THE
HYPNOTHERAPY JOURNAL

Issue 2 Vol 10 www.hypnotherapists.org.uk Summer 2010

Clinical Outcomes Measurement

Burden or Therapeutic tool?

Supervisors

Friend or foe?

Language

Impact on reality

Private Practice

The lighter side

Extravaganza Returns!

Solihull, 19th June 2010 - Details On Page 3

NATIONAL COUNCIL FOR HYPNOTHERAPY
Address: PO Box 14542, Studley, Warwickshire, B97 9HH
Phone / Fax: 0845 544 0788 / 0845 544 0821
Website: www.hypnotherapists.org.uk
Email: admin@hypnotherapists.org.uk

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

The NCH has a palpable energy and buzz as our new NCH committee members settle in their roles and start making their mark.

Top of the agenda has been the development of training standards and the process of Voluntary Self Regulation (VSR).

As I've been reading and reflecting on the committee chatter, I've found myself asking the question: *what's the intention of that?*

Those of you familiar with NLP will recognise this as a 'chunking' question (non-NLPers will of course use other terminology).

As I chunked up both aims - 'Regulation' and 'Training Standards' - I found myself left with one overriding common professional intention - '***increasing the credibility of our profession***'.

(Of course, I was able to chunk higher than that into personal intentions - for example: more credibility means more clients, means more people helped and more money etc - but credibility was the highest professional motivation.)

Anyway, it occurred to me that these twin pillars of credibility - 'Regulation' and 'Training Standards' - seem to be heavily entwined.

Perhaps that's because the ability to say who has the right to practice is the 'easy route' to ensuring higher standards of education - *If we stop all the 'charlatans' from being able to practice, then we'll achieve higher standards and more credibility.*

The problem is that one mans charlatan is another mans professional.

For example, as an NCH member, have you ever looked at the 'trained in a weekend' schools out there and thought, 'if only we could regulate these people out of business, we'd get more credibility as a profession'?

I know I have. After all, it's human nature to look for a 'bad guy' to vindicate one's own position.

By the same token, however, you can bet that there are (perhaps psychologically or medically trained) professionals thinking the same about us!

The freedom to practice "lay" hypnotherapy around the world has been successfully fought (notably by Gil Boyne and others) for many years on the grounds that there has never been a credible documented case of actual harm to a client resulting from hypnotherapy alone.

Of course, there are plenty of cases of client abuse (in all its forms), but these can happen in any perceived authority based relationship (therapist/client, doctor/patient, teacher/pupil, adult/child, priest/altar boy etc).

In other words, the practice of Hypnotherapy doesn't seem to be the problem... PEOPLE are the problem.

If we are seeking regulation as a means of achieving credibility alone, perhaps this is a dangerous game; I'm not surprised there are some mixed feelings about VSR in the profession.

For example, some believe that VSR under CNHC will harm our credibility by throwing our lot in with professions who have a questionable evidence base. There is also the concern that regulation will be the start of a slippery slope that may see 'lay' hypnotherapy marginalised by groups claiming it (or certain conditions) their exclusive domain on the basis of a perceived ability to harm.

Even with those reservations in mind, I believe that the present VSR process is broadly a good thing: it is uniting our once fractured profession under an agreed minimum set of standards and common codes of ethics and practice, and will hopefully make us strong enough to lobby effectively against any later moves to curb our freedom to practice.

Long term, however, I believe that credibility and professional security will come more from the focus on externally quantifiable training standards, with Professional Associations like NCH supporting members in marketing their practices and the profession effectively.

Unlike Regulation, the pursuit of Training Standards has no downside risk, and with the current shift towards evidence based methodologies, can only serve to make us stronger.

Enjoy the read.

Rob Woodgate

Committee News

View From The Chair

The deadline for this issue of the Journal has been pulled forward a little owing to the well deserved holiday of our highly esteemed Editor, Rob Woodgate, so as I am writing now a good few weeks before the General Election. You will no doubt be reading this in the reflective glow of a new bright and bushy tailed Government, or maybe by that time they will be telling us all how things really are!

The good news from the NCH is that all the changes we have introduced over the last year or so have enabled us to reverse most of the financial trends of the previous year. I am looking at the first draft of our year on year comparisons and I am delighted to say that subscriptions are up, total income up and our administrative costs and expenses are significantly reduced, which means once again we are in a good position and looking for new ways to invest our surplus revenue for the benefit of you, our members; you will already be aware that we have increased our advertising spend and are considering other ways in which we can support you, and we would welcome your ideas and suggestions.

This seems an appropriate time to mention that Margaret Wiggall our Finance Administrator has retired and has gracefully stepped back from the foray of administering a busy and initially complicated position. The transition from Margaret to Annie Dee Hughes has been smooth and efficient, for which much credit is due to Margaret's dedication and hard work and Annie's previous work experience and quick grasp of our procedures and processes. I am sure you will all join with me in wishing Margaret a very happy retirement and welcoming Annie to the family.

The Voluntary Self-regulation Process (VSR) is continuing to occupy much time with some key members of our Executive, with Mr. Martin Armstrong-Prior at the sharp end of the business. I think it is fair to say that the Executive are in the main (however with some noticeable exceptions and in varying degrees) embracing the move towards VSR. My position is very clear in that I do not see the CNHC as a destination but merely a part of the journey that we need to travel in order to ensure our profession is perceived by the general public and other healthcare professionals as being credible and regulated in the best interests of our clients. However, as we are now in the process of bringing together Training Standards/Learning Outcomes and the Codes of Ethics and Conduct, I believe that a dedicated task force of interested parties may make a valuable contribution to this process. If you are interested in VSR and in the future of our profession please do not hesitate to contact me directly as we would like your help and views in moving forward.

Many of you will be aware of the name 'Hypnobirthing' and its founder Marie Mongon; it has come to our attention that some time ago she made an application to the Intellectual Property Office (IPO) in the UK for a Trade Mark for the term 'Hypnobirthing'. This process involves two stages: Stage One involves a legal appraisal of the application by the Trade Mark Examination Team at the IPO. If the application satisfies the Trade Mark Act then Stage 2 is that the application will be published in the Trade Mark's Journal. After such time, interested parties are able to make 'observations' on the application.

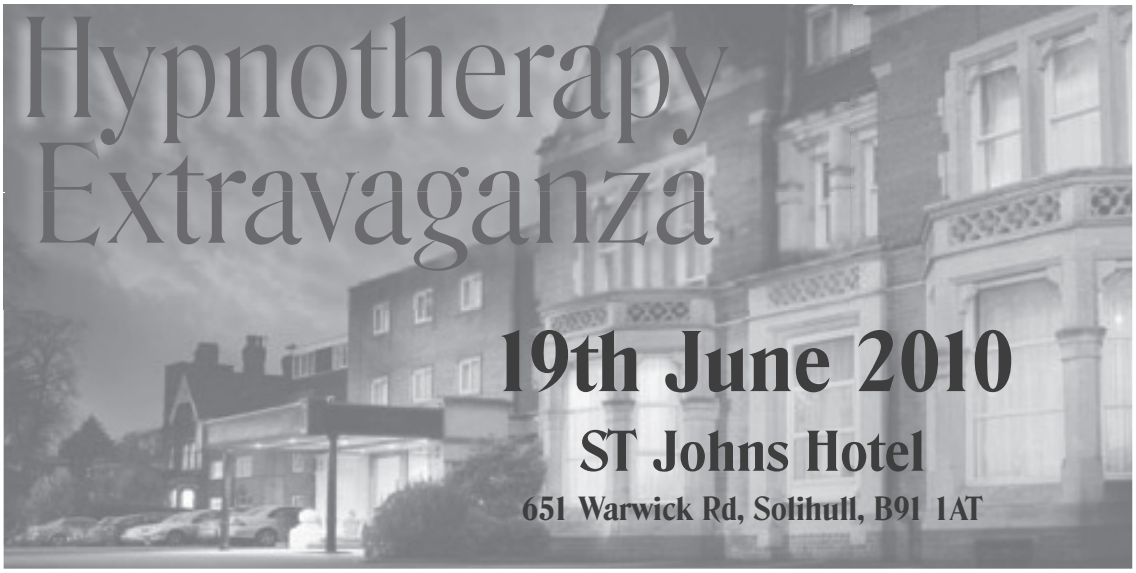
We have requested that the IPO, through their electronic caveat service, automatically make us aware when the application is published; at that stage we will resubmit the observations that we have already made regarding this application.

Once again I would encourage members with any views regarding this matter to contact me or any other member of the Executive to discuss the matter in more detail so that our formal observations will reflect the views of our members. Currently those members to whom I have already spoken are opposed to this application.

There is much more that I could write about but I know that many of my colleagues are looking forward to telling you about developments in their areas of responsibility so I look forward to seeing you at our Summer Conference/Extravaganza.

Paul White

Sponsored by towergate



Hypnotherapy Extravaganza

19th June 2010

ST Johns Hotel

651 Warwick Rd, Solihull, B91 1AT

Keynote Speakers include

For up to the minute speaker information visit www.hypnotherapists.org.uk/event

Dr John Butler is a highly regarded hypnotherapist with over 28 years and 30,000 hours of practice as a successful clinical practitioner. He is an instructor in hypnosurgery and teaches clinical hypnosis applications to surgeons and anaesthetists in a course accredited by the Royal College of Anaesthetists. His talk at last year's Extravaganza was so well received we have asked him to return to go into much greater depth about pain control. He intends to impart some techniques that you can experience and actually use in your practice.

Keith Antoine is a Performance Coach In the 90's he was appointed as the youngest GB National Coach for sprints & relays, Paralympic Team Coach, Senior Sprints/Hurdles Coach for the Midlands, as well as personally coaching athletes to medals in the European & World Junior Championships, and onto teams for the Commonwealth, European, World & Olympic Games. Keith will be showing you how you can use some of his coaching techniques to help your clients towards their goals. These techniques are used by some of the top athletes in the world, why not your clients too?

We are holding the NCH AGM at 2 pm and a members dinner in the evening to finish off this incredible day. It is only open to NCH members. The numbers for the dinner are strictly limited so book early to avoid disappointment.

Attendees are awarded with a CPD certificate.

Prices

Delegate - NCH member £60
(Including Lunch, Teas & Coffees)
Delegate - Non NCH member £100
Evening member dinner £20
(including wine sponsored by Towergate)
All prices exclude VAT

Don't delay

Special price for the first 100 members that book for the Extravaganza and the evening meal of £70 + VAT.
So make sure you get in quick, as space is now very limited.
To book go to
www.hypnotherapists.org.uk/event
0845 544 0788

Member Services News

First of all, I'd like to thank all members who either attended or expressed an interest in attending the focus groups we ran in March - some members travelled significant distances in order to attend. It was a great opportunity for those of us who attended to meet and share ideas. From both sessions it became clear that there were some key services that the NCH could be offering to members which would support them in both starting a practice and in maintaining and enhancing their practice.

As a result, the areas that we will be focussing on in our Membership Services Strategy and which were key areas of debate within the focus groups are:

- Building a strong sense of community amongst practitioners throughout the UK.
- Improving access to specialist information online and to our Specialist Advisors.
- Creating an online library of PDFs, facts sheets and useful forms.
- Affordable access to NCH events, such as the Extravaganza.
- Phase II of web development to improve online access for members.
- Improve transparency of structure, processes and procedures within the organisation.

In June we will be distributing the Strategy in more detail, and all members will be invited to comment. The deadline for responses will be the 31st of August. We will then issue an action plan with timescale for delivery clearly laid out.

Please take the time to read the strategy and to respond. As a membership organisation, we hope that as many of you as possible will take the time to get involved and help implement these changes.

Sophie Fletcher

Company Secretary News

In the last two Journals I have given you a lot of information about the developments in Regulation and in the Independent Safeguarding Agency.

We continue to work towards Voluntary Self Regulation (VSR) and have agreement on the Codes of Ethics and Practice that will form part of the proposal for VSR. The next task that we are looking at is describing the 'hoops' that candidates for entry onto the Register will have to jump through. These are much the same as those applicants to any professional body have to satisfy; 1) Probity, 2) Professional Insurance, 3) Agreement to abide by the Codes of Ethics & Practice, and 4) Competence.

Items 2 & 3 are easy to agree and have been agreed in outline. Membership of the ISA registration scheme is being considered for item 1 (why do the hard work when someone else is already doing it). For item 4, a set of Learning Outcomes validated to an acceptable standard is being considered. These may then be proved either by a Diploma that satisfies all those requirements or validated transferable learning. If we use this type of measure then we can deal with grandparenting, Hypnotherapists from the EU and applicants who have taken courses that have not been accredited to these levels but who can demonstrate the necessary knowledge and skills. The final task will then be to fill in the middle ground with the Core Curriculum, which will produce the necessary knowledge and skills in the successful applicant.

Many people are concerned about 'getting into bed' with the CNHC and its Complementary and Alternative Medicine (CAM) groups. THIS IS NOT THE ONLY POSSIBILITY. While the funding is being provided through the PFIH on the basis that we are working to this end, it is not a foregone conclusion. There are several other possibilities including a free-standing Independent Hypnotherapy Register. The process we are going through at this time is simply to produce a model for VSR that will be acceptable to the DoH who are the real paymasters. If we can produce a sound argument for the IHR then they may accept and recognise that outcome as well.

The ISA is now well underway. Many will be thinking that recommendation 8 of the Singleton Report means that we do not come under the Safeguarding Vulnerable Groups Act 2006. THIS WRONG! In fact it is now clear that all Hypnotherapy is a Regulated Activity within the Act. That means that most of the statutory requirements apply to us, though exactly where and when is yet to be made clear. So if anyone who is on a Barred List carries out a Regulated Activity, it will be an offence for which the punishment is 5 years in prison. As soon as I can get definitive statements of any other areas, I'll put them out. So watch the website and members bulletins. If item one in the list of Hoops is ISA registration, that will decide it all.

Letters To The Editor

Traumatised

Dear Rob,

I'm writing in reply to the recent letter published in the NCH Journal with reference to the subject of treating returning veterans with PTSD.

I can only echo the comments of the letter writer. I have been a suffer of PTSD for over 44 years and in the last 20 years I have been treating clients with PTSD as a qualified PTSD specialist trauma counsellor and I have recently completed my first part of my HPD. I also have set up to offer teaching to any therapist who needs and wants the training to become an accredited Trauma therapist. This training is accredited by the NCFE and is available through the Central England College.

I could not agree more with the opinions of the letter writer on the subject, as 98% of all therapists from whatever discipline are not qualified to treat Complex PTSD. Also there are very few therapists who can qualify to work as a supervisor in this field.

The average number of sessions to get a client to be stable is at least 12 sessions and probably more than that for very complex cases. It is a very specialised area and should not be undertaken by a therapist who has had no specialist training in this field, as it is very dangerous if you don't know what you are doing.

Unfortunately there are many therapists out there who go and treat clients with PTSD who do a lot of harm and even have led people to taking their own life. I have seen the end results of what well-intentioned therapists have done to their clients. It has taken me a long time to get the client stable again. So if you are not qualified in the subject please don't treat any clients with this complex problem but refer them on to some one who is competent and qualified in this field and who is properly supervised in this area.

There is a great need to have a large number of qualified therapists in this growing field as this also covers not only PTSD from a military background but also repressed childhood sexual abuse and also domestic violence. The demand for this service is going to grow and this is a problem that is not going to go away.

Initial training in understanding PTSD is not a long process as it can be done in a minimum of 30 hours but it is the ongoing CPD training that is most important as this is a field that is constantly developing. You as a working therapist have to keep up-to-date on the latest information and research that is on going in the big world out there. New research constantly comes to light and changes the methods that are proving most effective in the field for the clients.

To be really up to date in this field, you are really required to be members of the important professional bodies in the area of PTSD, such as the UK Trauma Association, the European Society for Traumatic Studies E.S.T.S.S. and also the International Society for Traumatic Stress Studies, I.S.T.S.S. These are important bodies, which will keep you, as a Trauma therapist, up to date on the latest research, and approaches that are being used effectively.

I have been working as a specialist in this field for a long time (20 years) and it is one that you need to be really dedicated in as a specialist in the subject. Hypnotherapy has its place in the field of PTSD and it can become one of the many effective tools in the psychological tool bag of therapies that are available for the therapist to use for the benefit of the client. There is no cure in the normal sense. What you do is to make the trauma manageable and then the client is able to cope on a daily basis. You cannot take away their history but by using cognitive methods you can make the way they view their history better and get them to be able to cope better on a daily basis.

This is only an opinion of a new member of your association but one who is long experienced in the field of PTSD, so I hope that my comments are taken in the manner in which they are offered and not seen a criticism of the opinions of others, but as a positive addition to the subject and to try improve things for any sufferers of PTSD that the members will come across in their work.

Regards love and light
John Roberts

Editor's Reply - Welcome to the NCH John, and well done for plugging your course.

If there ever were any members under the impression that the Help for

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 £20. Visitors are welcome to come and "try out" the club before joining by just paying £5 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 2010:
17/6
22/7
16/9
14/10
18/11

Chairman, Leila Hart
0207 4024311

Secretary, Fiaz Ayub
0207 2864107

Membership, Margaret Sinclair 0208 3956766

www.jamesbraidsociety.com

Heroes promotion was in any way about treating PTSD, they certainly shouldn't do now...

Shocked

Dear Rob,

I was shocked to read of Kay Cook's arrogant and patronising attitude towards to her client in the article in the Spring Journal. Has she never heard of the therapeutic relationship, building rapport, having one foot in the client's world?

One size does not fit all. Some clients are going to be nervous and we have to respond to every client as an individual. If they are nervous and don't understand, then we must reassure them, build a relationship where they feel comfortable and relaxed.

Sending a new (and anxious) client away with instructions to listen to a CD does not sound to me a good way to build rapport and help a client to relax and feel at ease. And surely this relaxed and trusting state is essential to success in our profession.

Think again, Kay. Accept every client as an individual and aim to meet their individual needs. You will be a better and more successful hypnotherapist and, hopefully, a more understanding and empathetic person.

José Penrose

Uneasy

Dear Rob,

I have yet to give this more thought, but I have an initial reaction of unease at this use of the NCH as an organisation to peddle a private company's wares, however excellent they may be.

I do not want to be bombarded by unsolicited advertising with the all-too-common nowadays initial front promise of 'Free' when this is more usually a marketing ploy.

Yours,
Steve Brenton

Editor's Reply - The NCH has always had the ability to email members with third party offers. You may remember, they were originally sent via email, and more recently through the E-bulletin.

We had a brief hiatus during the transition to our new website, but have now launched a more sophisticated system which allows you to specifically opt-out of 3rd party offers whilst still receiving all other member notifications.

The '3rd Party Offers' service allows the NCH to raise additional funds from advertising which we can use for member benefits, as well as allowing carefully selected advertisers to present special offers to NCH members.

We hope that you will choose to support the NCH by staying opted in to these occasional 3rd Party Advertiser messages - however, if you don't want them at all, you can opt out online via your NCH account.

Near2Home was the first 3rd party offer sent using the new system, and this was charged at the full commercial rate.

Got something to say?

Whatever your view, email your letters to me at:

journal@hypnotherapists.org.uk

Psycho(a)logical Semiotics and Neurolinguistic Pragmagic

By Patrick Jemmer PhD FRSPH

Alphabet Soup

As the language clanged and banged,
Verbs vibrated on the inner line,
Grammar grated along the black gates
And the slang slung on the trodden banks.

Drainpipes blocked with capitals and stops,
Abject dialect on the bar crawl
Littering the walls,
The Thames awash with dirty rhyme.

On all the park benches and in all the phone boxes,
Clattering messages with more stories
Paper scatters in the autumn fall,
Trails of ambiguous meaning.

While pythons hiss on the underground,
Passengers chatter
But make no sound
And it's soup to the untrained ear.

The lost tongue
Rolling around, lolling,
Licking the best phrases.
Leaving London.

Laura Dunlop [1].

Previous work has traced the development of language as a supremely creative human faculty [2], [3], [4].

And so we come to the philosophy of therapeutic magic: to the realization that "Reality exists outside language, but it is constantly mediated by and through language: and what we can know and say has to be produced in and through discourse" [5].

Now in terms of the "mediation of reality through language" we must remember that "The current general belief is that language and intelligence co-evolved, and that both are strongly influenced by context. That ought to ring bells with anyone who has studied neuro linguistic programming (NLP) – one of the principles being 'all meaning is context dependent.' And, in an NLP sense, the use of metaphor is a key that opens many of the doors in our mind whether we're aware of it or not" [6]. This is because "The human mind is a storytelling device, a metaphor machine ... it's how our minds work. It's a trick we use to simplify things that would otherwise be incomprehensible" [7].

This is the reason why "Stories are an essential part of the human psyche and we can use them to communicate more effectively and even direct change in our own life" [6]. We can identify four basic narrative types "1. Man vs. Self – 2. Man vs. Man – 3. Man vs. Nature – 4. Man vs. 'It'" [6] – although Shaw claimed these could be reduced to just two basic stories: Cinderella and Jack and the Beanstalk [6].

Even our hugely scientised and technologised modern existences are understood through myth and with faith; consider, for example, " ... CERN, the European Particle Physics Laboratory, where a huge accelerator is under construction that will enable experiments to be conducted into fundamental particles, the subatomic world of energy at the heart of seemingly solid matter, and which can also provide us with understanding of the origins of the Universe. The great accelerator is being assembled from parts made across the world with a precision that enables them to fit perfectly and completely together – an image of human communion and cooperation that is startling in a world which is so often divided. When lowered, again with wonderful precision, into the circular tunnel, several kilometres in diameter, this extraordinary machine will enable physicists to search for the Higgs particle – a particle believed to exist but which has not yet definitively been shown to exist. So from beginning to end this experiment, and the huge cost of the equipment needed for it, is a work of faith" [8].

We will return to the reconciliation of the myth of science and the technology of faith, later in this series of articles. However, the importance of such narratives in creating and maintaining personal and consensual realities is that " ... everyone takes something different from a well written story because they read it from their own frame of reference. Something that appears simple and boring to one individual might strike a deep chord with another – open to a completely different and more powerful interpretation" [6].

Moreover, there is an isomorphism between the narrative and the reality constructed, since "The same is true with our own lives – we act them

The Discovery of Hypnosis

The Complete Writings of James Braid
'The Father of Hypnotherapy'

Edited With Commentary by Donald Robertson
Senior Clinician Hypnotherapist (NCH)
Foreword by Dr Michael Heap

James Braid introduced hypnotism in 1841 as a scientific and rational alternative to Franz Mesmer's animal magnetism. This major textbook brings together all of Braid's writings on hypnotism for the first time. Braid's writings have been carefully edited and annotated to make them more accessible to the modern reader. This is absolutely essential reading for any hypnotherapist, hypnotist, researcher, or those with an interest in the history of Mesmerism and hypnotism.

"It gives me great pleasure to contribute this Foreword to The Discovery of Hypnosis: The Complete Writings of James Braid, the Father of Hypnotherapy. My first task is to congratulate its editor, Donald Robertson, on the quality of his work and in particular the fine scholarship displayed in his introductory chapters, of which I am sure all readers will be much appreciative." – **From the Foreword by Dr Michael Heap**

"This quintessential work should be obligatory study for anyone in the field of Hypnotherapy. Donald Robertson unfolds the history of this most powerful therapy, through the words and works, the experiments and demonstrations, of Dr. James Braid, in a straightforward, deeply educational and most enlightening fashion." – **John, Hypnotherapist, Ireland**

Purchase from NCH, Amazon, or most online booksellers.

RRP: £29.99

Published by the National Council for Hypnotherapy (NCH)
www.hypnotherapists.org.uk / Tel: 0845 544 0788
ISBN: 978-0956057006

out in the first person and often see them from only one perspective. But in our own lives ... we should remember that we are the storyteller as well as the character. We should occasionally stand outside our lives and look dispassionately at the plot" [6].

We can, perhaps, bring all these ideas together with the understanding that " ... digital signal processing is an apt metaphor for magic acting on reality (i.e. magic acts as a F[ourier] T[ransform] function on the input signal in our mental maps) ... The idea of reality shattering sounds like a metaphor for the concept that 'reality' is individually subjective, and that our realities join together and spill over into each others' minds" [9]. Thus we can envisage " ... reality – spacetime in its entirety – as being a Fourier Transform that localizes (collapses) into individual experience ... G Morrison's notion of the supercontext [10] – stepping outside time, seeing it all, looking at the transform, as it were" [9].

> The human mind is a storytelling device, a metaphor machine ... it's how our minds work. It's a trick we use to simplify things that would otherwise be incomprehensible

Morrison goes on to suggest that this "entry into the Supercontext" is " ... most likely to come in the form of a mass consciousness change – possibly triggered by planetary electromagnetic field alterations predicted to occur around that time – so that basically everyone will start peaking on the acid trip that never ends. 'Individuality' will dissolve and your minds will start to merge into one mass mind, which is likely to seem quite frightening and overwhelming, especially for the sheltered minds, and time will seem to disappear as we identify with the mitochondria in our cells, instead of identifying with the physical individual carrier 'bodies' we use to expedite the shuffling around of DNA" [10].

In terms of the "entry into a new age," – "The world's current social structures should collapse quite rapidly when that happens and chances are, only people capable of handling the immense influx of new information will be those already familiar with heavily-altered states of consciousness. For everyone else, it will seem like the Second Coming, the arrival of the Space Brothers, the Rapture, Hell on Earth, the 32nd path of the Tree of Life or whatever they decide to see – everyone will get their own personal apocalyptic transfer into this new mode of being" [10].

Thus everyone will respond according to their nature so that "Some poor souls will have to be guided out of hell, others will have to be coaxed down from sci-fi Ultraspheres but we'll all be living in a state of permanent psychedelic ecstasy and will have to restructure our entire existence to cope with the new consciousness. I have a feeling that psychedelic drugs provide a flashforward glimpse of this kind of consciousness and help prepare the human mind for when that mode of consciousness is permanent" [10].

Under these circumstances " ... we should see a lot of people freaking out when we re-enter what some Australian Aboriginals call Aljira (a word English is not up to the task of translating, so it comes out as 'Dreamtime') and I call 'the Supercontext'. When we see in a new way and become new to ourselves, we'll also see lots of stuff that will probably scare people who didn't know it was there all along. People in delirium and on the brink of death see these crawling, replicating 'wilkie-swilkie men' all over everything and soon, I think, everyone will start to see them. They are 'the spaces between things, come to life ... '" [10].

Now whilst such a "walker in the supercontext" might appear to us a "magician" I agree that "I've always really disliked the term ... In general, I think the old dusty magical lexicon needs to be scrapped and replaced to fit the times. We need new terms that adequately define the modern quantum relativistic chaos magicks we've all been deconstructing. Numagick is the umbrella term ... " [9].

Thus by performing the Numagick to " ... compare and contrast the idea of an UrSprach with that of the Logos" [9] and to question our personal logomyth – "Does it hang together – should it be re-written – is it becoming too predictable?" [6], we gain control over the "plot" and once again become "Lingwiz'ds of Is" – "Essendi Incantatores" enchanting and enhancing our own existences, true "modern day urban shamans and sorcerers" and not just mere "reality hackers" [9]. And in this way, we might truly become Homo sapiens (wise Man), rather than Pan narrans (storytelling Chimpanzee) [7].

We hope to come to the understanding that " ... meaning is not simply a message that has been expressed intentionally by the sender according to a precise communicative will, and consequently the work of the interpretant sign is not limited to the very basic operations of identification, mechanical substitution, to mere recognition of the interpretant sign ... signs at high levels of signness, of semioticity, cannot be interpreted by simply referring to a fixed and pre-established code, through mere decoding process" [11]. Then, maybe, we can develop an "Aesthetics of Chaosmos" whereby " ... we are slowly moving toward that level where we'll be instantly creating our own reality in a conscious manner (5D)?" [9]. And "Until we get there we're starting to get glimpses of the

plasticity of the past, present and future" [9].

So in summary, " ... we communicate using stories, we learn through stories, we share knowledge through stories. Our minds assign meaning to symbols, whether they are pictures, icons on your computer screen or words written down" [6].

Now, in attending to the above discussions we must bear in mind that "Discursive 'knowledge' is the product not of the transparent representation of the 'real' in language but of the articulation of language on real relations and conditions. Thus there is no intelligible discourse without the operation of a code" [5].

Moreover we must be at pains to realize that "There is no degree zero in language. Naturalism and 'realism' – the apparent fidelity of the representation to the thing or concept represented – is the result, the effect, of a certain specific articulation of language on the 'real'. It is the result of a discursive practice" [5].

There exists a multitude of codes to which we might refer, but we find that "Simple visual signs appear to have achieved a 'near-universality' in this sense: though evidence remains that even apparently 'natural' visual codes are culture-specific. However, this does not mean that no codes have intervened; rather, that the codes have been profoundly naturalized. The operation of naturalized codes reveals not the transparency and 'naturalness' of language but the depth, the habituation and the near-universality of the codes in use" [5].

Moreover, there is an arbitrary conventional relationship between sign and concept so that "The functioning of the codes on the decoding side will frequently assume the status of naturalized perceptions. This leads us to think that the visual sign for 'cow' actually is (rather than represents) the animal, cow. But if we think of the visual representation of a cow in a manual on animal husbandry – and, even more, of the linguistic sign 'cow' – we can see that both, in different degree, are arbitrary with respect to the concept of the animal they represent. The articulation of an arbitrary sign – whether visual or verbal – with the concept of a referent is the product not of nature but of convention, and the conventionalism of discourses requires the intervention, the support, of codes" [5].

In order to see further than the "naturalized perceptions" of sign-concept relationships we need a means of deconvolution, and thus semiotics was born: "Semiotics is defined as the study of signs as communicative phenomena that stand for or substitute for something else [12] ... de Saussure described a 'general science of signs' that considered 'any system of signs' to be a language [13].

The term 'language' is extended to include written and spoken words, sounds, music, images, or gestures [13]. The most basic unit that refers or stands for something is the sign – that which is comprised of a theoretical relationship between the signifier as a word, sound or image, and the signified as the concept referred to by the signifier [14]" [15]. The philosophy underlying semiotics might be summarized by saying that "Semiotics is a perspective which consists in asking ourselves how things become carriers of meaning. One reason for this is that one and the same sign/image instance may play several different parts at the same time: a picture may represent something, express something, refer to its own material character, allude to something, be a metaphor or constitute some other type of indirect sign for something. Since semiotics is interesting in finding general rules and regularities, it tries to describe these phenomena as generic functions in some kind of system" [16].

So given the existence of signs and communicators, how can we model the act of communication? "Michael Reddy [17] has noted our extensive use in English of 'the conduit metaphor' in describing communicative acts. In this metaphor, 'The speaker puts ideas (objects) into words (containers) and sends them (along a conduit) to a hearer who takes the idea/objects out of the word/containers' [18]. The assumptions the metaphor involves are that: Language functions like a conduit, transferring thoughts bodily from one person to another; in writing and speaking, people insert their thoughts or feelings into the words; words accomplish the transfer by containing the thoughts or feelings and conveying them to others; in listening or reading, people extract the thoughts and feelings once again from the words [17]" [19].

However, we need to pay careful attention to this notion, since "The underlying metaphor of communication as transmission underlies 'commonsense' everyday usage but is in many ways misleading and repays critical attention ... The transmission model is not merely a gross over-simplification but a dangerously misleading misrepresentation of the nature of human communication. This is particularly important since it underlies the 'commonsense' understanding of what communication is. Whilst such usage may be adequate for many everyday purposes ... the concept needs critical reframing"[19].

> We should remember that we are the storyteller as well as the character. We should occasionally stand outside our lives and look dispassionately at the plot

Let us look in more detail at the reasons why "The transmission model is not merely a gross over-simplification but a dangerously misleading misrepresentation of the nature of human communication." First, we see that "The transmission model is an instrumental model in that it treats communication as a means to a predetermined end. Perhaps this is the way in which some people experience communication. However, not all communication is intentional: people unintentionally communicate a great deal about their attitudes simply through body language. And, although this idea will sound daft to those who've never experienced it, when some of us write something, we sometimes find out what we want to say only after we've finished writing about it" [19].

Our minds assign meaning to symbols, whether they are pictures, icons on your computer screen or words written down

Secondly, it posits communication as "a one-way street" since "The transmission model fixes and separates the roles of 'sender' and 'receiver'. But communication between two people involves simultaneous 'sending' and 'receiving' (not only talking, but also 'body language' and so on) ... the source is seen as the active decision-maker who determines the meaning of the message; the destination is the passive target. It is a linear, one-way model, ascribing a secondary role to the 'receiver', who is seen as absorbing information. However, communication is not a one-way street" [19].

The problem here is the neglect of feedback, where "Feedback is the action that takes place in all processes of interaction within a state, or within an existence, or within an ecology of some sort; a social ecology, a techno-ecology, a biological ecology or any self-corrective system ... The thing about video here is that we find a means for modelling many of the processes of consciousness. Feedback is the response of the context to an output from the consciousness to which the consciousness responds becoming a process in action, live, containing and maintaining itself, open-ended, subject to change, and non-conservative. PROCESS" [20].

Thus "Even when we are simply listening to the radio, reading a book or watching TV we are far more interpretively active than we normally realize. There was no provision in the original model for feedback (reaction from the receiver). Feedback enables speakers to adjust their performance to the needs and responses of their audience. A 'feedback loop' was added by later theorists, but the model remains linear" [19]. Furthermore, in the transmission model, there is no distinction between content and meaning and "... even the nature of the content seems irrelevant, whereas the subject, or the way in which the participants feel about it, can shape the process of communication. Insofar as content has any place (typically framed as 'the message'), transmission models tend to equate content and meaning, whereas there may be varying degrees of divergence between the 'intended meaning' and the meanings generated by interpreters" [19].

And what about context? We know that "The 'same' text can be interpreted quite differently within different contexts" [19]. However, "Nor is there any mention in the transmission model of the importance of context: situational, social, institutional, political, cultural, historical.

Meaning cannot be independent of such contexts ... Whilst it is true that meaning is not wholly 'determined' by contexts of 'production' or 'reception' (texts do not mean simply what either their producers or their interpreters choose for them to mean), meanings may nevertheless be radically inflected by particular contexts of 'writing' and 'reading' in space and time." [19]. We have seen previously the importance of connotation and context and we can add to these the "socio-cultural" patterns to which we are exposed since "We are all social beings, and our communicative acts cannot be said to represent the expression of purely individual thoughts and feelings. Such thoughts and feelings are socio-culturally patterned. Even what we call 'our' language isn't our own: we are born into it; we can't change the rules.

Words have connotations which we don't choose for them. An emphasis on creative individuality is itself a culturally-shaped myth which had a historically 'modern' origin in Western Europe" [19]. What about the communication 'register' or 'role' in which we are operating? "We frame what is said differently according to the roles in which we communicate. If a friend asks you later what you thought of ... [a] lecture you are likely to answer in a somewhat different way from the way you might answer the same question from the undergraduate course director in his office ... People in society do not all have the same social roles or the same rights. And not all meanings are accorded equal value. It makes a difference whether the participants are of the same social class, gender, broad age group or profession. We need only think of whose meanings prevail in the doctor's surgery" [19].

Allied to this problem is the fact that "Transmission models treat decoding as a mirror image of encoding, allowing no room for the receiver's interpretative frames of reference. Where the message is recorded in some form, 'senders' may well have little idea of who the 'receivers' may be (particu-

larly, of course, in relation to mass communication). The receiver need not simply accept, but may alternatively ignore or oppose a message. We don't all necessarily have to accept messages which suggest that a particular political programme is good for us" [19]. And the final nail in the coffin is the fact that "... the model is indifferent to the nature of the medium. And yet whether you speak directly to, write to, or phone a lover, for instance, can have major implications for the meaning of your communication. There are widespread social conventions about the use of one medium rather than another for specific purposes. People also differ in their personal attitudes to the use of particular media ... The medium can affect both the form and the content of a message. The medium is therefore not simply 'neutral' in the process of communication" [19].

Now, having set up this simplistic model seemingly only to demolish it, what remains? In fact, the real learning from these observations is that "... meaning-making is not central in transmission models. It is widely assumed that meaning is contained in the 'message' rather than in its interpretation" [19]. In such models "It is as if communication consists of a sender sending a packet of information to a receiver, whereas I would insist that communication is about meaning rather than information. One appalling consequence of the postal metaphor for communication is the current reference to 'delivering the curriculum' in schools, as a consequence of which teachers are treated as postal workers. But the influence of the transmission model is widespread in our daily speech when we talk of 'conveying meaning', 'getting the idea across', 'transferring information', and so on. We have to be very alert indeed to avoid falling into the clutches of such transmissive metaphors" [19].

Indeed we find that "Some critics argue that this model is geared towards improving a communicator's ability to manipulate a receiver. Carey notes that 'the centre of this idea of communication is the transmission of signals or messages over distance for the purposes of control ... of distance and people' [21]. In an instrumental framework the process involved is intended to be 'transparent' to the participants (nothing is intended to distract from the sender's communicative goal). Such a conception is as fundamental to the rhetoric of science as it is alien to that of art. 'Perfectly transparent communication' is impossible" [19]. Moreover, "As Reddy notes, if this view of language were correct, learning would be effortless and accurate. The problem with this view of language is that learning is seen as passive, with the learner simply 'taking in' information [22]" [19].

So what is the real state of affairs? Patently we really do communicate: so what is the mechanism? One answer is "... to suggest that there is no information in language, in books or in any medium per se. If language and books do 'contain' something, this is only words rather than information. Information and meaning arises only in the process of listeners, readers or viewers actively making sense of what they hear or see. Meaning is not 'extracted', but constructed" [19].

Information and meaning arises only in the process of listeners, readers or viewers actively making sense of what they hear or see. Meaning is not 'extracted', but constructed

This leads us to conclude that "... there is no single, fixed meaning in any message. We bring varying attitudes, expectations and understandings to communicative situations. Even if the receiver sees or hears exactly the same message which the sender sent, the sense which the receiver makes of it may be quite different from the sender's intention. The same 'message' may represent multiple meanings" [19].

Another way of putting this is to go back to our semiotics and realise that "The signifier and signified are separate in theory but work together in a process of connecting some communicative representation with a concept or meaning. A word, sound, or image (signifier) operates simultaneously in association with its conceptual (signified) referent. The association of the signifier and the signified produce the sign through this theoretical correlation which is called signification or semiosis [13], [23]" [15].

Of course there are various types of sign and it becomes useful to make the following distinctions: "The icon is a sign that resembles something; an index provides a direct causal relationship between the sign and its referent in the world; and a symbol is a sign that is understood only through a shared knowledge of cultural convention. In any case, signification indicates the meaning of a sign within a particular cultural context of communication. While this may seem obvious, meanings are social constructions and their differences are the subtle objects of semiotic study [24]" [15].

But once again we bait the trap of "naturalized perceptions" applied to certain sign-concept relationships, since "Iconic signs are ... particularly vulnerable to being 'read' as natural because visual codes of perception are very widely distributed and because this type of sign is less arbitrary than a linguistic sign: the linguistic sign, 'cow', possesses none of the properties of the thing represented, whereas the visual sign appears to possess some of those properties" [5].

As an example of the caution we must exercise in this context, " ... the Pole Star, for instance, may be an index of the north celestial pole, but it is in no way caused by that astronomical location. Nor is a personal pronoun, or even a pointing finger ... actually caused by the person or thing for which it stands; and if they may be said to motivate it, then this is also true of all other signs. Moreover, if could be added that even some cases which are often taken to confirm the causal explanation are actually doubtful: the causal agent may not be that which is signified, or may not signify in the same respect in which it is the cause. Of all the innumerable causes that have to concur in order for a rap on the door to occur at a particular moment, the door and the material of which it is made, and a particular person and his moving hand may seem to be the most important. However, if, at this moment, no person in particular is expected, the sign will only carry some very general meaning such as there is somebody (probably a human being) outside the door who wants me to open it and let him in'. Neither the particular person, nor his hand or the door, which are the causal agencies, are here parts of the meaning of the sign ..." [25].

We can adduce further examples such as "A person having the rolling gait of a sailor [who] may, in fact, not be a sailor; and the pretzel hung out above the bakery (admittedly an icon of an index) is still to be seen when the bakery is closed, and no bakery products are for sale. Plausible indices of a unicorn may be produced using a set of horseshoes and a bull's horn, and do not testify to the existence of unicorns. A faked photograph of a unicorn, or whatever, may be assembled, using pieces of real photographs, processing them in a computer, or even creating them entirely by means of a computer program" [25]. Furthermore, " ... some indexical relations must come into being at the same time as the sign is produced, as is the case, for instance, of verbal 'shifters': the person indexically related to the sign 'I' is the one which at a particular moment pronounces the sound /ai/, which is to say that the indexical ground is produced at the very same moment in which the sign is put to use. Similarly, there is no class of 'pointed-out objects' known to exists, but a member of such a class is created each time an act of pointing takes place ... " [25].

The next article in this series goes on to show how "Language proposes the illusion of objectivity merely as an abstraction. The failure to recognize this illusory nature of language will inevitably lead to bad results" [20]. Thus we find that "The subjectivity / objectivity illusion exposes one of the major problems of language; that language allows for the appearance of concepts that in no way reflect the reality of things" [20]. With these understandings we can begin to develop our knowledge of psychosemiotics to therapeutic communication and individuation-through-language.

References

[1] Dunlop, L (2008) Helium: Creative Writing: Poetry: Language 4/13: Alphabet Soup. wapURL: O68PIAG.

[2] Jemmer, P (2007) "Nomen Omen" – Languaging and the Nature of Names. The Hypnotherapy Journal. Winter 2007, Issue 4, Volume 7, pp 24 – 30.

[3] Jemmer, P (2007) "Lingua Creationis" and the Creative Nature of Language. The Hypnotherapy Journal. Autumn 2007, Issue 3, Volume 7, pp 25 – 31.

[4] Jemmer, P (2009) "Omen Nomen" – Naming and the Nature of Life. The Hypnotherapy Journal. Spring 2009, Issue 1, Volume 9, pp 23 – 27.

[5] Hall, S (editor) (1980) Centre for Contemporary Cultural Studies: Culture, Media, Language: Working Papers in Cultural Studies, 1972 – 79: Encoding/decoding. London UK: Hutchinson; wapURL: KWVDUES.

[6] York, G (2004) Creatifica: Insight: January 2004: Let Me Tell You a Story. wapURL: 9LX7Q41.

[7] Pratchett, T, Stewart, I, Cohen, J S (2003) The Science of Discworld II: The Globe. London UK: Ebury Press.

[8] Rowell, G (2007) TimesOnline: 21 July 2007: Credo: Science and Politics Can Mean Nothing without Faith. wapURL: 9GK4EY2.

[9] Author Unknown (2008) Key 64: Making the Invisible Visible – Magical Language for New Magical Awareness (5 February 2005 – 20 May 2006). wapURL: JMZUQGR.

[10] Brown, M (2004) ComiX-Fan Forums: The New Age of Morrison. wapURL: QZW7PKH.

[11] Petrilli, S; Capozzi, R (editor) (1997) Reading Eco: An Anthology – Towards Interpretation Semiotics. Bloomington IN: Indiana University Press.

[12] Eco, U (1976) A Theory of Semiotics. Bloomington IN: Indiana University Press.

[13] Barthes, R (1978); Lavers, A and Smith, C (translators) Elements of Semiology. New York NY: Hill and Wang.

[14] Stam, R, Burgoyne, R and Flitterman-Lewis, S (1992) New Vocabularies in Semiotics: Structuralism, Post-Structuralism and Beyond. New York NY: Routledge.

[15] Gaines, E (2002) Semiotic Analysis of Myth: A Proposal for an Applied Methodology. The American Journal of Semiotics. Volume 17, Number 2, pp 311 – 327.

[16] Danesi, M (2002) A Glossary of Semiotics: in Understanding Media Semiotics. Oxford UK: Oxford University Press; From Sign to Image: An Introduction to Semiotics / "Vom Zeichen zum Bild. Eine Einführung in die Semiotik"; wapURL: 0BBY5X8.

[17] Reddy, M J; Ortony, A (editor) (1979) Metaphor and Thought: The Conduit Metaphor: A Case of Frame Conflict in Our Language about Language. Cambridge UK: Cambridge University Press.

[18] Lakoff, G and Johnson, M (1980) Metaphors We Live By. Chicago IL: University of Chicago Press.

[19] Chandler, D (2000) The Transmission Model of Communication. wapURL: WIK6W18.

[20] Jones, S (2008) The Brain Project: Notes on the Cybernetics of Language and Video. wapURL: NY191V1.

[21] Carey, J (1989) Communication as Culture. New York NY: Routledge.

[22] Bowers, C A (1988) The Cultural Dimensions of Educational Computing: Understanding the Non-Neutrality of Technology. New York NY: Teachers College.

[23] Barthes, R; Lavers, A (translator) (1972) Mythologies. New York NY: Noonday.

[24] Leeds-Hurwitz, W (1993) Semiotics and Communication: Signs, Codes, Cultures. Hillsdale NJ: Erlbaum.

[25] Sonesson, G; Pankow, C (editor) (1995) Indexicality as Perceptual Mediation. Indexicality Papers from the Symposium "Indexikala Tecken" University of Göteborg November 1995. wapURL: S2010UP.

For brevity, all websites are referenced with unique 7-Alphaneumeric "wapURL" addresses generated at http://wapurl.co.uk/index.cfm. These were all checked and found to be available as of 1600H 13 April 2010 and wapURL: S2010UP, for example, can be accessed via http://wapurl.co.uk/?S2010UP (watch out for the question-mark!).

Tokophobia - The Response from Hypno-Psychotherapy

By Sharon Mustard

A review and evaluation of primary research into anxiety disorders in childbirth and a proposal of effective treatments and interventions. This is Part 2 of a 4 part series of articles

Negative Consequences of Tokophobia

An untreated profound fear of childbirth can rule the individual's life decisions-restricting the choices they feel are open to them about their future.

Recent newspaper articles (The Observer 16th December 2001, The Daily Mail 17th December 2001) report that at least one woman in six is so terrified of giving birth that she induces a miscarriage or avoids becoming pregnant altogether. Fear or worry clearly can have a profound effect on whether the woman blocks becoming pregnant in the first place.

Let us look further at the potential negative consequences:

(a) Conscious decision not to have a child

Within the Nicholas (2007) article, 21-year old Ashley's repulsion of childbirth lead her to admit that, as she gets older, she feels unable to have relationships with men who want biological children of their own.

Some women who continue to want children never overcome their fear of childbirth and remain childless; some adopt. Many feel shame at their perceived inadequacy. The loss can be grieved into old age. The psychological impact of this can have far-reaching effects. Feelings of low self-worth, a loss of belonging and depression can result.

(b) Infertility

Following the pattern of phobias in general, a common tokophobic response is avoidance of the feared situation. This may be in the form of a conscious decision not to have a baby, or in the unconscious manifestation of infertility. For medically unexplained infertility, there is often an underlying psychological explanation - unconscious fears around being pregnant or giving birth.

(c) Choosing abortion

Although statistics are not available, it is acknowledged that in a desperate attempt to avoid the phobic situation, in extreme cases an abortion is opted for, driven by the phobia itself. Hofberg and Brockington (2000) reported two women who terminated a pregnancy because they were too terrified to endure a delivery. Unable to understand their own aversion to parturition, and in the absence of psychotherapy to assist in resolving it, women can feel that it is their only choice and to live with the psychological impact of that decision.

(d) Elective caesarean section

Extreme fear of natural childbirth can motivate a request for an elective caesarean section, in an attempt at avoidance. The physical and detrimental effects of this option are also well-documented. Hofberg and Ward (2003) cited the National Sentinel Caesarean Section Audit published in October 2001, who found that one in five of births in England and Wales were by caesarean section; 7% of these were at the mother's request with no medical reason.

(e) Effect on the process of childbirth

Zar (2001) suggested that a pregnant woman's expectations of the delivery are relevant to her experiences of and behaviour during delivery.

In childbirth, women can actually create the very situation they fear. The anxiety can create a ripple effect that extends to the woman's body, the baby, her partner and birth professionals.

(i) Effect on the baby

- More likely to experience distress
- Post-natal emotional state

A Bristol University Team found anxiety in late pregnancy was linked to higher cortisol levels in children aged 10. (O'Connor et al, 2005)

- Supply of oxygen to the baby is compromised

Pregnant women who were more anxious or stressed had significantly abnormal patterns of blood flow through the uterine arteries. 27% of the most anxious group had a resistance index high enough to be of "clinical concern". Only 4% in the less anxious group had similarly impaired uterine artery blood flow. (Teixeira, 1999)

- Encounter a resistant birth path
- Being on the receiving end of Post Natal Depression
- Likely to have more drugs in their system when first born
- Slower mental development

Mental development at 18 months old was shown to be significantly slower and they showed more fear and anxiety when born to mothers who reported stress in later pregnancy (Glover, 2006)

The fear of the whole process is likely to be passed onto the baby and the process of birth becomes frightening and traumatic. Assuming the baby has an unconscious recollection of having suffered that trauma, the foundations may already be laid for the development of a tokophobic response in the next generation.

(ii) Effect on woman's body and the process birth

Michel Odent (1984), as an obstetrician said, "One cannot help a normal physiological process, the point is not to hinder it."

Anxiety about childbirth has a corresponding physiological and chemical response within the body. The body is the action component of the mind. An anxious woman is much less likely to give birth naturally as the primitive survival mechanism 'the fight or flight response' will interpret the anxiety as a message that tells the body that this is not a 'safe time or place for birth', and the body will respond accordingly, favouring parts of the body involved in defence. This is often interpreted as something being 'wrong' and intervention is then started.

Under these circumstances the mind-body connection can cause:

- The cervix to be taut
- Arteries to the uterus to tense and constrict, blood supply diverted away to defence systems
- Restricted flow of blood and oxygen sent to the baby
- Slowed or stopped labour
- Stress hormone cortisol triggered (oxytocin production, required for an efficient labour, is hampered)
- Pain, behavioural symptoms of pain - swearing, aggression, screaming

Grantly Dick-Read (2004) observed the missing ingredient in easier, more comfortable births seemed to be FEAR.

- Slow recovery rate
- Increased chance of tearing or need for episiotomy
- More likely to want chemical anaesthesia
- Medical interventions are more likely - caesarean, forceps, ventouse

Women with a dread of childbirth are subject to an increased rate of emergency caesarean section or instrumental vaginal delivery (Areskog et al, 1983; Ryding et al, 1998 #1).

(iii) Effect on partner

- Tense and anxious
- Potentially negative experience, perhaps traumatic

- Reluctant for more children - making a conscious choice or infertility
- Loss of sexual interest in his partner

(iv) Effect on Midwives and support staff:

- Woman coming into hospital too early
- More time consuming
- Argumentative
- Uncooperative
- Request for more drugs
- More supervision required

(f) Parenthood and ability to bond

I have already mentioned that medical interventions are more likely with women who have a dread of childbirth. Ryding et al (1998 #2) found that the mode of delivery influences the women's psychological state after the delivery - with more negative psychological reactions being associated with assisted deliveries.

The biological sciences of the 1990's are now showing that the first hour following birth is a critical period in the development of the capacity to love. After the birth, there is a peak in oxytocin after the delivery of the baby which can induce maternal behaviour. An antagonist, such as cortisol, can hamper this (Odent, 1994).

The system which protects us from pain is also the system which gives us pleasure - natural opiates (endorphins), resulting in pleasure and attachment. If a mother and baby are close to each other before they have eliminated their opiates, they are creating a mutual dependency or attachment relationship.

Oxytocin is also produced during lactation - even when the mother hears the signal from her hungry baby. During lactation, the endorphins as a built-in reward system encourages the mother to breastfeed. The commonest causes of deficient lactation are worry and fear.

Positive prenatal, perinatal and postnatal bonding is important for increasing the baby's sense of security. Emotions cross the placental barrier too.

In Part 3 & Part 4 of the series, I will review possible treatment interventions from hypno-psychotherapy.

References

Nicholas S. (2007) 'Are you a tokophobic? The women who are too terrified of giving birth', Daily Mail, 27th October, 2007.

Hofberg KM. & Brockington IF. (2000) 'Tokophobia: an unreasoning dread of childbirth', Br J Psychiatry, 176, pp.83-5

Hofberg K. & Ward MR. (2003) 'Fear of pregnancy and childbirth', Postgrad. Med. J., 79, pp.505-510.

Zar M. (2001) 'Diagnostic aspects of fear of childbirth', Linköping Studies in Education and Psychology, Dissertation No 78.

O'Connor TG, Ben-Shlomo Y, Heron J, Golding J, Adams D, Glover V . (2005) 'Prenatal Anxiety Predicts Individual Differences in Cortisol in Pre-Adolescent Children', Biol Psychiatry, 58, pp.211-217.

Teixeira JMA., Fisk NM. & Glover V. (1999) 'Association between maternal anxiety in pregnancy and increased uterine artery resistance index: cohort based study', British Medical Journal, 318, pp.153-157.

Glover V. (2006) 'Antenatal maternal stress/anxiety and effects on child neurodevelopment', Early Human Dev., 82, pp.534-534.

Odent, Michel (1984) Birth Reborn: What Childbirth Should Be. Random House Inc.

Dick-Read, Grantly (2004) Childbirth Without Fear: The Principles and Practice of Natural Childbirth, Pinter & Martin Ltd.

Ryding EL., Wijma K. & Wijma B.(1998) 'Experiences of emergency caesarean section: a phenomenological study of 53 women', BIRTH, 25, pp.246-51.

Ryding EL., Wijma K. & Wijma B. (1998) 'Psychological impact of emergency caesarean section in comparison with elective caesarean section, instrumental and normal delivery', J Psychosom Obstet Gynaecol, 19, pp.135-44.

Odent, Michel (1994) 'Preventing Violence or Developing the Capacity to Love: Which Perspective? Which Investment?', Primal Health Research, 2(3) Winter.

As the founder and director of the Easibirthing institute, Sharon runs Hypnosis for Childbirth courses privately and as part of a contract with Salisbury District Hospital NHS Trust. She also trains practitioners throughout the UK to specialise in the area of 'Hypnosis for Childbirth'.

Contact Sharon on 01980 623089 or visit www.easibirthing.co.uk for course dates and information.

Message from the Editor: HELP!!!

I'm really keen that this Journal continues to be a platform for NCH members to communicate their ideas, discoveries and experiences.

If you have something to say that would be of value to your fellow members - whether it's something you have picked up from outside of Hypnotherapy that you think is useful, a metaphor, script or technique, a book you want to review, a case study, or a flash of inspiration you want to share - just send it to me:

journal@hypnotherapists.org.uk

The Lighter Side

By A. B. King

We are all familiar with the more serious side of our profession: helping the bereaved to come to terms with their loss; reducing the pain of terminally ill patients; freeing people of the nightmares that have come close to destroying their existence; dealing with the suicidal and those who have given up all hope. One has no choice but to develop an aura of detachment; yet all of us at times reach the end of the day feeling mentally drained from the effort put in. However, if we are honest, there is a lighter side to things, and I doubt if my own experience garnered over some forty years is much different from anybody else's.

When I first set up the clinic and opened for business, I soon discovered that my telephone number was very similar to the local acupuncturist's. At the time, this gentleman was offering a stop-smoking course involving the fixing of a stud to the ear of the patient which they were required to massage whenever they felt the urge to smoke. I was standing by the telephone one morning when it rang, and on picking the receiver up I heard a not-very-well-educated female voice saying: "'ere, are you the bloke wot sticks fings in people's ears?"

The resulting picture this conjured up has often caused me to smile. Hopefully, some of my other reminiscences will cause some of you to smile also, or maybe you will recognise the situation as being markedly similar to one of your own?

The elderly lady sitting in the chair opposite my desk looked at me in a dubious fashion. Vaguely resembling the 'granny' as featured in the famous Giles cartoons I was naturally keeping a wary eye on her tightly furled umbrella clutched defensively tight in her fist. She had arrived at the clinic without an appointment, and having a free period I had agreed to see her. Initially very noncommittal about the nature of her problem, I sought to allay her tension by explaining in broad terms the principles of hypnotherapeutic treatment. Judging by the glowering expression with which she favoured me, I was making little headway.

"Dunno wot yer talking abaht," she interrupted truculently, "Wossall that gotta do wiv my 'ip?"

I admit to being slightly mystified by the question.

"Your hip?" I queried, "You mean?"

"Corsits me 'ip; you thick or summit?"

I decided that the question was rhetorical and not worthy of a direct reply.

"Madam, if you have a medical condition, I don't quite see..."

I didn't get any farther.

"Well, is you or ain't you a 'ipolist?"

I have been retired for more than a decade now, and I can still see that lady clearly in my mind, and in a way, she was a salutary lesson in always being prepared for the unexpected. Like every other therapist with a few years practice, I soon learnt that whereas the majority of patients are perfectly reasonable people, things can go wrong from time to time; there may be misunderstandings, accidents or even gremlins to lighten the life of the hardworking practitioner. As I subsequently learned, this lady was firmly convinced that people in my profession existed solely to treat pelvic illnesses, and nothing else!

After some years of dabbling as a complete amateur, my professional career started under the guidance of a well-established practitioner, and I soon discovered that there is a wealth of difference between 'dabbling', and dealing with genuinely sick and worried people for real. Even after many weeks of serious training I was never unleashed on anyone with serious problem, being required to 'cut my teeth' on such basic tasks as helping people to quit smoking and the like. Eventually the day dawned when I was finally allowed to work directly with my first patient, and unsupervised. Well, there has to be first time for anybody!

The patient was a man considerably older than myself, who gave the impression of having little patience, and even less of a sense of humour. In those far off days, the stop-smoking course favoured by that particular clinic was a single one-hour session. I endeavoured to exude confidence and skill, although in truth I had little of the former, and even less of the latter! However, I'm pleased to say that the patient proved to be a responsive subject, and everything went by the book. At the completion of the session I asked him how he felt.

"Fine," he exclaimed expansively,

"absolutely fine!" and shortly after that he left, and I heaved a big sigh of relief at having passed the first major hurdle in my chosen career without mishap.

A couple of days later he was back.

"Hello, Mr So-and-so," I greeted him, trying to hide the anxiety I immediately felt on seeing him return, "You are not still smoking those disgusting cigarettes are you?"

"Good Heavens no, old boy," he responded jovially.

"That's good," I said, vastly relieved to discover that I had been successful after all, "What can I do for you?"

"I was just wondering if you could help me to stop smoking a pipe?"

Many years later I had an echo of that situation with another smoking patient. This one reminded me of a retired clergyman. A very quietly spoken man who seemed to be as dry as dust in his approach to everything; he never once smiled in all the time that I knew him. He came to me during a particularly busy period at the clinic, and I was working under about as much pressure as I could cope with, which is my excuse for what followed.

By this time I was making extensive use of tape recorders for dealing with standard conditions such as smoking courses etc, and my procedure, once I had established a requisite degree of hypnosis, was to advise the patient that I would continue talking to them via an audio cassette. (Naturally, all of this having been previously explained to the patient and agreed to.) On this particular morning I was running well behind schedule in everything, but luckily this gentleman settled down easily, and as soon as I could decently do so, I switched on the tape recorder and scuttled back to my desk where the paperwork was piling up in an ominous fashion.

Working in this manner, and having heard the cassettes so frequently, they were just background noise to me as I concentrated on the correspondence on the desk. I was half way through scribbling out some notes for another patient when quite suddenly warning bells started to ring in my mind: something was wrong! I immediately switched off from what I was doing and listened to what I was saying to the patient.

To my horror I finally registered what was wrong; there was my voice on the tape recorder solemnly assuring this venerable gentleman that never again in his life would he ever experience the slightest degree of difficulty with menstruation! Paperwork went flying as I made a frenzied grab for the recorder. Ad-libbing like a maniac I swiftly extracted the tape, substituted the correct one and finally settled down as I watched the patient like a hawk. There was no change of expression, and he remained totally passive to the end of the session. Finally he opened his eyes and looked at me with a strange expression, and I steeled myself for the worst.

"There we are, Mr X," I said as cheerfully as I could, "How do you feel?"

"Very relaxed, thank you," he responded politely, fixing me with his totally expressionless eyes, "but I'm afraid I didn't quite understand that bit in the middle."

Needless to say, it was the sort of mistake that a responsible practitioner never makes more than once!

I was in the reception of the clinic one day reading through some notes when the door opened and a man came in. The receptionist being at lunch, and with no patients due I looked up expectantly at this chance visitor. A short, round man of about seventy years of age who reminded me instantly of that famous comic of a few years ago, Charlie Drake, (no, he didn't say, 'allo my darlin'!')

he was very bandy, and rolled rather than walked in. He had the stub of a cigarette between his fingers, and he took a drag on this as he lurched towards me. He half collapsed on the reception counter, coughing and spluttering like blazes in the most alarming manner.

"I gotta problem!", he gasped, stating the obvious, and then took another deep draw on the cigarette.

"Oh yes," I responded dubiously as he coughed and spluttered in all directions, "and what might that be?"

"I just want you to 'ipnotoze her and get her to leave my boyfriend alone."

Another drag, followed by more coughing and spluttering as he stubbed the miniscule remains of the cigarette out on the ashtray that stood on the counter. This was immediately knocked onto the floor as another fierce paroxysm seized him, and finally he leaned on his elbows trying to focus a pair of bleary, blood-shot eyes on me.

"It's a terrible problem," he assured me solemnly, "it's going to kill me!"

"Well, that's what cigarettes will do to you if you don't quit!"

"Cigarettes be buggered, I drink too much!"

On another occasion, a quietly dressed, well-spoken middle-aged lady sitting by my desk explained that she was talking to me on behalf of someone else. This was the sort of thing that has happened many time; some nervous patients will send a relative or close friend to 'test the water' before summoning up the courage to attend in person. We spent some time discussing what appeared to be a fairly run of the mill anxiety related condition, and she seemed well satisfied with the information I was able to give her, and my explanation of what was involved in treatment. She eventually decided that she would like to make the requisite appointments.

Explaining that I would still need to see the patient before being able to make such a commitment, I asked her if she would mind giving me some details of the person for whom she was 'acting'.

"It is my husband," she replied, "surely I can make the arrangements for him?"

"I'm sorry," I persisted, "I shall have to see and talk with him before I can undertake any sort of treatment."

"I'm afraid that might be a bit difficult," she said, looking slightly embarrassed, "He likes to be asked about these things first."

"I quite understand," I responded gallantly, "perhaps either you or your husband will telephone once you have talked matters over?"

"Oh, there will be no need for that," she said quickly, and turning to look at a chair that stood against one wall of the consulting room she added, "Are you happy about this Charles?"

She caught sight of my startled expression.

"It's all right," she said, "he is a bit shy about talking to other people, but he says he is quite happy to come whenever it is convenient."

It isn't always patients (or my own shortcomings!) that produce lighter moments, and it has to be admitted that not all such moments are thought of as being 'light' when they occur.

For example, a good many years ago now I came into the clinic one morning a couple of weeks before Christmas and only upon arrival did I realise that I had left my briefcase at home. As it happened, there were no patients scheduled for that morning, and having explained the oversight to my receptionist, told her that I would be returning home to collect it. In the course of conversation it transpired that both she, and the young 'work experience' girl that we had on the staff at the time both needed to deliver cards to friends or relatives in the area close to where I live, and the long and the short of it was that I agreed that the pair of them could accompany me on this short journey so that they could make their deliveries.

I should mention here that the young girl, let's call her Helen, which is nothing like her real name, had a most unprepossessing boyfriend who used to hang around outside the clinic waiting for her to finish of a night. I had only ever seen him at a distance, and what I had seen hadn't filled me with any particular desire to decrease that distance. We returned from our brief journey in good spirits (along with the briefcase!) and as we pulled up outside the clinic we were astonished to see the boyfriend hammering with both fists on the clinic door, and obviously beside him self with rage.

"I know you're in there," he was shouting as I emerged from the car, "You filthy slut, how could you? I've heard all about men like him, you wait until I get my hands on the pair of you I'm gonna..."

"Excuse me," I interrupted, "can I help?"

"Who the hell are you?", he demanded, and resumed his hammering and shouting.

"I'm the man 'like him'", I said pointedly, " and the young lady designated

as a 'filthy slut' is standing behind me with her colleague. Now, you were saying that you are going to do; what?"

Helen told me later that the 'romance' was over, and I for one thought she had had a narrow escape

It was a hot summer's day, and the next patient on my list was a 'Miss X' who wished to speak to me about "a very personal matter." I spoke on the internal telephone to my receptionist to request that she be brought to the consulting room.

"I think it might be better if you come down here," she replied, " I've put her in the interview room. She's in there with her family."

"Is there some sort of problem?" I asked, picking up on the odd note in her voice straight away.

"Er, I'd rather you formed you own opinion."

I made my way to the interview room, which was rarely used unless we were being a bit run off our feet, and as I approached, the door opened and a woman of about fifty years of age emerged and headed towards me. She was considerably overweight, shabbily dressed, and the sheer undiluted body-odour she radiated threatened to choke me.

"I wanna word with you," she announced truculently.

"I'm sorry, I am on my way to see a patient," I explained as I fought for breath, "If you would like to see my receptionist, she will be pleased to make you..."

"Yeah, I know all about that," she interrupted, grabbing my arm and attempting to anaesthetise me with her breath which was even more pungent than the body odour, "That's my daughter; look, I don't care what excuse she gives you, just get 'er to leave my boyfriend alone!"

With that she flounced off out of the building. Feeling mildly amazed that the paint wasn't peeling off the walls I reached the door of the interview room and opened it up. Well, if the stench outside was bad, it was like roses compared to the interior of that room! Trying not to gag I looked round and saw two figures. One was a young woman, undoubtedly the prospective patient who appeared to be a slightly more immature version of the woman who had just left, and the second figure that of a man of indeterminate age who looked (and smelled!) just as offensively as the women.

Gormless is the word that's springs to mind as I think of that man. Dirty, unkempt, with straggly hair, a stubbly face, with the remains of what was probably his last meal on his chin, he sat there with a permanent grin on his lips and a vacant glaze in his eyes. The pair of them were holding hands, and it crossed my mind that if this was the 'boy-friend' I'd heard about, the woman deserved a medal. Still, there's no accounting for taste.

"If you would like to come with me," I managed to gasp, trying not to be sick over the patient (they tend to object to such reactions) as I spoke.

"Look, I don't need no treatment!", she announced, displaying an interesting selection of rotting teeth as she dropped the man's hands like two dollops of wet fish on his lap

"Then why are you here?"

"It was the only way I could get mum here."

"I don't understand." I said, more concerned about the difficulties with my breathing than anything else at that moment.

"I just want you to 'ipnotoze her and get her to leave my boyfriend alone."

The penny dropped.

"You mean, this gentleman here?"

"That's right, I only get him on Mondays, Wednesdays and Fridays, he has to satisfy her on Tuesdays, Thursdays and Saturdays."

"Who gets the benefit of his charms on Sunday?" I asked, by now going blue in the face.

"Oh, he goes home to his wife."

The girl was still protesting volubly as I ejected her and the 'boy-friend' from the building prior to throwing open every window and door in the place, and allowing my receptionist to revive me with a strong cup of tea.

I was well and truly caught by a clergyman quite early on in my career. A man of about my own age, with a university background and a pronounced 'Oxford' accent he appeared to possess no sense of humour at all, yet for all that I found him a most interesting man to converse with. Treatment for a personal condition went encouragingly to plan, and he was clearly well satisfied, and said so in his usual quiet and dignified manner.

On the day of his last appointment he came in a few minutes early, and I was fulminating over the latest outrages of a local gang of vandals who had been targeting the exterior of the clinic.

"I know how you feel," he said calmly as I finished a brief description of what had happened, and how annoyed I felt as a consequence, "From time to time I also suffer from the unwanted attention of feckless youngsters at the church."

"You know it is youngsters?" I asked curiously.

"Oh indeed, yes," he responded, "I sometimes come upon them as they diligently practice writing these strange four letter words that form such a major part of their limited vocabulary upon the doors of the church."

I tried to picture the resulting scene and failed.

"What on earth do you do if you catch the little b- er, miscreants?"

"What would you expect of a man of the cloth? I speak to them of the Word of the Lord."

Thinking of the feral pack of semi-human beasts I had been coping with recently I couldn't somehow see that working.

"But what do you do if that fails?" I asked.

"Oh, that is simple," he replied, putting the tips of his fingers together and looking decidedly beneficent, "I kick them up the arse."

He looked at me blankly, and to this day I don't know if he spoke in jest or in earnest!

I reached Mrs M's home quite late one evening. I had tacked her onto the end of my list as a favour to a mutual friend. The prospective patient was known to me by sight, although I had never actually spoken to her. She was a widow of about sixty years of age, smartly but not ostentatiously dressed, and her home, although perhaps small by some peoples' standards, was nicely furnished and decorated. She invited me in and bade me sit in a comfortable armchair, and after the obligatory mutual commendation of the weather, asked me if I would like a cup of tea whilst we discussed the nature of her problem, and how I might be able to help her.

"Don't talk daft, you'd never get three of us in this loo!"

It had been a long evening, and the thought of some liquid refreshment was quite acceptable, and so I agreed. She rose from her chair, and then paused as she reached the doorway to look back at me for a moment.

"By the way," she said, "If an old lady comes through here, pay no attention to her, it's my mother."

"Oh, I didn't realise you had your mother living here with you," I responded.

"Oh, she's not of the living," she said airily, "she just flits through here from time to time." And with that she departed, and I was left half expecting some sort of wraith to go drifting past!

Visiting patients in their homes is always a risky business, particularly in modern times. In fact it is a practice that I reluctantly had to abandon during my last years in practice. Most of the people I saw were decent reasonable types, but every so often one came across a situation which made everything a bit tricky, and none more so than the following episode that should be an object lesson for any therapist who offers a 'home-treatment' service.

This was a situation that arose out of nothing, and all but finished my career. It happened some thirty years ago now, yet it remains fresh in my memory, and it served to bring home to me the very real dangers of home visiting. For obvious reasons I have changed identifiable details, but the essence of the matter is completely true, and I freely admit that the potential humour of the situation only became apparent to me long after the event.

An appointment had been made for me to visit the home of a new patient to discuss what sounded to my receptionist on the telephone to be a case of agoraphobia. I reached my destination punctually, discovering to my annoyance that it was situated in a block of tenements close to the city

INTERNATIONAL ACCREDITATION

The National Guild of Hypnotists is the oldest (founded in 1951) and largest professional society for hypnotherapists in the world.

The NCH has negotiated a reciprocal agreement with the NGH in the USA, which currently has members in 40 countries. Check their website at **www.ngh.net** for more information about their conferences and publications.

A 20% discount is available for your first year's membership, which brings with it four editions of the Journal of Hypnotism and four editions of the Hypno-Gram.

If you would like to take advantage of this opportunity please contact the NCH administrators for an application form.

centre. Having trudged up several flights of stairs, (the lifts had been vandalised and were out of order) I found the front door standing wide open, to display a highly unsavoury interior. The door itself looked like it had been attacked with various substances and weapons over a period of years, and the internal décor, what little I could see of it was generally in a very poor state. One quick glance from outside showed that the tenant of the flat certainly wasn't terribly interested in matters domestic. The place stank, and rubbish was piled haphazardly in various places down the dingy hall.

I was tempted to turn around and walk away, and as events transpired, it would certainly have been the wisest option. However, in this profession one has to push one's personal feelings aside when it comes to helping a suffering human being, so I knocked loudly on the door.

"Oo is it?" called a woman's voice from somewhere within.

I announced myself as I stood close to the threshold.

"I'm on the loo!" the woman shouted back.

"Oh," I responded, "I apologise for calling at an inconvenient moment, I will wait."

"No, I want you to come in!"

"Are you sure?"

"Course I'm sure; you've got to come in to the toilet with me!"

Needless to say alarm bells were now ringing pretty loudly in my head.

"I'm very sorry," I called back, wondering what neighbours were making of this odd conversation, "I will wait until you are ready to receive some one appropriately. Do you have anyone here with you?"

"Don't talk daft, you'd never get three of us in this loo!"

By this time I knew that I was on a loser, and I informed her that in the circumstances I was unable to assist her, and thus had no choice but to cancel the appointment. The decision was not well received, and I departed to the sound of her screaming at the top of her voice that I had to go in the loo with her! I could still hear that demented voice as I beat a hasty retreat, secretly glad that I had not actually crossed the threshold! I returned to the office, thankful to have escaped, and congratulated myself that that was the end of the matter.

How wrong can one be?

I had been back less than an hour when I received a telephone call from a local radio station. It all started innocently enough, and I was given the impression that the call was an initial contact prior to arranging an interview to expound on the values of hypnotherapy. I have done several of these radio spots, and so it seemed natural to me that another would be in the offing.

Too late did I suddenly recognise the 'softening up' technique beloved of media interviewers, and before I knew what was happening I was being regaled with a report of my 'sickening crimes' that were now going to be put out as part of a programme by that radio station as the spearhead of a campaign to get 'perverts' such as myself who pretended to be 'therapists' off the streets and behind bars! It seemed that the 'lady' I had visited had been on to them in a state of great distress, alleging that I had forced her into the toilet of her home, removed her underwear, and made highly inappropriate suggestions before 'savagely' interfering' with her, etc, ad-nauseum.

For a while it looked as if I was really going to be put through the mangle, but fortunately for me chance took a decisive hand. No sooner was that telephone call concluded than I received one from a professional colleague on another matter. It crossed my mind that his premises were much closer to the 'patient' than mine, and that there was a chance that he either knew, or knew of, her. My luck was in, not only did he know the person concerned, he also knew the patient's GP! The end result was a formal apology from the radio station.

Like I said, the humour of the situation only occurred to me much later when another (and perfectly respectable!) patient confided in me that she had this 'thing' about using the toilet in her home 'in case an unexpected visitor should call'!

Miss Y had about the worst case of nonexistent confidence that I have ever come across. A lightly built young woman in her early twenties, she all but slunk into the clinic under the doormat. Although not unattractive, she did her level best to conceal the fact, and in a crowd of two you probably would never notice that she was there. Every word and gesture was an apology for even existing, indeed, I was mildly puzzled how she had got so far in life without somebody else doing something quite desperate to help her.

Be that as it may, we worked together for quite a long time, we dealt with a number of factors that lay at the root of the matter, and gradually the situation showed signs of improvement. The basis for the latter part of treatment consisted of instilling within her the correct attitude to life expressed in the mantra 'I can and I will'. Gradually she began to blossom, and I felt pleased with the results, and a the completion of treatment she thanked me profusely for turning her life round.

It must have been about a year later that she called in to see me during the lunch hour whilst my receptionist was out. I was standing in the clinic reception area at the time and failed to recognise her immediately.

"Can I help you?" I enquired, believing at that moment that she was just a casual enquirer.

"Hello Mr King," she said, "I'm Miss Y; I do hope that you remember me?"

"Oh yes," I said as recognition dawned, "How are you?"

"Well, that's why I came to see you; you remember that you got me to say over and over again 'I can and I will'?"

"That's right," I agreed, "and you did very well as I recall. So, what can I do for you now?"

"Well," she said tentatively, "how I shall I put this? My problem is not so much 'I can and I will' as 'I could and I did'!"

Only then did understanding dawn as I recognised that she had not just put on a little weight, she was very obviously pregnant!

I suppose that my favourite light moment came when I was invited to give a lecture to a ladies' club. The meeting was convened in a small comfortable hall, and there were about two dozen ladies present, of varying ages and from a variety of walks in life. The lecture appeared to have been well received, and during the course of my discourse I noticed that one of the ladies sitting in the front row was obviously in some degree of pain associated with her shoulder. Having already formed the opinion that she was highly suggestible, I couldn't resist finishing matters off with a touch of the light theatricals.

"I see that you are in some pain?" I said to her.

"Frozen shoulder," she explained, "I've had it for some time."

"Have you seen your doctor?"

"Yes, he just gives me tablets."

"Let me see if I can help you."

I then placed my hand on her shoulder and told her that she would feel warmth from my fingers, and the pain would then fade away.

The effect was total. She moved her arm gingerly at first, and then with increasing vigour, calling everyone's attention to her 'miracle'! I told her that she must return to her doctor and ask for an x-ray, but she could scarcely contain her excitement, and the effect on the rest of the audience was fairly predictable in the circumstances. One after another they started clamouring for assistance in dealing with various aches and pains, and foolishly, I was touching one after another, and of course as every one knows, the belief in 'miracles' once established is contagious. Naturally, I told each person in turn that they should seek proper medical evaluation of their condition.

Right at the back of the hall was a truly ferocious looking woman built something along the lines of a female Sumo wrestler, and a face that reminded me of a hippo. As I finally came close to her she looked up at me with a baleful expression, bared her yellow teeth and snarled: "Young man, if you think you are putting your hand where I've got a pain, you've got another think coming!"

She was dead right about that!

The Solution Focused Approach to Hypnotherapy

By Kay Cook

Milton H Erickson: The Inspiration

The history to solution focused therapy is a fascinating one and many people do not realise that it was inspired by the work of the very famous American psychiatrist and hypnotherapist Milton H Erickson. The life story of this gentleman is a huge inspiration and is of its own accord an illustration of the power of a solution focused mind. Erickson battled the paralysing affects of polio not once but twice having very unusually contracted the condition twice, the first time when he was a high school graduate.

When he heard the doctor tell his mother "the boy will be dead by morning" Erickson mustered an instinctive solution focused response to the news. He became infuriated but quickly calmed himself and requested his mother to move a piece of furniture to enable him to see the view from the window better. If his demise really was imminent he was certainly going to enjoy the best possible view!

Erickson regarded the time he spent confined to bed with only the senses of sight and hearing to entertain him as an education. He learnt to be an observer of human movement, intention, thought, expression and achievement. This close observation awakened in him the interest and understanding of unconscious patterns which were to become his future.

He would lay in bed visualising what it would be like to walk, noting the smallest of mechanics which were the cogs in the machine of the act of walking. Unwittingly he activated the rehearsal room of his mind as he went over and over the small changes which would be the beginning of standing and of walking, skills which he went on to regain.

Even then Erickson was sowing the seeds of utilisation by locating inner resources gathered in other times and other experiences and applying them in this new context. He qualified as a psychiatrist and hypnotherapist rapidly acquiring a reputation for what came to be known as his "teaching tales" and metaphors. He would often succeed therapeutically with cases where his colleagues had failed to create positive change.

Naturally Erickson's work was observed by many therapists who sought to recreate his success. Grinder and Bandler were inspired by some aspects of his work and created NLP (Neuro Linguistic Programming). Most hypnotherapists today incorporate some NLP techniques in their work.

Solution Focused Brief Therapy: The Beginning

Steve de Shazer and Insoo Kim Berg (a married couple) became the originators of Solution Focused Brief Therapy when they created the Brief Therapy Centre in Milwaukee, USA. They were soon joined by Yvonne Dolan and others. The solution focused approach was radical in that it was solution rather than problem focused; thus clients were enabled to move from a problem centred mindset to a solution focused mindset. The approach is client centred, non-judgemental and solutions are often not linked to the problem in a direct way. For example, a client found playing tennis improved her ability to concentrate at work as well as her social life!

The Brief Therapy Centre dealt mainly with family problems which had often become very complex over time. It was a revelation for the therapist to be able to ask each family member present what they would see as improvement, how would they recognise that improvement and what changes those small changes which were the beginnings of improvement would bring to others close to them. In this way the Client would shift from problem formation mode into solution formation mode.

a client found playing tennis improved her ability to concentrate at work as well as her social life

The originators of The Brief Therapy Centre used the therapy for a wide range of problems including depression, behavioural problems, addiction, family and relationship problems, anxiety, self-harm, phobia and stress related issues. Solution focused Brief Therapy spread to Europe and the UK with BRIEF being formed in London.

When hypnotherapists began to

be trained in the Solution Focused Approach the circle of inspiration had really turned full circle linking back to Milton H Erickson the hypnotherapist who inspired Steve de Shazer and Insoo Kim Berg!

Within the last ten years the number of hypnotherapists who have been trained in this approach in the UK has greatly increased. The approach is flexible and is as applicable to working with anxiety, phobia or depression as it is to exam performance or public speaking. Indeed the approach has been used successfully to maximise sporting performance both at the recreational and world championship level. I trained in Solution Focused Hypnotherapy at the Clifton Practice in Bristol in 2006 knowing the approach would be compatible with the evolutionary understanding of the mind which had interested me for many years.

Solution Focused Hypnotherapy: What to expect

a) Time spent discussing problem formation to be limited to understanding the difference between operating in problem formation mode and solution formation mode.

b) The formation or origin of a problem to be explained in terms of how the brain works. The influence of thinking styles will be discussed.

c) The therapist presumes you have inner strengths, potential, resources, creativity and life skills which you are not yet utilising.

d) Hypnotherapy is used in every session to lower anxiety, help you into solution focused mode and create the changes you identify at a subconscious level with greater ease and rapidity. A CD is usually provided for use at home.

e) In second and subsequent sessions the therapist will ask you what has been different, what has been better even in very small ways and what might other people have noticed.

f) Creativity is increased and positive happy memories are accessed spontaneously and far more often.

g) Playfulness, lightness, laughter and creativity to be present.

h) Therapy is non-judgemental, encourages mindfulness and is respectful of your own wisdom.

i) Homework experiments are suggested by therapist with clients being invited to add their own. If a client wishes to substitute their own homework experiment for the one suggested that is welcomed.

j) NLP techniques will be used by most therapists in some circumstances particularly where phobic or compulsive responses are present.

The Solution Focused Mind

Before we look at how and why this is so let us take a moment to look at why the problem focused mind is so unhelpful.

The Problem with a Problem Focused Mind

When we feel threatened we run the ancient fight, flight or freeze response which kept our ancestors safe and is a valuable response in dangerous situations but this response is our "emergency button". When we perceive a benign threat in modern life we still press our emergency button if our anxiety is at a high enough level when the following will occur:-

a) Our left brain capacity including our language faculty is greatly diminished and is calibrated to search for anything else which could go wrong (akin to a stone age man looking for more dangers).

b) The creative potential of the right brain is calibrated towards spotting more threats, becoming every more hypervigilant and creating more anxiety. Pattern matches to memories where an emotional not a logical match is made. This system of illogical pattern matching is very active in sowing the seeds of phobic responses or simply those times when we say to ourselves "I can't". Evolutionarily this emotional matching system is useful. For example, when a child burns itself for the first time it learns to be cautious around all sources of heat not just the one which caused the burn. It is emotional matching and feeling anxious too close to heat which allows the child to learn without the need for repeat burns. It is easy to see how helpful this response is in dealing with physical danger but how unhelpful when dealing with most 21st century threats.

c) In this mode the subconscious mind does what it did to keep our ancestors safe - it will reference back making an emotional match to the past. In this mode we are recycling a program and are not innovative thinkers - for innovative thinking we need to be in solution focused mode.

The benefits of The Solution Focused Mind

a) Our left brain intellectual and language capacity are fully available to us and are calibrated to deal with problems and make the most of life. We can train the left brain to take control in this way which includes the capacity to put itself in standby mode whilst we do something purely creative. We deal with things instead of sweeping them under the carpet. In solution focused hypnotherapy we greatly increase this capacity.

b) The holistic mind: The full creative positively focused potential

of the right brain is available to us and working in synergy with the left brain. The left brain is able to go into positive standby mode whenever the positively focused imagination of the right brain is the better resource to problem solve or enjoy life. Anxiety levels are kept low ensuring our automatic thoughts are positive ones!

c) The subconscious mind will create and keep updating new positive reactions and thoughts to help us as we live our lives. Our thoughts are both realistic and inspiring. The mind working in synergy in this way can be an awesome machine.

for innovative thinking we need to be in solution focused mode

Neurotransmission

We produce lots of wonderful serotonin which allows us to feel we are equal to and coping with the challenges of life. There are hundreds of neurotransmitters but it would seem that serotonin is the "key in the door" of positive neurotransmission. Major players in the neurotransmission cycle are serotonin, noradrenalin and dopamine. Serotonin helps us to cope with life, noradrenalin is a motivating factor so we create successful action and when we feel successful we create dopamine which leads to more serotonin - so as you can see solution focusing is an important tool within therapy but also a skill for life.

When our neurotransmission operates properly we cope with life better and this also has physical benefits. When we generate the proper chemicals we deal with long term conditions including chronic pain better and we sleep better. Our parasympathetic nervous system is in control which means we are calmer physically with lower blood pressure, better immune function, better digestion and many other improved functions. Evolutionarily we are meant to have our parasympathetic nervous system in control most of the time as our bodies work better and age more slowly that way - to do that in modern life we need to focus on solutions. The sympathetic nervous system is there to be activated by our emergency button in dangerous situations - it was designed for infrequent use and rapid resolution with a return to intellectual and parasympathetic nervous system control. By focusing on the solution we are creating the equivalent of that rapid resolution!"

Solution Focused Hypnotherapy and Neuroscience: Some Supportive Research

Day dreaming is what the brain gets up to when it is not occupied by anything in particular. Marcus Rachie, a neuroscientist at Washington University, St Louis has carried out a lot of research into this area. It had been established that the brain uses a huge amount of energy in proportion to its dimension using even more than the heart and he wanted to know what caused such a high usage.

He carried out studies into this area of the brain which utilised so much energy which fires up whenever the brain is otherwise unoccupied. In doing so he discovered a new functional system within the brain - default mode.

Guilio Tononi of The University of Wisconsin-Madison was very excited by this stating "it's not very frequent that a new functional system is identified in the brain..." Some neuroscientists assign this new functional system the role of selecting memories and mulling over future possibilities and combining them into a personal narrative.

Rachie also used PET to find brain areas associated with words and noted that these areas active at rest became quiet as soon as the person began physical activity. In 1997 these results were collaborated by Gordon Shulman and he and Rachie published a joint paper in 2001 positing they had discovered a hitherto unrecognised default mode which the brain only sets aside when it focuses on something else. This work led Rachie to speculate that the default network might provide the brain with an "inner rehearsal" for future actions and choices. This concept fits in very nicely with the model of the mind that we work from as SFBTHyp in which the imagination is the rehearsal room of life. In SFBTHyp we assist the client to operate the power of choice by setting the default mode to work in solution focused mode.

As far as hypnosis goes the work of Woolley went further positing that brain studies including PET and EEG's have shown the involvement of the anterior cingulate cortex, the thalamus and brainstem (pontomesencephalic) to be involved in the production of hypnotic experiences. The anterior cingulate cortex is active in novelty detection and dissociation from sensory input. Woolley notes "A conceptual framework has been proposed which integrates neurophysiology, systems thinking and psychology, as complementary factors in hypnosis (citing Hasegawa and Jameson 2002)". As hypnotherapists we have long since understood that hypnosis is both associative and disassociative allowing us to let go of unwanted response patterns and to install new preferred responses, it is good that we now understand how this operates within the brain.

Clinical Outcomes Measurement – Burden or Therapeutic tool?

By Catherine O'Neill

Outcomes measurement is now seen as an essential part of the administration involved in therapy, but many believe it can also be a beneficial therapeutic tool for use with clients to identify areas of progress (or lack thereof) and to formulate treatment plans.

At Anxiety UK, a user led mental health charity that provides therapy services nationally, we have recently undergone a reorganisation of our therapy services and introduced pre and post outcome measures into the service, to bring us in line with many statutory primary mental health care services.

We work with clinical hypnotherapists across the UK and value the contribution this group of professionals has to make in the treatment of anxiety.

However, with the movement towards evidence based practice, particularly in the NICE guidance and the commissioning on the basis of outcomes, all therapeutic services need to ensure they are able to objectively evidence the impact they make on clients.

David Richards, Professor of Mental Health Services Research, Mood Disorders Centre, School of Psychology, University of Exeter reports that, in many mental health services, the progress of patients is often assessed irregularly, subjectively and infrequently. Few services have instigated systems whereby objective rating scales are implemented and where data is used to help the clinician and the client plan and carry out treatment. Most systems have focussed on providing commissioners with service level audit data.

However, even this tends to be incomplete with the best attempts reporting less than 40% completion rates by clinicians for post-therapy measures (Stiles et al, 2006; 2008). Part of the reason for this is that most systems collect data intermittently, usually pre- and post-treatment. If people drop out of treatment before the post-treatment measurement point or clinicians forget to collect the next set of measures, services have no objective way of knowing the extent to which they have helped the person or not. Furthermore, we also know that incomplete data tends to overestimate the overall effect of treatment services, since it is likely that people who 'stay the course' will be those most likely to be improved.

Ironically, the idea that rating scales are useful and appreciated by patients is often resisted by clinicians but supported by patients themselves (Richards et al, 2006). As a consequence of the finding that patients appreciate the use of outcome measures during their contact with clinicians, the UK's Improving Access to Psychological Therapies (IAPT) national programme has instigated a procedure of sessional collection of these measures – i.e. at each and every contact with a clinician. In the IAPT programme, services have a target to collect repeated clinical data from more than 90% of their patients. Even people who drop out of treatment in an unscheduled manner, therefore, will have some evidence of their progress before they cease contact with services.

Within the IAPT programme, the importance of such regular data is particularly acute for the management of stepped care. Stepped care relies on a systematic method of assessing the progress of patients so that they can be offered the best treatment. Many people respond very well to low-intensity treatments such as guided self-help but others require more intensive therapy. Sessional outcome measures allow 'stepping up' decisions to be taken earlier rather than later and avoid people languishing in treatment programmes when there is little improvement. Unless health and/or social outcomes are recorded accurately, regularly and frequently stepped care cannot be self-correcting.

The measurement of clinical outcomes is not, therefore, merely an audit process. Clinicians can use the data provided by questionnaires to structure their conversations, feedback to patients their progress, confirm their clinical interview information and manage the therapy process. In IAPT, scores on some measures are collected onto electronic information systems which automatically alert workers and their supervisors to when a patient needs prioritising for supervision discussions. These measures are, therefore, a critical component of the IAPT method contributing as they do to

> the collection of outcomes data for hypnotherapists presents a unique opportunity to show this discipline as credible

supervision discussions, stepped care self-correction decisions and clinical decision making.

At Anxiety UK, we have found that the introduction of these outcome measures has been readily taken up by some therapists, yet others fail to return even one set of complete data for their clients. I believe the collection of outcomes data for hypnotherapists presents a unique opportunity to show this discipline as credible, professional, and to compare its effectiveness objectively with other disciplines.

I encourage hypnotherapy bodies to get behind this movement of outcome focused and evidence based practice. It will not only lead to hypnotherapy becoming increasingly mainstream, but will result in hypnotherapy achieving a higher understanding among mental health professionals.

Catherine O'Neill can be contacted at services@anxietyuk.org.uk or on 08444 775 774

Congratulations to our latest HPD qualifiers!

Lee S	ADLEY	Sarah	FORD	Natalia	MACKEY
John	ANGUS	Daryl	FRASER	Benjamin	MANNING
Susan	BAYLISS	Emily	GALE	Lesley	MCCALL
Thomas	BECK	Judith	GOLDSMITH	Paula	MCGOWAN
Jo	BIDDULPH	Carol	GOODWIN	Jayne	MOFFATT
Linda	BIGGS	Elaine	GORRIE	Giselle	MONBIOT
Frances	BROOKSBANK	Stuart	GREENWOOD	Nicola	MORWOOD
Penelope	BROWN	Joanna	GUILIE	Hilary	MURRAY
Dee	BRYAN	Ruth	GUTTERIDGE	Melanie	PHILLIPS
Richie	BRYAN	Seeta	HAIDER	Annaliiese	PLOWRIGHT
David	BURGUM	Ann	HALL	Barbie	POOLE
Chris	CALLOWAY	Clive	HAMMOND	Ian	POPLE
Karen	CARTER	laurie	HARVEY	Marie	POWELL
Wendy	CHALK	Nicholas	HOLLAND	Pauline	PRIEST
Tony	COK	Christina E	HOLLAND	Adele	RICHMOND
Gary	CONDON	Sam	HOLLINGDALE	Martin	RIVETT
Jenny	COOK	Nadine	HOLT	Sandra	ROYCROFT-DAVIS
Tessa	COOKE	William	HONEY	Samantha	SMITH
Sharon	CORBRIDGE	Jill	HOWLESON	Stuart	SMITH
claire	COTTON	Christian	HUGHES	Linda	STEWART
Marc	CRAIG	Janette	HUNTER	Agne	TALMANTAITE
Darren	CUDDY	Emma	JOHNSON	Tracie	TEMPORAL
Margaret	CURLEY	Jane	JONES	Susan	VIVIIAN
Susan	DRAKE	Sian	JONES-SOUABNI	Rebecca P	WHITE
Janette	DUMBLE	Erika	KEAT	Kim	WILSON
Jennifer	EDDOLLS	Caroline	LASKOWSKA	Joanna R	WITTELS
Prudence	ELKINGTON	Hedwige	LERICHE	Lubna	YAQUB
Andrew	EVANS	David	LEWIS	Lisa	YELLAND
Alexandra	EVERDEN	Dennis	LINDSEY		
Giancarlo	FALCHI	Ross	LIVINGS		

Want to see your name here?

Contact Jill Tonks at training@hypnotherapists.org.uk or visit www.hypnotherapypractitioner.org

CPD Diary

Important Note:

Official NCH CPD courses are listed with a purple background and are maximum of £60/day.

Other CPD listings are for information only; listing does not imply NCH endorsement.

Schools: Please see note at the end of the CPD Diary

June 2010

Date	Title / Trainer	Venue	Cost	Contact
Thu 10th	The Nature and Treatment of Tinnitus David Collingwood-Bell	Central London	£60	UK Academy (Wales & Borders) Tel: 01978 769178 Email: hypnodelwyn@aol.com
Sat 12th	Weight Control Masterclass Joy Gower	Norwich	£60	East Anglian Institute Tel: 0845 833 0842 Email: eainstitutenlp@aol.com
Sun 13th	Advanced Smoking Workshop Joy Gower	Norwich	£60	East Anglian Institute Tel: 0845 833 0842 Email: eainstitutenlp@aol.com
Sat 26th	Certificate in Working with IBS Carole Wan & Alan Cooper	Chesterfield, Derbyshire	£60	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Sun 27th	Certificate in Smoking Cessation Carole Wan & Alan Cooper	Chesterfield, Derbyshire	£60 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Wed 30th	The Nature and Treatment of Tinnitus David Collingwood-Bell	Liverpool	£60 +VAT	UK Academy (Wales & Borders) Tel: 01978 769178 Email: hypnodelwyn@aol.com

July 2010

Date	Title / Trainer	Venue	Cost	Contact
Sat 3rd	Past Life Regression Masterclass Joy Gower	Central London	£60	East Anglian Institute Tel: 0845 833 0842 Email: eainstitutenlp@aol.com
Sun 4th	Intro to Transactional Analysis & Inner Child Therapy Sarah McRobert	Norwich	£60	East Anglian Institute Tel: 0845 833 0842 Email: eainstitutenlp@aol.com

August 2010

Date	Title / Trainer	Venue	Cost	Contact
Tue 3rd, (3 days)	Masterclass in Depressive Disorders Carole Wan & Alan Cooper	Chesterfield, Derbyshire	£180 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Tue 10th (2 days)	Cognitive Therapy for Hypnotherapists Carole Wan & Alan Cooper	Sheffield	£120 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com

Date	Title / Trainer	Venue	Cost	Contact
Thu 12th	Certificate in Energy Psychology	Sheffield	£ 6 0 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Mon 23rd (2 days)	Cognitive Therapy for Hypnotherapists Carole Wan & Alan Cooper	Watford or Central London	£120 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com

October 2010

Date	Title / Trainer	Venue	Cost	Contact
Sat 30th	The Nature and Treatment of Tinnitus David Collingwood-Bell	Birmingham	£60	UK Academy (Wales & Borders) Tel: 01978 769178 Email: hypnodelwyn@aol.com

November 2010

Date	Title / Trainer	Venue	Cost	Contact
Mon 8th	Certificate in Smoking Cessation	Watford or Central London	£60 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Tues 9th	Certificate in Working with IBS	Watford or Central London	£60 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Wed 10th	Certificate in Energy Psychology	Watford or Central London	£60 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com
Thu 11th (3 days)	Masterclass in Anxiety, Panic & Phobias	Watford or Central London	£180 +VAT	Academy of Clinical & Medical Hypnosis Tel: 01246 416544 Email: acmhl@btconnect.com

Training Schools. If you would like to offer NCH approved CPD, please contact the Development Director, John Harrington (training@hypnotherapists.org.uk). For 'other' CPD, please contact the Editor (journal@hypnotherapists.org.uk) for Media Pack 04/07.

NCH Website News!

As part of our commitment to developing member services, and after numerous requests from advertisers, we've implemented a '**Third Party Offers**' email option.

This allows the NCH to raise additional funds from advertising which we can use for member benefits, as well as allowing carefully selected advertisers to present special offers which may be of interest to NCH members.

We hope that you will choose to support the NCH by staying opted in to these occasional 3rd Party Advertiser messages - however, if you don't want them at all, you can opt out online via your NCH account.

If you would like to advertise to NCH members via this facility, please contact the Administrators for current pricing.

Find out more: admin@hypnotherapists.org.uk

I am your Supervisor. Friend or Foe? Discuss.

By Joy Lawton

When I used to see this type of question in the past in an exam or test I always used to sigh and wonder how on earth to answer it. More recently I had a bit more of an idea for a potential answer when I got someone to look after the whippets, changed the wooden clogs for normal footwear, and set out in 2009 from a dark and rainy Leeds (it's nearly always grim up north) to travel down to light and sunny Cambridge for the start of my Supervision training. During my time 'down south' (northern expression there, sorry) I was given bucket loads of expertise, experience, time and opportunity to explore just what Supervision is, and what it means to everyone involved in this fascinating hypnotherapy world that we're engaged in.

Time went really quickly, although not so quickly when certain role play scenarios (don't we all love it when the trainer says its time for some role play situations?) didn't go quite according to plan, (finger points at me for some strange reason) and some occasional hilarity occurred. As the practical and theoretical training continued and then was finalised over the next few very busy months, I became much more aware of the many strands that make up the whole tapestry that we call Supervision.

So let's look at this tapestry and unravel it a bit so we are all 'in the know'. What can having regular Supervision do for you? Why should you give time, money and commitment to this process? Some of you may argue that your hard earned money could be spent furthering your practice instead of listening to someone telling you what to do and how to do it. Point taken. You may argue that your time would be better spent fitting in another client and that your commitment isn't in question. Both points taken. I can almost feel the boredom creeping in already about why you're required to do this when you feel you don't necessarily need Supervision. So thanks very much, but no thanks.

I've come to think of being a Hypnotherapist as akin to driving a car. Mine of course would be a big red flashy jag or sports car, although I reckon my husband (unfairly in my opinion) would suggest if I ever asked him that I would be better suited to a small neat little car with a top speed of about 40mph. Little does he know, even though we have been married for years, years, and years! Yes, it's been a long time now.

Anyway to get back to this driving lark again, your trainer/instructor has helped you get to where you are now, they have given you a structured and experienced route to take and you've travelled along it and have succeeded in passing your test. You are now qualified and ready to go! Bit daunting travelling on your own though isn't it? I certainly found it so.

Even if you've travelled some of the way along this new road of qualification it may still remain daunting despite your best efforts. By inviting us to climb (or in my case not so much of the climbing, more of a sedate gentle movement as the first flush of youth is now over) regularly from time to time into the passenger seat alongside you, we can take the opportunity to help and support you as you manoeuvre (have I spelt it right?) your car along the therapy route that suits you best and how you want to negotiate it. Remember it's your practice, it's your journey.

So, looking at junctions, judging any obstacles, avoiding any road works and going through safely on as many green lights as we can. (I never go through on amber or red, do you?) We do this together within an objective and professional relationship which allows for reflective practice. So you get what it says on the tin. A professional service that is the best we can offer you in order to take safe care of your needs and those of your clients. We'd better not forget them! I suppose they do enter the equation now and again if you come to think of it.

So how does this Supervision business work? Well, you have a choice of Supervisor to help you do your own thing. There are lots of us around, listed nicely and easily accessible for you in each edition of the Journal with our names, the area where we live/work and our phone numbers.

You can also catch up with us by punching in your own address or postcode on the NCH website, where you can easily locate us as therapists who offer Supervision in relation to wherever you happen to live. Here, for each of us you can find out more details of what we get up to and what we like to work with. I reckon that it's a good idea to contact a few of us to see how we would potentially get on together, if we would have things in common in how we work (remem-

ber we are therapists too) and if there is any chance of us not working well together, or as Human Resources call it nowadays 'a clash of personalities'. Whatever happened to Personnel?

We would provide you with some additional information so you would get a better idea about us personally, and in return we would ask you to tell us about yourself so we can both judge if we're going to be suited to potentially work together. My personal information sheet doesn't actually tell you that I eat chips occasionally (plenty of salt and vinegar please) or like the odd glass of red wine that I partake of purely for medicinal purposes after a busy client day, or that I can get through the top layer of a big box of chocolates before you can finish saying a basic induction (we're made of stern stuff up north).

Some things are better left unsaid like burping, or worse. Still it proves that we're human just like you, and have been there in similar situations from time to time, that you might find yourself in now or in the future. So, in a nice way we've been around the block, we've read the book, seen the film, bought the tee-shirt, and we're still in one piece. Well, almost.

You can opt for seeing us individually face to face if we live within reasonable distance from you, or instead you can have individual telephone supervision if we happen to live a long way from where you are. Either method is perfectly acceptable to us. I opted for telephone supervision as there was no one suitable in my area, and this is still ongoing. If my hour session has been arranged to suit us both early in the morning, I can talk to my Supervisor in my jimjams and not worry about how I look. Wouldn't admit it to her though. Just had a thought, she might do the same! We meet up from time to time and because we know each other's voice well we didn't walk past each other the first time that we met up. Although thinking about it now, one of us could have carried the Journal under our arm as a signal of our identity or our credentials (gosh, the dictionary is working hard today).

Our strategies could surpass even those of James Bond I reckon. You could also opt for group supervision although not every Supervisor offers this. So, a selection of Supervisors and various methods of Supervision for you to choose from. If all is tickety-boo then we would then draw up a contract that we both agree with which is reviewed regularly, and then off we go prepared and ready for that interesting and enjoyable journey!

Every now and again on this journey we would check the map, check your destination, what is occurring around you and see how together we can circumvent (I had to look that one up too) obstacles, red lights, obstructions or any tight corners, so we get a clear and smooth road as possible to get you from A to B with each client and any other additional facets of your therapy practice. We learn from each other. We develop together.

You have time and opportunity to be able to off-load any worries or concerns, and to share any disappointments and victories with us. We learn from, and utilise each experience in order to make any future journeys easier and better next time you go along that route or any other route by providing you with a safe and challenging way forward. We know that giving therapy and the confidentiality it necessarily involves can make our job a really lonely one sometimes. We understand. We would probably share interesting experiences too as all our clients arrive on time, are model clients, we never encounter resistance from them and they never cause us any hassle do they? Don't get me started on that one.

Our aim is to help you to move with fluency and ease, to increase your confidence and expertise as you negotiate your way along more complex, varying and demanding routes on any one journey. All this is done under a protective umbrella of safety, protection and stability. So, not really telling you what to do, or how to do it. That's really boring. You receive quality time on a regular basis to help fulfil your needs and those of your clients. A double whammy as they say.

Sounds great doesn't it? All we need from you is time, some money (remember I need my personal supply of BIG boxes of chocolates) and commitment – which brings us neatly back to where we started.

The threads in the tapestry I hope are now taking on more of a recognisable shape, size and content of its own so you can begin to get a more complete picture of how we like to work with you.

> I can get through the top layer of a big box of chocolates before you can finish saying a basic induction

Nothing can be as beneficial or as good as this I hear you say. Well, actually it has the potential to be both of those things if each of us is ready and willing to take up the challenge, and if there is an adequate sharing of rapport, empathy and trust between us. If you wanted to stay with this professional relationship that would be fine, or if after a period of time you felt you would benefit from working with someone else to freshen up your approach that would be okay too. We would formally close it down and you would be free to choose and work with someone else from the list. If you did choose to stay with one particular Supervi-

sor over a period of time then things would be reviewed on a regular basis to ensure that we were singing from the same hymn sheet as it were.

If things weren't working out as well as they should for any reason - whether it be either of us working together for a short or longer period of time - as adults we don't need to throw our toys out of the pram - we would take steps to sort it out so it was working and as beneficial as it could be. Although if all else failed then it would be acceptable to formally close the professional relationship down, learn from it and then move to someone else on the list that would perhaps be able to help and support you in different and more successful ways that would suit you and your practice better.

So as Elvis would have said (showing my age there) we're ready to rock and roll as your Supervisor. Are you willing to find out what Supervision can do for you? Because, as they say in the advert, 'we're worth it'. Okay, let's go back to the beginning again. I am your Supervisor. Friend or Foe? Discuss. It has been, and I reckon we are neither friend nor foe. We are primarily there as a facilitator to support and help you survive in a competitive market with varying ideas, strategies and advice that will encourage and contribute to your personal success. You decide what we are, and how we can support and help you when you say YES.

Right, I'm a bit tired now after all this discussion. Where's that plate of chips (not forgetting the salt and vinegar), or glass of red wine, or big box of chocolates? I might even go rash and have all three in one sitting! That detail isn't in my personal information sheet either. Remember, I'm a Supervisor, I have some pride.

SUPERVISION

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.

Peter Adamson	Warrington & NW	01942 677 426
Martin Armstrong-Prior	Leicester	0116 276 4911
Fiona Biddle	Loughborough & London	0150 988 1411
Dawn Biggs	Bexhill	0870 787 5218
Michael Cameron	London	0208 445 1369
Jennifer Charles	Gloucester	01452 760166
Nick Cooke	Birmingham	0121 444 1110
Tom Cottrell	Edinburgh and Biggar	0131 2254437
Josephine Goss	Scotland	01343 835705
Kate Harvey	Nottingham	0115 948 0815
Val Hird	York	01904 629 347
Christine Key	Surrey	01932 560725
Stephanie Kirke	Thatcham	01635 869444
John Lawrence	Linlithgow	01506 830190
Joy Lawton	Leeds	07771 556162
Mary Llewellyn	Doncaster	01302 743113
Theresa Long	Wimbledon	0208 241 7930
Lynn Martin	Honiton, Devon	0208 457 2643
Gloria May	London	0207 486 4553
Joe McAnelly	Newcastle upon Tyne	0191 286 1161
Susan McIntyre	Burnham on Sea	01278 784490
Hilary Norris-Evans	Wiltshire	01249 740506
Paul Peace	Sheffield & London	0114 235 1985
Su Ricks-McPherson	Daventry	0844 736 2904
Lynnzie Stirling	Edinburgh	0131 66 77 199
Carole Wan	S.Yorks & London	01246 416 544
Patrick Waterson	Ballymena (NI)	028 25631415

Do you run a not-for-profit peer supervision group? Advertise it free in the Journal! Contact the Editor.

Metaphor Corner

Dog with a stick

Have you ever seen a dog proudly carrying a big stick it has been playing with? The way they happily carry it around like a trophy.

Of course dogs are very intelligent creatures, capable of showing real measurable intelligence and also emotion. So with all this intelligence you would think it shouldn't be too hard for a dog to get through a gateway with the stick; after all there may be many gateways as it enjoys its walk.

But the dog just goes up to the gateway with the big stick held horizontally in its mouth and discovers the gateway isn't as wide as the stick - but that doesn't stop the dog trying - oh no, in fact it makes the dog just keep trying, and every time it tries, the stick stops the dog from going through the gate. Again and again it tries, the horizontal stick always catching the sides of the gateway. Sometimes the dog might even hurt itself; it just keeps banging the stick across the gateway but it still tries and tries and tries.

What the dog doesn't know is that, all it has to do instead of banging itself against the gateway, is to simply turn its head to the side a little. It doesn't take much effort or thought, and then it can get through the gateway and enjoy the rest of its walk, because it might be dark soon and the walk will be over.

- Gary Webster

Wooden Bowl

A frail old man went to live with his son, daughter-in-law, and four-year-old grandson. The old man's hands trembled, his eyesight was blurred, and his step faltered

The family ate together at the table. But the elderly grandfather's shaky hands and failing sight made eating difficult. Peas rolled off his spoon onto the floor. When he grasped the glass, milk spilled on the tablecloth.

The son and daughter-in-law became irritated with the mess. 'We must do something about father,' said the son. 'I've had enough of his spilled milk, noisy eating, and food on the floor.'

So the husband and wife set a small table in the corner. There, Grandfather ate alone while the rest of the family enjoyed dinner. Since Grandfather had broken a dish or two, his food was served in a wooden bowl.

When the family glanced in Grandfather's direction, sometimes he had a tear in his eye as he sat alone. Still, the only words the couple had for him were sharp admonitions when he dropped a fork or spilled food.

The four-year-old watched it all in silence.

One evening before supper, the father noticed his son playing with wood scraps on the floor. He asked the child sweetly, 'What are you making?' Just as sweetly, the boy responded, 'Oh, I am making a little bowl for you and Mama to eat your food in when I grow up. 'The four-year-old smiled and went back to work.

The words so struck the parents so that they were speechless. Then tears started to stream down their cheeks. Though no word was spoken, both knew what must be done.

That evening the husband took Grandfather's hand and gently led him back to the family table. For the remainder of his days he ate every meal with the family. And for some reason, neither the husband nor wife seemed to care any longer when a fork was dropped, milk spilled, or the tablecloth soiled.

- Author Unknown

Autopilot

It's wonderful to go through your life completely blissful and unaware of things around you, like being a aeroplane on auto-pilot - letting the navigational system do all the work for you... Some times you find you are veered off your course to where you want to go and you experience things you do not want to experience - these troubles, concerns and challenges come to your awareness and this can be like turbulence on your journey to your destination. When you try consciously to change the course, but cannot seem to get off of auto-pilot what do you do?

You notice... the things you are thinking... the images you make in your mind... the feelings this creates in your

body - where they are located, what would you call that feeling? Also how you are reacting to this feeling... and the results you keep getting.

Taking hold of the controls and steering your life towards your destination - your goals - is simple... Just by being aware you are empowered to be more in control of what you are thinking and feeling affecting how you are acting...

Grab hold of the controls and notice... if the feeling is bad, you are thinking about something you don't want... ask yourself, 'what do I want instead?'... make a compelling picture or movie and noticed how different that can feel. When you hear that critical voice inside, change it to something silly - and notice how it feels different...

That feeling inside... you can feel it... it's your choice. Give yourself permission to feel it fully... ask yourself if you are willing to let it go... and when... If not then give yourself permission to have it and ask yourself when you will be ready to let it go...

You can let your emotions carry you or you can carry your emotions - you can express them or you can suppress them - remember, they are part of your navigational system and have a purpose... They are appropriate at times... so you can be okay to acknowledge them --- to feel them and if you are capable and willing you can release them when you no longer need to have them to lighten your cargo. Feeling so much more lighter and brighter...

When you are back on track toward your destination, you can go back to auto-pilot... and just enjoy the ride, with new found empowerment giving you so much more.....

-Brenda Bentley

Book Reviews

Positive Shrinking

By Kevin Laye

Reviewed by Rob Woodgate

Positive Shrinking is a self help diet book, written as a narrative.

It follows the story of two friends who meet up for their annual spa weekend. Both have struggled to lose weight all their lives, but this time one of them has a made a surprising discovery... 'Positive Shrinking'.

The author, an NCH member, comes from the McKenna / Bandler / Callahan stable, and this is reflected in the choice of techniques presented; including Thought Field Therapy (TFT), a Kinesiology style ideodynamic test, NLP style positive imagery, mindful eating and a breathing exercise.

The reader is introduced to each of the techniques as part of the discussion between the friends, and there is a good summary at the end of the book.

This short book is a very easy read, and the humorous narrative blends story and instruction effortlessly. This, combined with his glowing foreword from Paul McKenna, will no doubt make this a book that piques the public interest.

Although aimed squarely at the general public, this is a great book for hypnotherapists to read too.

Not only is it a welcome and lighthearted stopgap between clients, but there is much to learn from the style. I was particularly impressed by the author's skilful weaving of hypnotic language into the narrative.

From the very start, I found myself nodding along and smiling as the characters portrayed typical dieter thoughts, feelings and behaviours - building empathy and rapport with the reader, before taking them along for the ride.

As the discussion between the characters develops, the author carefully seeds suggestions and catchy trigger phrases, such as 'makes you thin...k', 'eat like a pig, look like a pig', and 'Mind over platter'.

By the end, I was ready to 'Just do it!'.

In summary, I really liked this book. It is straightforward, concise, and skilfully delivers its message without pretence or pomp. As such, I think it will have broad appeal, and something useful to offer practitioners and clients alike.

ISBN: 1848501862
RRP: £7.99
Published by Hay House

THE HYPNOTHERAPY JOURNAL
Address: PO Box 149, Gravesend, DA11 8XL
Phone / Fax: 0845 544 0788 / 0870 7627329
Email: journal@hypnotherapists.org.uk
Editor: Rob Woodgate MNCH(Reg), HPD, NLP(Master Prac)
Proofreader: Lisa Langhorn, 01932 860107
Printer: Meridian Printers, 51-53 West Street, Long Sutton, Spalding, Lincs. PE12 9BN

CONTRIBUTIONS are welcomed, but we can accept no liability for any loss or damage, however caused. The preferred method for receiving contributions is by email in MS Word, Rich Text, or PDF format via email. Artwork can be sent as a Photoshop file (PSD), PDF, Encapsulated Postscript (EPS), TIFF or JPG (Max Quality Only).

Snail mail contributions should be provided on a CD or typed (14pt Arial please) on single sided paper. Include postage and packing if you wish your work to be returned, and a stamped addressed postcard if you wish an acknowledgement of receipt.

By submitting a contribution you grant the NCH an irrevocable worldwide non-exclusive royalty free licence to publish in The Hypnotherapy Journal or any other NCH publication, in any format capable of existence. You also warrant that the article is original, does not infringe any existing copyright, and that you have authority to grant us these rights to publish. Copyright remains with the author unless otherwise specified.

DEADLINES are the second week of January, April, July and October, unless by arrangement.

VIEWS expressed in The Hypnotherapy Journal are those of the contributor and are not necessarily shared by the Editor, Committee or members of the NCH.

The appearance of an advertisement should in no way be taken as an endorsement by the NCH. If you would like to advertise in The Hypnotherapy Journal, please contact the Editor by email for a Media Pack.

ISSN 1476-7570

towergate professional risks

Preferential Rates on your Professional Indemnity insurance as a member of the NCH

Have you considered what would happen if a client or third party tried to sue you as a result of your hypnotherapy work with them?

As an NCH member, you are entitled to preferential rates on Professional Liability insurance, which would protect you in the event of a civil claim against you for compensation.

If you're a student of an NCH Accredited Training School you could be entitled to pay just £25* for your first year's cover.

For a quote call 0113 391 9595, or visit:
www.towergateprofessionalrisks.co.uk

*This is an indicative premium based on a student practitioner taking out cover for £1m limit of indemnity, and includes 5% insurance premium tax and a £5 underwriting fee.

towergate professional risks

5382/065/FL/07.09