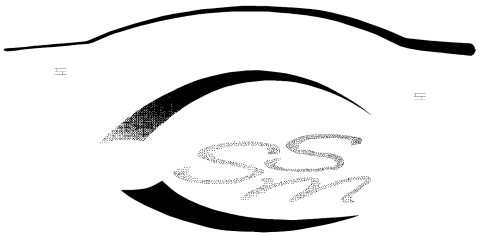

THE JOURNAL OF STRESS MANAGEMENT

PUBLISHED BY
THE SOCIETY OF
STRESS MANAGERS

VOLUME SEVEN
OCTOBER 2010

THE SOCIETY OF STRESS MANAGERS

The Association for Professional Stress Managers & Hypnotherapists
Company Registration 3707691- Incorporated in England & Wales

Registered Office: Suite 404,
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STRESS: the reaction people have to an imbalance between the demands they perceive to be placed upon them and the resources they have to cope.

The Society of Stress Managers was incorporated as a professional body on 1st February 1999. The Society is a Registered Company Limited by Guarantee and has a Council of Management with a provision for nine Directors and the Company Secretary. The Objects of The Society are:

to establish and promote a professional association for those persons qualified to nationally accredited standards in the skills of stress management and hypnotherapy;

to promote the training and continuing professional development of those persons;

to do all such things as are incidental or conducive to the attainment of these objects.

To meet these Objects The Society has adopted a 'Code of Conduct, Ethics and Practice', which sets out the principles that members of a professional association should follow at all times, both with their clients and their fellow Stress Managers. These principles include the ethical values of honesty, integrity and probity.

All members and potential members are invited to contact the Secretary of The Society of Stress Managers, Peter Matthews, for further information (see details below).

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All contributions to *The Journal* should be sent by email attachment to Mike Dillon at the email address above. Last acceptance date for inclusion of contributions in the next Journal is 1st MARCH 2011.

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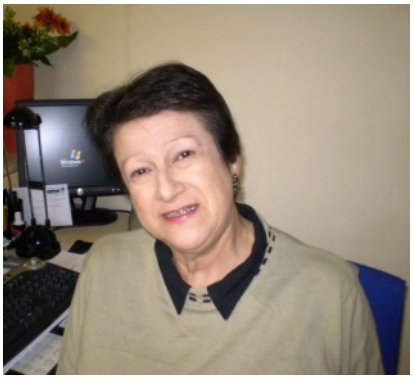

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EDITORIAL

Mike Dillon

Welcome to you all. All members will have received a copy of the circular 'The Journal of Stress Management' sent with details of our Annual General Meeting taking place at Hallmark/Midland Hotel Derby on Saturday, 11th September 2010.

It is a very important notice. If members want the Society's journal to continue into the future they should pay very close attention to the content of this document.

I sincerely hope by the time this current Journal is published, volunteers will have contacted Peter Matthews indicating the Journal role they are interested in taking over responsibility for.

I apologise for the late publication of Journal Six. It was caused by a number of unavoidable technical reasons.

I believe the following is a very important matter and should concern all those involved in the 'talking therapies'.

The Diagnostic and Statistical Manual of Mental Disorders (DSM)

It has been suggested by Allen Frances, Emeritus Professor of Psychiatry at Duke University School of Medicine, that the above manual, known as 'the psychiatrist's bible' would lead to tens of millions of people being wrongly diagnosed (labelled) as having serious mental disorders, and being massively over-treated with unnecessary drugs that are both expensive and harmful. It could provide a way for drug companies to have even more influence in the treatment of people presently diagnosed as having 'minor psychiatric disorders'. It could help promote a large expansion in the use of antipsychotic medications, with all the serious attendant risks. Frances has decried the process of compiling the *DSM-V* as secretive, disorganised, and blinkered.

There are many professionals in the field of mental health care who share concerns about the kind of **'psychiatry by numbers'** that such diagnostic manuals as *DSM* promote.

Richard Bentall, Professor of Clinical Psychology at the University of Bangor, is prominent among those concerned. In his most recent book, *Doctoring the Mind*, he memorably observed that he viewed psychiatric diagnoses as no more scientifically meaningful than star signs. He went on to express the opinion that despite all the current emphasis placed on evidence-based medicine that is supported by the requisite quality and quantity of research, the diagnostic categories and sub-categories that fill the pages of DSM were arrived at by committee (and squabbling committees at that), not by *research at all.

Farouk Okhai, Co**nsultant Psychiatrist in Psychotherapy at Milton Keynes Primary Care Trust for mental health care has given one of the best approaches to a client. "Having worked with clients for many years, I have found it far more useful, when face to face with a client, to set any possible diagnosis aside, ignore the categories and clusters and sub-types appendices, and ask instead, 'What does this person need, to live a full life?'"**

Editor Comments

In an endeavour to be effective with the therapy I deliver, my approach with clients who come to me is to find out what a client's conscious mind wants, then help the client look at their subconscious mind to see what is actually happening. Then, through therapeutic processes, to help the client change his/her thinking, so the subconscious mind is essentially providing effective support for the conscious mind to feel and believe what the client wants to change or achieve. Then the total consciousness can enjoy life in a more balanced and integrated way.

As regards people in general having labels attached to their psychological challenges, I personally believe this is never helpful, although it is natural for people to try to find reasons for how they feel. Unfortunately, it can persuade the client they **are the label** (the "that's the way I am" self diagnosis) and that therefore they can't really do anything about it.

All those in the 'talking therapies' should realise that this blinkered thinking in diagnosing 'psychiatric disorders' is quite capable of scooping even more innocent victims into its net, with all the ramifications that may have for them, now and later, for employment and insurance, not to mention health.

It is an area that those who help people with 'psychiatric disorders' other than by medication should be aware of and should let their opinions be known to as diverse an audience as they possibly can.

It is recognised that there are difficulties in producing rigorous *research in respect of 'the talking therapies'. These difficulties are due mainly to the delivery of the therapy and to the still rather disparate nature and organisation of these therapies, plus lack of the finance to carry out high-quality meaningful research on the efficacy of such therapies.

However, it gets more important as each year goes by that the necessary research on the validity and positive results that some of the 'talking therapies' achieve is carried out. Relying on anecdotal evidence and the occasional sensational newspaper or magazine report on some claimed astonishing result achieved is not good enough, if hypnotherapy in particular is to prove its validity in health care as a whole.

The sensationally presented articles are never a great deal of use in promoting 'talking therapies' without follow-up research. I have responded to a number of these articles in the past as to whether the therapist concerned would be prepared to have the results they achieve and the processes they use rigorously researched and then made available to the profession as a whole. I have never received any response to such requests. If not validated by research, these seemingly amazing results just encourage people to believe that a miracle will occur if they themselves go to a hypnotherapist for treatment.

I look forward to readers of the *Journal* taking up their 'electronic quills' and giving their views about the very important subject matter of the above article, by writing either **an article or a letter and sending it to the Editor for publication in the next *Journal* - Editor**

1. Frances, A. (2010). *Psychiatric Times*, 11 February.

2. Bentall, R. P. (2009). *Doctoring the Mind: why psychiatric treatments fail*. Allen Lane, London.

3. Okhai, F. (2006) 'Thinking outside the boxes'. *H.G.* 13,4, 11-17.

4. See www.dsm5.org

MIND BODY HEALING

PSYCHONEUROIMMUNOLOGY – A BRIEF INTRODUCTION

Dr Hugh Faulkner, Luisa Fioretto, Gaiovanni Narbone and Francesco Velicogna discuss the implications of the new understanding of mind-body healing

"Research… has shown that thoughts, beliefs, emotions, life events and how and where we live and work can all directly affect our immune system."

Can our thoughts, our emotions, our beliefs, our life-style, directly affect our physiology? Can the central nervous system communicate with the immune system and vice versa? If so, this has profound implications for health promotion, prevention and therapy. This is the area that psychoneuroimmunology sets out to explore.

Our interest in this field came about because seven years ago one of us, Hugh Faulkner, was found to have pancreatic cancer. After following a

macrobiotic diet and life-style, he appears to have achieved a complete remission – in orthodox medical terms, "spontaneous" remission or regression. Why has this happened? Spontaneous remission has attracted remarkably little attention among our medical colleagues, and there must be far more cases than the relatively few reported in the medical literature. Yet it should surely be an area of great importance for oncologists and all concerned with cancer. Why do spontaneous remissions occur? Are they due to pure chance? Could research find possible causal factors? Could any intervention make them more likely?

Our enquiries led us to psychoneuroimmunology, which we first learned about from the late Norman Cousins' book, *Head First – the Biology of Hope*[1]. The Angelo Celli Foundation of Perugia paid the travel expenses for Dr. Faulkner and his wife Marian, who is a trained nurse, to visit the USA two years ago. They were able to interview some of the leading research workers in this field and also a number of practitioners of holistic medicine who appeared to be applying its principles in their work. We are preparing a joint report based on material collected during this visit and a general survey of some of the recent literature in this rapidly expanding field. We hope to present this report at two seminars next summer – one organised by the Angelo Celli Foundation in Perugia and one in Florence in conjunction with the Department of Oncology of the Santa Maria Annunziata Hospital.

It has long been accepted that the central nervous system regulates the cardiovascular, genito-urinary, gastro-intestinal and endocrine systems. However, until recently, the immune system has been seen as independent and autonomous. A great deal of research on the immune system has taken place in the past fifty years and our ideas on it have changed considerably, though much still remains to be discovered. As Professor Norsal wrote in the special number of *Scientific American*, September 1993, "A new integrated biology has risen, built on the foundation of molecular biology, protein chemistry and cell biology, encompassing fields as diverse as neurobiology, developmental biology, endocrinology, cancer research and cardiovascular physiology". To this list, psychoneuroimmunology has added psychology and immunology, and seeks to demonstrate a two-way connection between the central nervous and immune systems.

Research with animals and human beings has shown that our thoughts, beliefs, emotions, life events and how and where we live and work can all directly affect our immune system. Psychoneuroimmunology is a relatively new area of this research.

One of the scientists at the Sloan Kettering Institute in New York said, "We are only taking our first baby footsteps". However, none of the workers interviewed doubted that the mind can directly affect our physiology. A clinical psychologist said, "I find this completely unsurprising". Negative factors, unemployment, bereavement, isolation, depression, and loss of hope can have a direct negative effect on the immune system.

We have found less evidence on the results of poor nutrition. In an article in the *Royal College of General Practitioners Reference Book* 1993, Professor Gurr says, "Although animal experiments have furnished plausible mechanisms to account for the promotional and suppressive roles of different types of fat, there is considerable uncertainty in extrapolating these conclusions to human disease". Evidence on the effect of specific dietary factors in cancer is conflicting. In the United States, the Kushi Institute has recently obtained a government grant to study the effects of the macrobiotic diet and life-style on health and illness, and we await their report with great interest.

It seems reasonable to assume, as Norman Cousins does, that if negative life factors *can* have direct negative effects on our physiology, positive factors – healthy diet and life-style, regular exercise, relaxation, optimism, family and social support – could have a positive preventive and perhaps curative role. This has proved more difficult to demonstrate scientifically, though there are many anecdotal accounts from those who believe that their bodies have been helped to resist cancer and some other conditions by the use of various diets and complementary therapies.

It is impossible to summarise in a short article the growing literature on PNI, and those who want more information will find Robert Ader's book *Psychoneuroimmunology*[2] invaluable. At the same time, research is proceeding in many other fields, particularly in psychoneurology and oncology. Those working in the field of psychoneuroimmunology are anxious that their work should not be used to further unjustified claims. But most appear to agree that the orthodox Western medical approach to cancer and other degenerative conditions has to make a fundamental shift from the lesion to the whole person. Despite the successes of heart surgery, and of chemotherapy, radiation therapy and surgery in cancer, they make no claim to guarantee cure. If some of the causal factors in degenerative conditions could lie in our diet, life-style, moods, emotions or environment, and we return to *these* conditions after apparently successful orthodox interventions, recurrence would seem to be extremely likely, as Dean Ornish has shown in cardiovascular disease.[3]

We believe a new paradigm is emerging in Western medicine, a shift from disease-oriented to holistic medicine, from concentration solely on illness to the whole man and his environment. Like all new concepts, it will be resisted by some of the more conservative sectors of the medical establishment and perhaps those with vested interests in the 'status quo'. But there are signs of change. Many patients who have not found the answers to chronic degenerative disease in orthodox medicine are turning in increasing numbers to complementary medicine.

Perhaps Western medicine must perforce become holistic. In the words of Hippocrates, "Natural forces within us are the true healers".

Hugh Faulkner is a Holistic Physician, Luisa Fioretto a Medical Oncologist and Giovanni Narbone and Francesco Velicogna Clinical Psychologists. Correspondence to: Dr. Narbone, METIS, Via Marconi, 118 Firenze, Italy.

References

1 **N. Cousins**, *Head First - the Biology of Hope*, E. P. Dutton, USA 1989.
2 **R. Ader, D.L. Felton, N. Cohen** (editors), *Psychoneuroimmunology,* Second Edition, Academic Press 1991.
3 **D. Ornish**, *Dr. Dean Ornish's Program for Reversing Heart Disease,* Ballantine Books, New York 1990.

HEALING AND THE MIND

ANYONE interested in psychoneuroimmunology would do well to read Bill Moyers' book *Healing and the Mind*. Moyers is a brilliant interviewer, most famous for his interviews with Joseph Campbell on *The Power of Myth*. In *Healing and the Mind*, he talks with many of the world's leading researchers, doctors, psychotherapists and healers, and delves with great perception into the links between mind and body.

We reproduce here an extract from the book of an interview with David Felten, M.D., Ph.D., Professor of Neurobiology and Anatomy at the University of Rochester School of Medicine, USA.

FELTEN: Much to our surprise, we found that if you took the nerves away from the spleen or the lymph nodes, you virtually stopped immune responses in their tracks.

MOYERS: Meaning that the mind was carrying on a conversation with the immune system.

FELTEN: That was how we interpreted it. The practical implication was that the many stressors we face in life, which affect the autonomic nervous system, might have an impact on the immune system.

MOYERS: The mind controlling the body?

FELTEN: Yes, and this was the first hint we had.

MOYERS: But I had always thought there was a lot of traffic between my brain and the rest of me. I just assumed that something was directing the movement of these arms, for example.

FELTEN: That was known for almost every system except the immune system. For a long time, immunology grew up believing that it was an autonomous field because a lot of experiments were done in the equivalent of test tubes. What researchers didn't realize at the time is that other signals come from the brain that may regulate what goes on. In fact, many immunology textbooks still talk about the immune system as an entirely autonomous, self-regulating system. Similarly, the brain scientists approached the neurosciences without taking immunology into account. So the two systems grew up ignoring each other.

MOYERS: And what you found suggested that they don't exist in isolation.

FELTEN: No, they clearly do not exist in isolation. Now there is overwhelming evidence that hormones and neurotransmitters can influence the activities of the immune system, and that products of the immune system can influence the brain.

MOYERS: Does this mean that the mind is talking to the immune system, saying "Hey, there's something dangerous down there. Be alert, be on your guard"?

FELTEN: I'm not sure it's saying it in that precise language, "Be alert, be on your guard". But certainly the brain is capable of signalling to the immune system in times of stress or loneliness, and perhaps under nonstressful, ordinary conditions. The higher centres of the brain can generate signals that very clearly influence hormonal outflow. In certain psychiatric disorders there are changes in some of the hormones. And when you're frightened, for example, there's a huge outpouring of adrenalin and noradrenalin from the sympathetic nervous system and the adrenal gland. What we hadn't contemplated before is that some of these signals that leave the brain when we feel certain emotions may have an impact on the immune system. Some researchers in this area are studying whether the stress that accompanies certain experiences, such as taking a medical exam, or divorcing, or going into a nursing home, are accompanied by changes in immune response. They've found that one factor contributing to a diminished immune response is whether or not an individual is in control of the situation; another factor is whether or not the individual feels lonely.

MOYERS: How does this affect the old notion that's been around the Western world for a long time – that the mind and the body are separate?

FELTEN: Well, I think that notion is down the drain. I can't imagine anybody thinking that the mind and the body could be separate in view of the multiplicity of connections from the brain to virtually all systems.

MOYERS: What does that mean for medicine?

FELTEN: It means that we have to pay very close attention to the feelings and perceptions of patients, and how they view their health, their disease, and the status of their illness.

MOYERS: And the further significance is that since the immune system defends us against disease –

FELTEN: Yes, our immune system defends us against invading bacteria, invading viruses, and inflammatory responses, for example. It also guards us against tumour cell formation... So here we have this great defence system, which has a wonderful memory and can generate responses to past insults that have come in again. And we also have the brain with its wonderful memory of past experiences. We had thought these two great memory systems were independent. But now it turns out they're not – they talk to each other extensively.

Healing and the Mind, by Bill Moyers. Published by Aquarian/Thorsons £12.99 Paperback, 366 pages. Highly recommended reading.

First published in *The Therapist* Volume 4 No 2. *The Therapist* was a predecessor of *Human Givens* (see www.humangivens.com).

OT *extract from… 'Affirmations'*

UP-LINK *for continuing professional development*

Imagine the typical comment overheard in the queue for the checkout…

"I just don't have the energy I used to…"

or…

"I could never do that…"

or…

"I just can't seem to lose weight…"

or…

"Well… I just don't know…"

or…

"Today's just not my day…"

or…

"I just can't…".

Recognise the style? Try an experiment. First, be a private detective. Spend a day listening out for overheard examples of this sort of *self-talk*, which is so accepting of a negative self-observation. Keep a note of some prime examples. Then, do the same exercise on yourself. Recognise anything familiar? If you don't recognise it in yourself, you will soon come to recognise such unquestioned assumptions in your clients! These are very typical examples of thoughts or comments from an individual. For these people, the phrase 'self-talk'[1] has been coined.

Self-talk is what you think or say to yourself, about yourself. If it were just words, it wouldn't matter. The problem is that our subconscious (or 'emotional') mind listens and picks up what we say, because there is an association between self-talk and the context that gave rise to the self-talk.

The sequence goes something like this…

- first, the emotional mind[2] monitors and logs these associations; for example, the Monday that starts with burning the toast…
- The next time the emotional mind perceives a similar context, the learned response will be triggered. Another morning when the toast burns, the powerful association

that "today's just not my day!" re-triggers a previous pattern.

- Next: because the emotional mind 'programmes' itself by recognising repeated experiences as patterns, it will extrapolate those patterns and will **anticipate**. A difficult morning at work will be confirmed by every little negative that comes along (like burning the toast!).
- Add the fact that when triggered, the emotional mind will respond twice as fast as the rational mind, putting the thought of "*today's just not my day!*" in place before the rational mind has had a chance to make a considered decision;
- and the fact that the rational mind cannot arbitrarily intervene to alter these powerful emotional responses…

…and the mental mechanism to maintain the client as having a bad day is complete. The **negative affirmation has been accepted and applied**! There is a critical, damaging link between the words and the experience, which is self-confirming and self-perpetuating. Self-assurance becomes self-doubt. A constant drip of water can wear down stone. Stand under a dripping shower and you will gradually get soaked. Every negative bit of self-talk is like a drip. (Your observations at the outset of this unit probably will have shown how in some people's day, negative self-talk comes every few minutes!)

A **negative, passive acceptance** of 'what fate brings' encourages us to accept 'sufficient' or 'satisfactory' as positives, abandoning ambition or dreams, and accepting less than we know we could have done. Adopting a 'don't care' attitude to survive, when the alternative could be frustration, despair and depression – all because of what we say to, or about, ourselves. This persistent, subliminal effect has been described as self-hypnotic.

For the person who realises something of this pattern in themselves, the next stage can look like a step forward… "I must do this", or "I should be that", or "I need something else". Recognising that this habit of thinking is at best limiting and at worst damaging, then **acknowledging the *need* to change** can feel like *doing* something…

"I just don't have the energy I used to…"

becomes…

"At my age, I really should be able to…"

or…

"I could never do that…"

becomes…

"I must try harder…"

or…

"I just can't seem to lose weight…"

becomes…

"I've just got to lose weight…"

or…

"Well… I just don't know…"

becomes…

"I must find out…"

or…

"Today's just not my day…"

becomes…

"I should be on top of things…"

or…

"I just can't…"

becomes…

"I need to be able to…".

Now try another experiment. Put that innocent-looking but deadly little word '*but*'[3] at the end of each of these statements.

The caveat is implied, so put it there… and see the real impact of those thoughts. They are not the action statement they seem to be. On the contrary, they are actually implying that **any escape from those old assumptions is futile**! Their apparent good intentions are in fact working against them.

It's probably at this stage that your client will have come to you. S/he may be frustrated or depressed that these apparent good intentions come to nothing; or s/he may have made **a decision to change** – but doesn't know how.

Here the role of self-talk begins to come into its own. Self-talk is…

- ✓ Words designed to capture the essence of how you know you can be
- ✓ Words that you repeatedly affirm in your thoughts
- ✓ Words that you say out loud about yourself in appropriate situations.

Remember: our 'emotional mind' listens and picks up what we say, when our comments relate to our feelings:

- It monitors and logs associations of feelings with the context;
- next time the emotional mind perceives a similar context, the learned response will be triggered …and what has it learnt?… …the experience of hearing your words spoken out loud in that particular situation.

Words that indicate a decision to change, **first challenge the old assumptions.** The old assumptions are to be consigned to the past, so the new words must be firmly fixed in the present…

"I just don't have the energy I used to…"

becomes…

"I no longer use 'age' as an excuse…"

or…

"I could never do that…"

becomes…

"I no longer give up without trying…"

or…

"I just can't seem to lose weight…"

becomes…

"I never eat more than I should…"

or…

"Well… I just don't know…"

becomes…

"I no longer put up with not knowing…"

or…

"Today's just not my day…"

becomes…

"I never assume the worst…"

or…

"I just can't…"

becomes…

"I never give up without trying…".

Read through these changes again. What a difference a few words make! And remember, the subconscious mind is listening, experiencing this new 'take' on those old situations. Remember, too, once you start repeating this new approach…

- ✓ the emotional mind 'programmes' itself by recognising repeated experiences as patterns. It will extrapolate those patterns and will **anticipate a whole new, changed perception next time.**

So far, you have guided your client to recognise old assumptions as part of the past and challenge them in the present. But you can go further, and **make the present better…**

"I just don't have the energy I used to…"

becomes…

"I have all the energy I need…"

or…

"I could never do that…"

becomes…

"I am going for it…"

or…

"I just can't seem to lose weight…"

becomes…

"I am controlling my weight…"

or…

"Well… I just don't know…"

becomes…

"I search out and find everything I need to know…"

or…

"Today's just not my day…"

becomes…

"I expect the best…"

or…

"I just can't…"

becomes…

"I am a trier – and it works!…".

OT *extract from… 'Affirmations'*

UP-LINK *for continuing professional development*

When you start a statement with a phrase like "I am…", the verb that follows is in the 'present-continuous' – in other words, it reflects 'now and hereafter'. Look again how far these statements have moved from…

1. (very typical) negative acceptance ("I can't"), through…
2. acknowledging that this is not satisfactory ("I must… I ought to…"), to…
3. making a decision to change (" I no longer…"), until…
4. reaching the 'new you' with positive affirmations of how things are, from now onwards.

This is not wishful thinking or make-believe. This is 'signposting' for the emotional mind. If we don't train it to recognise and accept new positive 'habits of thinking' (or patterns), how can we expect our emotional mind to support us in that powerful, subconscious way, to be the sort of person we know we could be?

NOTES
1. *What to say when you talk to yourself*, Shad Helmstetter.
2. For more details refer to the module on 'Emotional Intelligence'.
3. Watch out for this word in anything your clients are saying. Challenge them on it, and they will begin to monitor themselves.

REGULATION UPDATE

Report from CNHC meeting, held on 25 May 2010 – London

The Department of Health (DH) wishes to see a robust system of voluntary self-regulation (VSR) in place for hypnotherapy, either established and maintained by the profession itself (in conjunction with significant lay involvement) in the form of a Single Body Voluntary Regulator, or in conjunction with other complementary & alternative medical professions (CAMs) in the form of a Federal Regulator. With regard to the latter option, the DH's preferred voluntary body is the Complementary & Natural Healthcare Council (CNHC – www.cnhc.org.uk), to whom they have previously provided public funding for this purpose.

Whereas it appears that significant numbers of Hypnotherapists (probably the majority) do not favour the federal model, it is clear that the previous government did. The current coalition government, however, has clearly set out its stall in favour of personal empowerment (rather than state intervention), and continued financial support for bodies like the CNHC cannot be taken for granted.

It may also be of some relevance to the future of the CNHC that the Prince's Foundation for Integrated Health (the prominent Prince of Wales's charity responsible for setting up the CNHC in the first place) has recently been obliged to close its doors due to allegations of serious fraud against a former key staff member. While there is no suggestion here that the resultant police enquiry would necessarily involve the CNHC (now an entirely separate company), the whole matter nonetheless casts a dark cloud over the process of the

regulation of complementary medical professions.

Regardless of these observations, it still behoves the profession to remain prominently involved within the move towards VSR at this time, and while this does not necessarily bind us to any particular eventual outcome, nothing is lost, as identical preparatory work must be carried out whichever path is ultimately followed.

CNHC meeting report on the day's events

Opening statement from a representative of the Department of Health (DH):

The DH has been funding CNHC for the past 2 years, during which time it has recruited 9 disciplines to the register (with more earmarked for this summer and then subsequently). Its audit for last year was deemed OK. The CNHC states that it is still on target to be self-funding by March 2011 (which is when DH funding is due to cease). Originally it claimed to require 10,000 practitioners to be on the register in order to be self-funding, though it now claims that only 7,000 are required (which is the revised target for March 2011).

(Ed: there have been NO assurances to date that the recently elected Government will not cut the funding before this time as one of its many planned 'spending cuts'.)

Current CNHC registration figures:

Currently registered	2579
Part registered	698
Additional names against disciplines (i.e. eligible for registration)	2928

(Ed: these numbers seem slight compared to the tens of thousands of complementary therapists currently practising within the UK.)

The DH reiterated the purpose of the CNHC – it is not there specifically to encourage GPs or the public to use complementary medicine but rather to '*protect the public'*. Where GPs wish to refer patients to use complementary medicine they hope to persuade them to refer to CNHC-registered practitioners, but there are no guarantees that this will be the case. The DH is not working with any other federal Voluntary Self Regulators (VSRs) at this time. The CNHC itself clearly suggested, however, that if it should 'stumble' there will be no more funding from the government.

The Prince's Foundation for Integrated Health (PFIH) has recently closed. This now leaves a gap in the political arena of complementary medicine. The CNHC reiterated that while it was initially established via the Prince's Foundation, it is now a completely independent body.

Whereas it appears that significant numbers of Hypnotherapists (probably the majority) do not favour the federal model, it is clear that the previous government did. The current coalition government, however, has clearly set out its stall in favour of personal empowerment (rather than state intervention), and continued financial support for bodies like the CNHC cannot be taken for granted.

The verification of practitioners for registration onto the CNHC has been an issue. How do practitioners who do not belong to a Professional Association (PA) that is part of a CNHC Professional Forum (or otherwise has a relationship with the CNCH) obtain verification? The practitioner could approach (and pay) a relevant PA to verify them; the CNHC could meet with a PA that is not on the Forum; the Profession Specific Board (PSB) for the respective profession could review the standards of such a PA. In some cases a PA has multi-modality (i.e. it represents more than one discipline) and thus may be able to verify a practitioner for more than one discipline. The CHNC stated that the onus is essentially on the practitioner to find a way to obtain verification. While it admits this is not an ideal situation, it nonetheless needs to open up CNHC registration to all practitioners. It was suggested that the ideal situation would be to have for each profession a list of training courses that meet the CNHC criteria. However, this is a long way off, and in professions where courses are often changing, may never actually be feasible.

The CNHC admitted that there is a huge amount of confusion over definitions: *National Occupational Standards (NOS), Occupational Competency, Standards of Proficiency, Core Curriculum*, both within the CNHC itself and among the various professions, which would need to be addressed. While NOS are set as the minimum standard of entry for the CNHC, some professions' NOS will need to be reviewed before they are suitable.

(Ed: the NOS for hypnotherapy are in fact currently under review, and the Working Group for Hypnotherapy Regulation is participating within this process.)

While at present the CNHC is not looking at training accreditation, this is something that it feels it may consider in the future.

The CNHC is currently considering two main issues:

1. All members of the CNHC Board and Committee are currently lay (and take advice from the Profession Specific Boards – consisting of individuals from various PAs). How should they increase professional input?

2. The substantial amount of negative press surrounding the CNHC. Should the CNHC ignore or respond to this?

Current CNHC projects:

1. Communications, including web text; articles; leaflets (tailored communications to PA members); welcome letter to new registrants.

2. Website, PR; optimisation of the website so that it appears higher up in search engines (at present the website appears low down on web searches and CNHC admits that this will take some time to improve); how to communicate with practitioners who are not online; communication with the public (why are they not aware of the CNHC?).

Report ends

RECORDING HYPNOTHERAPY SESSIONS

Mike Dillon

Hypnotherapists must all be well aware that over recent years the method of producing recordings for their clients has changed radically from what now seem primitive cassette recordings to a variety of digital systems. I remember I started twenty years ago with a tape-to-tape cassette recorder and a hand-held microphone. Although like many of my age (72) I suffer from technology phobia, I have stuck at it to maintain my professional credibility, and for some time now have been sufficiently competent in electronic equipment support to maintain a modern-day practice – producing computerised client session recordings, burning CDs from computer recordings, and creating MP3 files using Audacity. I have also converted many of my generic relaxation and other standard cassette tapes to CD and MP3, enhancing the original quality while doing so.

I therefore thought it might be helpful to run through a few digital recording systems, in addition to the one demonstrated by Nick at the last AGM, that can be used to record client sessions and other recordings a therapist might like to create.

Creating MP3 files using Audacity

Although most hypnotherapists use a Windows-operated computer, the principles are the same for MAC, with some differences in the names of folders, files and commands.

Audacity does not have a way to save MP3 files, but you can add this by downloading and installing software called LAME. This software is easy to install and comes free of charge.

First, it is necessary to go to the Audacity download page: click on the 'stable: 1.2.6 for all users' link for Windows. At the download page under the 'Optional Downloads' section, you will see a link for the LAME MP3 encoder: click on this link. This will bring you to the 'How do I download and install the LAME MP3 encoder?' page in the Windows section. You then find yourself at the 'LAME Binaries for Windows' page. There are many duplicates of LAME on the Web; choose one that works for you. Click on the link and use the usual Windows dialogues to complete the download. In order to make it easy to find software downloaded, put it in a specifically referenced folder, as you need to know where it is.

When the download is complete, open and look at the contents of the folder. You will see a file: lame_enc.dll. As the downloaded folder is compressed, you will need to copy lame_enc.dll so that Audacity can use it. Right-click on lame_enc.dll and click on Copy. Then navigate up one folder level, and using Edit>Paste, copy lame_enc.dll into the folder you are now in. Make a note of this, as in order to carry out the next step you need to know where you copied lame_enc.dll to.

Saving MP3 Files

Now you will need to tell Audacity where you have installed LAME. Open up Audacity and make sure you have some speech/music loaded. Click on file->Export as MP3.

Audacity will then open a standard Windows box, enquiring where you want to create your MP3 file. Usually Audacity will use a project number name to identify your MP3 file, but you can change this to a name of your own. Using a suitable folder and name for your MP3 file, complete the usual Windows dialogue. Audacity will then display a message stating that it cannot export the MP3 file and asking whether you want to locate lame_enc.dll: click on 'Yes'.

Audacity will then open a standard dialogue box, asking where to find lame_enc.dll. Having referenced and remembered where you have copied lame_enc.dll, navigate in the normal way to where you saved it and when it appears in the dialogue box, click on 'Open'.

A screen will now be displayed on Audacity. On this you can edit additional pieces of textual information (tags), for your MP3 file. This indicates that Audacity has successfully located lame_enc.dll. When you have completed entering any tags, click on 'Okay'. Audacity will then show you the progress made in saving the MP3 file. This can take some time depending on the length of your recording and the speed of your computer, so be patient at this stage. When your MP3 file has been saved, you can copy it to an MP3 player, and if you want to, make specialised recordings available on your website.

Please note that it is necessary to download and install LAME only once. After that it will come up automatically.

More information can be obtained on: www.SoundboardUK.com/tutorials.

NB: Although charging rights are not made for non-commercial organisations or for commercial organisations where associated revenue does not exceed 100,000 dollars, it is as well to check on licensing on: mp3licensing.com/help/index.html#5.

<u>Creating CDs with 'Mini Hypnoke Digital'</u>

There is now a new 'Mini Hypnoke Digital system available that gives full and easy-to-follow instructions when you purchase it, so I will not cover installing and operating procedures in this article.

The new 'Mini Hypnoke' is not just a way of producing CDs. It contains many add-on benefits, which claim to:

* enhance the Therapist's voice and immediately focus attention on what the therapist is saying, creating a personal, one-to-one feeling of safeness, intimacy, warmth and relaxation;
* instantly enhance the therapist's professional image and the client's performance;
* be designed for operation by non-technical people and therefore very simple to use; (I can use it so it must be)
* be highly portable (weighing 3 kgs), small and quick to set up;

* record high-quality CDs directly to a PC with software supplied free;

* enable the adding of music from a CD player;

* be equipped with four audio channels for mixing music and voices in different combinations;

* cocoon clients in the musical environment and cut out any outside noises;

* enable plugging into three headset mics at once (very useful when working with couples);

* add an echo effect to therapist's voice;

* enrich the therapist's voice by means of bass, mid-range and treble controls;

* enable the therapists voice to be adjusted from left ear to right ear in both headsets, while the client's speech remains in stereo (avoiding distracting the client).

The new 'Mini Hypnoke digital' is also available with a professional 'Digital Recorder', so sessions can be recorded whenever therapist wants to. This enables brilliant stereo recording in an easy-to-use, ultra-portable device that records sessions in pristine audio. The recorder includes voice-activated recording and can store up to 4GB (138 hours) of audio recordings.

For further information go to: www.Hypnoke.com

Converting cassette tapes to MP3 or Wav files

Preparing your computer volume controls in Windows

Locate the 'volume control' icon in the system tray (that's the bottom right corner of your screen).

Right-click the mouse over it and click 'open volume controls'.

Make sure the 'line in' or 'mic' mute boxes are unchecked. Also keep the volume and balance slide bars in the middle of their scales. You can experiment later.

Once this is completed you can go to the next procedure.

Hooking things up:

What to look for on your PC:

View the computer as a cassette or tape deck upon which you want to record. You may have done this before.

Desktop computers

The audio input on a desktop computer is usually a 1/8² mini-jack on the back panel, labelled 'Line-In' or 'Aux', close to where the speakers will be connected to a similar type of jack. Sometimes you can find it on the front of the PC.

The 'Line-In' input is sometimes marked with a symbol, which is not to be confused with the speaker output marked with a different symbol, where the arrow points to the outside. To record from the connected player, in the 'sound recorder window' you typically select the sound source named 'Line-In or auxiliary'.

OR:

Laptop or notebook computers (and PCs that have mic jacks)

Most laptop or notebook computers have only one 1/8² mini-jack input, marked Mic or Microphone, close to where a headphone can be connected to a similar type of jack.

To record from the connected player, in the software you typically select the sound source named Mic or Microphone.

If your laptop or notebook or PC has a 'Line-In' or 'Aux' input jack as well, then it is preferable to connect the player to that input. In that case, you typically select the sound source named 'Line-In or 'auxiliary' in the software.

The plug that goes into the input of the computer has to be a stereo 1/8² mini-plug, similar to the one for computer speakers.

Note that this stereo mini-plug has two plastic rings at the tip, and is not to be confused with a mono plug that has only one plastic ring at the tip:

Using a mono plug to connect the player to the computer typically results in sound coming in on the left channel only.

You may prefer to use your HIFI, your tape Walkman or another tape player to play the music into your computer – particularly useful if you have cassette music that cannot be currently purchased in digital format, which you or clients in the past have especially enjoyed as background music. I, for instance, have a collection of tapes that were **especially** recorded for hypnotherapy sessions. It is entirely up to the therapist which of the following options suits them best.

The audio output on the player (e.g. your phones jack on your tape Walkman)

The type of audio output connection on your player depends on the kind and model of the player. It is usually marked 'Play-Out, Line Out, Audi Out' or some similar wording. If it is your Walkman you are plugging in, then it is the earphone jack or line out (if one there) which is the output.

If you record from your Hi-Fi with a cassette deck, use:

DIN Connectors
This type of connector is usually found on older European-made audio equipment, as on a Uher tape deck:

RCA connectors
This type of connector is usually found on modern audio equipment, as on a JVC cassette deck:

Mini-jack connectors
This type of connector is mainly found on portable players, like on a Sony minidisk player:

What if you only have headphones or speaker for outputs?

Some audio sets like boomboxes don't have audio output connectors other than headphones or speakers. The signal strength of these outputs is mostly higher than desired for the input on your computer, and their signal strengths depend on the volume control setting for that output. Special care is therefore required when connecting such outputs to your computer.

Before you connect the headphones or speaker output to the computer,

make sure to set the volume control on the player at zero first!

Headphones output (using your tape walkman to play the tape into the PC)

If your audio set has a telephone output connector, then using that one is preferable to using to the speaker output.

You will have to experiment with the volume control level for the headphones output, to discover which level results in the best recording quality. The headphones volume control, in combination with the recording volume in the 'sound recorder', determines the end result.

Setting the headphones output volume too high will result in distorted sound, no matter how low you set the volume control in the 'sound recorder'.

Speaker output

If your audio set has speaker outputs only, it is **NOT** recommended that you use this to record input into your computer, as the high signal levels could damage the audio output of the computer. Please try something else.

Finally, check what recording software you have on your PC

There is so much software for converting tape to MP3 that you may already have downloaded something, or it may have come with music library software you already store mp3/WAV files with. Check your music library software first, and see whether there is a tape-to-mp3 'recorder' facility. It would typically be under a heading such as 'recorder', 'tools', 'options', etc. Some freely downloaded software you have been using may need an upgrade for a small fee – check what the upgrade offers before getting it.

For example, MusicMatch Jukebox Plus 9. Once you have this facility, the software manufacturer will typically have a help section to walk through the recording process. This is very simple to do: just follow the instructions, and once you have done it, it will be very easy to repeat all the steps.

For software information, go to:

http://www.musicmatch.com
http://audacity.sourceforge.net/
http://www.mp3towav.org/cassette-tape-to-mp3-wav-wma.asp

NB:
*Use high quality jack plug connectors to reduce noise interference.
*There will always be some background white noise from tape to mp3, as the tape in the first place is never CD or digital quality. If you experiment enough, you will be able to tweak the settings and find out how to reproduce music/voice to the highest possible quality of sound.

The information on converting cassette tapes to digital is very detailed, as it was originally compiled as an 'advice and guidance' information sheet for my clients when many of them were shifting from cassette players to digital. I therefore had to take into account the ranges of different equipment people were using. So it may generate a yawn or two, but at least it is comprehensive.

If you would like to read a **general article** on client session recording see *The Journal of Stress Management* Volume Two, April 2008, Pages 12 to 16.

HYPNOTHERAPIST OR STRESS MANAGER?

Laurence Nicholas

Which one are you? At the present time, there appear to be two distinct groups within our organisation – those who call themselves Hypnotherapists and those who call themselves Stress Management Consultants.

Both names are, of course, equally valid, and if we help a client with a particular problem, I'm quite sure that they would be willing to recommend us to friends or colleagues in either capacity. However, speaking as someone who started practising in the late eighties, I always describe myself as a hypnotherapist.

On some occasions, I have described myself as a stress management consultant. The reaction to that is quite different from the one I receive when I say that I am a hypnotherapist. When I mention the word 'hypnosis', people usually react in a positive and interested way. When I talk about stress management, the reaction is usually much more subdued. Why is this?

I suspect that on the whole, the general public know, or at least think they know, what hypnosis is all about. After all, they've seen the television shows and the stage acts and all we have to do is wave a pocket watch about to make them go to sleep; so on one level at least, they have an idea what our work is about. However, it is of course a very limited level, and when one explains to them what problems can be dealt with using hypnotherapy, they are usually very surprised.

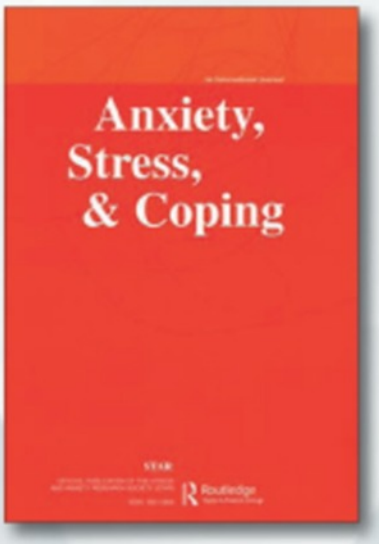
Stress Management is completely different. Stress? That's only for managing directors, MPs, and prime ministers, isn't it?

The fact that the individual you're talking to is none of those doesn't matter. Those sleepless nights, high blood pressure and lack of concentration are due to the credit crunch – not to stress, thank you very much!

I do feel that when talking to members of the general public, a hypnotherapist wins over (and you can read that two ways) a Stress Management Consultant.

You take your pick. I'm leaving Stress to the Managers and the recession.

Stress Journals from Routledge



Anxiety, Stress, & Coping

An International Journal

Official Journal of the Stress and Anxiety Research Society
www.star-society.org

Volume 23, 2010, 5 issues per year. Print ISSN: 1061-5806, Online ISSN: 1477-2205

Editors-in-Chief:
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This journal provides a forum for scientific, theoretically important, and clinically significant research reports and conceptual contributions. It deals not only with the assessment of anxiety, stress, and coping, and with experimental and field studies on anxiety dimensions and stress and coping processes, but also with related topics such as the antecedents and consequences of stress and emotion. We also encourage submissions contributing to the understanding of the relationship between psychological and physiological processes, specific for stress and anxiety. Manuscripts should report novel findings that are of interest to an international readership. While the journal is open to a diversity of articles, it is primarily interested in well-designed, methodologically sound research reports, theoretical papers, and interpretative literature reviews or meta-analyses.

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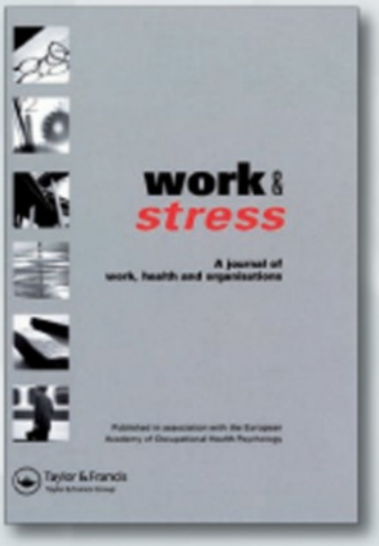

Work & Stress

Published in association with the European Academy of Occupational Health Psychology (EA-OHP)
www.ea-ohp.org

Volume 24, 2010, 4 issues per year. Print ISSN: 0267-8373, Online ISSN: 1464-5335

Managing Editor:
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Work & Stress is an international, multidisciplinary quarterly presenting peer-reviewed papers concerned with the psychological, social and organizational aspects of occupational and environmental health, and stress and safety management. It is published in association with the European Academy of Occupational Health Psychology. The journal publishes empirical reports, scholarly reviews, case notes, research notes and theoretical papers. It is directed at occupational health psychologists, work and organizational psychologists, those involved with organizational development, and all concerned with the interplay of work, health and organisations.

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