy text.

RW: It is a very good book. You are well known for your use of rapid inductions – for what reasons other than speed do you prefer these?

GB: First of all, there is a myth that persists, which is the deeper the trance, the better the suggestions will be accepted and the quicker the results will come. Trance is not a constant – it fluctuates during therapy.

People are reluctant to use the direct gaze technique but it is the most effective induction. For example, if I say:

> *"I want you to look me in the eyes. Don't take your eyes from mine. If you follow my simple instructions, nothing in the world can keep you from going into a deep trance in a matter of a second or two."*

I have told the subject exactly what will happen. There is no malarkey about it. There is nothing in my eyes that shows doubt or fear or nervousness.

RW: You have absolute conviction. You overwhelm the critical factor. Finally, of all your awards and accolades you have received, what means the most to you?

GB: It used to be the letters from clients who had very successful results. Then it became the testimonials from students who had attended a training course.

Now, the thing I enjoy most is receiving the following: "Dear Gil, I'm writing this letter to tell you I'm now retiring after 32 years as a hypnotherapist, and it all began with my training with you. I've had a wonderful and rewarding career and I want to say thank you. You have been an inspiration and a role model to me."

Letters like that mean a great deal to me.

I have been working in the hypnotherapy profession for 54 years and I have worked with thousands of clients, taught thousands of students throughout the USA, Australia, New Zealand, throughout Southeast Asia and the Far East and of course the United Kingdom. Many more have told me how they were influenced by my books and DVDs of therapy sessions.

I look back on my career with pride and gratitude.

RW: Well, you can add another couple of teaching hours, because today has been a real education for me. It's been an absolute pleasure to talk with you. Thank you Gil.

GB: It's been a pleasure.

Braid on Acting & Hypnotism

By Donald Robertson

In Neurypnology (1843), Braid coined the term "hypnotism" and developed the first fully-fledged psycho-physiological model of hypnosis, in opposition to the occult theories of the mesmerists. However, it is often overlooked that Braid developed, at this time, a theory of suggestion which was primarily physical rather than verbal. Indeed, Braid's many reported treatments by hypnotherapy depend primarily upon his method of "muscular suggestion", and were sometimes conducted in silence, though the role of verbal suggestion was acknowledged by him increasingly throughout his career.

Braid very clearly pre-empts the influential "James-Lange" theory of emotion, which suggests that (sometimes) the subjective feeling of emotion may be the effect of physical expressions rather than their cause. We normally assume that somebody feels sad (cause) and begins to cry as a result (effect). However, Braid, William James and Carl Lange, suggested that (sometimes) people may begin to cry first and gradually begin to feel sad as a result.

> Braid clearly pre-empted the "acting as if" technique of modern CBT

The most obvious example of this would be in the experiences of actors, especially those who allow themselves to enter deeply into their role (called "heated acting" by Sarbin). This notion has found many applications in the therapy field, most explicitly in the "acting as if" method of George Kelly, subsequently adopted by Albert Ellis and other cognitive-behavioural therapists. This technique is explicitly cited in classical philosophical therapy as far back as Ovid, but it finds its first "modern" psychotherapeutic articulation in Braid's writings on hypnotherapy.

Braid actually carried out several small experiments in this area, and discusses it extensively in his writings, from several different perspectives. The following passage, written in the middle of the 19th century, shows that Braid clearly pre-empted the "acting as if" technique of modern CBT. Ironically, many of the cognitive-behavioural techniques central to Braid's approach fell into disuse by subsequent hypnotherapists, only to be rediscovered by modern evidence-based cognitive-behavioural therapists who claimed them for their own. Arguably, however, Braid provides a more thorough exploration of the concept and its possible "psycho-physiological" explanation in terms of associationist psychology and basic neurology.

In one passage, he writes very clearly of the relationship between his "muscular suggestion" therapy and the experience of actors,

"A familiar example of the influence of muscular expression or action reacting on the mind, may be realized by any sensitive person, even during the waking condition. Let him assume, and endeavour to maintain, any particular expression or attitude, and he will very soon experience that a corresponding condition of mind is thereby engendered. Now, such being the case during the waking condition, when the faculties of the mind are so much dissipated and diffused by impressions on the various senses, we can readily understand why the influence should be so much more energetic during Hypnotism, the peculiar features of which are high sensibility, with the whole energies of the mind concentrated on the particular emotion excited. It is no doubt, in a great measure, owing to the same cause, that our greatest actors and actresses have become so profoundly penetrated by touching scenes as to shed floods of tears during their impersonations of character – the just conception of the character first producing appropriate physical action, and this again reacting on the mind in the extraordinary manner which was manifested in a [Sarah] Siddons and [Eliza] O'Neil [two distinguished 19th century English actresses]."

Braid seems to have been aware that the concept can also be used to re-interpret other practices, normally viewed from a different perspective. Most notably, the relaxed posture, neutral expression, closed eyes, and suppressed breathing, etc.., of the hypnotic subjects can be seen as "role-enactment" behaviour designed (in part) to evoke the same internal feelings and neurological states which typically accompany such external behaviour, i.e., as a kind of "acting" which begins with external behaviour and progressively evolves into deeper physiological change (q.v., White, Sarbin, et al.).

Braid was also aware of the relationship between this phenomenon and social role-modelling, and speaks of the fact that subjects become easier to hypnotise after they have first observed other subjects who readily enter the state. There is a tendency to mimic the external behaviour observed in others, which evokes a kind of sympathetic experience of hypnosis.

In recognising this, Braid obviously pre-empted the socio-cognitive theories of hypnosis which began to rise in prominence over a century later. Braid felt that the re-allocation of attention, definitive of hypnosis, meant that subjects become hyper-responsive to such muscular suggestion, where administered by the physical touch and manipulations of a therapist, or by their own adoption of a physical expression of emotion. As a result, it remained a central feature of his hypnotic therapy until the end of his career.

Warts, Healing and "Downward Causation"

By David Botsford

Let us begin with a discussion of warts. In 1872, D.H. Tuke reported that a folk cure for warts included rubbing the skin with beef stolen from a butcher's shop. He suggested that the vivid imagery triggered by this dramatic treatment contributed to the cure. (1) Mark Twain describes other colourful examples of "wart charming" in a conversation between Huckleberry Finn and Tom Sawyer. One involves the use of a bean:

> *"You take and split the bean, and cut the wart so as to get some blood, and then you put the blood on one piece of the bean and take and dig a hole and bury it 'bout midnight at the crossroads in the dark of the moon, and then you burn up the rest of the bean. You see that piece that's got the blood on it will keep drawing and drawing, trying to fetch the other piece to it, and so that helps the blood to draw the wart, and pretty soon off she comes."*
>
> *"Yes, that's it, Huck - that's it; though when you're burying it if you say 'Down bean; off wart; come no more to bother me!' it's better." (2)*

In 1927, Dr. B. Bloch, of Zurich, described how he treated patients with a device called a "wart-killer" with a noisy motor, flashing lights, and a fake X-ray. He reported that 31 percent of 179 patients lost their warts after a single treatment. (3) In 1953, Hans Eysenck, professor of psychology of the Institute of Psychiatry, London University, reported an experiment in treating children for warts. The children were divided into two groups. The control group received conventional medical treatment for warts, while the experimental group was subjected to suggestion treatment. This involved drawing a picture of the child's hand, with the wart on it, on a large piece of paper. Then, "with a certain amount of hocus pocus," circles were drawn around the wart and its size in the picture reduced day by day until the wart had completely disappeared in the picture. This procedure proved far more effective in removing warts than the control group's treatment. (4)

In surveying the literature on the use of hypnosis in treating warts, Dr. Dabney M. Ewin, of Tulane Medical School, found that "there is not a single case report in the literature of recurrence [of warts] after healing with hypnosis." (5) Dr. Ewin describes numerous hypnotic techniques used to cure warts. These include suggestions to "stop the blood supply to each wart on your body" (that is, make it cold) and also "increasing the blood supply to bring in more antibodies and healing substances" (in other words, make it warm). The common factor in successful hypnotic treatment is "believed-in efficacy" – that is, conveying a confident belief that control exists. In surveying the literature, Ewin found that it was not so much the patient's "hypnotisability" (as measured in standard tests) that was key to success, but the latter's ability to use the imagination, for instance in imagining the sensation of tingling in the warts. Indeed, one experiment found that suggestion without an induction produced results comparable to giving the same suggestions in trance.

Ewin cites three cases with children from the literature. A 14-year-old girl had suffered warts for five years. A cure was obtained by analysing the meaning of the warts and agreeing on the circumstances in which she would relinquish them – which she did two weeks later. A nine-year-old girl with 31 warts was able to experience tingling in the warts, and was given direct suggestions that the warts would disappear. After three months, she had only two small warts on her left hand. Six children were given hypnotic suggestions of visualising "killer" and "guard" cells in the immune system attacking and destroying the viruses which caused the warts. Three months later, four of the children were fully cured, the fifth healed 11 of 12 warts, and the remaining child four out of eight.

From his own practice, Ewin found that direct hypnotic suggestion was effective in curing children of warts, while with adults it was more useful to use hypnoanalysis (ideo-motor communication, regression to the onset and restructuring), followed by suggestions for healing. He found that it was best to give the patient a choice between "cold" and "warm" as to what they would like to imagine feeling in dealing with warts.

Ewin's nephew agreed to "sell" him his warts for 50 cents. Once Ewin handed over the money, he reminded him that the warts were no longer his and to ignore them, knowing that Ewin would soon retrieve them without the nephew's help. This resulted in a complete cure.

Sometimes warts played a metaphorical role as a manifestation of an inner conflict. One man was limping to protect large warts on his sole. In the single session he had with Ewin, he said, "Doc, I'm in love and I ought to walk away from it." Ideo-motor responses revealed a conflict between marrying his fiancée and ending their relationship. The patient made a decision to "walk away," his warts healed in eight weeks, and he married another girl six months later.

Dr. Lewis Thomas was a medical practitioner and scientific researcher who served at different times as dean of New York University and Yale medical schools. In discussing the curing of warts through hypnosis, he recalls that:

> *"I was once told by a distinguished old professor of medicine, one of Sir William Osler's original bright young men, that it was his practice to paint gentian violet over a wart and then assure the patient firmly that it would be gone in a week, and he never saw it fail." (6)*

He cites an experiment in which 14 patients with warts on both sides of the body were given suggestions under hypnosis that all the warts on one side of the body would begin to disappear. Within several weeks, in nine patients, all or nearly all of the warts on the suggested side had vanished, while the warts on the other side remained. However, one patient got left and right mixed up and eliminated the warts on the wrong side!

Dr. Thomas considers the implications for our understanding of the unconscious mind that derive from this ability to carry out the complex processes involved in curing warts:

> *"This is not the sort of confused, disordered process you'd expect at the hands of the kind of Unconscious you read about in books, out at the edge of things making up dreams or getting mixed up on words or having hysterics. Whatever, or whoever, is responsible for this has the accuracy and precision of a surgeon. There almost has to be a Person in charge, running matters of meticulous detail beyond anyone's comprehension, a skilled engineer and manager, a chief executive officer, the head of the whole place.... Among other accomplishments, he must be a cell biologist of world class.... You can't sit there under hypnosis, taking suggestions in and having them acted on with such accuracy and precision, without assuming the existence of something very like a controller....*

one patient got left and right mixed up and eliminated the warts on the wrong side!

"Just think what we would know, if we had anything like a clear understanding of what goes on when a wart is hypnotized away....[W]e would be finding out about a kind of super-intelligence that exists in each of us, infinitely smarter and possessed of technical know-how far beyond our present understanding. It would be worth a War on Warts, a Conquest of Wars, a National Institute of Warts and All." (7)

Our purpose here is to seek to understand one aspect of the unconscious communication which enables such dramatic and precise transformations.

The development of Western science over the past four centuries has rested largely on the concept of reductionism. Reductionism is the idea that activity in a large-scale and complex system can be understood by breaking it down to its smallest possible component units and studying the actions of the latter. In the reductionist model, the actions of the smallest units cause the activities of the system of which they are a part, which in turn cause events at a higher level, and so on up to the working of the system as a whole. This is known as "upward causation" – the notion that actions at the lowest (or smallest) level of the hierarchy of systems cause changes at ever higher levels, up to the level of the system as a whole.

A human being is a system. According to the reductionist view, atoms combine to form molecules in predictable ways. What happens at the molecular level then causes events at a cellular level, which in turn affect cellular structures, the actions of which in turn determine the functioning of the organs. The actions of organs influence the functioning of the various systems within the body (respiratory, immune, nervous, and so on), which in turn govern the working of the entire body. Western medicine and pharmacology generally take this reductionist view to helping people overcome illness. The body is understood as a machine, the functioning of which is impaired by a fault in one of its parts. This functioning can be repaired by introducing a new element that acts on the faulty part in an essentially mechanical way. Commonly, a drug will be prescribed which is intended to have an effect at a low level, which in turn affects higher and higher levels within the system.

Of course it is true that a human being can indeed be understood and affected in this way. However, a different way of understanding the functioning of the human being was opened up by the ground-breaking work of the psycho-biologist Professor Roger Sperry, of the California Institute of Technology. Professor Sperry was awarded the Nobel Prize for Medicine or Physiology for his pioneering studies of the specialised functioning of the left and right hemispheres of the brain. As part of those studies, he severed the corpus callosum, the "bridge" which unites

the two hemispheres, and found that each hemisphere was able to take on the functioning of the entire brain. He found that each hemisphere had its own individual "consciousness", but that this consciousness could be combined into a single "consciousness" across both hemispheres. This led him to develop the concept of "downward causation". He argued that, in addition to the "upward causation" of reductionism, in which small units affected larger ones, causation also moved down the hierarchy of systems from the highest to the lowest. He believed that reductionism was inadequate as an explanation of mental phenomena. He adhered to mentalism, the idea that subjective experiences are real, and can affect the objective material world ("mind over matter"). In order to understand the functioning of complex systems, and particularly human beings, he believed that it was necessary to incorporate the study of "holons", or holistic systems which interact with each other – systems which are more than the sum of their parts.

When any system becomes sufficiently complex, it takes on attributes which are features of the system as a whole rather than merely being the sum of its individual parts. This can be true of a network of computers, the weather, or a human being, or even an organ such as the human brain, which is sufficiently complex that if one part of the brain suffers damage, then the rest of the brain can often take on the functions which were previously performed by the damaged part. Professor Sperry demonstrated that the subjective experience of consciousness, or the level of "mind and meaning," acts as the central control mechanism which causes change "downward" throughout the human being as a system. A change in subjective consciousness affects the systems of the body, and below them the organs, and through them cellular structures, and below them the cells, and then right down to the molecular level, in the hierarchy of downward causality. He wrote that:

> *"the causal potency of an idea, or an ideal, becomes just as real as that of a molecule, a cell, or a nerve impulse. Ideas cause ideas and help evolve new ideas." (8)*

He compares the human being to a television set, in which the content of the programmes on different channels acts as the highest control mechanism, determining the flow of electrons across the screen:

> *"Complete knowledge of the electronic and physical theory that enables one to fully understand, build and repair the appliance, is no help to explain why Mary struck John on channel 4, or what caused the building to collapse on 2, or the laughter on 7. There is no way that these, or the political message on channel 5, can be explained in terms of the laws and concepts of electronics. They involve a different order or level of interaction. Yet these higher order, supervening, program variables do control at each instant, and determine the space-time course of the electron flow patterns to the screen and throughout the set – just as a train of thought controls the patterns of impulse firing in the brain. The shift to a new program or to a new channel can be compared to the shift in the brain to a new mental set, focus of attention, or to a new thought sequence." (9)*

It is this "central control mechanism" – what hypnotherapists would call the unconscious mind - which enables transformations to take place "downwards" throughout the hierarchy of systems which make up the human being.

Nor is the level of the individual person necessarily the "highest" system in which he or she participates. No man is an island, entire unto himself. Often, a person's situation – and the resources available for achieving his or her goals – can only be fully understood by an awareness of the functioning of the social systems of which he or she is a part, such ▶

as relationship, family, workplace, community, country, and even world. Events in these larger social contexts can powerfully affect an individual's condition.

To take a single example, the suicide rate in Northern Ireland has massively increased in the past few years, since the onset of the peace process. This may seem surprising. One might have expected that the end of violence and terror would have made people happier. What actually seems to have happened is that during the Troubles, people bonded with family, neighbours and communities in order to survive in a dangerous environment. Since peace has broken out, many individuals have "turned inwards", disconnecting from the people around them and brooding on personal problems. This has led to increased suicides. The breakdown of the interpersonal system of the individual's social support network thus becomes a factor that affects his or her internal condition.

The effectiveness of the exotic methods described above to cure warts cannot be explained by reductionism. But they do make sense in the context of Sperry's theories. The hypnotherapist's task is to communicate with the client's unconscious at the systemic level of mind and meaning, and allow "downward causation" to do its work.

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(6) Lewis Thomas, The Medusa and the Snail, Allen Lane/Penguin, London, 1980, p. 77.
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Case Study: Confidence Building – English as a Second Language.

By Simon Lea

Kolos (name changed) had been in the UK for eight months when he first came to me for confidence building hypnosis. He had come to this country to improve his already proficient English. Back in his native Hungary, his friends and family had encouraged him to pursue his language studies (with the hope of him returning to Budapest and finding a highly paid job in which his English would be appreciated and put to good use). The plan was simple: come to England, enrol in an advanced English course, chat to native speakers, improve and return home. However, he soon discovered that simple plans rapidly become more complicated when put into practice.

The first problem was that the advanced language course he signed up to was not quite as 'advanced' as he had expected. The topics covered were ones he'd had already anticipated and prepared for. His understanding of English grammar and vocabulary was already of an advanced standard, a higher standard than that expected by his teacher and fellow students. What he needed was the ability to communicate with native speakers in a variety of settings and environments. He had no problem reading English in books and magazines, or following written instructions, or talking to his teacher and fellow students in English. Where he felt out of his depth was when talking to native speakers in groups, over the phone or in confrontational situations. What he needed to work on was understanding English spoken by people not making a special effort to be understood. Someone talking to him, knowing that English is his second language and speaking slowly and clearly was not a problem. But in group situations, what one English person was saying to another English person was much harder to understand. Talking over the phone, not being able to see the speaker's facial expressions and other body language also made comprehension difficult. Kolos often found that he would lose track of the what was being said, allowing the words to flow past him whilst he waited for a phrase he understood that would help him get back into conversation. During these periods of non-comprehension he would feel alienated from the group and after the conversation he felt foolish for not keeping up with the others. Although these occurrences were rare, they were enough to dramatically reduce his confidence in his own abilities as an English speaker. The rarity of these situations was his second problem.

Kolos had planned on improving his English by speaking to as many native speakers as possible. However, conversations with native speakers were few and far between. The people he lived with were fellow Hungarians and unsurprisingly there were no native speakers on his English course. He had found work in a London coffee shop among a staff consisting entirely of people with English as a

second language. No-one in his circle of friends were native speakers. Many of his customers were English but the few people he did speak to at length all made the effort to speak carefully to ensure they were understood. When he spoke to more than one person at a time, he often experienced uncomfortable moments of being 'lost' unable to follow the conversation. After awhile, Kolos found himself avoiding conversations that involved more than one speaker.

One thing that was unavoidable was the weekly telephone conference with Head Office that he, as assistant-manager of the coffee shop, often had to take part in. Talking English over the phone was a problem for Kolos and he tried to avoid it whenever possible. When the manager was away the telephone conference was unavoidable and Kolos would find himself dreading the Friday evenings when they took place. Once a month, the man on the other end of the phone would visit Kolos' branch for a planning meeting. This too became a dreaded event. What was depressing for Kolos was that he had come to the UK in order to perfect his English in order to return home to a high status, high paying career in Hungary – and here he was in England feeling out of his depth as the assistant-manager of a coffee shop.

When Kolos first came to me his confidence in his English was very low. We first communicated via email and I had asked how good his English was; I was initially concerned about the hypnotism, having never hypnotised someone whose first language wasn't English. He described himself as an 'intermediate' (although it was obvious his written English was faultless) and I offered him a free initial consultation. During that first consultation two things became obvious: Kolos' English was better than intermediate and that he knew his problem was one of confidence rather than technical ability.

His problem, as he described it, was that he didn't have enough practice speaking to native English speakers and that he wasn't confident talking in certain situations. This lack of confidence made him feel that he wasn't the advanced speaker he previously believed himself to be. As I saw it, the problem of not getting enough practice speaking to English people was a practical one that with some little effort could be overcome. I asked him if he thought that coming to me, a person he knew to be an English speaker, and taking part in therapy conducted entirely in English reflected an effort on his part to reach English speakers. He agreed that it was and that he could make similar efforts to meet other English speakers in the near future. I then asked him if truly believed he'd overestimated his ability in speaking English or whether in fact his recent lack of confidence had led him to overestimate his inability. He wasn't sure on this point and we joked about how that fact that he was following this conversation at all must mean that his English was at least 'advanced'!

Kolos would visualise a scene in which he would lose track of the conversation – this would become his cue to say to himself "this is my chance for excellence!"

I put it to Kolos that the fact that he sought therapy with an English speaker to over-come confidence problems meant that he knew he could find English people to talk to and that he knew his problem was one of confidence. Having reached agreement on this point, we decided that the best course of action was to use hypnotism to build up his self-confidence. And armed with his new found self-confidence he would go out and meet native English speakers to communicate with.

In all we had five sessions together. In each session Kolos, under hypnosis, visualised himself talking to various English speakers in various scenarios. I learnt during our sessions that Kolos was a keen photographer and many of his scenarios involved him talking to [imagined] members of a photography club he planned on joining to pursue his hobby and improve his English. In each scenario Kolos would visualise a scene in which he would lose track of the conversation – this would become his cue to say to himself "this is my chance for excellence!" (a phrase he created) – and then proceed to ask the speakers to repeat their sentences or admit to them that he had lost track of the conversation.

Having the courage to ask people to repeat themselves or admit not following what had just been said was the most crucial part in Kolos' gaining confidence. From what he had told me, he appeared to avoid situations that proved his English was not currently good enough for him to have the career he one day hoped to have in Hungary. However, he was over here to improve his English so he could have that career – not come to the UK to discover if his English was good enough. Under hypnosis Kolos was able to correctly associate conversations carried out in the UK with learning and the pursuit of excellence rather than with situations that would expose deficiencies in his English.

Kolos has kept in touch with me since our last session and reported an improvement in his English communication and feeling happier and more confident about his progress and future.

The Impact of Negative Media on Stress Levels

By Su Ricks

This is a summary of Su's dissertation, entitled: "Evaluation of the impact of negative messages in UK media news on anxiety, stress and feelings of well-being", which won her the 2008 NCH 'Researcher of the Year' award.

The study was conducted to research the impact of repeated negative messages in the media, specifically via radio, television and newspaper news articles on levels of anxiety, stress and feelings of general well being in individuals. I first became interested in this area long before qualifying as a therapist, when witnessing my young son's responses to repeated images of the Twin Towers plane crashes which were shown after the 9/11 terrorist attacks. The television coverage was repeated so often during the days following the attack that within a couple of days, he was convinced that hundreds of planes had crashed into hundreds of buildings and had found this highly distressing. Obviously, once I realized this, I switched off the TV and explained that this was not an everyday occurrence, but because "everyone was so upset" about the incident, it had been repeated on TV over and over again.

Method

The data collection element of the research project was divided into 4 phases;

- Selection of volunteers
- Collection of baseline information & analysis
- Intervention
- Collection of comparative information & analysis

Volunteers were sought from my colleagues, friends and family by email. All volunteers were over the age of 18 and all were made aware that they could withdraw from the research at any time.

Confidentiality was guaranteed, as all volunteers were asked to provide a nickname rather than their real name, in order to allow comparison of baseline and comparative data.

Volunteers were asked to complete an online questionnaire, at any time between Wednesday 26th March 2008 and Wednesday 2nd April 2008. Once the target number of volunteers had completed the questionnaire (exceeded actually) the findings were analysed using a scoring method, to identify;

- the groups average score for exposure levels to TV, Radio and Newspaper news stories
- group members with higher than the group average exposure levels to TV, Radio and Newspaper stories
- group members with lower than the group average exposure
- the groups average score for anxiety, stress and general well being
- group members with a higher than average score for anxiety, stress and general wellbeing (low stress, low anxiety, high feelings of well-being)
- group members with a lower than average score for anxiety, stress and general wellbeing (high stress, high anxiety, low feelings of well-being)

The group was then divided into 2 subgroups, both of which contained group members with:

- an average or higher media exposure score and average or higher ASW score (anxiety, stress and general wellbeing score)
- an average or higher media exposure score and an average or lower ASW score
- an average or lower media exposure score and an average or higher ASW score
- an average or lower media exposure score and an average or lower ASW score

The Intervention Group, consisting of participants 15-27 were asked to reduce their exposure to media news for the period of one week, then to complete the final comparative questionnaire.

The Control Group consisting of participants 1-14 were asked to continue with their normal viewing, listening and reading habits, but to note any changes on the final comparative questionnaire.

Collection of comparative information & analysis

The comparative and final online questionnaire was made available between the 9th and 20th April 2008 and completed by 25 of the original 27 participants.

Results

Baseline results – Overall responses

Initial findings – Gender and Age

I was disappointed that the group was imbalanced in terms of gender, and had hoped to recruit a higher number of participants overall. That said, the minimum number of participants outlined in my dissertation proposal (20) was exceeded, allowing the selection of an intervention and a control group, and the collection of comparative date before and after the intervention activity for both groups. Due to size of the overall group, I chose to use indicators, scoring and comparisons against the group average to identify baseline information and track any changes which occurred following the intervention phase of the project.

The initial findings showed that the average level of media exposure for the women in the study group, was higher than the men. The average Anxiety, Stress and Wellbeing Score (ASW Score) was lower than the male participants and lower than the overall average.

Analysis of the average ASW scores and average Media Exposure Scores (MES) by age did not indicate any correlation between media exposure levels of any specific age group and poor ASW scores.

Initial findings – Residential Area

The group was fairly evenly divided into urban and rural places of residence. Participants describing their residential area as "Town" had a higher average media exposure score than those describing themselves as City or Rural residents. Town dwellers also had a lower than group average ASW score. Rural and city residents had higher than group average ASW scores, and this corresponds with their lower than group average Media Exposure Score (MES).

Initial findings – Hours worked

The three participants who reported working for 8 hours or less each week, had a higher than group average MES, and lower than group average ASW. This was similar to participants working 33-40 hours and 50-58 hours, but dissimilar to participants working more than 8 hours but less than 24 hours per week.

Initial findings – Ethnicity

Unfortunately the study group was not ethnically diverse, therefore no analysis could be produced using this as criteria.

Initial Findings – Marital Status

The make-up of the group was obviously skewed in that 16 of the 23 participants were married. This group, had a higher than whole group average MES, yet an average ASW score.

Initial findings – Children in the family

The average ASW score for respondents with no children was below the overall group average in spite of their MES score also being lower than the overall group average. Parents of primary school aged children presented a higher than group average MES, although their ASW score was in line with the overall group average.

Baseline results – Selection of Intervention and Control Group Participants

Each participants Media Exposure Score (MES), Anxiety, Stress & Wellbeing Score(ASW), Other Stress Influence Score OSS, and Relief Activity Score (RAS) was recorded and mapped in order to track any changes resultant from the intervention.

The average ASW score for The Intervention Group (participants 15-27) was 3.98

The average ASW score for the Control Group (participants 1-14) was 4.13

Phase 3 Findings

The 3 Phase 1 respondents who withdrew from the study and did not complete the final phase 3 questionnaire, were discounted from the Phase 3 calculations and comparisons.

Control Group findings

11 of the overall Control Group (14) responded to the final comparison questionnaire.

Of the 11 respondents;

- 6 respondents reported an ASW equal to the initial survey
- The average ASW score for the control group was 4.02 in phase 1 and rose to 4.21, representing a rise of .19 points of or 4.72%
- The presence of other stressful influences for this group produced an average of 2.73 in phase 1, which rose to 3.09 in phase 3, representing a rise of 13.18%
- The activities undertaken to relieve stress in this group averaged a score of 2.45 in phase 1 and rose to 2.55 in phase 3, representing an increase of .27 points or 4.08%
- 3 respondents reported an ASW higher to the initial survey, 2 of

whom reported lower levels of other stressful influences, and higher levels of stress relieving activities

- The 2 remaining respondents reported ASW scores lower than in phase 1

NB: Phase 1 Group Average Scores were calculated using only respondents who completed both the phase 1 and phase 3 questionnaires

Intervention Group findings

All 13 of the Intervention group completed the final comparative survey.

Of the 13 respondents

- 3 respondents reported an ASW equal to the initial survey, all of whom indicated either a heightened level of exposure to other stressful influences, or a lower level of stress relieving activity

- 8 respondents reported a higher ASW in phase 3 than they had recorded in phase 1. 2 of these also reported a drop in exposure to other stressful influences or an increase in stress relieving activity

- The remaining 2 respondents reported Lower ASW scores in phase 3, but correspondingly reported higher exposure to other stressful influences, and/or lower levels of stress relieving activity

- The average ASW score for the intervention group was 3.98 in phase 1 and rose to 4.34, representing a rise of .36 points of or 9.04%

- The presence of other stressful influences for this group produced an average of 3.23 in phase 1, which rose to 3.39 in phase 3, representing a rise of 4.64%

- The activities undertaken to relieve stress in this group averaged a score of 1.85 in phase 1 and rose to 2.31 in phase 3, representing an increase of .08 points or 24.85%

Comparison of the Intervention and Control Group Findings

- The intervention groups ASW score significantly increased over and above the increase reported by the control group. This occurred in spite of the higher levels of exposure to other stressful influences of this group in comparison with the control group, and the comparatively lower level of stress relieving activities

- Although both groups reported a higher level of stress relieving activity in Phase 3, than Phase 1, the intervention group reported a 25% rise in comparison to the 12% rise reported by the control group, which may of course have skewed the results

- The phase 3 intervention groups overall ASW score was higher than the control group ASW score in spite of the intervention groups overall score for exposure to other stressful influences being higher than the control group, and their stress relief activity score being lower than the control group score

exposure to media news is a significant factor worthy of consideration when dealing with clients suffering from high levels of anxiety and stress.

Stressful Influences and Newsstories noted

In order to establish any connection between specific news stories and individual concerns, I compared the news stories which were noted by participants with the stressful influences they believed may have affected them during the study period.

There was no real evidence of a correlation, although of the 10 respondents who reported money issues as being a stressful influence 5 had also taken particular note of news stories relating to the "Credit Crunch". Of the 9 respondents who reported concern over family matters, 5 had also taken particular note of the Shannon Mathews case.

Discussion

The evidence produced by this study illustrates that anxiety and stress levels may possibly be reduced and general well being increased if exposure to media news broadcasts is reduced over a period of time, and therefore that it is an element of an individual's behaviour and lifestyle patterns which may be worthy of closer examination if they are suffering from high levels of anxiety or stress which have no obvious cause.

Obviously this cannot be taken as conclusive proof, as all participants were exposed to other variables which could not be incorporated in the study, although to an extent these were negated by consideration of other stressful influences on participants, and other interventions used as stress relievers by participants. Participants in the intervention may at first sight appear to have made greater efforts to reduce their stress and anxiety levels by increasing their own intervention levels, however the overall score for stress relieving intervention for this group is still lower than that reported by the control group.

Furthermore, indications are that overall, the intervention group perceived

themselves as being exposed to more additional stressful influences than the control group, and yet returned responses indicating Anxiety, Stress and Wellbeing improvements. It should be noted, however that the control group recorded a greater proportional increase in other stressful influences during the study period.

The study was also limited in scope in terms of number of participants, gender balance and duration, and I would be interested in repeating the study on a larger scale, perhaps comparing results obtained where the intervention is operated over longer and shorter periods.

It would also be interesting to find out whether the results reported by the intervention group return to phase 1 levels once their media exposure returns to pre-intervention levels, or whether their awareness of the potential influence has been altered, resulting in a more permanent change in behaviour relating to this area.

The study obviously does not prove, that increased exposure to media news leads to increased anxiety, stress and reduced well being. Although this would be a fascinating intervention to observe, I believe that asking participants to undertake an activity which may lead to increased levels of anxiety would be unethical and therefore unacceptable.

Also, the intervention group was merely asked to reduce their exposure "as much as possible" and although they reported having done this, it was not measured. It would therefore, be interesting to observe results from repeating the study with groups where the reduction level was prescribed and measured and comparing the results of the different levels of intervention.

Another variable, which cannot be measured by this study is the impact of involvement on the awareness levels of the control group and whether they may have sub-consciously altered their exposure to media coverage as a result of being involved in the study.

A further variable, is that all participants may have become more aware of their stress and anxiety levels, resulting in their adding additional interventions of their own to reduce stress and anxiety and therefore inadvertently impacting on the results of the study.

Participants may also have responded differently depending on their beliefs regarding the impact of the media upon anxiety, stress and well being, with those who believe it does make a difference recording responses they believed I may have wanted to see, and those who do not believe it makes a difference recording responses which they believed would disprove the theory.

I also believe that the initial results relating to the number of hours worked by participants, may indicate another highly significant factor which could not be examined in this study. This is the indication of poor levels of wellbeing, higher stress and anxiety in individuals who report very low and very high levels of work activity.

Potentially those with a lot of time on their hands could be at risk of higher anxiety levels due primarily to an excess of time available to focus on themselves. Those working too many hours, may have insufficient time for themselves and therefore may also be at risk.

In summary, the study has obvious limitations, however I believe that it does demonstrate that exposure to media news is a significant factor worthy of consideration when dealing with clients suffering from high levels of anxiety and stress. From a practical point of view, it would be quite easy to identify levels of media exposure with such clients during the consultation and suggesting a reduction in their exposure to the stimuli would certainly do no harm, and may well contribute to the achievement of positive results for the client.

If applied in conjunction with other coping, reframing and post-hypnotic suggestions designed to relieve anxiety, I believe the results for the client may well prove more effective than using either in isolation.

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Eating Disorders Unit, Institute of Psychiatry, King's College London, De Crespigny Park, SE5 8AF, London, UK

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If you would like a copy of the full dissertation, please contact Su Ricks by email at: su@nsholistic.co.uk

Editors Note: Congratulations to Su for winning the 2008 'Researcher of the Year Award' with this research.

If you would like to be considered (or nominate a colleague) for the 2009 Researcher of the Year Award, please contact the Administrator with details of your research and findings: admin@hypnotherapists.org.uk

Pain Control

By Gloria May

Awake: 2.30am – freezing, head muzzy. Lunch tasted funny, is it food poisoning? And after lunch, when I put my hat on carelessly, Sylvia said I looked pale and pulled it over my right eye, at a jaunty angle – irritating.

I am in the bathroom, vomiting that lunch - straight up from my stomach – no time even to bend down – projectile. Flush it away, no spatters on the floor or wall, no need to clean up. Relief – I'll feel better soon - sleep.

Awake: 3am - vomit again. Head woolly, hurts more and more – what to do for pain: go through choices: freeze, numb or distract.

Scalp is shrinking and there's something pulling it off my head. Dry throat, water won't stay down - acid taste, burning as it comes up – is this how dragons felt, breathing fire? No wonder they died out. Summon will and get to fridge, cold bag and ice cubes. Licking the ice triggers more vomiting. Respite – cold bag numbs head but, not enough. More vomiting, more sleep. Five am: more of the same. Moisture sucked from every tissue – nothing left in stomach: whole body feels drained of fluid like a shrivelled bag with nothing to hold bones apart.

Lessen discomfort (don't say the word pain to the ailing – covert suggestion to hurt more. Not sure I agree). Try distraction: toothache technique: isolate pain and stick it on the ceiling - doesn't work for this, it's all pervasive. Try floating through the rainbow – too much physical feeling, that won't do.

A different kind of distraction: make it visual - avoid the body. But what? Ha – Sylvia altering the hat. What does she know – dresses like a Christmas tree – no wonder I was annoyed. Can how to wear a hat be learned?

Princess Diana knew how to wear hats: eventually - she learned. Duchess of Cornwall's are too big, never look right – over-anxious, uncertain. Hats - the sign of status and self-assurance. Saddam Hussein's were always too small, perched on the top of his head like pimples – completely straight, Was he having a laugh? – not likely - nobody brave enough to tell him. See him in a tiny hat – I feel a smile – it's working.

Perhaps straight is like a king's crown, severe and powerful, even if absurd. But soldiers wear theirs straight – conformity obedience – except the paratroops and commandos – sideways berets – independence, initiative.

And what about Americans – the Jackie Kennedy anomaly: on the back of the head, like a schoolgirl, Clark Gable, Gene Kelly, even Fred Astaire. But maybe that's democracy – equal and casual. Though even Americans wear Trilbys sideways, they call them something else, what is it? Look it up when I get better – if I get better. Of course I'll get better. It's only a virus.

The front door opens – here's Heather, back from Manchester.

'You didn't answer the phone – I was worried.'

Sister in charge: fresh cold bag, plumped pillows. I won't let her comb my hair, too painful. She looks hurt. Can't be helped. The doctor will come – in five hours.

I close my eyes and see more hats. I'm separating from my body. This is so good. Hats: practical; miners' with lamps; bowler hats – moving from factory to city. Somebody must write a book on hats – social history, philosophy, psychology – a life's work.

Here's the doctor – five hours go so fast - a beautiful young woman, with long black hair. She sticks the anti-emetic in, leaves electrolyte powder and instructions: 'Phone 999 if vomiting continues. I had it myself last week - nasty'. She snaps her case shut.

She has survived – I'm encouraged.

Back to hats – the doctor hadn't worn one – who would with that hair, the ultimate in status and self-assurance.

Time slows down, water stays down.

Ian Botham wouldn't wear protective headgear; Richard Sharpe, bareheaded, ferocious and outnumbered, defeated the French in their silly shakos; Tolkien's warrior princess threw off her helmet and slew the monster 'who could never be killed by a man'. Her golden tresses swirled as she stuck the dagger into its guts. Who needs a hat.

A cup of tea would be nice, I ask Heather to make one - and to give my hair a comb. I'm on the mend.

Congratulations to our latest HPD qualifiers!

Jackie	AITKEN	Karen	GREEN	Melanie Lois	PIERCE-JONES
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Seeing is Believing

By Joy Lawton

The following piece of therapy work came about quite simply. I had just finished a session with a client, who for various reasons, did not seem able to 'move on' and was sadly lacking in focus. She sat there after the session, taking off her glasses, and then putting them on again, saying that it was very hard for her to 'see herself as a worthy person'. This simple action got me thinking. I needed to put something together for this client next time to help her with what she so desperately wanted to see and focus on in her life – and to help her to successfully 'move on'.

So I came up with the following metaphor – there is only one proviso, your client needs to wear glasses in their everyday life! You may well think this work has no value for a vast majority of your clients, but you will be surprised how many clients do wear glasses some of the time, and unless you ask them casually at the information seeking stage, you might never know.

You can use this 'vision' work with all types of issues, as we tend to incorporate self esteem and confidence boosting at some stage for every client that we see. It could form part or even the whole of a session, depending on your client and what is needed. Visual clients really relate to this work, and even clients with more auditory and kinaesthetic preferences can, with your help, 'hear' and 'feel' the more subtle change that this visit to the optician brings them. I tend to start off a session with this script and then move onto more specific self esteem/confidence boosting work to suit the client and their issue. I then usually future pace to complete the session, bringing in all that we have done, and finally remind the client of their new 'focus' in life from now on.

So now you need to prepare your client for the work you are about to do, so before you take them into trance, simply ask them for a few words (and note) that describe how they 'see' themselves or their 'vision' of themselves. Clients come up with all negative types of words – e.g. ugly, unworthy, pessimistic etc., so pick out the one that is most suitable to work with. Then all **you** need to do is to come up with a positive word that is the **OPPOSITE** of the type of word that your client gave you. Logically then you may have a choice of – e.g. attractive, worthy, optimistic etc.

remind the client of their new 'focus' in life from now on

Now off you go! Simply insert the original word given into the script that follows, and insert the **OPPOSITE** of that word that you have chosen later on, and you will find you have given your client the facility of 'seeing' themselves or visualising themselves in a new, positive and focused way now, and for the future.

Seeing is Believing –

'Just imagine a visit to your optician... PAUSE.

You go through the routine of the usual eye tests and checking your responses to them. Then the optician dims the lights in the consulting room and asks you to look at the different charts full of letters of the alphabet at the other end of the room. The optician asks you to put on the basic frame that they will slide different types of lenses into in order to test your eyes, to allow you to clearly focus and see well...

Time after time they put different lenses into the frames and ask you to say which ones help you to very clearly see the different letters on those charts. None of them seem quite right, and when you have the last remaining set of lenses in and they ask you to read a particular line, you read slowly and with difficulty the entire word across which spells out e.g. W.O.R.T.H.L.E.S.S./other...

Does this word mean anything to you? Have you read it correctly? Just think about that word for a moment... PAUSE.

Then you are drawn toward a particular set of lenses lying there in front of the optician, and you ask them to take out the ones you have already got in and put these other lenses into the frame instead. Now the optician asks you to read the same line on the chart again and now you read very clearly the word e.g. W.O.R.T.H.Y./other. The lenses are very clear, making your focus on those letters much better now. What a difference you say to the optician, now you are wearing those newly adjusted lenses, how much better you can see everything around you in that room! What potential, to see everything around you from now

on, home, work, socially/other - all with a new clearer focus...

The optician says that they are happy with this new prescription for you, they feel they will suit you very well and will help you focus more easily on everything you do from now on. They can get them ready for you in a few days. You now decide whether you want new frames or whether you could have the new lenses fitted into your existing frames. You have a spare pair of glasses if you need to leave your existing frames with them. You return a few days later to pick up your new glasses and you are feeling really excited! The optician checks the fit and the position of the glasses on your face and around your ears, and suggests that you begin to wear them when you get home, so you get used to them gradually in familiar surroundings...

So, you get home and can't wait to put your new glasses on. **WOW!** You are wearing them now, seeing the world in a different way. Enabling you to focus more clearly and easily day by day. Seeing everything around you, your home life, your work and your social life/other, focusing on all those aspects in a new clearer way, enabling you to see life, feel life and hear what is going on around you as a e.g. WORTHY/other person... PAUSE.

Even if you don't have to wear your new glasses all the time, these new lenses give and will continue to give you a different and clearer insight into the world around you, as a e.g. WORTHY/other person. Remember, you can always return to the optician anytime or at your next routine appointment if you feel you need to. To have those lenses adjusted or even replaced by a new pair, if you feel that your vision of yourself, what you see, feel and hear needs to be refocused and made clearer again.'

A Shamanic Approach to Hypnotherapy

By Martin White

When I was a newly qualified hypnotherapist, several years ago, the thing I found hardest of all was matching the most appropriate technique to the presenting problem. This issue was only compounded when I tried to string a number of techniques together to form a cohesive treatment plan. As the years progressed experience made this easier, but I still felt that there was something missing; something at a fundamental level.

I should say at this point that I am always looking for additional healing modalities and interventions to add to my repertoire, sometimes using them as they are presented and sometimes adapting them; using Reiki as an induction for example would fall into the latter category – the ultimate induction for kinaesthetic clients! It was years later however that the 'missing' piece regarding treatment planning presented itself, and it came from a most unusual source. What I came across was a model of illness taken from a subject called 'core shamanism'. The term core shamanism was coined by an anthropologist named Michael Harner. Harner had studied healing practises from indigenous cultures across the globe and discovered that these societies had striking similarities in their approach, which he distilled down to form his 'core shamanism'.

These similarities include a belief that everything is alive or 'has spirit' and can be communicated with; that all illness is spiritual in origin; that effectively, illness stems from either missing something you should have (termed power or soul loss) or having something you shouldn't (termed a spirit intrusion). Mediation between the spirit world and ours is undertaken by a specialist within the society and Harner borrowed the word 'shaman' (taken from the Siberian 'saman') to describe this role.

All of this may seem a million miles away from our therapeutic practise in the western world, but when all the 'rattling and smoke blowing' is stripped away from the shamanic approach, the underlying model is remarkably pertinent.

The shamanic model of illness states that the first thing we need to do is to build up a client's strength to a point where they can undergo either a spirit extraction or a soul retrieval. In our terms this is preparing the ground for the main interventions and may include ego strengthening or basic relaxation techniques.

Next come extractions, which are always performed before retrievals. The logic behind this, is that when the original soul part was lost, it left a vacuum, which was then occupied by an intruding spirit, therefore, in order to bring the soul part back, the body must first be cleared of the intrusion so that there is a 'home' for it to come back to.

Spirit intrusion itself is a useful construct. You may consider a phobia as a spirit intrusion as might negative thoughts and feelings, panic attacks or compulsions. As you know, the subconscious loves imagery and drama, so giving form to what can be an ephemeral idea (such as panic) definitely makes it easier to deal with and provides fertile ground for creative interventions.

Soul or power retrievals are next and this is an immensely powerful idea. Soul loss states that when we suffer a trauma, part of us takes refuge in order to protect itself. As the subconscious 'doesn't do time' and only lives in the present, this missing part is effectively in a permanent state of trauma – or rather believes that the trauma is still taking place and therefore it is not safe to 'return'. Have you ever worked with a client where whatever intervention you use just doesn't seem to be hitting the spot; using the model of soul loss we can see that we are treating the wrong part of the person, the part we need to be treating isn't actually available until the soul retrieval has been performed. In our terms, soul retrieval may be seen as a specialised form of regression or timeline therapy in which we can communicate with the missing piece and negotiate its return after convincing it that the original trauma has passed. Interestingly, in most indigenous cultures the soul part only comes back after getting agreement from the client (through the Shaman) that certain conditions are met. These conditions more often than not involve the client making changes to elements of how they live or what they do in order for the soul part to remain and not take flight again.

I shall now illustrate how this works in practise by first describing a traditional shamanic intervention to a specific problem, and then showing how this can be remodelled into a workable therapeutic session for a typical client.

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

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Consider the case of Mary. Mary was made suddenly and completely unexpectedly redundant a year ago and she feels that this really knocked her confidence. Although she found work again after a three month search, she has never felt really secure in her new position. Two months ago she had her first 'episode' which just seemed to come out of the blue. She described a sudden blind panic overtaking her, heart rate increasing dramatically, difficulty breathing, sweating profusely, dizziness and nausea. She felt that she was dying. Since that first panic attack she has had several more and they are becoming more frequent. Mary is at a loss what to do and there seems to be no obvious trigger for the attacks; she is becoming afraid even to go outdoors at all, just in case she has an attack.

A shamanic diagnosis would indicate 'soul loss' due to the trauma of her sudden and unexpected job loss. Furthermore, a 'spirit entity' has taken up residence, filling the vacuum caused by the absent soul part. The panic attacks are the manifestation of the intrusion and the fact that they are getting stronger and more frequent indicates that the intrusion is feeding on Mary's energy, weakening her day by day.

A traditional shamanic approach would possibly involve Mary taking special herbal baths or being 'smudged' (a process of blowing smoke, usually white sage) all over her body. She would also be given a strict and quite bland diet to reduce stimulation.

Next would come the extraction. The shaman and Mary would lie side by side on mats on the floor, touching each other at the shoulder, hip and ankle, before closing their eyes and relaxing – the touching at these points induces a synchronisation in breathing rate and the shaman can relax Mary further by first pacing her breathing, then deepening their own to lead hers deeper and slower. The shaman then enters a trance state (which traditionally may be induced by listening to a constant 120 strokes per minute drum beat) and 'travels' to his spirit allies (often manifesting as animal archetypes). The allies are spirit helpers who either carry out the treatment themselves or direct the shaman in his actions. In this case, the allies might direct the shaman to scan Mary's body looking for the intrusion which traditionally takes the form of snakes, insects, a black, or dark coloured tar or other some form that the shaman finds particularly unappealing.

telling someone they have an intruding spirit in the form of a black tarry mass inside their body is less than helpful

On locating the intruding spirit, the shaman opens a dialogue with it and negotiates its departure – usually by offering it an alternative and more appealing home; an egg is used by many tribes around the world for this. If the spirit is reluctant to leave the shaman would get more aggressive in their approach, possibly using the sound of a rattle to agitate it and force it out. Either way, once the intrusion has gone, the shaman cleans up the wound (energetically speaking) before retrieving the lost soul part.

As you can see, many of the elements here would seem more than a little weird to the average client and may be completely ineffective for that reason. So how might we adapt this to our own cultural perspective?

For a start, some of the language may need toning down. In my experience, telling someone they have an intruding spirit in the form of a black tarry mass inside their body is less than helpful!

I might first suggest that we need to get Mary to learn how to relax, I might teach her self hypnosis for this purpose and I would probably back this up with an appropriate ego strengthener.

I would then guide Mary into trance and invite her to look into herself to find 'energy' that doesn't belong, energy that is disruptive and that is the cause of the panic attacks. My preferred method here is the get her to imagine she has floated out of her body, up to the ceiling and is looking down on a perfect, clear crystal replica of herself; looking inside it for the intrusion.

Once discovered I would get her to approach the intrusion and enter into dialogue, asking it why it is there, maybe getting her to explain that its presence is causing her much distress and that it needs to leave for a better home. I would probably get her to

ask it to describe what its perfect home would be like and then get her to lead it there.

Once the intrusion is out, I would invite Mary to repair the crystal version of herself in whatever way seemed appropriate, before getting her to re-enter the body and initiating the wake up. We would save the retrieval for another session.

If Mary found it difficult to extract the intrusion, then I could use a more direct suggestion, possibly getting her to see me extracting it or even getting her to imagine her own ally doing the job. The therapist needs to remain flexible in their approach and utilize the client's responses during the extraction; this flexibility is completely in line with a shamanic approach, most shaman are masters of utilization and have a very well developed sense of reading people.

In summary then, we strengthen the client first, then remove any unwanted or unhelpful thoughts and feelings, before returning any 'missing' parts and finally changing the clients environment (physical and mental) so that the problem does nor recur. In this way the shamanic model of illness gives a coherent approach to inform our treatment planning and brings a sense of order and cohesion to the interventions we use.

Of course this is only a brief introduction to the subject of shamanism and anyone who is interested and would like to become more familiar with the model and techniques and how to adapt them to a modern western setting should visit the website:

www.talkingcurestraining.co.uk

Supervision - How Necessary is it for Hypnotherapists?

by John Hayes

As a hypnotherapist who specialises in treating anxiety, people employ me to help them resolve emotional issues that affect their personal and professional lives. As a person with anxieties and issues of my own, I employ a supervisor to help me examine my practice and to explore relevant issues in my personal life. My supervisor, in turn, employs a therapist to help her, and he or she employs someone else. Thus the endless chain that links helpers and the helped not only extends indefinitely in length, but wraps around itself so that the client who employs me in my capacity as hypnotherapist may well be someone else's supervisor.

Clients then, especially those engaged in short term therapy, are highly competent and esteemed individuals in many aspects of their lives. That which separates them from the therapist can often merely be the imposition of the therapeutic boundaries agreed to by both parties for the duration of the therapy. Indeed, sometimes for a specified period of time after the therapy has terminated, for example, with boundaries that prohibit intimate relationships.

Such therapeutic boundaries require that practitioners to put to one side their own fears and desires in order that the client may focus entirely on examining their own. If these boundaries are broken or insufficiently defined, the agreed roles of practitioner and client are compromised, and thus the potential for effective therapy.

Naturally, the nature of the practitioner's and client's role changes according to the type of therapy engaged in. One way of distinguishing between "talking therapies" such as hypnotherapy, NLP, counselling and psychotherapy is by grouping them according to their duration and the degree of directiveness employed by the practitioner.

Counselling and psychotherapy, for example, tend to be medium to long term therapies. They are usually exploratory in nature and the role of the therapist tends to be as non-directive as possible. The emotional relationship between the therapist and the client, though not always explicitly explored, is an integral ingredient in the therapeutic process and, thus, so too are the powerful dynamics of transference and counter-transference - the projecting back and forth of "undigested" feelings and expectations. If the therapist is unaware of these dynamics, the therapeutic process can be seriously compromised. This is one of the reasons that all practising counsellors and psychotherapists are required by their respective governing bodies to partake in supervision, a component of which is to identify and deal with issues of transference and counter-transference.

Hypnotherapists and NLP practitioners, on the other hand, offer short

term therapy which prompts the practitioner to be more directive in their approach. There are, of course, different degrees of directiveness ranging from direct suggestion and semi-guided imagery to responsive guiding and metaphor. Still, the emphasis in short term approaches is on identifying solutions and applying step by step procedures rather than on examining dynamics and exploring causes. Goals tend to be more specific, models more fixed, exercises more structured, procedures more pre-determined and, most notably perhaps, the relationship between practitioner and client is left unexplored. However, even if the relationship between hypnotherapist and client is not examined, transference and counter-transference still occur. Indeed, many clients who seek out hypnotherapists bring with them the expectation that the practitioner possesses some kind of magical power and, by maintaining this expectation, transfer over to the practitioner the entire responsibility for the healing process.

many clients who seek out hypnotherapists bring with them the expectation that the practitioner possesses some kind of magical power

Equally, when a hypnotherapist guides a client through a regression, if there is any counter-transference taking place, the likelihood of inadvertently leading the client will significantly increase. If we, as hypnotherapists, are unaware of the processes of transference and counter-transference, these "un-monitored" feelings and expectations will compromise our objectivity, and our unresolved personal issues will impinge upon the therapeutic process, and vice versa.

Hypnotherapists are also subject to a whole host of other dilemmas which, if left unexplored, can significantly compromise our effectiveness regardless of our technical ability. How, for example, do we hand over responsibility to a person who wants to be magically cured? How do we guide someone through the therapeutic process without leading them? How do we stretch therapeutic boundaries without breaking them and how do we rebuild boundaries once they have been broken? Do we challenge an illusion that affords protection and purpose when there is nothing to take its place? What do we do when our own anxieties and desires begin to influence the direction of the therapy? How do we follow a tried and tested procedure without losing spontaneity? Do we share our own feelings? Can we be friends with our client or have intimate relationships? If so, after how long? What do we do if we find ourselves out of our depth? How do we deal with sabotage? How do we allow for messy endings? What do we do when our approach isn't working?

Even if we know the answers to these conundrums, they are unavoidable and necessary ingredients for any therapeutic encounter to be real. The answers also vary according to the scenario in which the questions pose themselves, and they are influenced by our own fluctuating states of mind.

Supervision provides us with an arena in which we can monitor transference and explore these dilemmas in order that we are able to retain our objectiveness and separate our personal lives from our professional ones. With this in mind, supervision should include not only an examination of the techniques and procedures we employ in our practice, but also an examination of any personal issues that may impact upon our ability to carry out these techniques and procedures.

By investing in supervision, we ensure that the client gets to receive the best possible service. We provide ourselves with a way to maintain our own personal and professional boundaries. We assist in improving the status of hypnotherapy which, at present, is still seen by many within the world of talking therapies as the "poor cousin" - in part, perhaps, due to the lack of supervision regulation.

Fortunately, there seems to be an increasing desire by therapists of different schools to become more integrative in their approach. If hypnotherapy is to capitalize on this trend and to improve its professional status, it is essential for practitioners to examine and monitor both their practice and their own emotional worlds by engaging the services of an adequate supervisor. Sooner or later, supervision may well be mandatory for all practising hypnotherapists. Indeed, for some governing bodies representing hypnotherapists supervision is already a pre-requisite. For most hypnotherapists, however, it is still largely up to the individual to decide whether or not supervision is really necessary.

John Hayes is author of the book *Safe Space; a self-help manual and practitioner's guide for treating anxiety and panic* which is reviewed in this edition of the Journal.

QUOTE-NOTES

"Action may not always bring happiness; but there is no happiness without action."

Benjamin Disraeli

Metaphor Corner

The Butterfly

There was once a very kind, caring and thoughtful woman, who was known to be the most helpful person in the family. She was so kind-hearted that she couldn't bare to see anyone in distress and would immediately step in and help in which any way she could. Her goodness knew no bounds.

One day this woman was walking in the countryside and she came across a chrysalis on a leaf and whilst she watched, it slowly split open and just inside she could see the butterfly moving.

She watched it for a while as it pushed and struggled to open the shell sufficiently to get out until she could bear it no longer, and being the kind and loving person she was, she opened the shell for the butterfly to escape.

The butterfly immediately fell to the ground, fluttered a few times and died as it had not reached the point where its wings were ready and strong enough to take flight and move onto the next stage.

The moral of this is that sometimes we need to step back and allow the people we love to struggle and find their own path.

Marilyn Joslin

The £20 Note

A well-known speaker started off his seminar by holding up a £20 note. In the room of 200, he asked, "Who would like this £20 note?" Hands started going up. He said, "I am going to give this £20 to one of you but first, let me do this. He proceeded to crumple up the £20 note. He then asked, "Who still wants it?" Still the hands were up in the air. Well, he replied, "What if I do this?" And he dropped it on the ground and started to grind it into the floor with his shoe. He picked it up, now crumpled and dirty. Still the hands went into the air. My friends, we have all learned a very valuable lesson. No matter what I did to the money, you still wanted it because it did not decrease in value. It was still worth £20.

Many times in our lives, we are dropped, crumpled, and ground into the dirt by the decisions we make and the circumstances that come our way. We feel as though we are worthless. But no matter what has happened or what will happen, you will never lose your value. Dirty or clean, crumpled or finely creased, you are still priceless to those who DO LOVE you. The worth of our lives comes not in what we do or who we know, but by WHO WE ARE.

Author Unknown
Sent in by Alexis Savage

The Angels and the Room

A man went to heaven and was being shown round by some angels. They showed him where everything was and what was expected and were very kind. He was surprised therefore that they didn't open one door. He asked why not. 'Well, we can't forbid you to open that door', they replied, 'but we strongly recommend that you don't'.

Of course, this increased his curiosity and before long he opened the door. There inside was everything he ever wanted: a happy family, untold riches, good health, a nice home. He went back to the angels and asked: 'Everything in that room was great; why didn't you want me to see it?'

'Because' they replied, 'they were all meant for you, but you never believed you could have them.'

Attributed to Michael Neill
Sent in by Patricia McBride

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Book Reviews

Childbirth without Fear: The Principles and Practice of Natural Childbirth By Grantly Dick-Read

Reviewed by Alan Grievson

I read this book because I was informed it was the basis for HypnoBirthing™. Written in a somewhat prosy style by modern standards, it is however an informative book on the processes involved in pregnancy and labour.

The author believed (he died c.1959) that childbirth is a natural event and should be easy and pain free. However, because of old wives' tales and bad medical practices, stress is created in the mother which in turn creates anxiety and a general tightening of the muscles; hence painful childbirth for mother and child. An example he gives is that of a woman giving birth in the wild: should a predator come by, the anxiety of the situation will cause the labour to stop because of the muscular tightening at the neck of the womb; once the threat goes away delivery proceeds. In the refined West, we force the mother to push against the muscular restriction caused by the anxiety of perceived pain.

In later editions the author added a part about hypnosis, although he doesn't believe it is relevant. He maintains that all that is required for pain free child birth is better education for medics, nurses, midwives and the expectant mothers. Education, he believes, removes the unfounded fears.

Although it is acknowledged that practises have improved since the book was initially written, within the health professions there is still room for improvement. An interesting book if you have not read it and you are/or maybe considering HypnoBirthing™.

ISBN: 0953096467
RRP: £8.99
Published by Pinter & Martin Ltd

Safe Space: A self-help manual and practitioner's guide for treating anxiety and panic By John Hayes

Reviewed by Rob Woodgate

When I first started reading *Safe Space*, I had doubts. With a subhead billing the book as "a self-help manual & practitioner's guide for treating anxiety & panic" and a footer classification of "Self-help / Hypnotherapy / Psychotherapy / Counselling", I couldn't see how it could possibly cater to such a diverse audience.

Thankfully, John Hayes' compassion, enthusiasm and understanding of this area shine through, and the easy reading style quickly had me turning pages.

I went from being mildly irritated by some of the 'politically correct' overtones in early chapters to being quite impressed: this book not only creates a "Safe Space" for panic and anxiety sufferers, but also a "Safe Space" for the various therapy disciplines to better understand each other. No mean feat.

The *Safe Space* model draws on concepts that will be familiar to Hypnotherapists, Psychotherapists and Counsellors alike, and John takes great care to lay the foundations by bringing all readers to common ground in a largely jargon free way that will especially appeal to the self-help audience.

John's explanations of concepts and procedures are very concrete, and these are made even more so through his thoughtful use of case studies. I especially liked the Family Analogy that is central to the *Safe Space* procedure, as well as finding numerous other nuggets to pass on to my clients.

There is no doubt this is a brave book, but I think the gamble has paid off. *Safe Space* provides a useable framework for dealing with anxiety and panic, whatever your background.

For Hypnotherapists in particular, this is a wonderful example of a clearly passionate and knowledgeable practitioner in action, so whether you are newly qualified and looking for a template for good practice, or a seasoned professional looking for some inspiration, there is something here for everyone.

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... and A Very Happy and Prosperous New Year!

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