HYPNOTHERAPY TODAY

ASSOCIATION FOR SOLUTION FOCUSED HYPNOTHERAPY JOURNAL ISSUE 13

WE CAN FIX IT

COULD SFH BE THE PERFECT THERAPY FOR MEN?

Also:

Living in the primitive brain

The case of the phantom limb pain

In practice with Michael Hughes

Research interview with Leah Bevan

MEMBERS ASK: DO WE REALLY NEED A DISCLOSURE AND BARRING CERTIFICATE?

The simple answer is "YES". It is a requirement of the AfSFH that you must have this in place.

Sharon Dyke CEO of the AfSFH explains that the DBS was established when the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) merged in 2012.

Its main function is to prevent unsuitable people from working with vulnerable groups, including children, through its criminal record checking and barring functions.

Sharon states that you can't legally apply for your own DBS check if you are self-employed, as you can't assess your own suitability for a job. However, there are alternative ways to obtain clearance that include:

◆ Applying for a DBS / CRB check by registering with an umbrella agency. The agency would be eligible to ask an exempted question as it would be the agency assessing the individual's suitability. In this example the agency could countersign the application form.

◆ Alternatively, individuals are able to make a 'Subject Access' request to their local police force under the provisions of the Data Protection Act 1998, which will provide up-to-date details of any criminal records in the UK. Visit www.met.police.uk/information/request_forms.htm for more information.

Sharon states there are several types of DBS check, however, for the purpose of our members it is important to acknowledge that the AfSFH requires its members to apply for the Enhanced check as this is the requirement when working with potentially vulnerable people and includes:

◆ Details of an individual's convictions, cautions, reprimands or warnings recorded on police central records and includes both 'spent' and 'unspent' convictions together with any information held locally by police forces that it is reasonably considered might be relevant to the post applied for.

Sharon goes on to explain that the DBS checking process will cost approx £60 depending on who you apply through, and involves several different stages before an applicant receives their certificate such as:

◆ Stage 1 - application form received and validated: the application form is checked for errors or omissions. Within 24 hours of receipt the form is either scanned onto the DBS computer system or returned for correction to the counter signatory.

◆ Stage 2 - Police National Computer searched.

◆ Stage 3 - children and adults lists searched, where applicable.

◆ Stage 4 - records held by the police searched: Enhanced checks are sent by secure, electronic means to the police for an additional check of local records before the information is sent back to the DBS.

◆ Stage 5 - DBS certificate printed: all the information to be disclosed is printed under highly secure procedures and sent to the applicant.

Sharon says its important for our members to know that the AfSFH recognises that introducing the need for the DBS certificate to be in place has resource, cost, and time implications that Hypnotherapists need to manage" and people may ask "why do we think now is the right time to be promoting yet another priority spend"?

The simple answer to that is, "to prove you are not barred from working with children and/or vulnerable adults, to protect you as a Hypnotherapist and to encourage organisations such as NICE guidelines to take our discipline seriously in the future.

For more information on this subject please contact Sharon Dyke directly at ceo@afsfh.com ■

LETTER FROM THE EDITOR

Welcome to the July 2014 edition of Hypnotherapy Today. This edition focuses on Men, but I would read the introduction page really to see why I have chosen this subject for a whole edition. I would also like to thank all those who personally contacted me about the very first paper edition, 99.9% of the responses were very encouraging and positive. The 0.1% that wasn't, I only have to say that it's open for people to write interesting, constructive and informative articles. So if you want to see more research, then we need people like you to do that research and write it up, if you want to see more business ideas, then we have a huge number of experienced hypnotherapists to tap into, it's about communication and letting us know what you want ■

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

Penny

Penny Ling, Editor

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Stuff:

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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:
Donna Adlington
Trevor Bedford
Christian Dunham
Sharon Dyke
Trevor Eddolls
Mark Hallwood
Michael Hughes
David Mclean

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.

Being a SF therapist we come from a not knowing stance - but I wanted to know the answer...

Penny Ling raises her head above the parapet...

Back at the beginning of the association we carried out a poll of typical clients and found that 73% of clients seen during the week we studied were female, 72% of our therapists at this time were women – I was interested in why the number of male clients were so low, and so I decided to contact a large proportion of our male therapists and ask them their views. I managed to get some interesting articles from Trevor Bedford, Christian Dunham and Mark Hallwood, all experienced hypnotherapists and willing to have a closer look at their own clients and statistics.

Was the answer that men don't have as many problems as women?

Having spent most of my life, often being the only female working with men, I did not think that was the case. The main difference I found was that women have a lower tolerance of discomfort, many of the men I have worked with would wait until something became unbearable before tackling it. (A few of my female clients over the age of 55 cite their husband's health was a constant worry to them and their lack of action was a puzzle to most. One told me that her husband didn't want to go to his GP about his depression because he would be labelled and put on the "looney list". In some cases health insurance ask about depression, perhaps to weigh up time taken off work or tendency to suicide. But I see that as a plus point for us in the private health sector.

Is it that men think differently about problems?

Christian Dunham's article touches on this, and this is backed up by a very interesting book called the "Male Brain" by Dr Louann Brizendne, which offers fascinating insights into a range of subjects including emotional intimacy, anger, aggression and winning, it also answers some of the questions that "ultimately keep the divide of the sexes well and truly in place despite years of trying to demand true equality." (The books words not mine!).

Apparently the Temporal parietal junction towards the back of the brain rallies the brain's resources to solve distressing problems while taking into account the perspective of other people. In men this switches on much quicker, so to a woman, when she's distressed she tends to prefer comforting first - the empathy that friends and family bring - whereas men will want to try and sort the problem out, and so may appear colder, less empathic. But it's just because they have switched to a different brain function.

Or is it lack of information out in the wider world?

The recent news about eating disorders effecting young men highlighted a number of issues – that the GPs failed to pick up the symptoms, or certain problems are always written about with young women in mind, so it becomes a female issue, much in the same way domestic violence and rape was just presumed to be a female problem until a campaign was set out highlighting the problem with males. I recently spoke on BBC Radio Oxford about this subject and mentioned that the awareness campaign was over 25 years ago, so each generation needs to be reminded that any problem effects both men and women. My co-guest suggested that men would not own up to something so humiliating. Years ago we only had a limited media, now there are hundreds of TV channels and the internet, broadcasting information to help people has become watered down. ■

Eating disorders are not just the realm of emotional teenage girls

Penny Ling looks at recent research from Oxford University

When I started asking other therapists about the idea of why there was such a gender difference in seeking therapy, out of the blue came a study by two Psychologists at Oxford University, Ulla Raisanen and Kate Hunt. Their study was called "The role of gendered constructions of eating disorders in delayed help-seeking in men: a qualitative interview study".

The objective of the study was to understand how young men recognise they have an eating disorder, then whether or not they seek help for it. Most of the volunteers were students aged between 16 and 25. The eating disorders studied were Anorexia Nervosa, Bulimia Nervosa, Binge eating and EDNOS (Eating disorder not otherwise specified).

Anorexia Nervosa has one of the highest mortality rates of all the psychiatric conditions during adolescence[1]. It costs NHS about £50 million in inpatient care and an additional £5-20 million for outpatient care. So spotting the condition early can help with the care available and the long-term prognosis.

So when the question was asked about the difference in the proportion of men to women who had been diagnosed with an eating disorder, it took two paths: One was looking at the training amongst health professionals in diagnosing and treating the problem[2] and the other in the public perception of eating disorders, and the amount of information and quality of information available[3].

Previous studies focused on exercise, body image, dieting practises and sexual orientation, or on eating disorder services provided[4]. This study however concentrated on:

- How do men make sense of their early (and later) signs and symptoms of disordered eating?
- How do they realise something might be wrong and require intervention?
- Are there perceived barriers to accessing primary care (or other) services for men with EDs?
- What are mens experiences of health professional's responses to their initial presentations of ED signs and symptoms?

Only 10 men took part in the study, which shows to some extent the numbers used in trials such as

Continued over...

these, 8 were white British, one Latino and one mixed race, 6 were students, 2 employed and 2 unemployed, 3 were homosexual.

The first part of the interview allowed the interviewee to just talk about his experience and then the second part was more questionnaire based.

The results showed that all of the men took some time to recognise their behaviours as a symptom of an eating disorder. Those with Anorexia Nervosa (AN) started generally by skipping meals, restricting their calorie intake and eventually go for days without eating anything. Those with Bulimia Nervosa (BN) started to comfort eat and purge and gradually built it up to be habitual. Their daily routines revolved around obsessive calorie counting and exercise regimes, and weighing. Often they experienced other problems such as self-harm and isolation.

The 10 men explained their actions as so:

1) Did not think he had a problem.

"I didn't know men could get eating disorders then …cos that would be like I've years ago and there wasn't really much said about men with eating disorders then didn't know the symptoms, didn't know anything, it was just, to me it was just happening. I didn't really know what was going on"

2) He did not interpret his disordered eating behaviours as symptoms of an illness, or as anything recognisable and treatable; rather he saw his symptoms as mundane aspects of his life, something that was just happening.

"Like you hear like the side effects of having an eating disorder on like women. Like they can become infertile and stuff like that, but I've never seen any for men. So I like went and was like 'Look, well what are they for men?' Cos like that I could like have a side effect and I wouldn't know. I think I read somewhere that men can become infertile by it, and I'm like,'Yeah but no one tells you that'. They need to like tell you 'this could happen, that could happen'. Like you can get, I know you can get like osteoporosis which I've only seen like written about women, which is obvious it could happen in men as well. So it could lead like some people to think, 'Oh there's no side effects for men.' When there is and it's just not, you just can't, I think, I had to like scroll through the whole of the Internet trying to find bits of information."

3) The idea of an eating disorder did not enter his head. His parents suggested he was just "being silly", about his eating.

4) He developed his bingeing and purging as a coping mechanism and thought he'd invented it.

"I thought I made it up myself you know, something that only I did, you know, I never thought in a million years this was something that lots of people did, and deliberately did to cause damage to themselves. You know, it wouldn't have crossed my mind."

5) He thought ED was something highly emotional female teenagers suffered with, not "one of the lads" who played Rugby.

6) He had been investigated for gastric problems to his purging; no one, including his parents and clinicians suggested it was psychological.

"The only information I got was [er] a scare sheet basically. It was this was going to happen if you keep going. Basically the big one that they circled was, Oh you won't be able to be sexually active' for men. And that was the biggest thing. I got about five or six different sheets from them, and basically the main fact was, 'Oh yes, your organs won't work, you know. You'll lose nails, hair will thin. You cannot have sex".

7) He thought people at school knew about his problem but it was something not discussed. He knew for a long time that his habitual bingeing and purging were causing problems, but had no name or understanding to make sense of it.

"I didn't really know what, where to go or what to do to be honest. [Um] We've all heard of the like, female anorexia and all of that. And everyone, I think I'd heard of anorexia [um] that isn't what I was going through as such. And I didn't really know what it was or where to go. I did start googling it and I came across [um] eventually on Facebook that men have eating disorders too, as well, and there was a couple of other websites that I looked at. [Um] But there's still in my opinion there's still no real information of what you do or where you go".

8) He became more introverted and isolated and then realised things were "not normal".

9) He became gaunt and his spine protruded, and it was only during an emergency home visit from his GP was he told to admit himself to hospital otherwise he'd be sectioned. He had seen his GP before, and they had wanted to weigh him, but he refused so nothing happened next.

10) He had restricted food intake and was losing weight when his girlfriend forced him to re-evaluate his behaviour.

In addition to delaying seeking help, there was also the fear of not being taken seriously. There may also be history in a GP not helping with a previous unrelated problem. In some cases there was a reluctance to relinquish behaviours as they felt it was something they couldn't live without.

It was a positive experience with a health care worker, GP or counsellor which dictated what happened next, one GP just wasn't able to offer any help as her area did not provide any services!

Some had to visit their GP several times before being taken seriously; another had tried to commit suicide before being admitted to A&E and was immediately referred to intensive outpatient treatment.[5]

There are many resources for eating disorders such as - http://www.nationaleatingdisorders.org, but as therapists we can help highlight, not only eating disorders but other mental health problems that are suffered by both genders. One aspect was highlighted whilst reading through this and that is the idea of the stereotypical male, that they should be "man" about problems, and to show weakness was frowned upon. Hopefully these stereotypes are gradually being changed over time, despite having been popular for over 50 years now, it may take another to truly filter down, but let's hope it's shorter ■

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Trevor Bedford gives us some of his statistics

I am a male Hypnotherapist in my 50's. My marketing sets out that I am ex-military, South African and used to practise as a chartered accountant, worked as a financial director and managing director in a number of companies. Despite this I still get clients.

More seriously, these factors may impact on my attracted client base and are therefore significant. I am passionate about hypnotherapy, having never intended to practise; I take on between 5 and 10 clients a week. Most of my marketing is word of mouth.

I have analysed my client lists (all ages included) over the past two years, looking at a total of 86 clients attending 520 sessions with some interesting results. 36 were male, that is 41.9% and 50 were female being 58.1%. Of the 520 sessions, males attended 42.5% and females attended 57.5%.

These numbers show that as a male hypnotherapist I may attract a higher proportion of males than the average hypnotherapist. Is this due to my sex, career history or age?

The profile of my male clients is interesting in that the 90% of the male clients consist of professional people. Doctors, lawyers, managing directors, farmers, self-employed wealthy clients and some privately educated boys, brought to me by both mothers and fathers. The age range is mostly 40-60 years old men or teenagers. This applies to my female clients as well.

Does this information support the hypothesis that both males and females in the 20-40 age range are less likely to seek hypnotherapy for support? Or is this simply a result of my own profile?

Of the males that I have worked with, they almost all have never had any therapy at all in the past, so they come to the initial consultations with some trepidation. This is not the same for my female clients; many have tried some sort of therapy in the past. Without exception, except for smoking clients, my male clients all open up extremely quickly and express their relief at being able to talk to someone who is understanding of the male perspective on their issues, and is at the same time distant enough not to be embarrassing in knowing their inner most secrets, dreams and fears.

There is certainly consensus with my male clients that most men do find it difficult to admit to needing outside help, preferring to believe that they can overcome problems without needing to ask anyone for help. I know I fell into this bracket before I studied under David Newton's excellent tutorage and guidance.

From the profile of my male clients, does the highly trained and successful professional male have a more open mind to hypnotherapy or is it because they have very stressful jobs? There are legal, moral and productivity reasons for companies to support therapy and therefore there may be a more informed insight to the benefits from this sector of the market.

So what do my male clients come to therapy to achieve? 16.7% of my male clients come for one session to help with smoking, compared to only 4% females. The others come for very similar issues to my female clients:

Client A, a solicitor and the firm's managing partner came to me after I gave a talk at the local Chamber of Commerce. At the talk I made the ridiculous comment that some clients bring their children to see me, when the real problem often lies with the parent, not the child. Anyway, this did bring in a new client, if not PC marketing on my side.

Mr A asked me to help him deal with his difficult child as a result. Mr A was open minded and receptive from day one. His lack of self-confidence was immediately apparent as he worried about his ability to do his job, not understanding why people came to see him for his guidance on legal issues. This was a surprise to me, as I have never doubted a solicitor's confidence in their own abilities. Mr A suffered from anxiety and stress, not enough time and too much work. He also has OCD and children tend to test even the most patient of people at the best of times.

Mr A has found ways of enjoying his spare time now, is less irritated about his child and his personal possessions getting lost or broken. He has adjusted his work balance and even coped well with the family conflict issues that arose after the death of his father, which sadly happened whilst he was an active client.

The case of Mr B, a managing director, who suffered from a fear of public speaking, was one where we never discussed his fear after the initial consultation. At each session we would work on his self-confidence, again, he did not believe he deserved his post at the top of the company (shame some of the city bankers don't suffer humility).

Mr B sent me one of the most joyful letters after we had finished our therapy. He had decided he was worth his role and would stay with the company because he had and was achieving corporate changes and objectives, he was adding value. Not only that, but he felt he was now a much better father and husband, loving life and with a renewed relationship and zest for living. Oh, he did mention that he was conducting board meetings with authority, lecturing in the business sector and enjoying a number of public speaking roles. He just had not realised that he was doing them.

The case of Mr C, a consultant marketing expert, suffering from cystic myalgia and the acute pain that comes with it. Mr C is married to a lady with bi-polar disorder, with a life-time of serious mental problems. Mr C was aware of them when he married her and was aware that his problem was more than likely down to the anxiety from having to live in such a stressful environment for so long.

Mr C was acutely depressed from the pain and on the verge of suicide, although he did not reveal

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this to me until quite late on. An extremely loyal and honourable man (or so he told me) he could not leave his wife as he knew she would (and had tried many times) to commit suicide if he left her. He could no longer cope.

We spent many sessions working on pain control, with huge success as he took on board techniques that worked for him. At the same time we worked on his depression and reducing stress, both impacting on the pain. The breakthrough came when he realised that he had married his wife because she was dependent on him. Now he resented her dependence. With that he was able to change his thoughts and love her, faults and all. He now smiles and laughs, which in turn is impacting on his family, much to all their benefit.

Finally, Master D, a 6 foot 4 young man, county cricket and rugby player of 16. Not very academic, Master D suffered from a complete lack of confidence, which is quite revealing when this strong and manly young man looks down at you. This supports the saying, "don't judge a book by its cover". The youth of today have the same fears as all youths have had to learn to cope with over thousands of years, although maybe 24 hour communication stresses are impacting on them more than any group of people in the past.

Master D was also extremely sensitive to criticism, especially his academic abilities; sadly this was impacting on his social life and sporting confidence.

We worked on academic expectations, helping him to be proud of his results when he had worked hard. His C or B was as good an attainment as the high performance students who achieved A results with equal hard work. Master D had a good relationship with his parents, what he did develop was to communicate better with his parents, letting them know he was working hard, so they in turn could understand that his results were not due to lack of effort.

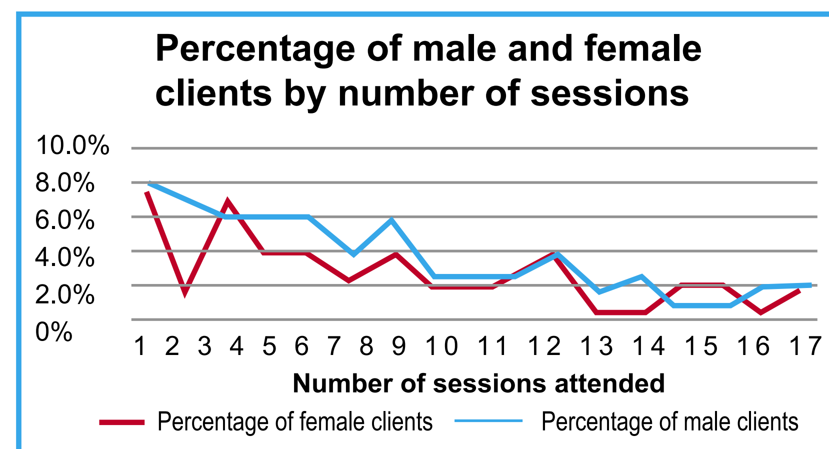
"I believe men suffer the mental pressures as much as females, but they are reluctant to admit to weakness"

Master D developed a confidence to talk to peers and adults clearly and with pride. He now loves being with friends, no longer fears working or writing exams, seeing exams as an exercise to show the teachers what he does know, not worrying about what he does not know. His sporting abilities have also continued to improve with his confidence.

Based on my limited professional hypnotherapy and personal experience, I believe men suffer the mental pressures as much as females, but they are reluctant to admit to weakness. Statistically females are believed to have a higher fear of failure than men. My question is: is admitting the need for help a fear of failure? If so, then perhaps men simply do not admit their failure or fear of it.

On the next page are some graphic statistics of male versus female clients:

The first graph shows that there is little statistical difference between the numbers of sessions a male client attends compared to the number of sessions a female client will attend.



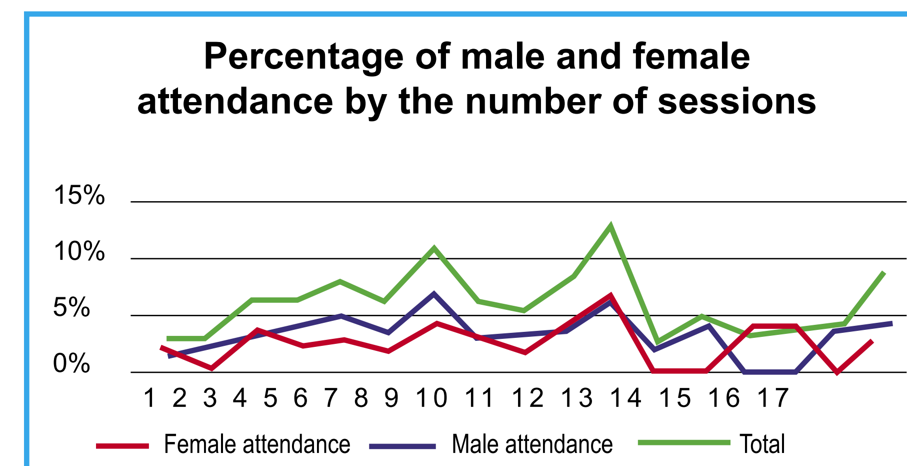
Again, this graph shows that my male and female clients have a similar ratio of the number of sessions they attend in relation to each other and the total of both groups. I have removed smokers and those who did not continue after the initial consultation.

This data is remarkable in not being remarkable. Once men and women have made the decisions to seek help, both have a similar determination to continue until they achieve the desired results.

The statistics that highlighted differences were the higher ratio of men seeking help with smoking as detailed above, as well as the difference in those who did not continue after attending the initial consultation. My female clients not continuing were double the male percentage, being 10% female to only 5% males. Did the potential female clients find it difficult to confide in a male therapist? Were males more comfortable with a male therapist? What is the average conversion from the initial consultation?

My conversion ratio (90% female, 95% male) leads me to suspect males were more comfortable with a male therapist. This opinion is also supported by my higher males to female client ratio (42%) to that of the industry (33%) as well as the statistic that my male clients on average attended 7.61 sessions compared to my female clients who attended an average 6.79 sessions.

There is little information to understand if males and females need mental support more or less than the other, what is proven is that men seek help less often. As alpha testosterone filled beings, the need to not just survive, but show strength at all times may have been critical to attracting partners in order to procreate. Can this be the reason, or do men just not suffer from mental issues as much as women? ■



Trevor Bedford is a Solution Focused Hypnotherapist based near Curry Rivel, Langport, Somerset. http://www.naturalhealthnetwork.co.uk/practitioners/trevor-bedford.html

Christian Dunham

"Women look for solutions but men want to be the solution"

Christian Dunham shares a recent case study

I am aware of the stereotype that 'men don't do therapy' and, after being asked to write this article, I decided to do a quick check through my diary to get an idea of the numbers. I was pleasantly surprised to find in my practice a fairly even split between men and women. This week exactly half the clients I will see are men.

That said, the vast majority are coming for therapy on the recommendation (or insistence) of a female significant other. Whether they be wife, girlfriend, sister or mother, it is often the women in our lives who direct us towards getting help. I think this is because women want the problem sorted, while men want to 'sort it out'. Of course that is a generalization but it makes sense to me that the nurturing, settler influence of women look for solutions, while the warrior, alpha, facet in men want to be the solution.

When we do finally get to speak face to face, the Initial Consultation is a wonderful level playing field on which to begin.

Case Study

Daniel came to see me at my London clinic.

He is in his mid thirties and suffering from anxiety attacks. During the Initial Consultation he explained he had a history of depression and anxiety. It started at university and the last episode was four years ago.

Daniel is a design executive, working in a small, fast moving company. He is very innovative and creative. He loves the spontaneous brainstorming of creative sessions, often leading the design team with wild ideas. He has just created a concept for an international client that will mean regular transatlantic trips. He has also started a new relationship.

Daniel is finding it hard to relax. His mind is constantly working overtime, obsessing about the to-do list that seems to get longer by the day. He is having the horrors about the new client and his ability to 'cut it' at an international level. He is hyper-vigilant about the future and this is causing him to withdraw from the creative process. Add to this his new relationship and the prospect of less time together due to travel. Daniel worries about being able to make the relationship work. This is affecting his libido, which has dropped considerably, the anxiety of which is compounded by occasional premature ejaculation. He feels caught in a loop that is spiralling down.

Daniel was totally engaged during the Initial Consultation. Pennies dropped and light bulbs went on as we talked about how the brain works. He could clearly see how his confidence grew when he lost himself in the creative process. He recognized the obsessive, negative, hyper-vigilant behaviour associated with his anxiety and how it attached itself to thoughts. Daniel really 'got it' when I explained how anxiety is created through negative thinking. It's not the events in our life that create anxiety, it's the thoughts we surround those events with that cause us to lose intellectual control.

At our next session I asked Daniel what had been good about his week. He said he went home feeling very positive after our first meeting. He was listening to the CD every night and he had noticed a general 'lightness of being' about the week.

He had come up with a great idea for a new client that had raised a few eyebrows at work with its emotive impact on the client. I asked him who else had noticed the change in him and with a wry grin he said his girlfriend had definitely noticed. He went on to say it hadn't all been wonderful. The anxiety still crept up on him but he felt that just by understanding what was happening in his brain he had a more optimistic outlook on dealing with the anxiety.

By our third session Daniel was really firing. Where he had scaled himself at around 3 or 4 out of 10 in happiness and confidence when we first met, he was now at 6 and 7. He spoke of being aware that certain situations require certain resources and he was finding himself using techniques that had worked in the past to deal with those situations. Techniques that he realized were sub-conscious resources from the past were now becoming conscious. He was more in control in situations that had previously been causing anxiety. Daniel noticed he wasn't 'trying' as much. He called it 'a taste of effortlessness'. Daniel's confidence was beginning to grow.

Daniel and I met nine times. At our last session I asked him what was good about his life. He said what was different was that now he was focusing on what had to be done and crossing it off the list. He was in control of the list. He was waking up feeling excited about the day ahead and he had more energy. He was surprised at how excited he felt about the international travel that was about to begin. He was also surprised at how his growing confidence and excitement about work had actually strengthened his relationship. It was like his girlfriend was getting a buzz about the possibilities for the two of them. The premature ejaculation had not been mentioned since the initial consultation and his libido was working fine.

As he walk out of my consulting room he turned and said,

"Oh, another good thing that happened this week. My girlfriend and I moved in together.... I nearly forgot about that."

I said I would add it to the list ■

BIOGRAPHY

Author of 'Clear, Calm and Confident: How To Change Your Life In 30 Days', Christian Dunham is a Solution Focused Hypnotherapist. Originally from Australia, he treats clients of all ages and from all walks of life for a wide range of psychological conditions in his clinics in Bath and London. Christian is a member of The National Council for Hypnotherapy and the Association for Solution Focused Hypnotherapists.

Feedback from Mark Hallwood

I was prompted to work in the field of hypnotherapy as a result of a visit to a male therapist a number of years ago following an injury to my back. I would have been comfortable visiting either a male or female therapist for this particular problem, however, when I was researching practitioners I realised the number of male therapists was somewhat limited and on reflection there are perhaps a number of topics which some male clients may understandably prefer to consult a male practitioner about.

First of all though, men need to recognise it's OK to look for help to deal with the various problems that can arise as a result of all the stresses that life hurls at us, and it's not an admission of failure to do so.

I can personally vouch for the benefits that solution focused therapy can bring and would encourage anyone to experience for themselves the positive life-changing transformation that can be brought about.

Raising awareness and general acceptance of this relaxing and holistic approach is important and it is rewarding to be working in a field that is increasingly gaining recognition in health care circles.

I would say it's a matter of ego or pride that needs to be overcome. Many men are perhaps too proud or 'above' this type of therapy with regard to seeking it out as a treatment. Also, it may simply be that people (men in particular) do not like to spend money on things that they perceive as unnecessary. Perhaps many are too busy getting on as best they can with life to take a serious look at this type of thing.

Possible ways forward that AfSFH members could participate in.

Running an awareness campaign aimed at men, to promote the benefits of therapy - to help dissolve the misinterpretation that therapy can often be seen as 'soft', i.e. female orientated. Getting the point across that it's not an admission of weakness. Advertising/leaflets in male focused magazines/ venues. Holding 'therapy for all awareness groups'/ open day. Trade stands at appropriate health orientated 'fairs' – don't know if there are any as haven't researched! ■

Mark Hallwood, is a solution focused hypnotherapist working in Newton Abbot, & Teignbridge in Devon.
He can be found at:
http://www.hallwood-hypnotherapy.co.uk

Living in your primitive brain

Trevor Eddolls takes a look at how people behave without thinking!

As hypnotherapists, we spend a lot of our time encouraging people to make use of the Mr Spock part of their brain – the cerebral cortex. This is where they can make logical decisions about their life and how they want to behave. The problem is that decisions made in the cortex can often be slow. Brains can make fast decisions using the more primitive parts associated with the limbic system – and it can be quite illuminating to see what those decisions are.

Leonard Mlodinow's book, Subliminal, takes a look at a host of psychology experiments that illustrate some surprising and quick decisions that subjects have made.

For example, Mlodinow says that the stronger the threat is to a person feeling good about themselves, the greater their tendency to view reality through a distorting lens. And he illustrates this with examples such as Dutch Schultz the mobster, who thought he was a public benefactor, and OJ Simpson, who continued to justify his behaviour in front of the sentencing judge. When asked how they get along with others, 100% of US high school seniors reckoned that they were average or above; 60% put themselves in the top 10, and 25% reckoned they were in the top 1%! Similarly, 94% of college professors reckon they do above-average work. Engineers, the military, doctors, have all proved to have equally over-inflated views of their performance. And, you'll not be surprised to learn, we even over-estimate our ability to resist over-estimating our own ability!

Motivated reasoning is the name given to finding evidence to fit our beliefs and to ignore evidence that doesn't. There's evidence to suggest that even scientists will still hold on to beliefs even when all the evidence is contradictory. And their opinion of the work of their colleagues depends on how well their colleague's conclusion fit their own beliefs.

Our illusion of reality – our belief in our own innate superiority – must maintain the illusion of objectivity. We can only be so good, and not any better or evidence might interfere with our belief. The same applies to politics and football teams, and much else.

Evidence shows when interviewing, that we will make a choice and then look for evidence to justify our choice. Worse, evidence shows that this bias affects our memory. When recalling school grades

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years afterwards, people are more likely to remember they got an 'A' (about 89% of the time) to about 64% for 'B's, 51% for 'C's, and only 29% remembering their 'D'.

It seems that every client we see, in fact everyone we meet, in fact even ourselves, is a living illusion. Every individual holds a positive illusion about themselves and their past.

We also have a bias towards traits similar to our own. In a study of marriages in three US states, people were more likely to marry people with the same surname. More Smiths married Smiths, more Johnsons married Johnsons, more Williams married Williams, more Jones married Jones, and more Browns married Browns than any other combination of surnames.

You're probably familiar with Orr's Law. Dr Leonard Orr, the founder of the American rebirthing movement, suggested that within everyone are two people – one is a thinker; the other a prover. The thinker, which roughly corresponds to your conscious mind, is that part of you that thinks up ideas and generates possibilities. The prover, which approximates to your unconscious mind, has the job of collecting just the right facts to support whatever it is. Orr's Law state that whatever the thinker thinks, the prover proves.

Research also shows that we're not very good at understanding our own feelings, but we do it with high confidence.

What about eating? What affects how much we eat? Is it taste? The answer is no – it's how big a container it comes in. An experiment with popcorn involved people being given either tasty or stale popcorn, and either large or small containers. People with large containers of stale popcorn ate lots of it. And menus that use 'flower modifiers' – you know, "slow roasted x drizzled onto a bed of crispy y" sort of thing – help people to enjoy food more. Yes, people prefer food with adjectives! Using hard to read fonts in a recipe book makes people think the recipe is more complicated and so they are less likely to try it.

What about shopping? You surely make sensible and reasoned decisions about purchases? Seemingly not. Put identical German and French wines for sale next to each other and play French-sounding background music and 77% of the wine sold is French. Play German background music and the reverse happens. In another experiment, four pairs of identical silk stockings had a scent added to them. People then chose the 'best' one. And, of course, without realizing it, they chose the pair with the nicest smell – and without consciously noticing that there was a smell.

Even how clever you are depends on what others think! Rosenthal gave children IQ tests and told their teacher the results. Some children identified as 'gifted' were no better than average. Then eight months later the children were retested and 80 percent of those labelled as gifted had improved by over 10 points, and 20 percent had gained over 30 points.

So it seems, most of what we do is decided by our unconscious mind and then justified logically by the logical parts of the brain.

Nobel prize-winning Daniel Kahneman in his book Thinking Fast and Slow also describes some surprising aspects of our and our clients' thinking. The book explains that we have two ways of thinking, a quick way that we use all the time (what we'd call the primitive emotional brain), and a slower, more reflective way that we're often too lazy to use! (What we'd call our intellectual brain.) Did you know that being brave was tiring? According to Kahneman, stifling an emotional reaction reduces your physical strength. This he calls 'ego depletion'. Ego depleted people are more likely to give up tasks such as dieting. Priming is a way to get people thinking about something without ever mentioning it. In one experiment, students were asked to go through a number of words associated with being old. When they left the experiment room, they walked down the corridor more slowly. Or people who balanced a pencil on their top lip (causing a smile) rated cartoons as funnier than people holding a pencil in their teeth (causing a frown). Money-primed people are apparently more selfish than others.

Kahneman goes on to suggest that there is a confirmation bias – in that people look for evidence to confirm their ideas, rather than challenge them. And he comes up with a rule – What You See Is All There Is (WYSIATI) – that explains so many bad decisions. Basically, people only take into consideration what they know about a situation and ignore what they don't know. So even though they may know that there are things they don't know, they don't let that affect their choice.

How can you tell how successful a politician is going to be? Do you look at their voting record? No, apparently you look at how strong and trustworthy they look!

Kahneman suggests that our fast brain likes to see the world as a well-ordered place. He suggests the halo effect to explain how our fast brain will attribute attributes to someone just because they exhibit other attributes. For example, just because we think a baseball pitcher is handsome and athletic, we will rate him as being better at throwing a ball. Think about how that might apply to people or your clients! The suggestion is that your brain builds a coherent narrative about people and events from very limited information. We think we understand past events and that the outcomes were never in doubt – and therefore, we should be able to predict what will happen in the future. Kahneman calls this the illusion of understanding.

Experiments show that you perceive people as friendlier when you're holding a hot drink than when you're holding a cold one. You're more likely to wash your hands after thinking about bad deeds than good ones. You'll perceive a heavy book as being more important than a lighter one.

The second illusion that Kahneman describes is the illusion of validity. He describes how he and a small group of others looked at recruits and decided who would make the best officers. They were confident that they were right, based on their observations. And even when evidence from future training of the soldiers showed that their decisions were wrong, they continued to make them. And he goes on to show that the same can be said of stockbrokers picking stocks. So why does the illusion continue? The answer seems to be that powerful professional cultures maintain the illusion. In fact, most research shows that experts are no better at predicting the future than anyone else would be. It seems that in an unpredictable environment, no one can predict the future. Remember that, the next time you really think you know what a client will do next.

But you know there are times when you just have a feeling that something is right or that it will work. You just know what's going to happen and what your client needs to do to accommodate that. Kahneman has a chapter on intuition and formulas. His example is the future price of wine. Experts make a guess about the quality of Bordeaux wine and predict how much it will sell for. The accuracy was tested against an algorithm using weather features – average

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temperature during the summer growing season, the amount of rain at harvest time, and the total rainfall during the previous winter. And the algorithm was a better predictor of wine prices. Similarly, the Apgar test (an algorithm) is applied to newborn children to ensure they are not in distress. We learn that when choosing people to work with, perhaps in a new clinic you are setting up, you need to choose up to six characteristics that are important. Ask questions and score potential colleagues for each trait. That way you'll get the best team. Don't select people just because you like them.

There are times when you can accept expert judgements, and that seems to be when a system is fairly predictable and when circumstances are similar to previous events. Effectively, this is when the expert remembers a similar event and uses that to base decisions on. This shows the value of feedback and practice. And this is where we are most often when working with clients. We have seen something similar and so we can use that to predict what will happen next.

Another point that Kahneman makes is that people don't look at external evidence when making a decision. He highlights a time when he was leading a project team and asked everyone to write down how long they thought it would take for the project to conclude. The answers were around the two-year mark. He then asked an expert on the team how long similar projects had taken. The answer was seven to 10 years. In fact, his project took eight years. So, next time a client seems to be making marvellous progress after two sessions and appears ready to stop coming, remember that in your experience clients need perhaps eight sessions to not only make progress, but also to consolidate that progress. Take a look at what you know from all your clients, not just from this particular one.

Kahneman states that when we make a decision, we focus on what we know and neglect what we don't know, which makes us overly confident in our beliefs. Let's all take that as a warning ourselves, but also pass it on to our clients.

So it seems, from both books, that there are plenty of documented examples of how most people make the same mistakes and get themselves into difficulties. And they all seem to be a consequence of using our primitive brain too much and not engaging our intellectual brain enough ■

Trevor Eddolls is a member of the executive of the AfSFH, he's in charge of our IT and is a Solution Focused Hypnotherapist working from Chippenham Wiltshire. http://ihypno.biz/

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The case of the Phantom leg pain client

An unusual case with Donna Adlington

During an initial consultation, the client reported that she was experiencing phantom limb pain in the leg that she had removed due to an accident. She explained that she was on 2 different types of pain killers (Tramadol and Pregabalin) but despite this she experienced numerous episodes a day of sharp stabbing pains where her calf, shin and feet used to be. This pain worsened in the evening, (She believed due to her medication wearing off), and she also had constant pins and needle throughout the missing leg.

I asked her what her ideal outcome of the therapy would be and she explained that she would like to feel no pain or pins and needles, and to come off the painkillers she was on. She also explained that she had tried in the past to come off the painkillers, but that the pain was so constant and intense that she had had to go back on them within a couple of days.

During the initial consultation, we also discussed what she would like to feel instead of the pains and she said 'comfort' and that she would also like to be able to feel both of her toes pointing. I explained the effects of serotonin on the brain in regards to pain, and asked her under what circumstances she already didn't notice any pain, she said whilst she was sleeping and mornings / early afternoons. We discussed the possible effect of her bucket filling throughout the day, and she said that she thought this was likely as she had suffered what she labelled 'depression' in the past, but it sounded more like anxiety to me. She also explained that she had suffered from insomnia for years until recently and that she actually missed it because she used to get more done. I explained that our primitive minds do not like change, so can miss things even if they were unhelpful. She then asked if that could explain why she was getting pains in her amputated leg? Maybe her mind would rather feel anything (including pain) rather than accepting that the leg wasn't there. I said that this was a possibility and if it were the case, then we could choose to change the pain into a nice sensation instead.

During the 1st session she said she was a 5 on our 'Happiness Scale' that this had risen from a 1 in the

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Case of the Phantom leg pain client

past because she felt more mentally stable and had the support of family and friends. She had been a 9 in the past when she was more socially active, so her small change was to re-connect with at least 1 friend that she hadn't contacted for a while. We baselined her physical symptoms so that we could recognise changes. She said that the stabbing pains hurt (On a scale of 1- 10) at 9, they were totally random and she was getting anywhere between 2-3 in the day and 3-4 at night. The pins and needles were constant and on a pain scale a 1-2.

I based the hypnosis on 'anxiety release session' script because it included the feeling of relaxing all parts of her body bit by bit (Including BOTH of her legs). We agreed that I would get her to feel relaxation in both her legs before doing this.

Session 2

– What has gone well?

The pins and needles have started to fade into a nice sensation. The stabbing pains which were lasting on average 10 seconds were getting shorter and the pain intensity was now at a 5. She said that she was also now only experiencing 3-4 a day although now they were totally random and didn't get worse in the evening. She'd been out for a meal with her mum for her Mum's birthday and realised that although the meal was in the evening, she had not noticed any pains throughout the meal. She'd started some training course applications that she'd been putting off and felt happier. She had lowered her meds to the lowest she could be on. Her small change was to finish her course applications.

I gave her lots of reassurance about how well she was doing and hypnosis was 'Star' induction, Tropical Island and village metaphor to encourage change.

Session 3

– What has gone well?

She'd enjoyed walking the dog and her gym classes. She'd been finishing her work earlier and relaxing in the evenings. The sensation which replaced the pins and needles was fading even more. The sharp pains were reduced to 1-2 a day and she'd decided that she was going to try 1 day at the weekend completely off her medication to see how it goes. I reminded her of the frequency and feelings she had 2 weeks ago and asked her what would show her that it was ok to stay off the meds, she agreed that if being off the meds resulted in no more pain / frequency than 2 weeks previously while she was on full meds, that this would be progress.

The hypnosis was colour changing for pain, so that if she did experience any kind of pain, she could use self- hypnosis to control it.

Session 4

– What has gone well? She'd been off all meds since Saturday. I told her how fantastic that was and reassured her how well she was doing. She said that the frequency was 3-4 a day (randomly), not worse at night and they weren't quite as sharp as they had been prior to hypnosis. (Pain scale 5-6). She said that the pain colour changing technique had worked initially, but wasn't working as well anymore. She said that she would like to feel as though she was pointing her toes, so we did 10 minutes of mirror therapy. (A large mirror placed between the legs and angled so that the healthy leg is reflected and looks like 2 working legs because as the healthy leg moves, the client can see 2 healthy legs moving). She was smiling a lot and said that it made her happy and that she also really felt like both sets of toes were pointing, she said that this would make it easier for her to practice 'pointing her toes' throughout the day and really feel as if it were real.

Hypnosis was an adapted version of 'stairs and room' script, where the room was a place where there was no stress and she was perfectly fit and healthy. She could go to the room anytime she liked just by walking down the stairs and opening the door in her mind. I also had her imagine bouncing up and down all over the nice comfy sofas like she had done as a child. I also used parts of the reframing script and creating happiness through changing your thinking.

Session 5

– What has gone well? Another week off her meds. Fantastic! She said that the mirror therapy had helped and that she had been practising pointing her toes and it felt real. She had been doing this routinely, a couple of times a day and noticed also that if she felt pain that pointing her toes made the pain stop so that she felt more in control of any pain. She said that a small change would be 1-2 short pains or less a day and being able to feel both sets of toes moving 1-2 times every day. We discussed a routine for regular toe-pointing practice and she asked for more mirror therapy so we did another 10 minutes. I also asked if she had a large mirror at home and she said that she did.

Hypnosis was self-recognition, migration metaphor, positive thinking and doing.

She asked if next week we could work on her constipation!!

Session 6

– last session - What has gone well? Still off meds, pains a lot fewer (not even every day) and hardly noticing them when they are there. She'd been practicing pointing her toes morning and night and it felt good. She said that she would still like help with her constipation, so we discussed practical solutions such as diet. We also discussed 'letting go' of things that are no longer serving us and the effect that this has had on her with regard to her previous insomnia and leg pain, and how it may also help her physical flow of nutrients to embrace positive change and recognise what to let go of and what to keep. We discussed the miracle question in detail about how much better she would feel if her digestion ran more smoothly and what would show her that this was working. I reminded her that she had the resources within her to make any change that she wanted, and that the knowledge she had gained through these sessions could be applied in all sorts of situations.

Hypnosis was not scripted, but made up to help her to imagine decluttering her life of those things she no longer needed, and keeping what was still useful. Reminding her of all the changes we make through life with no problem, (New schools, friends, not needing nappies etc,) Migration metaphor (again) trees metaphor and confidence building.

What did I learn from this client that I didn't expect?

I learned that you can never predict. I guess I expected that I would be helping her mind to accept that her leg was not there so she couldn't be feeling any pain. The reality seems to be that she didn't want to accept that her leg was not there at this time, she just needed to feel nice sensations which she chose, instead of the constant reminders that her primitive mind was giving her instead. I believe that I saw a direct correlation between her choosing to do exercises to feel nice feelings, and the reduction of the painful reminders ■

Donna Adlington is a solution focused hypnotherapist working in Cheltenham, she can be contacted at: http://www.happinessfromwithin.co.uk

An interview with...

..Michael Hughes

Originally trained where?
I trained at the Clifton Practice in 2005 on intake 36.

Year qualified
2006 - seems like ages ago now. How time flies, makes me ancient in hypno terms.

Additional therapy qualifications
NLP, Life Coaching, Mindfulness, SFBT Supervision, CBT, Drug Addiction Biology and Belief, Miracle Question Seminar, Impact of Hypnosis on Pain and Disease Seminar, Refresher Course, How to Get More Clients Course, Neuroscience with Dr Naeem Iqbal, The Relationship Between Neuroscience and Obesity, attended about every CPD at CPHT, too many to list really.

Any positions held in any organisations, i.e. AfSFH, NCH etc
Previously Research Officer for AFSFH but had to stop as my practice became so busy I had no time to spare. Really enjoyed it for the year that I volunteered.

Number of clinics you work from: 2
I am so lucky to work from two very beautiful clinics, one in Clifton and one in St Andrews and I feel incredibly lucky and very privileged to work from them both.

Number of clients a week (rough estimate between lowest no and highest i.e. 10 – 16 etc.) 18-24 is a bog standard week for me. Lowest has been 10-12 and at its highest was around 39 - 42 (Which was too many) around 18-20 is my choice set point these days for great work life balance.

What made you interested in studying hypnotherapy to start with?
I started out in NLP and Life Coaching and NLP initially sparked my interest and made me research into Hypnotherapy. I despised my job in the public sector and hated my boss and the politics around the job which made life very difficult so decided I wanted out and to work for myself so looked to retrain and after a lot of careers research Hypnotherapy came out top and that's what I decided to do in terms of retraining. I can honestly say it was one of the most happiest and memorable days of my entire life when I handed in my notice to my boss to say I was becoming a full time Clinical Hypnotherapist and at the time it felt like a huge leap of faith and it did wonders for my motivation to be a success and I never looked back. I remember a business advisor friend of mine gave me the advice of; "Don't try and be like everyone else, just be you and there will come a day where you'll just wake up and you will know when the time is right" He was right of course. It was exactly like that.

What did you do before you trained as a hypnotherapist?
I worked for the local authority for several years. Before that I was a Customer Services Centre Manager in Bristol and also worked in HR Flexible Benefits before that a Team Leader for a large Business Utility Company.

Did anything you did in the past, help you in building up your business?
Yes, being in a job you don't like, prior to becoming a hypnotherapist, really motivates you!

Also, my own experience with battling debilitating anxiety, panic attacks coupled varying degrees of OCD for about twelve years prior to 2005, just about everything we treat I have suffered from in the past, so on reflection that experience served me very well in terms of having a wealth of understanding when it comes to what my patients present with. I trained predominantly because I was severely failed by the NHS and in my sheer frustration I knew I could help people so much more than what was out there and I passionately wanted to help people and I didn't want people to suffer for years the way I did in the early days. CPHT and David Newton's teaching and expertise and Susan Rodrigues' compassion and support changed all that and I'm so grateful to both of them for that.

I started with the best website I could muster and flyers, lots of flyers. Lots of hours delivering them too. Money was spent on Adwords, although it was mostly luck and guesswork. And a few adverts were paid for in the very localised pamphlets that had a large local distribution list. But in the main part my business was built on flyers. I've never used twitter and with Facebook I'm either all or nothing with it really, I can close down the account in a heartbeat when I've had enough of it and other times I enjoy using it. I'm not really a naturally outgoing person and all of my business has been word of mouth and referral and sustained by a constant belief that I am very good at what I do and I really enjoy it.

David Newton often says that therapists become successful because of their engaging personalities, what other attributes do you feel are important?
I agree. I speak my mind and I very much do things my way. Over the years at least outside the consulting room I've become much more direct, critical, impatient and intolerant of certain things. I think because time becomes more of a precious commodity as you get older so I won't abide time wasters, non-compliance or rudeness, they can go somewhere else and behave like that.

I do love helping people and lots of them, having been consistently busy for years now with all referrals I know I am doing everything right, the way it's meant to be done. Being determined and persistent helps. Stubborn yet flexible when required. Outside of the consulting room, not giving a monkeys what other people think of you helps enormously or not being afraid to let people go that hinder you and no longer help you. Be open to welcoming people that genuinely will help you, there are lots of people that helped me in the early days and I never forget that. Everyone is different yet experience and practice is what really counts.

How do you get your clients?(i.e. referrals from other health professionals, advertising?)
These days it's about 98 per cent referral that sustains the business. These mostly come from recommendations from previous clients or other complementary therapists or body based practitioners such as osteopaths, acupuncturists, herbalists, TCM practitioners and nutritionists, chiropractors, the list is endless or there are other hypnotherapists refer clients to me too, you know and never refer the easy ones!

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I stopped advertising last year as the business took care of itself and self-generated and it's stayed consistently busy but I work incredibly hard and I've put in so much effort to get to this stage in my career. I'm a hypnotherapy workaholic which stems from my very competitive and obsessional nature which was channelled in the right way and I've remained incredibly focused. I'm obsessional about everything to do with the brain and neuroscience.

I know in the first couple of years starting out, you often saw people for weight loss, but have changed to other areas, which areas do you enjoy most now and why?
The area I currently enjoy most are working with relationship areas and the most common area I get referrals from are relationship and sleep issues like insomnia.

I really enjoy some of the more complex areas too. However my work has been so varied and diverse that no day is the same and that keeps me on my toes. I stopped seeing smokers as they annoyed me with changing their mind and it became unmanageable in the diary that I simply wasn't enjoying treating them or wasting precious clinic time, so I only do stop smoking sessions with people who want to stop that are already in session with me. Weight loss people I carried on seeing but there were so many referrals in the earlier years to see me for weight loss that I had to put them on a waiting list so I have structured and waiting time system now to allow me to see a variation as I feel that this keeps things fresh and I have a diversity within the clinic. There are certain things I will not treat and I will choose to refer on and I think you naturally do this the more years you are in the business.

Do you take credit cards, or do you have any payment schemes?(i.e. PayPal etc)
No but I do allow people to do direct bank transfer but I have to keep an eye on it and that can be a bit time consuming and it's being reviewed at the moment.

Do you do anything else that uses your skills in hypnotherapy outside the clinic room?
I use SF language in day to day life outside the clinic; it permeates through the fabric of interactions. I write metaphors and scripts like I breathe air, like all the time, I'm passionate about writing and really enjoy it. I listen to a couple of hypnotherapy CD's regularly at night. I'm rekindling some of my earlier meditative practices to reconnect to what I used to do in the early days before I became so busy. I also rekindled the use of grounding imagery and meditation before I start clinic and shortly afterwards. I'm very critical by nature so SF provides some balance. I go to the gym 4 times per week and I regularly use the skills I've learned in work that translate well in the gym for the results that I am focusing on.

You have worked in a variety of places around Bristol, what differences have you found in the different locations?
I started in Backwell progressing to The Clifton Practice to get the business off the ground then left there to move to Montpelier, and currently in a beautiful practice overlooking College Fields in Clifton and another wonderful clinic in St Andrews near St Andrews Park. A précis of the locations; Backwell was a waste of time and it was too small. I decided more central was better and The Clifton Practice with lovely help from David Newton and Susan Rodrigues was a great grounding and platform to build a concrete business and then to fly the nest as it were. Montpelier was where all the intensity and hard work really happened despite noise challenges I clearly earned my stripes during this time and built my reputation as a practitioner and worked on successful outcomes and then I was approached, based on that reputation and high successful outcomes to work at College Fields and St Andrews is where everything has settled. It's so important to work in a treatment room with a window, I found that it makes such a massive difference to have a nice view. These days I just sit back and do what I do best and in the most part I'm rather contented. I do feel like I have reached the top of the profession and that's a very rewarding feeling and I have my eyes on the next challenge.

If you could give one tip to a new graduate, what would that be?
If doing the HPD then write your case studies up as you go along and answer the questions bit by bit so as not to panic at the end.
I would say make sure you go to supervision but that's become a tad tiresome to say and reiterate as the current guidelines from the main associations outline a lazy opt in. Since the NCH took the stance on essentially dumbing down of the profession I think it took a step backwards and this needs urgent redress. I believe that supervision should be a requirement of practice like it is in counselling. I also believe this for so many reasons one of which is to prevent burnout. I remember hearing that there is no such thing as therapist burnout but I think that's an outmoded and dangerous assumption. There is, such a thing, ignoring it is as ignorant as it is stupid, you have to pay attention to your workload and what you can do and what you can't and listen to what your body tells you. Look after yourself, eat right, exercise, go to a spa, have hypnotherapy, find your own ways to switch off and relax, it is really important to your own well-being.

Secondly is the benefit you get of interacting and connecting with other therapists and the knowledge that you gleam for the supervision groups. I am still surprised that there are some practitioners out there who do not bother with supervision and that the profession somehow even tolerates this. This is where there needs to be tougher rules. I would say above all have self-belief and be ruthlessly determined, don't care so much about the opinions of others when you reflect back you'll realise they don't actually matter as much as you thought they did. Marketing doesn't need to be overcomplicated however you'll come across many people that will attempt to tell you otherwise. You don't need to spend bags of money although you'll feel like you have to. I'll give you a good example, there's a hypnotherapist in Cardiff and now a great friend of mine who built her business by talking to as many people as she could and handing out business cards to as many people as possible and she has a very simple website and the stream of referrals for her have been a constant over the years. She openly admits she has NEVER paid for any advertising although she can talk for England, or should that be talk for Wales and she talks incredibly fast. Her name is Anna Sainsbury Thomas. She is an inspiration and always makes me laugh; cherish the people around you who make you laugh, like belly laugh. It's such precious gift.

Telling people you exist and what you do and the great work that you do, tell everyone and anyone. Proof that it can be done very simply with no gimmicks, maximum effort, minimum fuss. I know that she is one of the busiest and brightest stars that ever graduated from CPHT.

So, keep things simple, work on your cadence and ensure that you know the initial consultation by heart and stick to the CPHT template, you can use your own elements later on but in the main, sticking to it is key. Stop worrying that you don't know everything about the brain, even neuroscientists don't know everything as the brain changes all the time so you'll always be playing catch up to some degree and that's the fun part as what we know about the brain is constantly evolving and changing. At a basic level, get those simple things right and you have the ingredients for success right there.

Invariably, the more clients you see, the more you really do become a better practitioner. Enjoy it, embrace it. It is fantastic profession and I feel lucky and so privileged to be a part of it.■

NEW AND EXCITING OPPORTUNITY

Association for SOLUTION FOCUSED HYPNOTHERAPY

The **AfSFH** is seeking to recruit a highly motivated volunteer. Are you creative, innovative and passionate about solution focused hypnotherapy

Do you hold the relevant experience and qualifications to provide ongoing support for our members?

- Experience of using solution focused hypnotherapy
- Strong communication skills
- Ability to network and build strong partnerships
- Strong leadership and management experience
- Evidence of continuing personal and professional development
- Good self-management and team working skills

If you believe you have what it takes to enable our members to keep up to date with information related to solution focused hypnotherapy then please apply for the following post.

Head of Marketing Ref:afSFH01

(Voluntary role, expenses reimbursed)

Ideally you will have a marketing qualification at degree level, or equivalent experience; evidence of strong networking and collaborative working; excellent and demonstrable verbal and written communication skills, with attention to detail; friendly and professional approach in marketing and establishing contacts and relationships. You will demonstrate ability to work on your own using your initiative. You should be able to provide creative and innovative solutions to marketing and branding at international, national and local levels, whilst showing enthusiasm and commitment to the development of the association and all its members.

By volunteering you can...

- Meet new people - volunteering can bring you into contact with like-minded-people as you volunteer together for a cause. It is also a good way to meet people from different backgrounds.
- Have fun - many people tell us about the fun they have whilst volunteering.
- Build confidence - while volunteering you will experience challenges and develop new skills. This can help you to build confidence.
- Boost your employability - volunteering is a great way for you to develop skills such as communication, organisation, teamwork and time management that many employers look for in today's competitive market.

For an informal discussion about this role or to apply, **call Sharon Dyke on 07766250113** or email ceo@afsfh.co.uk for an application pack. Closing date 31st July 2014.

Magazine Advertising Sales Ref:afSFH02

(Voluntary role, expenses reimbursed)

Ideally you will have experience in telesales, and some experience is preferred in media sales; evidence of strong networking and collaborative working; excellent and demonstrable verbal and written communication skills, with attention to detail; friendly and professional approach in sales and establishing contacts and relationships. You will demonstrate ability to work on your own using your initiative. Liaising with the Editor of Hypnotherapy Today, you will responsible for approaching potential advertisers to appear in the journal, whilst showing enthusiasm and commitment to the development of the association and all its members.

For an informal discussion about this role or to apply, **call Penny Ling on 07759 820674** or email journal@afsfh.co.uk for more information. Closing date 31st July 2014.

For full member benefits and all other information go to:- http:// www.afsfh.com

The Association for Solution Focused Hypnotherapy Limited is a Not for Profit Private Company Limited by Guarantee.

Company Registration Number: 7412098

David Mclean speaks to Hypnotherapist Leah Bevan about the importance of research

Leah Bevan is a SFH, working within two locations in Plymouth including The Observatory Practice. She qualified in December 2011. She is a full time practitioner currently seeing around 15-20 clients per week, she juggles a flourishing hypnotherapy career with being a busy Mum. Her previous job was in medical sales which relied heavily on research. Leah says that "evidence is what the NHS and the science world expects, therefore we need to produce our own measurable results to add to this. This this is what our research is and will continue to provide":-

1. When did you start the Outcome Rating Scale (ORS) programme?

"I started the ORS shortly after Matthew Cahill presented it at the Clifton Practice for the first time. I found it very valuable and interesting and knew it would become a great addition to me in my therapy room."

2. What convinced you that it was a good idea?

"As my previous job relied in the main on evidence and proven research, I understood the benefits that I would have immediately. I spent many years in medical sales convincing GP's that my new product was better than the one they were using at the moment. I could only do that with up to date, positive research. It also reaffirms the individuals progress and 'forces' them to think in more detail about their positive changes in their lives."

3. How does it make you feel that you are adding to real world research in terms of SFH?

"Fantastic! It's exciting to be part of something that is starting to make its mark on the world. It will take time I'm sure, however the more of us that record our outcomes, the closer we will be to letting the world know just how powerful SFH is."

4. What benefits does it give you in the therapy room?

"It's a huge benefit to the client, they (the client) don't always feel that they are making much progress particularly if they are still 'working' from their primitive emotional mind. This allows them to affirm their positive change as they have input their details on the system themselves. It helps us to prove to them they are getting better by showing real time changes on the graph. It also gives unequivocal evidence (due to them inputting the data) that they are improving. It allows them to focus in and actually see the wood instead of the trees for a change."

5. Have you upgraded to the Clifton Practice Outcomes and Research Programme (CORP) yet?

"No not yet, I was unable to attend the launch date however I fully expect to attend the next available one. It's necessary to attend this if I want progress with my research."

6. Do you plan to start it in the future? What do you feel the benefits of the new improved system are?

"Yes absolutely, this is the next level that Matthew Cahill and others has been working so hard on. This of course, sits alongside and is a large part of, our advanced HPD. It sets us apart in our field in terms of level of qualification. The additional functionality of being able to measure other, more specific outcomes, can aid in marketing which is an extremely valuable tool, one which I am very much looking forward to using in my every day therapy sessions."

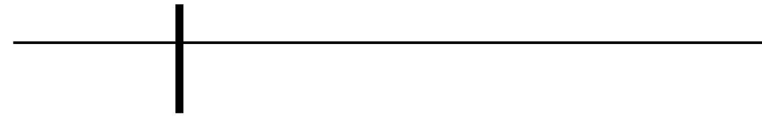
7. How important is our individual research in terms of the overall visibility of SFH?

"It is extremely important. Firstly, as a tool within the therapy room, it measures our client's subjective view of their quality of life and the positive impact they and the therapy are having on it. Secondly and importantly, it gives us a voice within the huge field of complimentary therapy. A voice that allows people to know that SFH is a measurable, successful therapeutic process, one which cannot be ignored." ■

Session No:

CPHT Outcome rating
- research programme

Please make a mark on the line that indicates where you feel you are, ie if you don't feel you're achieving much place a line closer to the Low end



1) Thoughts - *to be able to reflect in a positive way and recall good happenings*
to be able to forecast positively

My thoughts are all negative ______________________________ My thoughts are positive

2) Interaction - *to be able to interact in areas of choice in a positive and constructive way with family, friends, colleagues etc*

Interaction is poor ______________________________ Interaction is good

3) Activity - *to be able to create activities of choice or renew involvement in activities that were beneficial and enjoyable in the past.*

I do nothing at present ______________________________ I am fully engaged

4) Confidence - *to have that belief in oneself to achieve what one wants to achieve.*

Low confidence ______________________________ High Confidence

5) Resources and strengths - *an awareness of "what's good about me" with new resources and strengths and renewing and re-establishing old ones*

Few resources ______________________________ Many resources

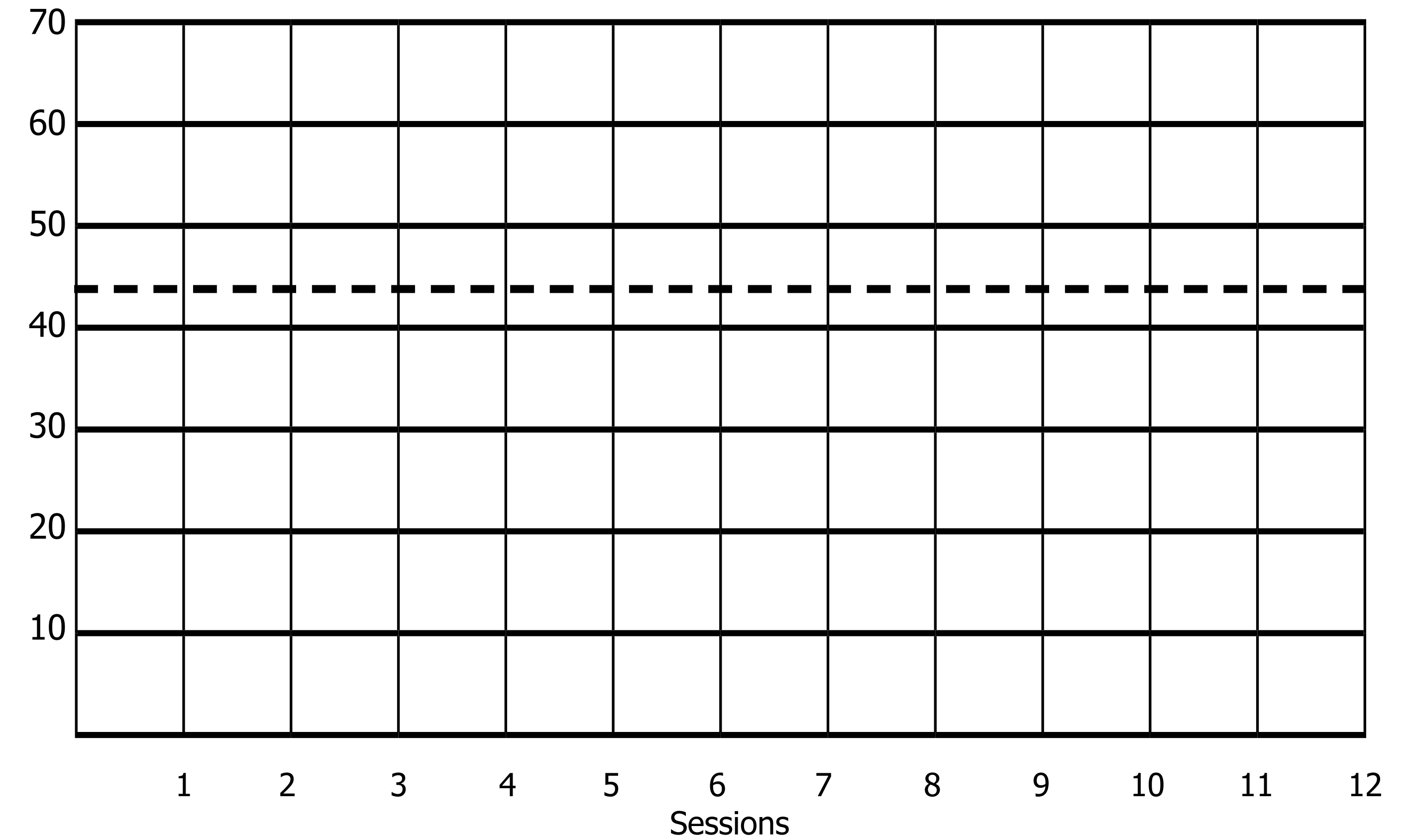
6) Achievement - *what has been achieved in moving towards the "preferred future".*

Low ______________________________ High

7) Happiness - *a reflection of the scale*

Low ______________________________ High

Outcome rating results



IS ATTENDING SUPERVISION REALLY THAT IMPORTANT?

The simple answer is YES!

Sharon Dyke CEO of the AfSFH fears Hypnotherapists may not be taking supervision very seriously as Supervisors report a recent fall in attendance.

Sharon reminds us that supervision is a way of using reflective practice and shared experiences as a part of continuing professional development (CPD) and more importantly, it has the support of the AfSFH and the CNHC.

She explains that in terms of the number of people involved and the way in which they interact, clinical supervision can take several different forums and there are no hard-and-fast rules as to which of these forums is best; it will depend on the particular way clinical supervision is set up in your local area. However, it appears the main types of clinical supervision include:

- One-to-one supervision
- One-to-one peer supervision
- Group supervision with a named supervisor
- Peer group supervision
- Network supervision

Sharon suggests that these supervision forums appear to fit well within the clinical governance framework, helping to ensure best practice and this is crucial for our discipline if we want organisations such as the NHS and NICE guidelines to recognise Solution Focused Hypnotherapy in the future.

By submitting this article Sharon aims to provoke thought and asks members to consider the following question:

Suppose you could talk about what has helped you most at a supervision session, what would you tell new students?

Sharon states, "for me the answer is simple: I would emphasise how, in my opinion, clinical supervision is a formal process of professional support and learning which enables me to develop knowledge and competence. She adds that attending regularly enables her to assume responsibility for her own practice and this enhances her client's protection in what can often be deemed, complex clinical situations".

Sharon suggests that attending supervision does this by making it possible for her to reflect on her practice and identify room for improvement. It also provides the opportunity to develop expertise, to find new ways of learning, and to gain professional support, which is particularly important for her as she often works alone.

Sharon also believes that clinical supervision aims to motivate Hypnotherapists to remain client-centred and focussed on Safeguarding. Recently this belief was reinforced as she raised the same question in a local supervision group and the responses included:

- improved practice through the use of evaluation
- new learning opportunities
- improved efficiency and effectiveness.

Sharon goes on to say: "Of course we recognise that introducing clinical supervision to practice has resource, cost, and time implications that Hypnotherapists need to manage" and people may ask "why do we think now is the right time to be promoting yet another priority spend"?

Sharon argues that recently, various forces have come together to make the adoption of clinical supervision an important issue for therapeutic services such as:

- The change from task-oriented to client-focused therapy puts more emotional strain upon Hypnotherapists.
- The isolation of therapeutic working environments and lack of line management leaves a gap that needs to be filled.
- The Scope of Professional Practice (AfSFH) and the CNHC Code of Professional Conduct make practitioners responsible for their own practice, and Hypnotherapists may need support in taking on this responsibility.
- The increased intensity of Hypnotherapists workloads, and the adoption of lone working means that Hypnotherapists have few opportunities to discuss their work informally.
- Changes in public attitudes to Hypnotherapy mean that there may be a higher risk of complaints by clients ending up in court.
- Continuing technological change and increasingly evidence based practice requires Hypnotherapists to be lifelong learners.

These changes suggest that if we want to continue to grow as a profession then we must also adapt to change and embrace the requirements as a positive move towards professionalising Solution Focused Hypnotherapy, so we could ask, "why wouldn't we think now is the right time to be promoting yet another priority spend"?

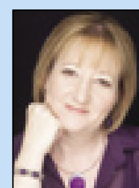
And so finally, I believe supervisors are the guardians of our profession and as Hypnotherapists we have a responsibility to the wider community to try our best to work ethically and to a high standard. Rules and regulations cannot eliminate bad practice. However, as group dynamics explains, that which occurs in a group, community or system needs to be resolved within it. I am not at all sure we can ever prove conclusively that clinical supervision works but a system that monitors everyone's process within our discipline feels a good enough check and balance to me ■

Sharon Dyke - CEO AfSFH

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

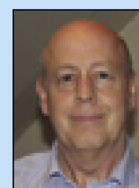
Sandra Churchill
Location: Warminster
Tel: 07515 441 825
sandrachurchill@virginmedia.com
www.churchillhypnotherapy.co.uk

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

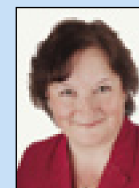


Kim Dyke
Location: Trowbridge
Tel: 01225 765411
M: 07825 957013
kimdykehypnotherapy@hotmail.co.uk
www.kimdykehypnotherapy.co.uk

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



Trevor Eddolls
Location: Chippenham
Tel: 01249 443256
http://ihypno.biz/super.htm



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

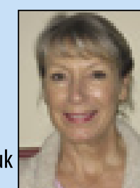
Michael Hughes
Location: Bristol
Tel: 0117 9076 412
info@michael-hughes.co.uk
www.michael-hughes.co.uk

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

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

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

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

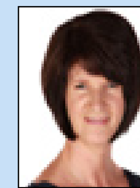


Susan Ritson
Location: Axbridge & Frome
M: 07837 562602
susan@ritsonhypnotherapy.co.uk
www.ritsonhypnotherapy.co.uk

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

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

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



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

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

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

Don't Forget!

See website for more details on Supervision and CPD for different levels of membership.

Writing for Hypnotherapy Today

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.

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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

Trustees

AfSFH.com

Association for
SOLUTION FOCUSED HYPNOTHERAPY

Chairman and Trustee: David Newton

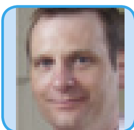
David Newton founded the AfSFH and is an avid supporter of getting the word out to the public of what Solution Focused Hypnotherapy is all about. His inspiration brought the Association to life and has allowed us to flourish rapidly in our early days. His support of all that we do is greatly appreciated.

Trustee: Nicola Griffiths

Nicola did a wonderful job as secretary but has had to step down, but remains a trustee. 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.



Trustee: Matthew Cahill

Matthew is one of our Trustees whilst also being heavily involved in training Solution Focused Hypnotherapy. He is also a director of UKCHO which is involved with moving the hypnotherapy profession forward.

Company Secretary: Sharon Dyke

Sharon has taken over the role of Company Secretary for the association - is there no end to this woman's talents! Additionally she wears our Legal hat, keeping an eye on things such as Data Protection etc.

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, and Metamorphosis which brings our articles to the attention of the public.

Operations director: Deborah Pearce

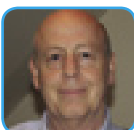
Deborah's current role within the Association is to oversee the operational aspects of the organisation and to provide support to the CEO. In practice this means that she does whatever needs doing and often involves standing in for people when we are between volunteers.

Marketing Officer: Position to be filled

Please see advert on page 26

Treasurer: Denise Barkham

Denise 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 Manager: 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!

Head of membership: Kim Dyke

Kim is looking forward to encouraging the growth of our Membership further and to help improve the services we provide to you, making your experience as a member an even better one!

Events co-ordinator: Sandra Churchill

Sandra works full time as a Clinical Hypnotherapist, and is looking forward to working with such an amazing team and working on some exciting and informative events for this year. So watch out for more information in the journal and the newsletter.

Head of research and campaigning: David Mclean

David has come in to help with research, this will happen by initially, publicising previous correlated research with a view to move onto our own unique contribution to real world research, with continued analysis of our results both from a qualitative and importantly a quantitative viewpoint.