Hypnotherapy Today

ASSOCIATION FOR SOLUTION FOCUSED HYPNOTHERAPY JOURNAL ISSUE 9

The Polar Bear is still in the Car Park!

Negative emotions serve their purpose but should they rule our lives?

Membership

The purpose of the AfSFH is primarily to inform the public of the benefits of Solution Focused Hypnotherapy. Secondly, we aim to support the Association members and help them build and sustain their businesses.

Membership of the AfSFH entitles you to:

- Press releases to send out in your own name
- Access to our online Journal which provides valuable information and resources
- Significant preferential Insurance rates
- Marketing materials, such as website copy, that can be downloaded
- Discounts on AfSFH business courses and workshops
- Permission to use our name and logo
- Discounts on products and services the AfSFH has negotiated on your behalf
- Regular Email updates to help your business

Our members have to be fully qualified in 'Solution Focused Brief Hypnotherapy' (SFBH) or in training. The Clifton Practice Hypnotherapy Training School runs a short Conversion course on SFBH for those who have previously trained in Hypnotherapy.

Affiliate Membership is provided for those not trained in SFBH but who have an interest in this area. This gives access to our very well received quarterly Journal, Hypnotherapy Today. The Journal supplies valuable information to both inform and help hypnotherapists within their businesses.

Membership fees:

Students training at CPHT - **Free** *(subsidised by CPHT)*	
First year after graduating	**£40 per annum**
Full Membership	**£60 per annum**
Affiliate Membership	**£75 per annum**

For more information visit:
http://www.afsfh.com/member_benefits. ■

Don't forget!

The association has a private group presence on Facebook.

Join today by searching for Association for Solution Focused Hypnotherapy at the top of your page. You'll find the group and you can ask to join - If you're good we might let you in. But seriously it's a great way to pass information quickly like news topics you can tweet or share on your own Facebook page, or be alerted to scammers by publishing their details as it happens. Ask the more experienced practitioners questions and share ideas and tips. And of course it's free and fun - don't miss out! ■

Letter From the Editor

I know summer is all about being happy, having fun and enjoying oneself but while we have the edge on positivity, many of our clients may not see it that way.

In this issue we look at the negative emotions that drive many of our mental health problems, from the stress response itself through feeling jealousy, anger, grief, and depressed moods. But some jobs such as being a policeman bring high demands on the person, by our own keeper of the peace - Andy Workman - shares his experiences of coping and how to separate work from home life.

There is more help for fresh new hypnotherapists on the scene from Trevor Eddolls who has put together some websites for non techies to use - all very helpful stuff.

So thanks again for all the positive feedback I receive for this journal, hope you'll contribute something soon too.

If you have any contributions or comments to make, please email me at:-
journal@afsfh.com

Penny

Penny Ling, Editor

Contents

July 2013 - Issue 9

Stuff:

Hypnotherapy Today

Journal of the Association for Solution Focused Hypnotherapy.
8-10 Whiteladies Road
Bristol
BS8 1PD

Email: journal@afsfh.com
Editor: Penny Ling

Contributors to this edition:
Jess Driscoll
Trevor Eddolls
Nicola Griffiths
Heidi Hardy
Michael Hughes
Debbie Pearce
Roger Stennett
Alan Wick
Andy Workman

Thanks to my proof reading team.

The Journal of the Association for Solution Focused Hypnotherapy established 2010 represents the practice of solution focused hypnotherapists as a distinct profession in its own right. Membership is open to those practitioners who have the appropriate qualifications and experience within the field.

MEDICATE?

"Don't Keep Taking The Tablets"

says experienced writer and therapist Roger Stennett

This is my seventh year practising as a Psychotherapist, Counsellor, Clinical Hypnotherapist and Supervisor. During that time I have experienced in excess of 2,500 face-to-face hours with clients, and many of these have entered therapy because of symptoms a clinician would call 'Depression'.

Leaving aside the debate around pathologising natural sadness, or adding labels to human behaviour as if they could ever be definitive in an area of health care where there is no objective scientific laboratory test for any mental health condition, I'm concerned that a number of my clients arrive in my consulting room having been prescribed SSRI anti-depressants from their GP, often on the basis of a fifteen minute health centre visit and cursory examination.

While some people are literally and metaphorically happy to 'swallow' any advice they are given, many are not happy to take Psychotropic drugs. The way in which this is made more palatable, and one which is endorsed and actually invented by the vested interest that is the global Pharmaceutical Industry, is to use the scientifically meaningless phrase that Depression is caused by "a chemical imbalance in the brain".

This 'imbalance' can conveniently be corrected if a patient takes one of a range of popular Selective Serotonin Re uptake Inhibitors (SSRI) anti-depressants, possibly without any need at all for any self- reflection or psychotherapeutic intervention.

The metaphor of 'wallpapering over the cracks' springs to mind.

A conspiracy of silence often exists in the world of 'Big Pharma' broken only by the highly informed voices of clinicians and Neuro-Scientists like Peter Breggin MD and Dr David Healy who, in books like 'Medication Madness', 'Your Drug May Be Your Problem', 'Brain Disabling Treatments in Psychiatry', 'Toxic Psychiatry', 'Let Them Eat Prozac' and 'Psychiatric Drugs Explained' examine the chemistry of Psychotropic drugs and stridently challenge the "wisdom" that "the pills work."

What is interesting about the books above is that they are not originating from a cabal of 'New Age' thinkers, but from Doctors, Psychiatrists and Neuro-Scientists who are often called as expert witnesses in multi-million dollar legal cases when things go wrong with the 'meds', which happens far more often than the multi-national manufacturers would ever admit.

The words 'Biopsychiatry' and 'Biopsychiatrist' have become popular in recent years, as has the suggestion that mental health issues can neatly be routed back to very specific chemical interactions in particular parts of the human brain. The "wisdom" goes that having found what exactly needs to be done, then some?? A magic chemical bullet can, profitably, be found to deal with it.

This has gone along with a steadily expanding list of mental health definitions within the DSM IV and the soon to be DSM V, in which the 300 new definitions of mental illness have grown/been invented in the last 20 years alone.

Please refer to 'Making Us Crazy - DSM – The Psychiatric Bible and The Creation of Mental Disorders' (Kutchins & Kirk).

The great thing though is that almost all of these pesky brand new illnesses have produced brand new pills to alleviate them.

A happy and very profitable coincidence.

In 2001 in the USA 24.5 million patient visits were made to GPs for Depression and 69% of these visits resulted in the prescription of SSRI anti depressants.

In 2006 in the USA anti-depressant prescription was 227.3 million items with total revenue to the Pharmaceutical companies of $ 13.5 billion.

While the situation in the UK is more modest, and while NICE has guidelines that endorses the efficacy of talking therapies in respect of mild to moderate Depression, and all with no chemical side effects, there is still a tendency for a GP to reach for a prescription pad rather than to try to arrange Counselling, whether through the NHS or referral to private agencies and practitioners.

But that's no secret.

What does seem to be a secret though is that Doctor and patients alike have conspired to swallow a 'pill' that hypnotises them to the scientific facts.

Dr Peter Breggin uses the word "spellbinds" when he says that the primary effect of Psychotropic medication is simply to assault, confuse and even damage the human brain. Breggin even uses the word "myths" when he talks about conventional wisdom and talks about "brain-disabling" and toxic drug treatments, and going further talking about effective "chemical-lobotomy." Higher human function is actually impaired by Psychotropic drugs, and sometimes the effect of this, particularly if it is sedative, might give the subjective impression to the distressed client/patient of an improvement of the symptoms of sadness.

There is nothing more personal than choices we make about caring for our health. What we need is informed material upon which we can make informed choices, whether as client, patient or therapist.

At the moment what we have is pharmaceutical propaganda and mind-control of the most cynical sort.

As therapists, and even as clients and patients, it is our duty, to the best of our individual ability, to keep up to date with scientific information about health.

Reading even one of the books mentioned earlier would at least present a more balanced picture.

People can then judge for themselves, and clients and patients can make informed decisions about whether they wish to start/continue to take medication, which could be contributing to the very distress that they are hoping to alleviate.

Continues over...

MEDICATE?

When we are trained as therapists, it is made clear that it is not our role to question the decision of a GP or Doctor if he or she should choose to prescribe anti-depressants or atypical anti-psychotics.

In all of the time I have been working, I have applied this principle in my own consulting room. But as time goes by, and as evidence mounts contra-indicating the efficacy of Psychotropic medication, I seriously begin to question the ethical position in which I find myself.

While not suggesting that I should tell my clients NOT to take anti-depressants, I do think that ethically it is now my responsibility, as a therapist, to suggest to them that they consider both sides of the question, and seek out material that will help them do just that. Failure to offer such balanced advice seems to be unprofessional, and just buying into and timidly endorsing a status quo, which I no longer feel is clinically or scientifically valid.

Once upon a time people believed the Earth was flat. Once upon a time The Church believed that the Sun orbited the Earth. Once upon a time people believed that Depression was caused by 'a chemical imbalance in the brain'

I don't.

Neither does Dr Peter Breggin :

"Drug companies heavily promote the unproven speculation that the problems they treat are biological in origin and result from biochemical imbalances. The repetition of these unscientific biochemical speculations condition people to believe that psychiatric drugs are specific treatments for biochemical disorders… Psychiatric drugs achieve their primary effect by causing brain dysfunction and do more harm than good. Psychiatric drugs are not specific treatments for any particular so called mental disorder. Instead of correcting biochemical imbalances, psychiatric drugs cause them. Sometimes permanently."

As a therapist perhaps it's time to do a little more research and make up your own mind ■

Roger Stennett
www.rogerstennett.macmate.me

A SHEEP IN WOLF'S CLOTHING

Nicola Griffiths stays calm and carries on

This story is of an observation that should have been apparently obvious some years back, but really I've only got my brain round it in the last couple of years. There are some people who wander into my therapy room and as they start talking I find myself thinking, "I'm not sure I like you". Now this is very unprofessional but occasionally, though very rarely, this thought simply pops into my brain.

It only happens when I have someone who is consistently obtrusive, I mean really in my face. I have a strong character, built through many trials and tribulations in life, but I feel challenged when meeting someone like this and I have to dig deep, sit back and stay calm. I do this by considering my professional reputation and who this person might know in the outside world and what word would spread if I was as obtrusive back. This seems to do the trick as it allows me to remain calm; my reputation is more important to me than this one client.

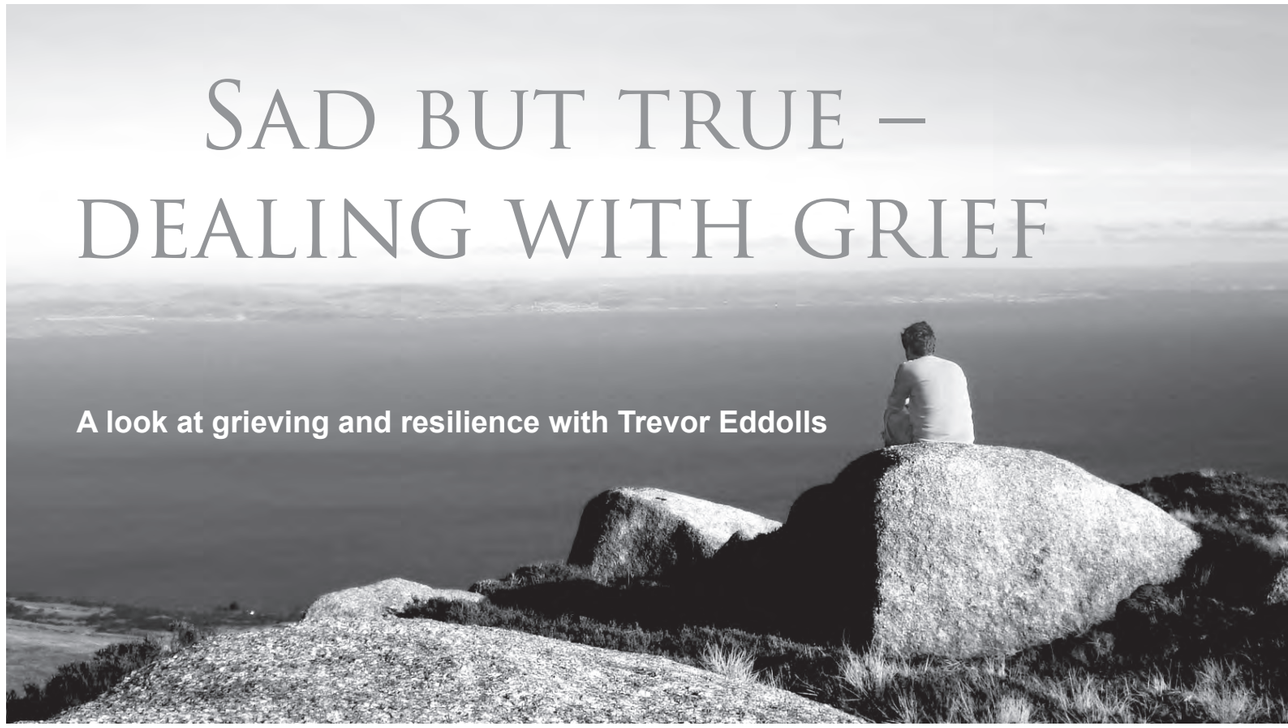
Now here's the thing, after some years something has dawned on me. As the hypnotherapy begins to weave its magic on these occasional individuals, their subconscious begins to relax and their true personality begins to emerge, sometimes that happens quickly and sometimes it takes a little longer. The sheep begins to take off the wolf's coat and a nicer person emerges.

So I now have a new tactic. I now consider the initial obtrusive person as someone who has hijacked the gentler individual; I take the view that it's just a waiting game for that positive person to emerge as the sessions progress.

I can recall a rather brash American lady who came to see me and was truly angry towards me. Given this was the Initial Consultation and I'd never met her before, I knew it wasn't a personal thing, so I reigned myself in and kept my cool. Interestingly, 8 sessions later I was in the same therapy room with the same client and the receptionist commented afterwards "I didn't think you were supposed to have fun in those sessions!" Yes, I was actually enjoying the session. Obviously I've subsequently given the receptionist a taster of how fun my sessions can be so that's altered her opinion to the positive of what solution focused work is all about.

So the moral of this short story is, don't be fooled by what you get when someone is in their negative mind. It's a very simple tale and one that should be apparently obvious to all of us that have completed the CPHT course. But when you are in situ - and that type of client sits in front of you, it can be a challenge to remember.

So who do you have that is a sheep in a wolf's clothing? ■



SAD BUT TRUE – DEALING WITH GRIEF

A look at grieving and resilience with Trevor Eddolls

The first time I had a client with grief issues, I wasn't quite sure what to do. I knew they needed to get into their control brain and out of their emotional brain, but I wasn't sure what stages of grief they had to go through or whether my experiences of loss were of any value in this situation.

Grief usually follows a loss. A person can grieve for a dead family member, and they can also grieve for lost friends, a lost home, a job, even a country. Whatever form the loss takes, a person can experience grief.

Watching TV programmes and films, you'd think everyone went through the five stages of grief that were first specified by Elisabeth Kübler-Ross in her book On Death and Dying. The stages are:

- Denial – "I feel fine"; "This can't be happening to me".
- Anger – "Why me? It's not fair!"; "How can this happen to me?"; "Who is to blame?". People can be angry with themselves, or with others.
- Bargaining – "I'll do anything for a few more years"; "I will give my life savings if..."
- Depression – "I'm so sad, why bother with anything?"; "I'm going to die soon so what's the point?"; "I miss my loved one, why go on?"
- Acceptance – "It'll be OK"; "I can't fight it, I may as well prepare for it".

But these stages were only what Kübler-Ross had observed and were not meant to be prescriptive, only descriptive. Other researchers have not observed people moving through these stages.

So, if people aren't working their way through the five stages of grief, what are they doing?

George Bonanno suggested that a natural resilience is the main component of grief and trauma reactions. He came up with, what he called, four trajectories of grief. He even showed that the absence of grief or trauma symptoms is a healthy outcome. He found that grief responses can include laughter, celebration, and bawdiness, as well as sadness (which is what you'd expect). He called these counter-intuitive strategies "coping ugly". He also found that resilience is normal for people.

His four trajectories are:

- Resilience – the ability to maintain relatively stable, healthy levels of psychological and physical functioning.
- Recovery – following Post-Traumatic Stress Disorder (PTSD) episodes.
- Chronic dysfunction – prolonged suffering and inability to function.
- Delayed grief or trauma – when adjustment seems normal but distress increases months later.

Continued over...

GRIEF

Charles A Corr suggested that individuals may try out different coping strategies only to reject them. He also thought that a person may pursue several strategies at the same time, even if they are not compatible.

According to the Changing Minds Web site, "we are not always able to cope with the difficulties that we face. As a result, we are subject to feelings of tension and stress, for example the cognitive dissonance and potential shame of doing something outside our values. To handle this discomfort we use various coping methods." They go on to suggest a number of types of coping mechanisms:

- Adaptive mechanisms – that offer positive help.
- Attack mechanisms – that push discomfort onto others.
- Avoidance mechanisms – that avoid the issue.
- Behavioural mechanisms – that change what we do.
- Cognitive mechanisms – that change what we think.
- Conversion mechanisms – that change one thing into another.
- Defence mechanisms – Freud's original set.
- Self-harm mechanisms – that hurt ourselves.

Hypnotherapy can help clients to manage their internal experiences, so that they can move from feelings of pain and sadness to those of acceptance and calm. Hypnotherapy can help make the process of bereavement and mourning less painful and more manageable by:

- Helping people come to terms with their loss
- Visualizing a positive future and setting goals
- Lowering emotional responses of fear and loneliness
- Increasing levels of self-esteem
- Overcoming temporary responses such as poor eating, lack of exercise, etc
- Dealing with unresolved issues with the deceased
- Celebrating the life of the deceased.

Clients may need help before the funeral. They may also need help to get through the funeral. And they will probably need help for a period of time after the funeral. The funeral doesn't mark the end of their feelings of grief.

People who come to see you about grief and bereavement issues may be experiencing shock and disbelief at their loss. They will probably be feeling very sad and may cry a lot. Some people may be feeling guilty about the things they said or didn't say. Or they may feel guilty at their feelings of relief (for example after a long illness). They may be feeling angry at the world for taking away their loved one, or they may feel angry with themselves. They may be feeling fear because they have been left alone to cope or because they realize their own mortality. And they may be experiencing physical symptoms such as fatigue, nausea, insomnia, aches and pains.

It's important to tell clients they have permission to express their feelings (not just during a session) and they can do this by talking to an empty chair (a Gestalt technique), or writing a letter to the deceased. They need to understand that they don't need to 'move on' or 'get over it' until they are ready. Grief is a natural process, it won't last forever, and the client will be able to move on when they're ready. You can plan ahead with the client for occasions that will trigger their sad feelings, for example anniversaries, or visiting places they associate with the deceased, etc. Let them know that they are allowed to cry when they're with you – and they're also allowed to laugh – whatever feels right for them. And be prepared to hear the same story over again. The client is processing and accepting the death, and repeating the story helps to lessen the pain of the loss for them. Of course, it's never good to start sentences with "you should", when suggesting things your client might do, and it's worth avoiding platitudes, such as saying "it's all part of God's plan".

Prolonged Grief Disorder (PGD), also called complicated grief, presents as long-term and severe grief symptoms. Most people are resilient and start to move on with their life. However the Helpguide.org site suggests that after two months there are warning signs to look out for indicating that people need help. These are:

- Difficulty functioning in daily life
- Extreme focus on the death
- Excessive bitterness, anger, or guilt
- Neglecting personal hygiene
- Alcohol or drug abuse
- Inability to enjoy life
- Hallucinations
- Withdrawing from others
- Constant feelings of hopelessness
- Talking about dying or suicide.

You may well see people experiencing some of these difficulties following bereavement.

Going back to resilience, which is sometimes called hardiness, mental toughness, or resourcefulness, but whatever term is used, it is refers to an individual's ability to cope with stress and adversity. For people who have suffered a loss, it's their ability to cope with their grief. Fredrickson in 2003 identified more-resilient people as those who noticed positive meanings in the problem they faced, experienced fewer depressive symptoms, and experienced more positive emotions than less resilient people. Ong found low-resilient people had difficulties regulating negative emotions and over-reacted to normal daily events. As hypnotherapists, we need to help clients to be more positive about aspects of their life and recognize good things in their lives (which, I guess, we're all doing with our clients anyway) ■

REFERENCES:

Kübler-Ross, E. (1969) On Death and Dying, Routledge, ISBN 0-415-04015-9

Death and Dying, Life and Living by Charles A Corr, Donna M Corr, Clyde M Nabe: Wadsworth; International Ed edition (8 May 2008). ISBN-10: 0495506486

The Other Side of Sadness by George Bonanno. Basic Books; Reprint edition (20 Jan 2011). ISBN-10: 0465021905

http://changingminds.org/explanations/behaviors/coping/coping.htm

http://www.helpguide.org/mental/grief_loss.htm

Fredrickson, B. L.; Tugade, M. M.; Waugh, C. E.; Larkin, GR (2003). "A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2002". Journal of Personality and Social Psychology 84 (2): 365–376. doi:10.1037/0022-3514.84.2.365. PMC 2755263. PMID 12585810.

Fredrickson, B. L.; Tugade, M. M.; Waugh, C. E.; Larkin, GR (2003). "A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2002". Journal of Personality and Social Psychology 84 (2): 365–376. doi:10.1037/0022-3514.84.2.365. PMC 2755263. PMID 12585810.

http://en.wikipedia.org/wiki/Psychological_resilience

The Stress Response

Jess Driscoll stops to smell the flowers

As humans we all come with a hardwired survival mechanism, it is preloaded information, our survival instincts. This information is stored in the part of our brain often referred to as the reptilian or primitive part of the brain. The amygdalae, hippocampus and hypothalamus, among others, drive our instinctive responses. They tell us when we are in crisis or emergency and then inform us how to behave. The problem comes, however, when instead of primitive dangers such as wild animals and other tribesmen, we perceive an event in our lives as a crisis for example, problems with our jobs, relationships and self- esteem. The primitive brain responds in exactly the same way to the crisis, tripping the switch of the stress response and encouraging us to fight, flight or freeze.

How does this manifest itself then? To fight or flight means we are flooded with chemicals and neurotransmitters to make us stronger and faster, such as adrenaline and cortisol. Once in our system these make us feel anxious and angry, our heart rate increases and we feel on the edge of panic or anger, or even both. Then there is the other end of the stress response, the freeze, we opt-out and put everything on hold including our chemicals in order to save valuable energies in case we need them later on. We are in a state of high alert, obsessive and vigilant in case we need to change quickly to fight or flight mode. Sometimes though, people can freeze and then spend so much time 'opting out' so as to avoid potentially harmful situations, this can lead to depression and sleep disorders.

If we think about our job, relationships and self- esteem in negative ways, as things to worry about, we will trigger our stress responses as our mind receives information that we are under threat, in crisis and all is not well. We, in effect, put ourselves on red alert. The only behavioural outcome then is routed in panic, anxiety, anger and depression. If we are lucky enough to sleep well and have good social support structures this doesn't evolve into a problem and is soon dealt with effectively by our brain and put into perspective, de-aroused and we are able to move forward. However, when this is not the case panic/anxiety/depressive disorders can develop and we may find that help is needed to get back on track.

In addition to anxiety and stress disorders there is also of course the modern day coping method which is reaching for our Drug of Choice (DOC). Our DOC could be caffeine, nicotine, salt, sugar, and of course alcohol. We are training our brains to accept this 'quick fix'. We take on the chemicals contained in our DOC and this becomes our 'pick-me-up' – it doesn't take long for the primitive brain to pattern match to the DOC and we become serotonin depleted preferring again and again to use our 'fake' comfort response instead of getting our neurotransmitters generating the crucial feel good chemicals we need. Humans are the only animals on the planet to have a neurological system hardwired with a need for rewards. We need to take positive action, have positive interactions and positive thoughts in order to feel motivated and achieve goals. It is only through the achievement of these goals that we can become fulfilled and motivated. It is little wonder then that addicts of various DOC's, through their depletion of feel good chemicals, lack the motivation to want to make changes.

> Our Drug of Choice could be caffeine, nicotine, salt, sugar, and of course alcohol. We are training our brains to accept this 'quick fix'.

The good news is that with understanding and insight getting back on track and back in control can be achieved. Once we understand that this mechanism is actually activating our stress responses we are immediately better equipped to return to intellectual control, turn off our fight, flight and freeze response, switching our focus from negative to positive. Sounds simple? It is simple but not necessarily easy. Changing thought and behaviour patterns does take effort, like learning and acquiring any new skill. So, how do we turn-off our stress response and get back a sense of control?

Well, we need to address our sleep. Sleep is absolutely pivotal to positive mental health -all the usual advice is an excellent place to start, good bedtime routines, exercise, getting time outdoors and anything that promotes relaxation such as meditation, acupuncture, massage, hypnotherapy, listening to music and much more besides. Taking control of the negative radio in our heads is also pivotal - all those negative thoughts accumulate. Positive thoughts, distraction and forming manageable achievable goals will help restore intellectual control and turn down the stress response.

Imagine this - if you were out for a stroll in the jungle and you thought you heard a lion approaching; you would begin to turn on your panic response. Gradually you would feel more and more panicked, more and more stress hormones would race through your body, losing more and more intellectual control until the fight, flight freeze switches on. But, what if you happen upon a stunning orchid grove. You stop to smell the flowers and begin to drink in your environment. What then? Well, your brain would stop panicking for a start! It would know that if you had time to stop and wonder at the vibrancy of the flowers and the beautiful sights and smells that surrounded you then the panic must be over and the threat must be gone.

Apply this to modern day stresses and the effect is the same. Stop to notice the moment, be mindful and be in the present noticing little wonders all around you, smells, sights, colours, trees, birds, smiles, songs – basically anything at all that focuses you on the here and now; stops your mind and your negative radio racing away with you. Being mindful is a way of paying attention to the present moment, using techniques like meditation, breathing and yoga. It helps us become more aware of our thoughts and feelings so that instead of being overwhelmed by them, we're better able to manage them.

> When a patient is in a hypnotic trance the amygdala automatically shuts down the rapid alert system and turns off the stress hormones.

Practising mindfulness can give people more insight into their emotions, boost their attention and concentration and improve relationships. It's proven to help with stress, anxiety, depression and addictive behaviours, and can even have a positive effect on physical problems like hypertension, heart disease and chronic pain.

Turning off our flight, fight, freeze response is also crucial, and of course, being relaxed is the opposite of being stressed. In her paper 'Talking to the Amygdala: Expanding the Science of Hypnosis' Muriel Prince Warren, explains that by talking to the amygdala, an experienced hypnotherapist can relax the autonomic nervous system, shutting down, or curtailing, the trigger that sets off secretion of the adrenal and pituitary glands. When a patient is in a hypnotic trance the amygdala automatically shuts down the rapid alert system and turns off the stress hormones epinephrine (adrenaline), cortocotropin, and glucocorticoids and we can then inhibit the flight, fight or freeze mechanism. In the cases she mentions in her research the technique of relaxation through hypnosis has proven to be a highly effective tool in giving the body a chance to heal itself through its own inherent wisdom system.

When we focus on what we want then the Reticular Activating System (RAS) will notice anything through our senses. Primarily what we see or focus on increases and the RAS can find those previously elusive solutions because we have changed from a problem focus to a solutions focus; when we change our filters our viewfinder has been modified so we can see things differently. Also when we are positive we become more attuned to noticing opportunities and we cope better with setbacks and remove obstacles (Warren cited by M. Hughes in 'Hypnotherapy Today' Association for Solution Focused Hypnotherapy Journal Volume 2)

Continued over...

With improved sleep, more positive thinking and the formation of achievable goals we can go a long way to combat the effects of stress and living in today's hectic and demanding world. Couple these with some enjoyable regular exercise and we really can tip the balance in our brains, being much more relaxed and calm, and when we are relaxed and calm we remain in control and able to make a proper assessment of the situation. Taking frequent effective exercise is one of the best physical stress-reduction techniques available. Exercise not only improves your health and reduces stress; it also relaxes tense muscles and helps you to sleep. Once free from the negative and primitive brain responses that are instinctively tied to feelings of anger, anxiety and depression; all of which fuel addiction and of course the NEED for that DOC we are once again able to see the wood for the trees and that feels good.

Once we have something to feel good about we are winning - instead of stress chemicals coursing through our veins we can instead generate serotonin, dopamine, noradrenalin's etc., chemicals that make us feel happy, motivated and successful. We can't argue with our chemistry! How we think really does affect how we feel, our brain releases the chemicals we tell it we need, based on our assessment of the reality we inhabit. So, stop to smell the roses, get your heart pumping, attend to your sleep routines and use all the tools you have to get your intellectual thinking self back on board, taking your foot off the flight, fight and freeze response, and therefore feeling much calmer. And if you only do one thing differently, do something for yourself, only for yourself that you enjoy ... when we do this we feel good and ultimately have more resources available for others. Relaxing and focusing on the positives really does help restore intellectual control, putting you back on a 'full set of cylinders' and able to make proper assessments of life's situations ■

References:

http://www.hypnosisnetwork.com/articles/talking-to-the-amygdala-expanding-the-science-of-hypnosis
http://www.afsfh.com/afsfh/member_journal_afsfh.pdf
http://helpguide.org/mental/stress_signs.htm
http://www.isma.org.uk/national-stress-awareness-day/
http://www.bemindful.co.uk/about_mindfulness
http://www.mindtools.com/stress/Defenses/Exercise.htm

Jessica Driscoll
Psychotherapist, Clinical Hypnotherapist and
Solution Focused Brief Therapy Practitioner
029 2021 1301
jess.hypnotherapy@gmail.com

Book Review - The Big Book of Metaphors

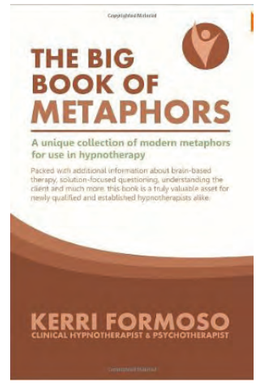
What I enjoyed about reading this book in particular is the skill in its explanation. They say that the devil is in the detail and yet, the author has managed to eruditely explain the workings of the brain and brain-based therapy with relative ease in the opening chapter and indeed throughout the rest of the book with simplicity and candor, of which people reading it will more than appreciate.

Now what I do know is that some therapists don't always find metaphor easy and there's no harm in that, that's just the way they feel about it, it's like a punctum caecum, or the more well known blind spot, that they have to keep checking, while others seem to find that metaphor comes easily to them, it's simple, pertinent, understood and just slips off the tongue. I think that learning to successfully incorporate the simplicity of metaphor, like with anything perfects itself over time with rehearsal and practice, practice, practice. One of the best ways to hone this skill is when we start investigate and to become familiar with metaphors that are already out there. This is where the beauty of this book comes into its own. The metaphors have a very modern slant which is as refreshing as they are malleable. You can adapt and play around with them, which is one of the best ways to learn.

Now, from a different vantage point, casting the net a little wider, in the past, where many incorporated under the umbrella of metaphor books fell at the first hurdle, is lack of straightforward explanations, as not all are clearly understood and the short precis at the beginning of each metaphor that highlights each metaphor, the intended delivery and purpose, The way these are explained in this book are like gold-dust.

I think that the overall appeal of this book of metaphors can be widespread and I am sure it will become a well-thumbed resource, not just for newly qualified practitioners but also useful for a fresh perspective for the more established practitioners within the profession. The words can invoke and inspire and cultivate learning, can provide stand alone usage or a reference template to modify and in doing so, that can show you how you can become more accustomed and confidant with using metaphor.

As an addition to your existing library and as a compliment to the therapist toolkit, the big book of metaphors can only enhance what you already do as a hypnotherapist. So if you are the type of therapist who invests in your practice, then you would do well by investing in this big book of modern metaphors ■



The Big book of metaphors by Kerri Formoso
Publisher: CreateSpace Independent Publishing Platform
ISBN-10: 1480295310
Reviewed by Michael Hughes
★★★★★

Research news

According to the results published in the December 2012 issue of the Scandinavian Journal of Medicine and Science in Sports, a study where people who had undergone surgery to repair the anterior cruciate ligament of the knee (ACL) were randomly assigned to one of two groups to see if intervention after surgery would influence the outcomes.

All participants received standard rehabilitation during the six months after surgery, but one group also practised guided imagery while recovering. The imagery, which was conducted in sessions with a therapist and recorded for later listening, included mentally rehearsing physical therapy exercises and visualizing the physiological healing process specific to ACL surgery, such as scar tissue becoming flexible with gentle stretching. The group that practised imagery showed greater improvements in knee stability and reduced levels of stress hormones. The study authors speculate that imagery may speed recovery by reducing stress, which has been shown to interfere with healing.

http://onlinelibrary.wiley.com/doi/10.1111/sms.2012.22.issue-6/issuetoc

How the Police deal with stress

It's not an occupation for everyone, but Andy Workman shows us how it can be done

In approaching the end of my police career, I can reflect on the changes that have happened over the past 28 years. When I think of the equipment and technology involved in my everyday working life now, it seems difficult to imagine that my first eight years were spent on the beat in Bristol, looking like Dixon of Dock Green (showing my age) with nothing more than a wooden stick in my pocket for protection. Never did I expect to be wearing body armour, carrying CS Gas and utilising computers in every aspect of my work.

As with any walk in life, throughout all of this change some things remained constant, including the type of challenges that face a police officer during every tour of duty. Other things that remain constant include the things that people say to you when on duty. It is for example an unwritten law that when a police officer enters any place of work at least one person there has to shout at a fellow worker "Here they come, I told you they'd catch up with you". This goes alongside the next law that states a police officer must laugh loudly in a manner which convinces everyone that this is the first time they have ever heard that line!

Of course one of the most used phrases heard by a police officer is "I couldn't do your job for all the tea in China". This is understood - every officer realises that the job wouldn't suit everyone. That doesn't make those who do perform the duty of a Constable "special" in any way, it's just the way it is. It not everyone's idea of fun to work in a job where you never know what is around the next corner, what you'll be faced with next or what ridiculous or dangerous task you'll be ask to perform. It can be the most rewarding, exciting and challenging job ever, but it very often comes at a price. Divorce, injury, illness and stress related conditions are unfortunately not unusual, but contrary to popular belief, they are not as common place as you might imagine. So how do the vast majority of men and women serving at "the sharp end" manage not only to cope, but to deal with life when chaos reigns?

The answer to that question is not a simple one, but we can at least try to look at a number of factors – aggravating and otherwise – that might help us understand some possible answers.

Encounters. When I joined the service in 1986, I executed foot-patrol, on my own, every day for the whole shift. It was expected of me to walk "the Beat" and to engage with everyone I met (good, bad, old, young, male, female – we could go on) and to spend my down time building bridges with the community and collating intelligence about criminals and their activities in order to keep my community safe. With cut backs, public demands for ever quicker response times and a massive increase in community size (disproportionate with limited recruitment of additional officers), things have changed dramatically for officers starting out today. In 2013, officers can expect to be solo-crewed, on mobile patrol and having incidents stacked up awaiting their response. They don't get any chance to engage with passers-by or any "foot time" in which to do so.

Police Officers meet their public in one of four situations;

1. They have been a victim of crime
2. They are the perpetrator of crime or have committed an offence
3. Someone has died unexpectedly or if it happened away from the immediate vicinity, the officer has some very bad news for them.
4. They are making a complaint against another officer.

I am generalising a little, but this is not far from the truth. To us as Solution Focused Hypnotherapists, the problem is abundantly clear. All of these encounters are negative interaction.

The coping strategy is simple. For every action there is a reaction. When asked, most officers will say that their "buzz" comes from helping people. It's not as corny as you might first think. Most calls for service stem from some form of localised and temporary break down in order, whether it is in the street, a shop, a pub or someone's home. The incident they walk into is far from positive, but their impact on those involved and the situation as a whole can be. Trust me there is nothing more satisfying than those two small words – "Thank you" - as you clear up the debris of another one of life's wobbles. That confirmation that you have helped, even in the smallest way, is enough to get the serotonin flowing for hours.

Keeping it in Perspective – Bringing peace and order where there is harm and hurt is every day work but in a strange way, it helps to be surrounded with disorder. You see, as with everything repetition makes things easier. It would be unfair to suggest that police officers become numb to emotion and feelings but with constant exposure, things that would upset other people become everyday events to those who experience them every day.

Uniform – for those who perform emergency duties, the clothes we wear serve many unseen purposes, above and beyond those immediately apparent. Yes, they make us instantly recognisable, they are designed and constructed from materials to offer some a level of protection and they display the wearer's rank to assist colleagues and customers in deciding where the buck stops. Uniform also engenders teamwork within those who wear it, exercising our primitive tribal responses in recognising who is one of our Clan. More than this though, I can tell you from personal experience that uniform is much more powerful than that. I never wear my uniform when travelling to and from work. I put it on when I report for duty and I change out of it at the end of my shift before travelling home.

Many would suggest that this is to avoid any problems that might be caused by any less than desirable "customers" recognising me off duty – well my face will help them with that. Some would suggest that it is to avoid having to do anything at any incident I might come across on my way to work or journeying home, but my human spirit wouldn't let me drive by and do nothing, no matter what I might be wearing. No – the simple reason is that my uniform acts like that of a Super Hero (not that I am suggesting for one moment that I am one), in that it separates my working life from my personal one.

When I put on my uniform I think, feel, behave, speak and respond like a Police Officer. When I take it off I am "Joe Public" and it would take something pretty extreme for me to act as a Police Officer when off duty. The old adage that "A Police Officer is never off duty" has absolutely nothing to do with us never switching off, it's far more to do with friends, family and acquaintances not allowing us to do so. I have lost track of how many times I have been asked for advice, stories or world-crisis solving answers when off duty and trying to relax. Uniform helps us to cope.

When we put it on insults and physical assaults against us are not personal, they are against the organisation, the establishment or the situation and so we can lessen the effect on us as individuals. When we wear it, people listen and respond to our request and directions and so horrific situations can become more manageable, not only because of the assistance we gain from those around us but because our focus is on what we are doing rather than what we are looking at. When I go home, I am "Andy" or "Dad" walking through the door, rather than Inspector Workman and so the reaction I get from my fabulously supportive Wife and Sons allows my subconscious to receive messages confirming the security and relative normality of home, where I can switch off my "respond" response.

It never surprises me when I look back at the drinking culture that used to exist (and still does in some parts) within the "plain clothes" departments of the Police Service. Gone are the "Life on Mars" days of Detective Chief Inspector Gene Hunt and his CID Squad going to the bar every night and not leaving until the optics are dry, but that was not uncommon when I first joined

Continued over...

"The Job". Is it any wonder? Detectives wore (and still do wear) their civilian clothes to work. They may never realise it but how often is that particular shirt or that one tie, triggering their pattern match for the murder or rape scene where they last wore it. How often does that particular suit trigger a deep seated response when the hippocampus pattern matches to the awful child abuse investigation they conducted whilst wearing it. "What's the difference?" I hear you ask, "You wear your uniform to the same scenes!" Yes, I do – but the same colours and patterns match to every incident I attend and so the impact of the pattern matches to extreme incidents is lessened. Even more impactive is the fact that I don't wear it home. I hang up all my problems and leave them at work. The Detective literally wears their work home, and to the social events and to that wedding – the list is endless. No wonder there was a drinking culture – it was an escape.

Sense of Duty - helps immeasurably and can override the worst of scenarios. In my case I am squeamish. Many of us are. I cannot watch Holby City, Casualty, or any of the "Having Your Bits Cut Off Live" television shows (all of wife's favourites), but when I am on duty I can deal with anything. Ridiculous isn't it? I have in my service seen, heard, smelt, touched and yes even heard things that I will spare you here (suffice to say that they have been unpleasant in the extreme) but I have dealt with them all. At the time in question I have HAD to do so. One of the first things you get used to is that no matter how many people are at the scene of an incident, they all take a huge step back when the Police arrive. The huge sigh of relief is audible and then the burn of everyone's focused attention on YOUR actions is tangible. "What is he going to do now?" Of course as a reasonable intelligent man, I am acutely aware that the magical powers that everyone at the scene believes I possess are about to fail me again, for the umpteenth time that shift, and I am going to prove myself both fallible and human, but I also have to ignore the overwhelming temptation to either turn tail and run or utter the immortal words "euurghhh, that's 'orrible". I just have to get on with it. It is often not until very much later that you stop and think about what you have dealt with, but of course that is AFTER the event and your subconscious already knows you can cope with it because you just did – just like the last time you did something similar. My pattern-matches to blood are completely different dependant on whether it is on a TV screen or on the pavement or cadaver immediately in front of me.

Camaraderie - The beauty of the Police Service is that you never feel alone. Well, those nights walking around dark unlit alleyways on my little vulnerable own-some were a bit hairy at times but I was never truly alone. There is an unspoken support between the men and women who serve together, very much as described by service personnel on a ship, in a regiment or squadron. At times, such as the tragic murder of a colleague (anywhere in the world – whether we have met or not) the bond is voiced, but at other times, it's just there. I still get goose-bumps when I remember dealing with an incident in which a two-year-old girl had been knocked down and killed by a motor car. It is true that dealing with anything involving children is particularly difficult, but I was closest to the scene when the call came in and heaven had decided it was my turn to make sure the next angel arrived safely. The next afternoon I arrived at work earlier than everyone else and I sat in the briefing room waiting for the rest of my team to arrive (having made them mugs of tea – I was the junior boy after all). An experienced colleague, Paul, came into the room, said nothing, walked behind me and as he did so put his hand on my shoulder and squeezed. The electric went through me like lightning. He just sat down and reached for a mug of my delicious, well-practiced and award winning brew, but in that instant, without uttering a word he had said "Been there mate, done that and know exactly what you're going through. If you need me you know where I am". That was all I needed. That's all that any of us need and luckily that's what we give and receive from each other every day in bucket loads – none of it ever said.

> AFTER THE EVENT YOUR SUBCONSCIOUS ALREADY KNOWS YOU CAN COPE WITH IT BECAUSE YOU JUST DID

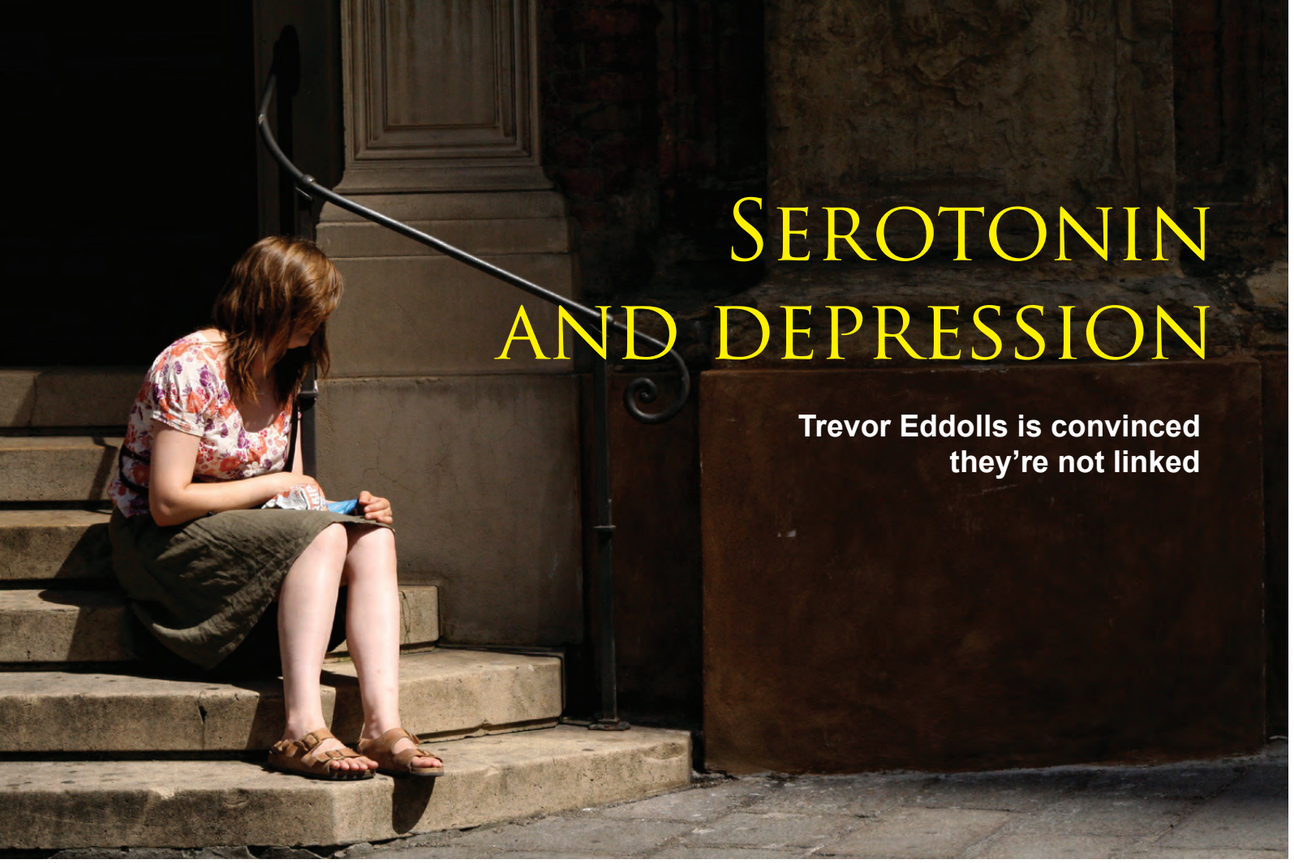
Humour – is the Police Officers defence to EVERYTHING. I have often heard colleagues talk humorously about things in a way that might shock others. I recognise that we find the oddest things funny and would have to admit to a fairly "warped" sense of humour myself at times, but it is largely due to it being used as a coping strategy. No one ever told me I should learn to laugh at strange things, I just learnt to do so and looking at it now with my SF training and knowledge, I realise that I have developed a pattern match that provides the serotonin and dopamine I need to raise my spirits after less than pleasant experiences. Officers do "take the Mickey" out of each other, but the nicknames, pranks and jibes just thicken the skin in preparation for the real attacks from those who truly mean to hurt us.

Family Support – is essential. Spouse, partner, children, parents are just some of the family and friends that we rely upon to keep us going. At my "Passing Out" parade in 1986, the reviewing officer welcomed all of the family members present into the police. In his words "when your loved one here joined the Police Service, so did you". He was right. This year, my lovely wife Karen and I celebrate our 25th Wedding Anniversary and I am so proud of that. As a Police Officer, that is a genuine achievement as the relationships of so many of my friends and colleagues have unfortunately not managed to survive under the strain of shift work, stress and worry etc. Karen is my rock and I know I would not have made it to my rank or even remained as an officer without her unwavering support. Just being there and offering a modicum of normality when I get home, being able to listen as I "unload" about an incident and at times being a shoulder to literally cry on, she has no idea of how much I owe my sanity to her. I am blessed and recognise it every day. I believe I have probably driven her insane as a result!

Sport – It is remarkable how todays constraints have changed our service and not for the better. In times gone by, Police Officers were encouraged to participate in sport, sometimes during duty time. I can hear so many of you screaming "What? I pay for that time! I'm glad they don't do it anymore!" As a tax payer myself I agree, but as an experienced Police Officer I have to observe that the amount of money we spend on Occupational Health referrals for mental health related issues easily outweighs the cost of a few officers playing football for a couple of hours a month. It is also no surprise that the number of such referrals rose considerably when the opportunity to exercise and compete was removed. "Well my company won't pay for me to play sport!" I hear you say, and in some cases your right, though I suspect some of you may be fortunate enough to enjoy some corporate subsidised gym membership or the like. The difference is that the Police – like the Armed Forces, Fire and Rescue Service and in some cases Ambulance Service – require their staff to maintain a minimum level of fitness in order to perform their duties. We know that we have all seen that HUGE copper at some time and no doubt commented on his or her ability to run after a burglar, but in the main our officers maintain a reasonable level of "fighting fitness". Many of us use sport or exercise as a stress release or "down time" and even more than ever are eating sensible nutritionally balanced meals, recognising the benefits of doing so. The infamous fast food culture of the police was born of the fact that you never know where or when you might eat during a shift and so burgers, kebabs or pasties were easy to grab on the move. These days the importance of sensible eating is strongly felt within the ranks and as we SF practitioners recognise, nutrition can play a huge part in maintaining a healthy mind as well as body.

> NO ONE EVER TOLD ME I SHOULD LEARN TO LAUGH AT STRANGE THINGS, I JUST LEARNT TO DO SO

As an SF therapist I fully appreciate that all of us, regardless of professional or lifestyle will have our own ways of coping and that this list only scrapes the surface of my own strategies but what in writing this I recognise so many of the principle things I use with my clients and that you undoubtedly utilise too. We encourage them to separate their work and leisure time as much as possible, we use humour and strive to find the positives and strengths in the most tragic of circumstances. We endorse the healthy introduction of exercise and recognise the role played by sensible nutrition. We bring things into perspective and share experiences to build collegiate relationships with clients (camaraderie) and offer support whilst encouraging them to identify other sources of support within the family and friends. When people find out I am a hypnotherapist, they often say "Police Officer? Hypnotherapist? That's a bit of a contrast!" I have to say, I don't see it that way. ■



Serotonin and depression

Trevor Eddolls is convinced they're not linked

Research shows that serotonin and depression are not directly linked.

Everyone knows that low serotonin levels cause depression – in much the same way that everyone used to know that the Earth was flat! Everyone knows depression is caused by low serotonin levels – in the same way that everyone knows that headaches are caused by a lack of paracetamol or aspirin.

The blood-brain barrier separates Brain ExtraCellular Fluid (BECF) from circulating blood. It consists of endothelial cells that restrict the diffusion of microscopic objects and large or hydrophilic molecules, but allow the diffusion of small hydrophobic molecules (O2, CO2, hormones). Glucose and specific proteins are actively transported across the barrier.

The trouble is that many people believe there is a direct link between neurotransmitter serotonin levels and depression, and many hypnotherapists are saying this to their clients. According to Ben Goldacre in Bad Pharma: "The 'serotonin hypothesis' for depression, as it is known, was always shaky, and the evidence now is hugely contradictory".

Most drugs used for depression are SSRIs – selective serotonin reuptake inhibitors – yet Goldacre informs us that tianeptin is equally effective, and it is a selective serotonin reuptake ENHANCER. It should have quite the reverse effect, if the theory held water.

Why is it so hard to prove this one way or another – either serotonin levels effect depression or they don't. It's hard because scientists would have to work on living brains, and not many people would agree to have part of their brain mashed up for science (and those darn ethics committees wouldn't be very happy either!). The only way the science can be done is by measuring serotonin levels in blood. You can see the problem. Serotonin is a neurotransmitter, it exists in the synapses between neurons. There's a blood-brain barrier that stops large molecules diffusing in or out. And serotonin is made in other parts of the body too. It seems that about 90% of the serotonin in our bodies is in what are called enterochromaffin cells. These can be found in the gut and are used to regulate intestinal movements.

Even allowing for these difficulties, scientists made an estimate of the serotonin levels in the brains of depressed people - and they found that they were pretty much the same as the rest of us.

So, scientists tried another experiment. They took normal healthy people and reduced their serotonin levels. (It's done by messing about with tryptophan, a serotonin precursor.) And guess what? The subjects didn't become depressed.

Other scientists even came to the conclusion that too much serotonin causes depression – and suggested this as a reason for the side-effects of SSRIs.

But there's another issue here. Does a low (or high) serotonin level cause depression, or does depression cause a change in serotonin level?

Let's take a more detailed look at the arguments against serotonin causing depression. Firstly, how come it takes a month of taking SSRIs before there are any noticeable effects? Wouldn't raising the serotonin level kick in pretty quickly if the theory was correct? Isn't that what people argue as they tuck into a bar of chocolate. The evidence from medication would suggest that you should eat chocolate for a month before you felt happier!! Secondly, SSRIs would work on everyone in the same way. Yet the evidence suggests SSRIs work on only 60% of people.

SSRIs obviously work – albeit slowly and on just over half the population – so how are they working? It looks like they also increase neurogenesis – the birth of new brain cells in the hippocampus. Experiments on animals (those ethics committees again) show the animals eat more tasty food and move around more when treated with antidepressants. And if you depress them, they do less of it – and neurogenesis is reduced as well.

So, it looks like (it could well be that) increasing serotonin levels in the brain increases neurogenesis, which reduces depression. That would explain the three to four week delay before the effects of the SSRI medication can be felt.

Or, of course, it could be something else entirely! ■

It's like that part in the television programme QI: the screen has gone black and is flashing because Alan Davies has just said something that most people believe, and Stephen Fry is gloating over the error and showing his superior knowledge. We've all been Alan Davies, shortly (and without the gloating) we'll become Stephen Fry!

ANTI-DEPRESSANT MEDICATIONS

Selective Serotonin Reuptake Inhibitors (SSRIs):
- Fluoxetine (Prozac).
- Citalopram (Cipramil)
- Paroxetine (Seroxat)
- Sertraline (Lustral)

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
- Duloxetine (Cymbalta and Yentreve)
- Venlafaxine (Efexor)

TriCyclic Antidepressants (TCAs):
- Amitriptyline (Tryptizol)
- Clomipramine (Anafranil)
- Imipramine (Tofranil)
- Lofepramine (Gamanil)
- Nortriptyline (Allegron)

MonoAmine Oxidase Inhibitors (MAOIs):
- Moclobemide (Manerix)
- Phenelzine (Nardil)

References:

Bad Pharma: How drug companies mislead doctors and harm patients by Ben Goldacre; Publisher: Fourth Estate; ISBN-10: 0007350740
Hypnofacts by Trevor Eddolls; Publisher: iTech-Ed Hypnotherapy (30 September 2012); ISBN 9781291100822
http://www.newscientist.com/article/mg20727703.300-serotonin-cell-discoveries-mean-rethink-of-depression.html
http://www.webmd.com/depression/features/serotonin
http://www.guardian.co.uk/science/blog/2010/sep/28/depression-serotonin-neurogenesis
http://www.psychologytoday.com/blog/charting-the-depths/201007/the-serotonin-theory-depression-is-collapsing
http://en.wikipedia.org/wiki/Serotonin

Jealousy

Penny Ling shares a study which shows how complex some cases can be

There is often confusion between the definitions of jealousy and envy – they are both negative emotions and they often cross over in situations. Wiki separates the two as follows

The common experience of jealousy for many people may involve:

- Fear of loss
- Suspicion of or anger about a perceived betrayal
- Low self-esteem and sadness over perceived loss
- Uncertainty and loneliness
- Fear of losing an important person to another
- Distrust

The experience of envy involves:

- Feelings of inferiority
- Longing
- Resentment of circumstances
- Ill will towards envied person often accompanied by guilt about these feelings
- Motivation to improve
- Desire to possess the attractive rival's qualities
- Disapproval of feelings

From a therapist's point of view, client's are often puzzled as to why they have these feelings and realise they are childish and stupid, but feel totally compelled to keep up their unhelpful behaviours.

You often find unhealthy jealousy when a threat is posed by a third person in a relationship with someone important to you. It's a very primal instinct and when you consider it in terms of our survival, it often highlights what we perceive as threats. The threat of a rival in love can highlight that your love object is either not trustworthy or you have low levels of self confidence. The threat of a new step mother or father can mean a reduction in contact with your blood relative. A new sibling means that mother or father are spending time with the new born and the first born is suddenly thrown into a situation it would rather do without – think of the song "Oh what a lonely boy".

You can be envious of someone else without a third party being involved, a promotion at work, earning more money when doing the same job or getting a new car for example.

At the heart of jealousy is a mix of self-esteem, lack of trust, anxiety, anger, self doubt and fixed ideas which can lead to setting traps, placing restrictions on your partner, constantly checking where they are, snooping, spying and mental bullying. At its extreme it can lead to not only domestic violence but also murder. I have known 2 women who were victims of extreme jealousy, one would be locked in a cupboard for hours and the other was murdered after she had split with her partner because of his jealousy and he asked her to meet up to talk. They met in a barn close to where she lived, and he took out a gun, shot her and then himself. At no point was anyone aware that his controlling behaviour would lead to such tragic circumstances. Luckily for my friend who had been locked in the cupboard, she managed to placate her partner, and then when he was out packed a bag, escaped through a window and hitchhiked all the way from Cornwall up to Bristol. She then had a court order placed on him.

Sometimes though, as in my case study, the real reason for jealous behaviour may not become apparent until a few sessions in.

Case study

Kimberely is in her late 20's, married to Matt, who is in the armed forces, and she came for therapy because she felt jealous about her husbands activities. She recognised it was a problem for her, and didn't want it to ruin an otherwise good marriage. Her goal for therapy was to feel OK about Matt socialising with his friends and colleagues. On hearing about how the brain works and the role of negative emotions, and jealousy being a threat she's still puzzled as to why it's happening.

I then give her some examples of other cases I'd seen to get her thinking about possible causes, but nothing came forward. The sessions followed session 1 in their questioning but I have shortened some of the Q&A's for space.

Session 1

What's been good? *Just come back from a trip to Denmark which was a business trip. It was enjoyable.*
What else? *Erm – that's it!*
(waiting) *Nope that's it.*
Asks Miracle Question *I'd wake up, go about my usual business, not notice anything in particular unless Matt came back at lunchtime and said he'd be going out later.*

So he does this and what would be different?
I'd say "Great, have a good time", I'd feel happy that he's happy and confident he can do that.
What else? *I'd feel more relaxed.*
What else? *I'd feel less selfish.*
What else? *Erm…I'll say "Ah! Brilliant that he feels so good.*
What else? *Nothing really.*
Pause *no nothing else.*

So scoring out of 10 – 0 being the problem and 10 the miracle happening where would you say you were right now?
5

What tells you you're a 5? *I can rationalise, but Matt still notices when I look stressed.*
So at 6, what would be different?
He'll have more opportunities to go out and I'll let him.
So have you ever been a 10?
Yes, last year, it wasn't a problem.
What do you think has changed in that time?
Don't know, I just feel different now?
What events have happened which have changed circumstances, maybe unrelated in the past year.
Sits and thinks and shakes her head!
If you could choose a certain quality to have more of at the moment what would it be?
Self confidence
Self confidence. Ok Imagine you wake up tomorrow morning and you feel totally confident, what would it be like?
I'd wake up feeling more secure, more relaxed.
If you were more secure and relaxed what would be different?
I'd be able to enjoy more, knowing everything was OK. I'd be able to not feel the pressure of doing the right thing.
Scripts: included confidence building and carrot egg coffee.

So session 1 gave us an insight into her levels of confidence but not what it was driving the jealousy.

Session 2

What's been good this week?
Felt really positive, Matt went to a hockey match and we went out in the evening. We're getting on really well with no arguments.
Scaling? 8

Wow! What makes you an 8?
Just felt on top of everything. Matt's not stressed at the moment, he's even noticed how more relaxed I am.

Missing quality?
Confidence
Imagine waking up feeling totally confident?
Matt and I wouldn't argue, I'd be able to go out and he'd be able to go out. No jealousy there.

Now there are 2 things about this session I was aware of 1) the client suddenly being an 8, and 2) confidence could be the real issue here. I felt we needed another week to see how things would change. She considered herself cured, and I had to insist that we needed this to be consistent, so I wanted to see her next week too.

Session 3

What's been good?
I feel I've really picked myself up this week, Matt is uplifting and I haven't felt jealous once.
Scaling? 7

What's telling you you're a 7?
It's been a really bad week. I'm not pregnant AGAIN, (real emphasis on again), *my sister in law came round with their baby and I went to bed and cried. Matt and I argued a lot because I was so hormonal.*

All these things happening and you tell me you're a 7! Wow! What are you doing right?
Guess I'm holding it together better.

Kimberley had not mentioned getting pregnant before.

So Kimberley, the fertility appears to be an issue with you, and let us just remind ourselves of the brain and negative emotions. Jealousy can come about by some form of anxiety, so your puzzlement about the jealousy, do you feel it may be connected to this?
She shrugs.

OK, I'll ask you that miracle happening, and this problem went away, what would the first thing you'd notice?
I'd google things less

I looked puzzled.

When I'm fretting about not getting pregnant I fret. I'm always googling how to get pregnant all the time. I'm permanently focused on it. So I guess I'd be doing it less.

If you're doing it less, what would you be doing more of?
Work, exercise, seeing friends, those sort of things.

I then went on to talk a little bit about the links between fertility and stress. I wondered if her jealousy was how the anxiety was manifesting because without Matt there would be no baby. She hadn't thought about it like that before.

Scripts included confidence key to success.

Session 4

What's been good?
Had dinner with friends,
Feeling positive
Had a confidence blip on Wednesday but Matt and I talked about my insecurities

This isn't good, but I want to be more selfless. I'm far too selfish.
In what way?
Well I'm too concerned about myself instead of thinking about others.

I explained a bit about the brain and the low confidence and high stress tends to make us focus on ourselves because that part of the brain is trying to keep us out of trouble.

If you woke up tomorrow morning and you were selfless, then what would be the first thing you'd notice?
I'd be helping others who feel awkward in social situations.
Such as?
I'd go up to people in groups and get them to talk about themselves.

If you did this what would be different?
I'd like myself.
What else?
I'd be a better person.
What else?
I*'d be helping other people*
As a job or volunteering?
In social situations.

So we have gone from jealousy to fertility to feelings of low worth and lack of confidence, none of which were evident at the beginning and pretty much a surprise to Kimberley.

Scale: 5
I'm beginning to realise I'm not free of this jealousy, that in fact there are quite a few things I need to deal with.

If you were a 6 what would be happening?
I'd be making an effort to do more for others.
Such as?
Talk to more people in social situations.

Session 5

What's been good?
Matt & I are getting along fine
So why are you here?
Laughs – This is helping me get my head around things.

I smile and nod. Is that all? Anything else?
I let her think for a few minutes.

To be honest it hasn't been the best week. It's all to do with my hormones and getting pregnant. I started a period this week, so I had all the usual dreadful feelings that go with it.

So where would you scale yourself? 4

What's telling you, you're a 4 and not a 0?
I'm still alive and kicking. I just know I'm not at my lowest.
So tomorrow, you're a 5 – what's different about tomorrow?
I'd stop feeling sorry for myself.
I'd stop trying to be Mother Theresa.

So if the miracle happened this week?
I'd be more relaxed about things, I'd be thinking about others instead of myself constantly.

I briefly went over some of the brain functioning that makes us focus more on ourselves in negative rumination and how changing our perspective to what we desire would help focus on that.

What activity in the next week could you do to see yourself thinking of others?
I'm going to see a friend who's husband is abroad, and I will get to look after her daughter while she gets some time to do the things she needs to do.

Session 6

What's been good?
I feel positive,
What else?
Feeling less stressed.
What else?
I helped a friend and she really appreciated it. I also wasn't so stressed at not conceiving this month.
What else?
Been doing lots of socialising and getting on great with Matt.

That's great, so where would you scale yourself?
Definitely a 9 – I've felt so different.
Wow What's helped you get to 9 so quickly?
It's Christmas, I so love Christmas.
What the miracle be this week then?
Oh I'd be going down the gym, I'd be exercising more, be more positive when in social situations, feel the improvements lasting.
Anything else?
I've noticed I'm becoming tidier!

What do you think will help you maintain this 9 now?
Thinks – exercising and socialising more

Session 7

What's been good?
Really enjoyed Christmas, I went to my sisters for Christmas and we had all the family round and I played with my nieces and nephews and loved it. I even felt fine with being around children. Before I would get tearful because I want my own so much, but playing with my sister's children didn't trigger my usual response – very odd, but good odd!

Anything else?
Thinks – You know I feel more level headed and sensible – laughs. Don't know if that's good or not!

We both laugh.

Scale this week? 8
Go on
Spent a lot of time talking to Matt about our life choices.
Miracle this week?
When I woke up, I'd be thinking about others instead of selfishly thinking about myself all the time.

During the Christmas holidays, how much time were you actually doing this?
(I knew she had been doing it so I was slightly surprised it was still on her MQ answer).
She thought, laughed and said – Most of it actually!

So the miracle is already happening?
Getting there.

Sessions 8 and 9 were both 3 weeks apart and Kimberley said she's had some 5's and some 9's but on the whole she felt she was there, although I wasn't 100% convinced. She was however moving away because of he husband's job in the military. She had decided part of her problem had been she didn't know what to do as an occupation, and since starting the hypnotherapy and me coaching her to think through problems instead of shoving them to one side, she had decided to train as an acupuncturist. This she said could fit in with her trying to become a mother and doing things for other people.

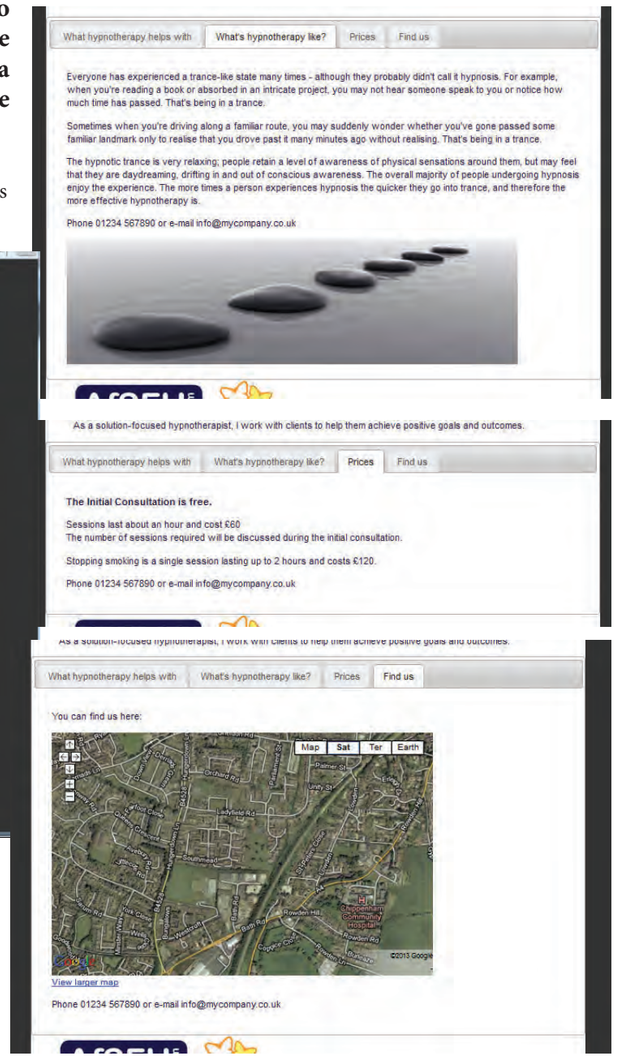
She wasn't feeling so stressed out about not getting pregnant, as our little talk about fertility treatment a few weeks back had made her feel more secure that it would happen and she still had plenty of time to do it. Her jealousy over Matt had diminished to 0 – "*haven't thought about that at all these last 2 months, he's going away to the US in March and I'm fine about it, as I'll be busy packing everything up for the move.* "

FREE WEB SITE

Trevor Eddolls explains the latest offer for AfSFH members.

Starting out with a new hypnotherapy business can be a daunting task. You need to make sure you know your stuff. You need to find somewhere to practice, and you need to get clients coming to see you. One of the best ways to be found by potential clients is to have a website – but how do you do that when you have so much else to think of? The AfSFH has prepared a basic website that you can personalise and use pretty much straight away.

The site is at http://afsfh.zxq.net. It looks like this



You can change the banner across the top to include your logo and any images you would like, as well as putting the name of your business and contact information (phone, e-mail, etc). The existing graphic is 800 pixels wide by 200 pixels high.

At the bottom of the page are the AfSFH logo and the trained at CPHT logo. You can add any other logos you want. So, if you're a member of the GHR, NCP, NCH, etc, you can add their logos too.

In the middle section are four tabs. This is an easy way to put lots of information into a limited amount of space. Again, you can change these, and you can change the text and graphic under each tab. The tabs are "What hypnotherapy helps with", "What's hypnotherapy like?", "Prices", and "Find us".

So let's get technical for a moment. If you don't have drawing software to create and modify graphics, a really good free program is called Paint.Net. GIMP is another great graphic tool. If you have a 'Save for Web' option with your drawing program, use it. Web graphics don't need so many bits as printed graphics. They also load faster if they are smaller.

The next thing you need is some way to edit the HTML – that's the code that displays the text on the page. You can read the code by right-clicking on the Web page and selecting "View Page Source". You can select all the text that appears, copy it, and then paste into Notepad – the software that comes free with Windows. Under "Edit" there's "Find". That allows you to find a piece of text that you want to change – like changing contact details to your own. Next, you want to "Save" your file. I'd create a directory called 'website' and "Save as" into that. The name for your file is 'index.htm'. As long as the extension is htm or html, you can view the contents as a Web page – that means it will show up in your browser (Firefox, Internet Explorer, etc). Any graphics you create can go in the same directory (the one we called website).

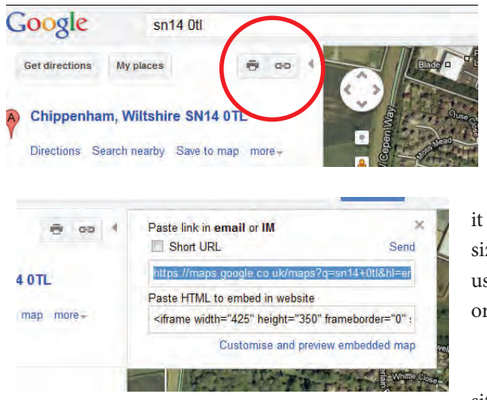
One word of caution: don't change anything inside the angle brackets – eg <p> – unless you know what you're doing. This is the HTML code that tells the browser what the page should look like.

Near the very top of the HTML it says:

```
<title>AfSFH site for members
</title>
```

You can delete "AfSFH site for members" and insert the name of your hypnotherapy company.

The clever part is on that fourth tab where I've put a Google map showing where your business is located. How can you do that? Go to https://maps.google.co.uk/, put your post code in the box at the top – your local map will appear. Zoom in. Then click on the icon that looks like chain links (in the red circle in the diagram):



Underneath where it says "Paste HTML to embed in website", select that code and paste it over the top of the existing code on the page:

```
<div id="tabs-4">
<p>You can find us here:</p>
    <p style="font-size: 13px;">
      <iframe style="font-size: 13px;" src="http://maps.google.co.uk/maps?f=q&amp;source=s_q&amp;hl=en&
      <br style="font-size: 13px;" />
```

It just over writes that one line – and now your location will show up in that fourth tab.

One final technical bit - the logos at the bottom of the page are hyperlinked to the AfSFH Web site and CPHT.. Were you to add an NCP logo, you'd want to hyperlink that too. Here's how:.

```
<a href="http://www.ncphq.
co.uk/" target="_blank">
<img src="imagencp2.gif"
width="100" height="98"
style="border: 0px;"
alt="LNCP" title="National
Council of Psychotherapy"/>
</a>
```

That top line has the Web address for the NCP. You could change this for any other organization. The next two lines have information about the graphic – giving information about where it is, what size it is, and that 'title' tag creates text that will pop-up when people move their mouse over the graphic. The last line simply closes everything. You can repeat this for more logos.

How do you get a graphic for the Hypnotherapy organizations? If they don't have them on their website, search Google images. Once you have a logo, you'll probably want to resize it (make it smaller so it's much the same size as the existing logos). You can do that using your drawing software (Photoshop or Paint.NET, etc).

You now have a personalised website sitting on your computer. What next? You need to get your website out there so people can find it. And that means two things – you need Web hosting and you need a domain name. Now, because these are early days in your business, you don't have much budget left after arranging consulting rooms etc. You can get free hosting from a number of companies (a Google search will help). I used zymic.com for the afsfh.zxq.net site. You control the first part of the name, so you can personalise it – myhypno.zxq.net or tranceformer.zxq.net, or anything-that-someone-else-hasn't-already-thought-of.zxq.net.

Lastly, you need to get your files to the domain. Some free hosting sites offer file uploading mechanisms. Internet Explorer has a convoluted way of loading files. Or you can download software that makes it easy – things like Filezilla. Once you've uploaded your index.htm file and your graphics, your website will be online. You can modify your Web page on your computer, look at it, decide you like it, and then upload the new version. And you can do that as often as you like.

You now have your own website with as little effort as possible! ■

For more information or help and advice contact trevor@itech-ed.com

Support a charity and get more clients!

Deborah Pearce shares recent graduate Sharon Francis's great idea

I love going to supervision. I always come away invigorated and inspired, as well as benefiting from sharing ideas and knowledge with other therapist.

It was at one of Matthew Cahill's supervision sessions earlier this year that I was completely blown away by a brilliant idea developed by a recent graduate – Sharon Francis, who runs a growing practice in Bideford, North Devon.

She had been running paid adverts in local publications with some success and had been racking her brains to come up with a way of getting free publicity. She had previously trained as a nutritionist and had run a number of weight loss groups. Her husband had volunteered for a local mental health charity, WAND, and she recalled that he had raised a significant sum by putting on a concert for the charity which attracted substantial local publicity.

An idea was born!

Sharon decided to offer free weight loss classes to a group of people in exchange for them raising sponsorship money for WAND. She approached the charity who were delighted with the idea.

She contacted the local paper about her idea and, as it was for charity, they were more than happy to help. They sent a photographer and did a helpful write up asking for three volunteers to take part in the sponsored slim.

The result? 40 people applied! It took quite a time for Sharon to sift through the emails and phone calls to select the lucky candidates. She found evaluating the applicants quite difficult as some of

their stories and reasons for wanting to participate were quite harrowing. In the end, she chose four people to take part in the scheme.

When Sharon contacted the unsuccessful candidates she offered them discounted hypnotherapy sessions and 6 of them became paying clients!

Here's how the scheme worked:

- Sharon ran weekly group sessions over a period of 10 weeks.
- They were free but the participants had to commit to raise a minimum of £250 in sponsorship money – this was entirely their responsibility, although Sharon did their fund-raising progress from time to time.
- The charity supplied leaflets and fact sheets to help the participants get sponsors. Sharon gave the participants sponsorship forms.
- She set up a Facebook Like page to publicise the group's progress – she posted weekly updates at first and later posted bi-weekly updates.

The sessions covered:

- Brain based information (as per the initial consultation)
- Dietary advice
- Motivation for exercise
- Demos
- 20 minute relaxation and visualisation session

Of the four people who were originally selected:

- One person stopped attending sessions after two weeks due to work pressures, although she has kept in touch and is still planning to raise sponsorship money.
- One participant lost 9lbs in six weeks, but had to pull out of the scheme due to relationship issues. She had been a key member of the group and was very motivated. She'd previously lost 2 stone with Slimming World but had plateaued.
- Another lost 12lb and is almost at her ideal weight.
- The fourth lost 6/7lbs.

Of the six non-selected people who became clients:

- Three dropped off very quickly due to lack of motivation (Sharon feels that if she had charged more they might have tried harder).
- Of the remainder, Sharon is helping them with other issues and weight loss has become a secondary issue.

The local paper offered to print an update half-way through the course of sessions and a follow up at the end. Unfortunately, other local news eclipsed the midway update, but Sharon is hopeful the paper will honour their promise to publicise the scheme at the end. She is arranging a cheque presentation of the sponsorship money to the charity.

Sharon has enjoyed the project, which has proved beneficial in a number of ways:

- The charity will receive at least £500 in sponsorship money.
- The number of Sharon's Facebook followers is growing week by week.
- The scheme has helped to raise Sharon's profile locally – people who don't know her ask her how the group is getting on.
- The raised profile has undoubtedly brought in more clients.
- It has helped her gain more experience of doing hypnotherapy and of running a sponsored slim.

Overall the whole scheme has proved to be very successful and Sharon is considering running it annually. She has really enjoyed making it happen and the women who participated have become friends rather than clients.

Sharon is more than happy to share her expertise with other therapists and we are really grateful that she has allowed us to share this brilliant idea with other Association members. Check out her Facebook page at http://www.facebook.com/sfhypno

An amazing achievement for someone who only qualified in June2012! ■

To use or not to use testimonials …

"People relate to other people like them" - By Heidi Hardy

I have used testimonials on my website ever since the ban was lifted on their use within our sector. I used to work in an industry that used testimonials and we found them to be useful and powerful tools – "People relate to other people like them".

I request general feedback after the clients' sessions are completed via a feedback form that I send in the post to them with a SAE; it includes the option for them to agree (or not) to the use of anything they have submitted in my marketing material (only one person has ever refused permission).

Not all ex-clients return the form and I make it clear in my covering letter that they are under no obligation whatsoever to do so.

I believe that by requesting this information after they have finished therapy is the sensitive approach. Personally, I wouldn't consider asking for this kind of information, particularly for marketing purposes, during sessions or at the last session.

I use them on my website for the following reasons:

Predominately to help prospective clients identify with others that have been helped through Solution Focused Hypnotherapy – this can be the first inkling for some people that there could be a way forward for them to change their lives – 'light on the horizon' if you like.

We use metaphor in our consulting rooms so this is just their use at an even earlier stage (possibly).

By asking for feedback in general we get the opportunity to find out things that the client didn't divulge in the room; this can be simply of interest to us or it can be a helpful learning, whether positive or negative.

Additionally, 'Google' likes it when we make changes to our website so, by adding recent testimonials and deleting older ones is a way to help search engine optimization.

It must be noted that using a handful of testimonials in this way is not, of course, truly representative of every single client case; they are not a form of research and should not be perceived as such. They are simply a marketing tool that we can use to help us reach people that we may be able to help ■

Testimonials.. Bad, or Just Misunderstood?

Alan Wick weighs up the pros and cons

Going back just a few years, pre 2010, I was supportive of the policy stated within the Code of Ethics of the National Council for Hypnotherapy which excluded me from using client testimonials. I agreed with the NCH that client testimonials were easily made up and hard to verify, at least for the casual reader of a website or leaflet.

I was aware during this time that members of other Hypnotherapist organisations were not limited in this way by their own bodies, and used Client Testimonials more or less prominently on their websites. Some were comically bad, and others even appeared to be from clients whose therapy was ongoing, which really amazed me.

I was concerned on a number of levels regarding the ethics of this type of advertising, such as use of photographs claiming to be of ex clients, remarks that appeared to be incomplete or out of context, some with outrageous claims, testimonials solicited during ongoing therapy, even use of actual names (claimed at least), and if I'm completely honest, and given that these testimonials were likely to be persuasive to members of the public, I was a little annoyed that a poor ethical stance on the part of some Hypnotherapy Regulatory bodies meant that unethical practitioners were probably getting a better share of business than I was.

This started to become more pertinent and urgent when I became aware of the chatter around the 2009 NCH Annual General Meeting (pre 'Extravaganza'), and it was suggested that members of 'the board' had tried to 'wave' a motion through that would have allowed members to start using Testimonials. The attempt was defeated, but the intent was clear, and I had to consider carefully how I would respond.

I made a decision to start collecting Testimonials, and deal with any change in the rules as and when they arose. I already had a scrap book of Thank You cards and Postcards, along with emails and letters, but of course, I didn't have consent to use these remarks as testimonials, and didn't especially want to detract from them, as I saw it, by re-approaching those clients.

After some thought, I decided to use the January doldrums, such as they can be, to compile and send out what has now become an annual survey of all of my clients, less those who expressly requested no contact be made. In the first instance the survey is a review of their subjective opinion about the effectiveness of their treatment/therapy, with an invitation to then make remarks, and a request to be constructive! The final couple of lines is a request for signed consent, allowing the remarks to be used in my advertising material.

I felt that even in this limited approach, there were ethical considerations that had to be overcome. Firstly, the survey had to feel as routine as possible. I was concerned that to return to the client and essentially ask 'how are you' could introduce a note of doubt, and so the fact that this was a routine, 'annual' (well, it turned out to be!) survey of all clients was stressed, as was the clients absolute freedom to choose not to reply, which was underpinned by my promise that there would be no further approach made unless it was requested.

I made it clear that comments used in print would be anonymous, and that any information within the comments that threatened anonymity would be altered or redacted, and also undertook to later remove any Testimonials on request, should anybody change their mind.

The first response to this annual review was very gratifying, and I certainly got as many, if not more testimonials as/than I would need. Clients remarks were also illuminating and I can say with no fear of exaggeration that at times they were a revelation, but that's another article. Suffice to say the exercise seemed well worthwhile.

As events went, it wasn't long before I had to make the decision to use the Testimonials. As the NCH Code of Ethics became subsumed by the CNHC Code of Ethics, we discovered that there was no longer any mention, pro or con, of Testimonials. Pressed on the subject, the NCH acknowledged that 'no mention' was in effect tacit approval, and so barriers were removed from us all to begin using Testimonials. Thankfully I was ready, and therefore not disadvantaged.

I have no idea whether the testimonials used on my site have generated any more business (with the remarkable exception of a journalist who video logged his treatment with me, and subsequent success, and then allowed me to embed the two videos on my site, which has been referenced as decisive by several clients), but I do know that the advertising industry is in little doubt as to their effectiveness, so I feel I can be reasonably confident that I'm at least not losing out.

I was also amazed that the idea of testimonials acting as client metaphor had glided right past me, until it was mentioned in the AfSFH forum discussion, from which this article has arisen, and it's an idea I like very much, how about that for pre-sessional change!

So, am I still ethically opposed to the use of testimonials, at least in principle?....mixed feelings, I think I've come to see them as just something else that can be done well or done badly...and we see that in unacceptable behaviours in lots of areas, just for example, the use of great strings of letters after names that denote nothing more than membership of organisations, people who believe they're therapists after 2 week crash courses, the very provision of 2 week crash courses by supposedly professional organisations, Groupon promotions, absurd promises, the Carnival Side Show pantomime of Past Life Regression, and much more.

I think it's up to us to be seen to be better than the examples above, being proud of our HPDs, practising the most up to date and effective approaches, being honest about our capabilities, and applying the same high standards and integrity in our efforts to promote our businesses, which can include testimonials, but only if they're collected with the same attitude, and with respect for our clients ■

News - NCH say gastric band therapy doesn't work

As a Solution Focused Hypnotherapist we know that the secret to weight loss is about getting everything right. The idea that you can just suggest to someone to feel full is unlikely to be very effective and recently Paul Howard, Director of the Surrey Institute of Clinical Hypnotherapy, and Marketing Director at the National Council for Hypnotherapy, said on the subject of the craze for Gastric Band hypno, "This whole procedure (Gastric band) can take up to 4, sometimes even 6, sessions, whereas the Surrey Institute of Clinical Hypnotherapy believe in the first place that it only takes about 15 minutes to install the hypnotic gastric band. For the vast majority of weight loss clients, it is totally inappropriate and, therefore, unethical to be using it as a technique, let alone 4+ sessions."

"I can understand the lure from a client's point of view. It is an ideal scenario, no surgery, a fraction of the cost and no after-surgery complications or pain. But the fact of the matter is that for most people with weight control issues, it has little or no practical application." Howard continues, "If you are eating large portion sizes alone, then it may have some beneficial effect, but for most people the decision point of what and how much to eat is way before you actually sit down to eat. I have yet to meet anybody who has had 'gastric band hypnotherapy programme' that has lost and kept off the weight, without supporting changes in behaviour." This is what we've been saying all along, so hopefully it will trickle through to the population and we can get on with the real issues ■

Do you have an idea for a story?

Or are you interested in doing research?

Then contact Penny Ling on journal@afsfh.com

Out Now...

The latest edition of Metamorphosis. Go to:- http://issuu.com/pennyling/docs/metamorphosis_issue2_summer2013/1

Metamorphosis is for you to promote to the public - it's for you to print off and give to your clients - it's for you to link directly to the magazine from your website - it's for you to publicize the association and your own work - in other words...It's for you!

Hypnotherapy Today is published quarterly by the Association for Solution Focused Hypnotherapists and is free for members.

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 to **afsfhjournal@gmail.com** in **.doc** or **.pdf** format. If providing photographs please make sure these are high resolution (300 dots per inch as opposed to 72dpi web format) photographs are to be attached separately to the document; **please do not embed**. Please make sure there are no copyright issues with the photographs sent, and that all photographs are originals. These must be sent as a **.jpg** file. Any articles must have the references included and numbered.

If you have any case studies, scripts, metaphors, book reviews, news, areas you feel we need to investigate, then don't hesitate to get in touch.

By submitting to the AfSFH journal you grant the AfSFH an irrevocable worldwide non-exclusive royalty free licence to publish in Hypnotherapy Today. You also warrant that the article is original, does not infringe copyright, and that you have authority to grant these rights to publish. Copyright remains with the author unless otherwise specified.

Views expressed in Hypnotherapy Today are those of the contributor. Please only send in articles of a solution focused nature.

Submission deadlines

First day of February, May, August, & November.

Issue Dates

January, April, July & October

Supervision Directory

Terry Baker
Location: Bristol
Tel: 0117 9732 350
Terry.Baker@Talk21.com
www.terrybaker.moonfruit.com

Colin Hudson
Location: Worthing
Tel: 01903 331507
info@apollo-hypnotherapy.co.uk
www.apollo-hypnotherapy.co.uk

Susan Rodrigues
Location: Bristol
M: 07743 895513
www.susanrodrigueshypnotherapy.co.uk

Claire Brigg
Location: Bristol
Tel:07984 305239
www.clairebrigg.com
clairebrigg@blueyonder.co.uk

Michael Hughes
Location: Bristol
Tel: 0117 9076 412
info@michael-hughes.co.uk
www.michael-hughes.co.uk

Paula Rose
Location: Newport
M: 07951 501108
www.hollickhypnotherapy.moonfruit.com

Matthew Cahill
Location: Plympton & Plymouth
Tel: 01752 342124
hypnotherapysupervision.co.uk

Alison Jones
Location: Bristol
Tel: 07970 191027
www.solutionshypnotherapy.co.uk

Susanna Simms
Location: Malvern
Tel: 07947642735
www.susannesimms.co.uk .
Email: Susanne.simms@btinternet.com

Sandra Churchill
Location: Warminster
Tel: 07515 441 825
sandrachurchill@virginmedia.com
www.churchillhypnotherapy.co.uk

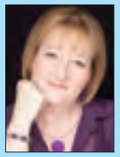
Penny Ling
Location: Oxford & Reading
M: 07759 820674
Solutionshypno@yahoo.co.uk
www.PennyLing.co.uk

Roger Stennett
Location: Bristol
M: 07968 919255
roger.stennett@gmail.com
http:// web.mac.com/roger.stennett

Jessica Driscoll
Location: Cardiff
Tel: 02920 650038
M:07583 385652
jess.hypnotherapy@gmail.com
www.solutionhypnotherapy.co.uk

Sam Luxford
Location: Aberdeen
Tel: 07867 936505
www.aberdeenhypnotherapy.com

Stuart Taylor
Location: Bristol
M: 07840 269555
www.taylorhypnotherapy.co.uk



Kim Dyke
Location: Warminster & Bath
Tel: 01225 765411
M: 07825 957013
kimdykehypnotherapy@hotmail.co.uk
www.kimdykehypnotherapy.co.uk

Pam Madden
Location: Chew Valley
Tel:01761 237400.
M: 07740 918426
www.westofenglandcoachingandcounselling.co.uk.

Marion Ware
Location: Whitstable
Tel: 07833 473967
info@marionware-hypnotherapy.co.uk
www. marionware-hypnotherapy.co.uk

Sharon Dyke
Location: Taunton
M: 07766 250113
sdhypnotherapy@yahoo.co.uk
www.sharondykehypnotherapy.co.uk

Nick Mawer
Location: Keynsham
M: 07954 425548
nickmawer@live.com
www.nickmawer.co.uk

Alan Wick
Location: Wrexham & Manchester
Tel: 01978 781606
positivehypnotherapy@yahoo.co.uk
www.positivehypnotherapy.net

Trevor Eddolls
Location: Chippenham
Tel: 01249 443256
http://ihypno.zxq.net/super.php

Deborah Pearce
Location: Sidmouth
Tel: 07939 840788
dpearcehypno@gmail.com
www.deborahpearce.co.uk/for-therapists

Andrew Workman
Location: Bristol
Tel: 07890 027083 or 0117 932 3472
hypno.workman@gmail.com
www.workman-hypnotherapy.co.uk

Nicola Griffiths
Location: Cirencester
Tel: 0773 866 5172
nicola.griff@btinternet.com
:www.nicolagriffiths.co.uk.

Susan Ritson
Location: Axbridge & Frome
M: 07837 562602
susan@ritsonhypnotherapy.co.uk
www.ritsonhypnotherapy.co.uk

Don't Forget!

If you are a member of the NCH, then you can register your details of your supervisor (If they have been accredited by the NCH) with them - online. www.hypnotherapists.org

Committee Members

Chairman and Trustee: David Newton

David Newton founded the AfSFH and is an avid supporter of getting the word out to the public of what Solution Focused Hypnotherapy is all about. His inspiration brought the Association to life and has allowed us to flourish rapidly in our early days. His support of all that we do is greatly appreciated.

Company Secretary and Trustee: Nicola Griffiths

Nicola chairs and tries to keep control of our Executive meetings! She works closely with the Executive in order to push the Association forward. The bee in her bonnet is to support both newly qualified and experienced Hypnotherapists in their careers, so she comes up with many of the initiatives that help our members improve their businesses.

Trustee: Susan Rodrigues

Susan is our mainstay who oversees our Executive meetings to ensure we're on the right track! Her knowledge ensures that our brain waves keep to the ideals (and regulations) of the solution focused world.

Assistant Company Secretary: Sharon Dyke

Not content to be Nicola's Deputy, Sharon has taken on the role of Risk Assessor AND taken charge of long term planning for the Association. So we now have a vision for the future – all she needs to do now is keep us focused towards our goal!!

Journal Editor: Penny Ling

Luckily for us, Penny was in publishing before she became a full-time Hypnotherapist. Working with a team of volunteers who submit articles, Penny (amidst occasional tearing out of hair) writes, designs and produces our amazing Journal which has received unprompted and excellent feedback.

Communications manager: Debbie Pearce

Having decades of experience in PR, Debbie is in charge of national publicity. She also works hard behind the scenes establishing relations with publications and organisations that will benefit the AfSFH as we move forward. She also brings a large dose of energy to the Executive which keeps us motivated!

Member Benefits Officer: Andrew Workman

Andy is responsible for obtaining discounts on products and services that you find on the Member Benefits page of our website. He approaches many many companies using his persuasive powers to encourage them to offer these discounts! We don't like to ask how he does it, we just leave him to it…..

Marketing Officer: Su Brampton

Su has joined the Committee to help Debbie with Marketing and she now has responsibility for our press releases and those lovely e-newsletters you receive!

Treasurer and Events Co-ordinator: Denise Barkham

Not content to organise our Events, Denise also has the responsibility of keeping us in line when it comes to spending money, keeping a tight hold of the purse strings and balancing our books!

Website Officer: Trevor Eddolls

Trevor, for his sins, is charged with updating the website and inspiring us with ideas to further progress the site. A challenging and key role as we grow bigger!

Assistant Journal Editor: Kim Dyke

Kim has thankfully come to the rescue of Penny who was drowning under a mass of admin and chasing up copy so Kim will be the liaison between writers and the editor in the future.

Administrative Secretary: Shelley Sanders

Shelley is our lovely new Administrator who deals with all your queries and those of the public whilst Claire is looking after her new baby. Shelley has already had to keep up the pace during the last association meeting and AGM with all the minute taking - so thrown in the deep end already!