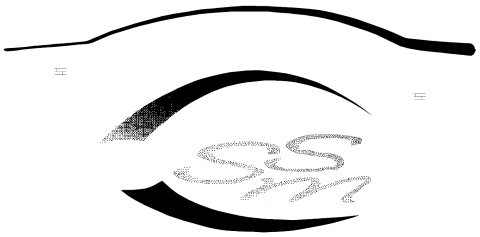

THE JOURNAL OF STRESS MANAGEMENT

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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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CONTENTS

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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 SEPTEMBER 2011.

TESTING THE BRAIN CELLS

Most people know the sentence:- **The quick brown fox jumps over the lazy dog.**
Yes indeed – it contains all the letters in the English alphabet.

The following sentence is probably more challenging. Study it for a while.
If you cannot find out what the significance of this sentence is, the answer appears on page 15 of this Journal.

A brown cow in a great green field ate grass greedily, and gosh it grew fat!

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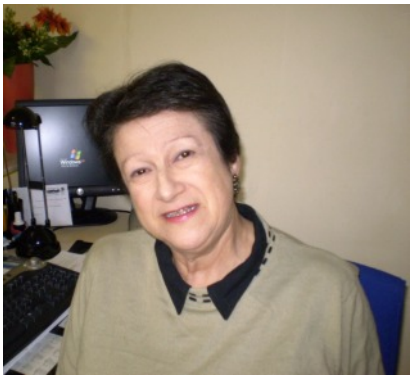

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EDITORIAL

Mike Dillon

May your friends always bring you joy. A wonderful 2011 to you all!

Welcome to Journal 8. I hope you all survived the arctic winter weather okay.

Journal articles

After the Society's AGM on Saturday the 11th of September, Terence Watts gave a talk on 'Warriors, Settlers and Nomads'. It was well received by all members who attended on the day. As always some members, on this occasion myself included, were unable to attend the afternoon session. I therefore asked Terence if he would be kind enough to write an article about the theme of his talk, which he kindly agreed to do. The resultant article appears in this Journal. The article will enable those members who were unable to enjoy Terry's talk, to read about the very interesting subject of 'Warriors, Settlers and Nomads'. Those who did attend can revisit the very fascinating and interesting subject matter of this compelling article.

In the article 'Myth of the Chemical Cure', two eminent psychiatrists – Joanna Moncrieff, senior lecturer in the Department of Mental Health Sciences at University College London, and Farouk Okhai, consultant psychiatrist in psychotherapy with the Milton Keynes Primary Care Trust – discuss 'why drugs do not deserve their exalted place in the psychiatric treatment of emotional and psychological ill health'. All complementary therapists in the 'talking therapies' should be encouraged when such views are expressed about drugs used to alter the chemicals in the human brain.

Marilyn Upton agreed to take part in the 'Reflection' article that appears in this Journal. It is always interesting to learn more about members in a little more depth than the occasional social chitchat reveals. I always find these articles very absorbing and interesting. I hope readers of the Journal do.

Complementary & Healthcare Council (CNHC)

The Complementary & Natural Healthcare Council (CNHC – www.cnhc.org.uk), the Department of Health's funded regulator of choice for complementary medicine, has now accepted that hypnotherapy is sufficiently united, with all required professional mechanisms in place, and as a consequence opened its register to hypnotherapists on 1st December 2010. All full practitioner members of a number of professional associations (including the SSM) have been accepted as meeting the required standards and are eligible for fast-track registration with the CNHC.

The main purpose of the CNHC is to provide a single national register that the public may access in order to locate a variety of complementary practitioners (including hypnotherapists) who all meet agreed standards for practice. The CNHC will now take on the role of investigating complaints against those therapists registered with them, which frees up

the professional associations to concentrate upon the vital function of providing services and support for their members.

"Over the last two years the CNHC has clearly done a lot to set standards for a range of complementary healthcare disciplines and the Department welcomes its continued good work. The CNHC is sponsored by the Department and we recommend that where people are looking for complementary healthcare practitioners, they use someone who is CNHC-registered." (Department of Health, January 2011.)

The CNHC has also produced a template publicity letter that they invite registered members to use and adapt for their own particular needs in marketing their practices.

REVIEWS

Mike Dillon

The following reviews do not cover subjects directly related to any specific complementary therapy but cover wider issues that I feel are not unconnected to how therapies may develop in the future.

The Quantum Revolution: Modern Physics for Non-Scientists

Richard Wolfson, Professor of Physics, Middlebury College, Winner of the Perkins Award for Outstanding Teaching

"It doesn't take an Einstein to understand modern physics", says Professor Richard Wolfson at the outset of his course on what may be the most important subject in the universe.

Quantum physics touches the very basis of reality, altering our commonsense notions of space and time and cause and effect, and *in my view therefore affects the principles on which modern therapy is based.* Professor Wolfson believes that the basic ideas behind quantum physics are, in fact, simple and comprehensible. *As a person who has studied this subject, I agree with this statement.*

He goes on to explain the theory of relativity and the landmark equation $E=mc^2$, in a way that can be truly understood. *When I first studied this course I found it a mind-stretching, thought-provoking experience that changed forever the way I think about the universe I live in.*

In Dr Wolfson's investigation of the quantum world, he shows how inquiry into matter at the atomic and subatomic scales has led to quandaries that are solved, or at least clarified, by quantum research and discoveries. It represents a vision of reality so at odds with our normal experience that it nearly defies language. *His clear, insightful explanations of seemingly complex subjects left me with a clear understanding of what we know today and where we are headed in the future.*

The course provides hypotheses about the origin, development, and possible future for the whole universe, and the possibility that quantum physics can produce a **'theory of everything' and account for everything that happens in the world.** *If that is so, then as further research and discoveries are made it must also affect the future and development of health and well-being, including all therapies that deal with the human body and mind.*

Understanding the Brain

Jeanette Norden, Professor of Cell and Development Biology at Vanderbilt University School of Medicine, University Chair of Teaching Excellence, Vanderbilt University Teaching Excellence Award, Vanderbilt University School of Medicine, The Robert J. Glaser Distinguished Teacher Award

Understanding the Brain is a course by award-winning author Professor Jeanette Norden of Vanderbilt University School of Medicine. It takes you inside the brain to show in a practical way what an amazing complex organ it is and how it works. In a combination of neurology, biology, and psychology, the course helps non-scientifically trained people to understand how we perceive the world through our senses, how we move, how we learn and remember, and how emotions affect our thoughts and actions.

The course clearly describes everything that goes on inside your body and how the brain controls every interaction you have with the outside world. It allows you to cope amazingly with your everyday environment. It is capable of producing breathtaking athletic feats, sublime works of art, and profound scientific and psychological insights. It goes on to describe how the brain produces an enormous range of emotional responses that can take us from the depths of depression to the heights of euphoria. All this, in an organ that weighs on average three pounds.

It enlightens us to the mystery of the brain and shows how recent decades have seen unparalleled advances in understanding how the brain does what it does, pinpointing how many areas of the brain work.

Above all, having a deeper knowledge of the brain helps us to understand how the brain is organised, and gives a feeling of wonder and appreciation of all that it accomplishes.

I have always believed that having a sound knowledge of the physiology of the brain enables therapists to talk to their clients from a more knowledgeable viewpoint. The confidence to do this also passes on to the client knowledge that can increase their belief in what they are trying to achieve. When engaging clients in visualisation to heal psychological challenges, therapists can help clients to use their creative imagination by directing their focus to the relevant parts of their brains rather than visualising in an unspecific way. This is particularly important with very logical and practical minded-clients.

Source of reviews: ***Great Courses**: Great Courses Taught by Great Professors*.

Diploma of Higher Education and BSc (Hons) Clinical Hypnosis Degree

St Mary's University College, Twickenham, London, in collaboration with the Brief Strategic Therapy Clinical Hypnosis Foundation (BST Foundation), has announced a step forward in clinical hypnosis training. Following on from the development of the first UK Diploma of Higher Education (which had already commenced) in 2010, a BSc (Hons) Degree in Clinical Hypnosis, requiring one further year of part time study, has also been established.

The stated aims of this initiative are to raise the profile and recognition of clinical hypnosis as a sound psychological and scientifically based therapeutic discipline (and thereby to increase the level of academic research in this field), and to create the opportunity for suitable applicants from both medical and non-medical backgrounds to obtain a formal academic qualification with the assurance of comprehensive training of high practical and theoretical university standards.

The first two years of the course are based on developing client-centred therapeutic skills and knowledge, whereas third-year students are actively engaging in clinical research in a broad range of topics. It is anticipated that this will lay the foundations for an increasing body of knowledge and levels of validated clinical research that will contribute to hypnosis being recognised as a serious science-based discipline. Ultimately, it is hoped this will be good for the field of hypnosis in general and for all practising hypnotherapists, whether they choose to gain a recognised university award or not.

There is the further intention of embarking on the process of establishing a centre of excellence for clinical research and treatment. It is hoped that this will provide future students and qualified hypnotherapists with the environment and opportunities to gain formal research-based postgraduate qualifications such as MSc and PhD in clinical hypnosis once undergraduate training in clinical hypnosis has been completed.

There have been many enquiries about fast track access to the Degree and Diploma in Higher Education programmes from hypnotherapists who have been practising for a number of years and wish to update their training with a recognised university qualification. Despite the rigour of the course and the stringent regulations, it is recognised that experience and sound theoretical knowledge and determination to engage in new learning can often form a sound basis for continued study. If practising therapists can demonstrate the appropriate prior learning, they may well be eligible for acceptance straight onto year two of the BSc (Hons) degree programme.

Gavin Emerson, Academic Director BST Foundation. Contact www.bestfoundation.co.uk. Dr Tig Calvert, Clinical Hypnosis Programme Director, St Mary's University College. Contact email: calvertt@smuc.ac.uk

ARTS AND MINDS

Arts and Minds is a registered charity (110944) that believes that access to and participation in all forms of the creative and expressive arts are good for people's health and well-being.

The charity runs artist-led projects throughout Cambridgeshire and Peterborough for small groups of participants who are vulnerable or at risk, many with mental illness or learning disability.

Projects are often offered in partnership with other local voluntary organisations. Art forms include creative writing and storytelling, painting, pottery, textiles, photography, music and dance. Volunteers work with the artists to support the participants. All their projects are evaluated to ensure that their aims are met and the intended benefits achieved.

One of The Arts and Minds projects is 'Poems in the Waiting Room'. This project provides a three-page folded leaflet of chosen poems that are circulated to hospitals and doctors' waiting rooms for patients to read while waiting for their appointments.

An example poem follows:

Though hope betrays us each in turn
And is by time itself betrayed,
Though in its forge we roast and burn
Still cursing as the embers fade –

Amid the ash of ruined dreams
We persevere, against the odds
While any speck of hope yet gleams
To stand against the whims of gods.

If hope is but a fuel to scorch
What men think lost, with fate the spark,
At least it counterfeits a torch
To hoist aloft and dupe the dark.
(*Felix Dennis – Island of Dreams).*

The 'Poems in the Waiting Room' leaflet I picked up at East Grinstead hospital particularly interested me, as some years ago I realised that the magazines and journals I left in my waiting room for clients to read were in fact not being read because they were waiting for only about five minutes if that. The magazines and journals were just cluttering up the table without any good purpose.

I therefore put some small books of poetry on the table instead – inspirational poetry of hope, trust, and other subjects that I thought might help clients if they read two or three poems while they were waiting. It went down very well, and clients, even some who readily admitted that they had never read poetry before, often took details of one or other of the books to purchase for themselves.

(Submitted by the Editor).

WARRIORS, SETTLERS & NOMADS

Terence Watts

The idea for this book arrived from two diverse paths and only came together during a moment of what might be aptly termed 'inspired boredom'. The outcome was two years of obsessive research and scribbling, culminating in a book which has enlightened and inspired many, as well as providing the basis for some effective therapy.

In 1995, I was working on a short presentation about the link between personality types and illness, both emotional and physiological, based on Freud's *Anal/Paranoidal, Oral/Schizoidal* and *Genital Hysteric* classifications. It was not going well, and I eventually arrived at the conclusion that I had discovered the exact reason why Freud himself seemed not to have approached the concept in any great detail. Too many variables, too many contradictions and way too complicated. Anyway, it was boring, and I don't do boring very well at all, so I decided to watch television instead. Writer's block takes many forms, and with me it's an urge to go to sleep or watch TV.

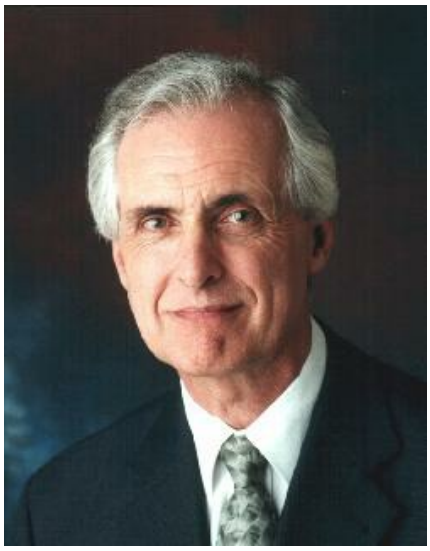
It being around one in the morning and me not having satellite TV there were not many programmes to choose from, and after clicking the remote control a few times I ended up on **Open University,** where they were talking about applied mathematics. This was even more boring than trying to make sense of the link between personality types and illness, so I went to sleep… but only for a while.

I awoke to a natural history programme of sorts, showing something I had seen a couple of times before. It was the back end of a turtle digging a hole in the sand, depositing eggs and kicking sand over them before leaving them to their own devices. Time lapse photography soon revealed a disturbance; then a head, flippers, shell, and suddenly a whole turtle appearing and scuttling towards the sea. The camera panned back to show the whole beach teeming with scuttling baby turtles, all of them heading unerringly and with great haste in the direction of the sea. I was suddenly wide awake as the enormity of what I was looking at dawned on me.

- For a turtle, the first awareness is an enclosed space little bigger than itself
- Somehow, it knows to use its beak to break the shell of the egg
- Sand. How on earth does a new creature know what to do with that?
- How does it know it is supposed to move upwards?
- When it surfaces, how does it know it must get to the water, and quickly?

Of course, the answer is simple: instinct. We all know that. Just like every other newly hatched or born creature. A baby alligator knows to hide from creatures that it will one day feed on. Magnificent. All living creatures have powerful survival instincts associated with their particular species that have been honed over generations and passed on in the genetic code from their parents. A newly hatched bird doesn't try to dig its way out of its nest any more than a baby turtle sits about waiting for its first meal. Each creature has perfectly suited instincts for eating, reproducing, hunting, killing… survival of self and survival of the species are paramount. But there is one group who quickly learn that some of their instinctive behaviour is undesirable and might even result in physical pain. Humans.

It was this that had suddenly jerked me awake. Humans are taught to suppress instinctive drives and if an instinctive drive is suppressed, it will be discharged in some other way – and very likely in a manner that is inappropriate in the situation in which it is displayed. In other words, a **Symptom.** At that precise moment, I could not 'tie together' the idea of different personality traits, instincts, and symptoms, and yet in the same instant I knew I was on to something. Tiredness forgotten, I began writing down my thoughts, and with a sudden flash of realisation I had it. I had it, and then lost it again, with the exact feeling you get when seeking to recall a dream and you find yourself scrabbling away at the fragments of memory which become rapidly more elusive. All I was left with was a certainty that instincts were somehow involved.



Terence Watts

Terence Watts is Chairman of the Association for Professional Hypnosis and Psychotherapy, Principal of the Essex Institute of Clinical Hypnosis, and a Fellow of the Royal Society of Medicine.

Terence has been in practice as a hypnotherapist since 1989. He is the author of several books on hypnotherapy and psychotherapy, including Warriors, Settlers & Nomads, Rapid Cognitive Therapy, and Hypnosis: Advanced Techniques in Hypnotherapy and Hypno-analysis.

He has presented extensively at home and abroad, including the USA and Hong Kong, and has written many courses and manuals. In 2007, he gained Membership of the City and Guilds Institute for his work with Psychosexual Dysfunction, and is so far the only member of the psychology-related professions to have achieved this award.

Over the next few months, I discovered more about the way that instincts can be formed. For instance, in 1940 a researcher in learning behaviours, one Robert Choate Tryon, selected rats that were either 'maze bright' or 'maze dull'. As the names suggest, these were rats that were either particularly adept or particularly poor at negotiating a simple maze.

Successive generations bred from these rats showed a steady increase in their natural trait – the 'maze bright' line became steadily more maze-bright while the 'maze dull' became steadily less capable. Inherited instincts, a kind of genetic memory, were at work.

But what of humans? I discovered that our particular species, *Homo Sapiens Sapiens* (*Homo Sapiens* was actually an earlier genus, a kind of primitive version of us), came into being somewhere between 140,000 and 275,000 years ago, though some think it could be as recent as 90,000 years or so ago – there are many conflicting claims. Some people believe we originated via the so-called 'African Eve', because one of the earliest fossils of our species was found in an African cave in a remote archipelago. Others are certain that there was a kind of 'parallel evolution' whereby our particular species appeared in different parts of the world at about the same time. What seems certain, though, is that at these new humans had bigger brain cavities and therefore bigger brains. They would have had the same inherited instincts for survival that all living creatures have, but with an increased ability to think and reason. Of course, they were all hunter/gatherers, nomads, living where life took them.

A hypothesis

Now we come to an unprovable hypothesis, albeit one which is likely to be somewhere close to the truth – and much of what is written here is known fact anyway. All of the tribes that existed then were small, consisting of around twenty-five to fifty individuals. Along with increased intelligence comes increased awareness of self and a subsequent need or wish to relate to other individuals in the environment. Or perhaps to control them. Some of these tribes retained the aggressive and violent savagery of their ancestors; there is no doubt of that. This means that they would not only fight other tribes when they encountered them, but also fight for supremacy among themselves. In this way, they would establish a hierarchy of chief at the top, a few immediate cohorts, then the body of the tribe. Warriors, all of them.

Others learned the value of cooperation with each other – this we know, because it would have taken a combined and cooperative effort to establish the earliest settlements out of an untamed land, though this did not happen until, by most estimates, around 10,000 years ago. These, then, are the Settlers, and it is around this time that the fun really started.

Remember the rat experiments. Successive generations strengthen some traits and might weaken others. It's not too much of a stretch of the imagination, then, to entertain the idea that the Warriors had become even more aggressive than their earliest ancestors, while the Settlers, already starting out with a disposition to cooperation, had become far less so. Warriors were excellent at fighting and did so instinctively. Settlers did not.

In earlier times, it seems likely that the Settler types would simply have departed the scene very quickly indeed if they encountered a tribe of Warriors… but now things were different. They now had their fixed abode, their huts and crops. Escape was less of an option and it was only a matter of time before a Warrior tribe encountered this earliest attempt at civilisation with all its inherent advantages. Perhaps fortunately for the Settlers, the Warriors were also crafty and realised that their opponents could do many things that they had no skills for. So they would not have killed all the Settler individuals; perhaps it would have been only enough to persuade the survivors to employ their farming and building skills for *their* comfort. The Warriors would want to protect their new investment by safeguarding the settlement from another attack by violent marauders such as themselves. In this way, they would unwittingly also be protecting the Settlers, whose lack of fighting ability was what allowed the Warriors in in the first place.

This situation, where the stronger both exploit and protect the weaker, exists to this day, in business, in politics and in family life.

Some of those Settlers (and maybe even some of the Warriors) might have decided at this point that things were getting a little violently boring and so might have chosen to follow their most ancient instincts – the nomadic hunter/gatherer existence. They took to the road once more.

Up to this point, all the tribes had strengthened their inherent traits by continual reinforcement for many tens of thousands of years. Now, though, there was a mix of individuals, some orientated towards control, and others whose entire existence revolved around the community spirit of helping each other. It is not difficult to imagine that there would have been a fair amount of sexual activity going on right from the outset and so it was that their offspring possessed a built in propensity for conflict right from birth – not a true difference in genes necessarily, but the result of 'generational evolution' or 'ancestral memory' in which both behaviours, control and community, could have equal, or very nearly equal, impact upon the psyche.

And what of those who had followed their most ancient ancestors and walked away from the battle and the possibility of much work in the future? Not for them responsibility or settling down to hard work to survive; for them, it was much more satisfying to keep moving without having to worry too much about the consequences of their actions… so they would have spread *their* genes, their instincts, far and wide. This scenario would have been played out many times; the nomadic instinct was still very strong in the human species and many people would have continued to wander the world just as their forefathers had.

Fast forward now to the modern day.

Some four hundred generations on, those instinctive behaviour patterns are well and truly disseminated throughout the human race and all of us have elements of each, though they are seldom balanced and there is very rarely more than about 45% of any one trait. In fact, empirical testing with a variety of assessment tools indicates that even that percentage is excessively high, and when it exists is usually accompanied by quite severe emotional difficulties.

So, whether we like it or not, we all carry the traits of each personality type and are likely to exhibit all of them on

occasion; it's just that what we show *most of* and/or *most frequently* identifies our orientation. Of course, we are all complex beings but you will recognise people you know (and probably yourself) from the descriptions that follow shortly.

Professional classifications

Although the terms 'Warrior', 'Settler' and 'Nomad' trip nicely off the tongue and are definitely user-friendly for work with clients, there are also 'professional' names for the three types. These are:

- Warrior: **Resolute Organisational**
- Settler: **Intuitive Adaptable**
- Nomad: **Charismatic Evidential**

These designations describe the basic behaviour pattern of each type, and for the remainder of this article I shall refer to them by their 'professional' names, which describe them in some detail as well as outlining their possible behaviour in the therapeutic setting. There is also a 'quick recognition guide' and a conversational personality test.

RESOLUTE ORGANISATIONAL – the Warrior

Personality profile:

Forceful: can always make their presence felt.

Resolute: high levels of tenacity and determination.

Organisational: able to plan well and bring those plans to fruition.

Achilles heel: the need to be always in control.

Areas of conflict: concerned with issues of loss of respect/dignity/integrity or any sort of 'attack' – being frightened, picked on, humiliated, punished, bullied, etc.

Symptoms: usually based around phobic response patterns or control issues – body or mind. There are often physical manifestations of the digestive tract, including ulcers, IBS, constipation, etc.

Abreaction type: sometimes almost invisible – any tears are likely to be sparse, though s/he will feel as if they have been laid totally bare. The approach of abreaction will often be indicated by fear or anger.

Personality: the RO personality tends to have a reputation for firmness and a no-nonsense attitude to life. Psychologically stronger than either the IA or CE personality types, they find no difficulty in taking charge of things and easily attain the respect of others. They are cautious yet rapid thinkers who are unsurpassed at finding and exploiting the flaw in any argument. On the negative side, there can sometimes be a problem with cynicism and jealousy and there is not usually an immediately friendly response. They don't like being questioned and there will sometimes be a significant pause before answering any questions that are put to them. Even then, the answer will often be carefully phrased in such a way to leave as many options open as possible.

Physical traits: this type is the least physically animated of the three groups. There are few changes of face expression during conversation, and few changes of body position. The angle of the head, in particular, may remain unchanged for longish periods (usually tilted, with a 'contra tilt' of the body so that their head appears upright) making them reminiscent of an excellent card player, giving away absolutely nothing about inner thought processes. They appear to be – and indeed are – watchful and perceptive, with a steady gaze which may be away from their conversation partner if they are nervous. Any tension or anxiety will show in a taut body shape and a set facial expression leaning towards irritability or hostility.

Positive attributes: determined and tenacious; methodical and organisational; perceptive and easily able to spot the pitfalls in a plan/situation; sound but not necessarily fast decision-making abilities; natural team leader and co-ordinator; quick thinker in discussion or argument, able to easily see and exploit loopholes or advantages; practical and logical; good at recalling/using facts and figures.

Negative attributes: *as with the other two groups, these traits are only possible tendencies and are not necessarily evident in any one individual – in fact, it is unlikely that any one individual will show all these traits. The positive traits in this group are very decisive and specific, and this forthright attitude tends also to be reflected in the negative traits.*

The RO character is inclined to force rather than subtlety and in negative mode can be pedantic, domineering and impatient, and might also appear rude and sarcastic. They have a driving need to be in control and can sometimes be quite ruthless in their determination to be so, being very good at manipulating people and events to their advantage – this, of course, may in some circumstances be viewed as a positive trait. The two things they hate most are not getting their own way and having to admit that they are wrong. Underneath all these attempts to maintain power and control, there are often secret feelings of self-doubt, leading to cynicism and jealousy. They are prone to phobias, hypochondria and/or obsessive thought or behaviour patterns, and they might actually take a considerable amount of actual pleasure in being bad-tempered or unreasonable.

INTUITIVE ADAPTABLE – the Settler

Personality profile:

Sociable: gets on well with almost anybody

Intuitive: a high level of instinct and general awareness.

Adaptable: able to make the best of any situation.

Achilles heel: the need to be liked.

Areas of conflict: concerned with emotional states, predominantly guilt, shame, and injustice issues.

Symptoms: usually concerned with feelings – inadequacy, depression, inferiority, low self-esteem, fear of what others think, excessive regard for authority, guilt, shame, etc.

Abreaction type: usually tearful and childlike. The approach of abreactive

states will often be indicated by sudden quietness and an increase in any hypnotic flush. A hand may be raised to the mouth, which may tremble or straighten. Within the abreaction, tears and weeping can be copious.

Personality: the IA personality, being able to fit in with almost any situation, is necessarily a kind of psychological chameleon. The most obvious traits are a pleasant and responsive attitude to others, but sometimes with a tendency towards mood swings from happy to miserable – or the other way round – at the slightest provocation, the smallest event. There is also often an 'all or nothing' tendency, in which if they cannot have *absolutely* what they want, they will simply refuse to have any part of it at all and will 'cut off their nose to spite their face'. Excellent talkers and communicators, they are unrivalled when it comes to having an instinctive grasp of all that is going on around them. They are usually reliable and come over as 'nice' people, which they usually are.

Physical traits: easy to recognise from their physiology, they are responsive during conversation, with active but not excessive body/head movements, nodding when they should, smiling when they should, any disagreement being expressed politely and tactfully. Their face expressions are reactive to the conversation and there is a tendency to smile often unless they are depressed. Any tension/anxiety present tends to speed up body movements and speech, and increases the visibility of any lines on the face, and there will then be a leaning towards a worried/anxious expression.

Positive attributes: instinctive understanding of others; caring and compassionate; excellent communication skills; generally optimistic, cheerful and polite; tolerant and easy-going; powerful instinctive responses (it can seem as though they possess a genuine sixth-sense of the unadmitted attitudes or mood-shifts of others); flexible approach to the plans of others.

Negative attributes: *there are many IA individuals who appear to show none – or very few – of the following traits. <u>They are only tendencies and not necessarily present.</u>*

The complexity of this character can be exasperating to others if they once get into a negative mode of operation. They can be just on the brink of success when they will suddenly give up, claiming that they simply have not got what it takes, even if other people think they have; feelings of inferiority and inadequacy can lead to problems with decision-making and displays of under-confidence or unassertiveness; and they can seem to take far too much notice of the opinions of others, an excessive need to be liked sometimes leading to difficulty in saying "No" when necessary. There are often feelings of failure or of being in some way fraudulent. They are prone to shyness, depression and/or bouts of debilitating melancholia/depression.

CHARISMATIC EVIDENTIAL – the Nomad

<u>Personality profile</u>:

Restless: must always have something 'going on'.

Charismatic: naturally outgoing.

Evidential: what-you-see-is-what-you-get.

Achilles Heel: the need for constant stimulation.

Areas of conflict: concerned with image issues and loss of freedom or things that they really do not want to do/face. These can seem to be quite minor events.

Symptoms: anything dramatic. Hysterical blindness, paralysis, 'massive' panic attacks, spontaneous vomiting, 'phantom' illnesses of all kinds from 'blackouts' to crippling or catastrophic conditions.

Abreaction type: noisy, often including screaming and shouting, as well as thrashing arms and legs. Anything that *dramatically* illustrates how bad they are feeling. The approach of abreaction is usually rapid and almost indeterminable from the abreaction itself.

Personality: the CE personality in its purest form tends towards extremes in many things. They enjoy life to the full and can give much pleasure to a great many people along the way – except for the occasions when they get carried away with frivolity and excitement, loving to shock others with loud and embarrassing behaviour and being amazed when someone complains about their excesses. This exuberance tends to show itself quite often and can be quite exhausting as well as tiresome for their companions. Most of the time, though, this personality is tempered by more sensible traits from the other two groups, not unusually producing an individual who can uplift others with their irrepressible sense of fun and enthusiasm.

Physical traits: animated behaviour is the most obvious trait here, but as with most things in this group, it tends to be exaggerated. There are excessive movements of the head and face, the body, and especially the hands, and they can liven up any gathering with sparkling wit – as long as not too much serious stuff is expected from them. Often quite generous and outgoing, and almost exclusively extroverts, they are always on the search for something new and exciting to do. They adore telling jokes and stories with lots of noise and action and always do it well. Under any sort of pressure, they tend to become louder and more expansive in their gestures and movements.

Positive attributes: enthusiasm for new projects; lively approach to life and work; inspirational in outlook and communication; exceptionally confident and outgoing; uninhibited in all areas of life; quick eye for creating an image; uncomplicated personality – what you see is what you get; good presentation skills; ready wit, especially in response to others.

Negative attributes: *as with the IA and RO personalities, these negative traits will not <u>necessarily</u> be apparent.*

The biggest problem for the CE personality is in maintaining application of effort, and as a result they can appear unreliable or fickle. They themselves are unconcerned about this, however, relying on sheer force of personality/charisma to see

them through and usually getting away with it; they may even boast about it. There is a childish need for instant gratification – they cannot abide waiting about for things to happen – and a distinct tendency to flamboyantly exaggerate their successes. Their relationships are usually distinctly one-sided and they are masters of tactlessness and bad taste. Under pressure, they are prone to dramatic illnesses like paralysis, apparent blindness, 'black-outs', memory-loss, etc., which may or may not be genuine.

QUICK RECOGNITION GUIDE

Here is a quick recognition guide for each group which will give you a good idea of where anybody 'fits', just by watching them for a moment or two.

Resolute organisational/Warrior

Physiology: fairly straight-faced, few body response patterns, steady gaze.
Positive: practical, tenacious and self-sufficient. Quick thinkers. Often personable.

Negative: suspicious, dictatorial, manipulative. Cannot easily admit mistakes.

Dress: plain, sometimes austere, sometimes tends towards darkish colours.

Intuitive adaptable/Settler

Physiology: responsive body and head movements. Frequent smiles.

Positive: caring, cheerful, pleasant, talkative and tolerant. 'People' people.

Negative: depressive, indecisive, under-confident. Prone to mood swings.

Dress: conservative, 'sensible', with a tendency to co-ordinating colours.

Charismatic evidential/Nomad

Physiology: often expansive in gestures. Can be animated/noisy. Laughs easily.

Positive: fun-loving, enthusiastic, outgoing. Inspiring and optimistic.

Negative: unreliable, childish, boastful. Prone to exaggerate mild success.

Dress: individualistic, either 'designer' or deliberately downbeat. May be 'showy' with accessories.

A brief personality test

This brief test is conversational in nature and can easily be committed to memory. Used skilfully, your client will not recognise that they are being tested and so will not bias the answers in their favour.

Question 1: *"If you had to choose one or the other, would you choose to be: **rich, loved** or **famous?**"*

Question 2: *"Ok. If you were suddenly rich and you had to choose, would you prefer to: **save it, share it** or **spend it?**"*

Question 3: *"Where does that part of you that you call 'me' or 'I' actually live in your body?"*

The questions can be paraphrased as you wish – and expanded as you wish – without affecting the accuracy of the test, as long as you make sure that the meaning remains clear enough for your client to understand what he or she is being asked. It doesn't matter how long it takes your client to decide on his or her answers, and it is also ok to discuss the questions as long as you do that in a rather 'lightweight' conversational manner. It is important that we do not accept 'don't know' as an answer to questions 1 or 2, though this is quite acceptable for question 3, as you will see.

Defining the Type

Once you have your answers, you are easily able to assess the basic personality of your client; you might need a little mental dexterity if you're using the test entirely conversationally and don't want to write the answers down, though it *is* possible, with a little practice. Here are the indications that each answer gives us:

Question 1:
'Rich' indicates **RO**
'Loved' indicates **IA**
'Famous' indicates **CE**

Question 2:
'Save it' indicates **RO**
'Share it' indicates **IA**
'Spend it' indicates **CE**

Question 3:
'Head' indicates **RO**
'Heart' (or torso/stomach, etc.) indicates **IA**
Any other answer (including 'don't know') indicates **CE**

The analysis is immediately obvious. For instance: If somebody answered: 'Rich', 'Share it', 'Head', we can see that this means **RO**, **IA, RO**, so it's likely that **RO** is dominant.

If the answers were: 'Loved', 'Spend it', 'Heart', this shows **IA, CE, IA** – a clear dominance of **IA**.

From time to time, you will discover mixed influences: 'Loved', 'Save it', 'Don't know', for example, where we are looking at **IA, RO, CE**

It is actually quite easy to do this test 'in your head', since the answers are always in the same order: 1 = **RO;** 2 = **IA;** 3 = **CE.** This means that you only have to make a mental note of, for instance, 2, 3, 2 or 1, 3, 3 to know which trait is dominant. If you get 1, 2, 3 *in any order* you have the evidence of mixed influences and you can ask this fourth question as a 'clincher':

Question 4: *"How do you think other people are most likely to describe you: **determined, pleasant,** or **'a bit of a character'?**"*

It is probably evident that the choices here show **RO, IA, CE** respectively and again, they are in the same numerical order, so the response will clarify any mixed-influence answer.

It is entirely possible to conduct an entire therapy using this concept, especially if you consider it as a kind of modern 'Parts' work in which the 'Parts' are 'ready to go'!

*The book **Warriors, Settlers & Nomads** by Terence Watts is published by: Crown House Publishing, 2000; ISBN 978-189983648-2. It is available from many outlets, including the author's website: http://www.hypnosense.com*

REFLECTIONS

Marilyn Upton answers questions asked by Mike Dillon (Editor) about her life as a stress manager.

Thank you, Marilyn, for agreeing to reflect on your work and life.

MD: *Can we get the ball rolling, Marilyn, by you giving some brief details about your life before you became a stress manager?*
MU: **I grew up in and around Oxford. I went to Goldsmiths' College, London University. After a couple of years teaching in this country I went with my husband to live in Jamaica for five years, where I also taught. My first son, Robin, was born there. Then we went to the Seychelles, for five years. I taught there too and had my second son, Mike, there. It was good to see how other people lived, especially in developing countries. When we came back to U.K., my husband got a job here in the West Country and I've stayed here ever since.**
MD: It always fascinates me that so many Society members have experienced such interesting lives, many having worked overseas for some years. Your life, Marilyn, in this respect is probably the most varied I have so far heard about. Five years in Jamaica and another five years in the Seychelles; you can't get much more exotic than that!
MD: *What inspired you to train as a stress manager and enter the therapy profession?*
MU**: I grew up in a very traditional family, but living abroad showed me that things could be done differently. I became frustrated by the increasing bureaucracy in my particular teaching job, and was looking in the Times Ed. for one with less form-filling and more hands-on work, when I came across the ad for the Society. Working one-to-one appealed to me, and I felt this was a profession where I could still make a difference but with less form-filling!**
MD: I can appreciate what you mean, Marilyn. One can see that after life in Jamaica and the Seychelles you were looking for something new back in the UK. I know about all the bureaucracy in teaching. My eldest daughter Susan was a teacher for many years, and she got fed up with the direction teaching was going in the UK. She now works in Hong Kong. Her husband Andy is a project manager in Hong Kong. Susan and Andy live on Lantau Island and the lifestyle is certainly different from that in the UK.
MD: *Getting back on track. To what extent did you find your experiences in life, before becoming a stress manager, helped you in your training and work as a therapist?*
MU: **I think my studies at Goldsmiths' (Psychology and Philosophy in particular) were a good grounding to build the training onto. Moving about the world and meeting so many different kinds of people prepared me for the fact that no two people are the same. Which is good to know, when you have unique people with unique problems coming through the door! Fortunately our training, and the many courses I have done since, also gave me the tools to deal with them!**
MD: I doubt whether one could have a better grounding for working in the 'talking therapies' than psychology and philosophy, plus the experience of the different cultures you have been fortunate enough to live in.
MD: *What particular personal skills and resources did you possess that you felt were of most advantage to you when you started training and later helped to develop your skills as a stress Manager?*
MU**: I think I'm quite adaptable, and our profession is obviously quite different from teaching, so the training was fun rather than a difficult challenge. With clients at least, I am quite a patient person, and a good listener! I have a good memory for what people tell me – you can't write absolutely**

everything down. I think I empathise quite well with clients.

MD: Yes, I believe writing too much down in cold print can short-circuit one's subconscious mind thinking and the insight that is so necessary in the therapeutic process.

MD: *Did you experience any aspects in your training, or when you started up in practice, that you found particularly difficult and challenging?*

MU: **It was difficult becoming known and trusted as a stress manager at first. I had to put a great deal of time and effort into that. Some business people in particular were surprisingly hostile and unhelpful. Probably they were the people who needed me most, but I will never know! I'm glad that I became part of the Nine Springs Clinic. We are a big community of alternative therapists. I'm on the website and whenever I run a new meditation course or de-stress workshop it's put on there.**

MD: *I know you have studied and used Life Coaching techniques with your clients. What attracted you to this particular area of self-development?*

MU: **My study of Life Coaching really came as a request from clients. Once they had solved their initial problem, quite a few wanted to push their potential further. I could see their potential, but couldn't really help them channel it. With the structure of Life Coaching I am able to help them decide what to do when, to achieve what they want to. It's really rewarding watching them develop.**

MD: Yes, I have noticed over the years many of my clients posed the question, "Now I have sorted out my emotional and behavioural problems, I would like to go ahead with how I can develop my life positively". I haven't studied Life Coaching, but I was able to help them.

MD: *Obviously you are a therapist who believes it is advantageous to have more than one discipline to use in your work as a stress manager. How important do you think a variety of techniques is essential for a therapist to provide a really professional service to their clients?*

MU**: For me it helps, as people approach things differently, and what works for one doesn't for another. Some clients, for example, respond well to CBT, others to a more spiritual approach. It means I have a toolbox of approaches, and it's satisfying finding the approach that matches the client!**

MD: *Marketing and advertising appear to be a difficult challenge for many stress managers. Have you found this a problem for you? Can you give a brief account of what you have found difficult and what you have found successful in marketing and advertising your practice?*

MU: **I know some people say leafleting doesn't work, but for me in Yeovil and the surrounding towns and villages it did. It got my name known. Doctors and health professionals started referring people to me because they had read my leaflet. Concerned friends and family had something to show a potential client. Now, as part of my rental to the Clinic, I have a space on the website. That generates a high percentage, also my Yell.com listing. Word of mouth works particularly well, and other therapists at the Clinic refer their clients to me too. When I started practising I wasted a lot of money on press advertising that didn't work, but I know what works now.**

MD: It is an old 'chestnut' but it is so true, that one needs to find the marketing methods that work for you in the area you work in. Incidentally, I also found distributing leaflets when I started working as a therapist worked for me in the same way you described.

MD: *It is always of interest to stress managers what they can do with marketing and advertising that does not cost a lot of investment. Can you give any examples of how you have marketed your practice without having incurred any monetary cost in doing so?*

MU**: In addition to leaflets I have also been round to Doctors' surgeries with a pack. It takes time but is an effective way of being known. Talks to groups also work to a certain extent for me, but are a bit more random in their results**.

MD: *Have you ever worked as a stress manager in any specific areas of work that could be called a niche market?*

MU**: I suppose working with children, and teachers, could be called my niche market. Because I'm a trained teacher I'm able to offer this, and to understand what they're going through if it's a problem at school.**

MD: I find working with children, indeed all people who could be termed young, very satisfying. They can gain so much from a competent therapist as a platform to a happier and more successful life.

MD: *Most stress managers during their working life come across unusual or humorous experiences or cases of particular interest. Can you let the Journal readers know of any such cases you have been involved with?*

MU**: The funniest time was when a client had a phobia of the dentist's drill. She was just nicely relaxed and about to go into a T.R. when someone started drilling up the pavement outside! I carried on, silently cursing, and afterwards apologised for the drilling outside. She said, "What drilling?"**

MD: Good one, Marilyn. I had a client who came to me in such a nervous state she walked around the room for most of the assessment session. After a few lessons I asked how her anxiety feelings were now. She replied, "What anxiety feelings?"

MD: *What advice would you give to a person who came to you and showed interest in becoming a therapist in the 'talking therapies' but did not know which particular therapy they wanted to be trained in?*

MU: **To be honest, I would tell them to look at all the different talking therapies. I would tell them it depended on what appealed to them, and how much time and money they had for training. Then I would tell them that I believe stress management and hypnotherapy can help people deeper and faster than any other therapy. I always say, "Hypnotherapy reaches the parts that other therapies don't reach!"**

MD: *The Complementary and Natural Healthcare Council (CNHC) was launched with government backing through the Department of Health in April 2008 with the purpose of protecting the public by means of a voluntary register for complementary health care practitioners. Their functions are:*

To establish and maintain a voluntary register of complementary healthcare practitioners in the UK who meet standards of competence and practice;

To make the register of practitioners available to the general public and to

educate them about the CNHC quality mark as a quality standard;
To operate a robust process for handling complaints about registered practitioners;
To work with professional bodies in the complementary healthcare field to further develop and improve standards of professional practice.
What are you views about the CNHC? Do you see their role, as detailed above, essential for the future positive development of complementary therapies, and have you joined the CNHC hypnotherapist register, and if so, why have you done this?
MU: **Yes, I have joined the register. Although I don't see it as a problem, because my clients are testimony to my efficacy, it would appear that accountability is an important part of a profession being trusted by society at large. I look forward to the day when, for example, the NHS can refer patients for hypnotherapy, and the hypnotherapist is paid by the NHS to carry out the work. I believe this would save the NHS thousands of pounds in psychiatric departments. Belonging to a body such as the CNHC will, I believe, create a general climate of confidence in our profession**.

Life in general:

MD: *As therapists, we usually emphasise to our clients the importance of happiness in life. What makes you happy?*
MU: **The biggest thing that makes me happy is being authentic, in other words, being me. I feel that I can be me in my work, and that I am me in the things I choose to do in my spare time. I'm also particularly happy when I'm with my three-year-old granddaughter, walking dogs with friends, watching dragonflies flying over the river near where I live, and being with my sons.**
MD: Very glad to hear you say this Marilyn. I believe the two most important aspects of life are being oneself and enjoying loving relationships.
MD: *If you could change one thing about yourself, what would it be?*
MU: **My earnestness!**
MD: That's interesting, Marilyn. As far as I recall the definition of 'earnest' is "ardently or intensely serious; zealous; not trifling or joking". This is not how you come across to me in any detrimental way. I would say genuine, determined and able to see the funny side of life. However, you know yourself better than anybody else.
MD: *So to continue, as therapists we all know how important happy memories are in coping with the bad times. What's your happiest memory?*
MU: **My most vivid memory is of staying at a luxurious hotel in Guatemala, up in the mountains, after slumming it for several weeks on a South American tour. I have a photo of it. I'm sitting on a wall warmed by the sun, watching a boat being rowed by some locals in national costume over a large mountain lake at sunset. I remember thinking that same sun also warmed and sustained my own country.**
MD: *What is your favourite treat?*
MU: **Climbing up a large hill not far from home, with several stops for breath, with the dog and anyone daft enough to join me. It's an old hill fort, reputedly used by King Arthur as Camelot (and who's to say it wasn't!). From the top several counties can be seen, Glastonbury Tor rises majestically out of the mist, and there's a spectacular view over the Somerset Levels.**
MD: Absolutely wonderful!
MD. *Is there anything you could not live without?*
MU**: My spaniel, Gem, my family, and my photographs.**
MD: *As stress managers, we always encourage our clients in the important task of dealing effectively with life's ups and downs. How do you deal with any setbacks in your life?*
MU: **If something traumatic has happened, I stop and go to sleep! That seems to do some healing, so that I can then re-group and concentrate on what to do next.**
MD: Wow! How cool is that? Go to sleep and let the subconscious mind sort it all out. Great!
MD: *What do you do to maintain a healthy mind and body?*
MU: **I keep busy: doing things I like to do, including walking the dog and reading books by William Bloom, although the filing doesn't always get done.**
MD: I know what you mean, Marilyn. Let's face it, when it comes to filing or walking the dog, the filing hasn't got a hope in hell of winning.
MD: *We all feel run down from time to time. How do you cheer yourself up when you are feeling down?*
MU: **If I'm feeling down, I stop and go out in the sunshine, or do something with my plants, play with the dog, chat to friends, listen to my favourite music or attempt to play the piano.**
MD: That all sounds good to me.
MD: *A stress manager's work can be very stressful. What do you do to relax after a hard day's work?*
MU: **I cook myself a meal with good food, or if it's been very hard, listen to a meditation CD.**
MD: *What is your idea of a perfect day?*
MU: **A meal out with my family, somewhere by the sea, then a walk together.**
MD: Sounds ideal.
MD: *What do you consider is your greatest achievement in life?*
MU: **Becoming authentically me, not what others think I should be.**
MD: I believe this should be everybody's main goal in life.
MD: *What is your philosophy of life?*
MU: **Try your hardest to achieve your goals, but if they don't work out, have a Plan B!**
MD: Thank you, Marilyn, for sharing your reflections with readers of our Journal about your work and life. One thing I have learned from your answers to the questions I have put to you is how much in common we have. It has been a joy to know more about you and having confirmation yet again of how many really special people there are amongst members of our Society.

ANSWER TO THE 'TESTING THE BRAIN CELLS' QUESTION ON PAGE 3.

English is generally considered to have eight parts of speech: noun, pronoun, adjective, verb, adverb, preposition, conjunction and interjection. The sentence contains all the eight parts of speech. Did you spot all the eight parts without having a **peek** at the answer?

MYTH OF THE CHEMICAL CURE

Joanna Moncrieff tells Farouk Okhai why drugs do not deserve their exalted place in the psychiatric treatment of emotional and psychological ill health.

OKHAI: Dr Moncrieff, thank you very much for meeting with me to discuss your book *The Myth of the Chemical Cure*,[1] which very clearly explains the concerns of psychiatrists who are wary of the frequency and intensity of drug usage in psychiatry. You point out in many places that 'the facts' as taught to medical students and psychiatrists and in textbooks are simply wrong. For instance, anti-depressants don't work to any significant extent, in the way they are said to work; lithium has very little effect on bipolar disorder; and antipsychotics just control symptoms, rather than mitigate the disease process, which, in fact, is not at all well understood. What particularly impressed me about the book is that you have been at great pains to provide references for every assertion that you make.

MONCRIEFF: I make an argument that the conventional way of understanding psychiatric drugs is wrong, and I propose an alternative way of viewing them. I have tried to show that much of the research on psychiatric drugs supports my argument, and I hope that by doing this I have made a convincing case.

OKHAI: Yes, indeed. You propose a drug-centred model of drug action, as opposed to a disease-centred model. Can you explain this distinction and why it is so important?

MONCRIEFF: The orthodox way of looking at how psychiatric drugs work is what I call the disease-centred model of drug action. What this model implies is that there is an underlying disease process. In other words, people who have psychiatric disorders have some sort of physical abnormality in their brains and what the drugs are doing is helping to reverse this process in some way. So drug treatment, according to the disease-centred model, is helping to move an abnormal brain, where there is a disease process going on, towards a more normal state. I don't think even the most fervent supporters of psychiatric drugs would claim that drugs are actually normalising a pathological process. But the conventional belief is that they are helping to make an abnormal state more normal.

The other way of viewing how psychiatric drugs work is what I've called the drug-centred model, and the key contrast here is that the drug-centred model suggests that far from correcting an abnormality, drugs are themselves inducing an abnormal state, and that it is this abnormal state that may have benefits for people with psychiatric disorder or may appear to have benefits for people with psychiatric disorder. So the drug-centred model doesn't make any assumptions about whether or not there is an underlying disease process. The drug-centred model is simply saying that drugs create drug-induced states, and that these drug-induced states appear to improve some of the symptoms of psychiatric problems.

The reason that this distinction is so important is because the disease-centred model, by its very nature, assumes that drug treatment is a good thing. If you are correcting an underlying disease state, if you are helping to normalise abnormal brain function, then it must be a good thing to take psychiatric drugs. The drug-centred model, on the other hand, because it suggests that drugs themselves produce an abnormal state, makes the act of taking a psychiatric drug a much more ambiguous act. There may be benefits, but these are always likely to be balanced by the negative effects of the drug-induced state.

OKHAI: Do you use the drug-centred model in your outpatient practice and on your wards?

MONCRIEFF: To the extent that I try to explain to my patients what is known about the drug-induced effects of the various drugs that we prescribe in psychiatry. I then like to have a discussion with them about whether or not those effects will be useful in the circumstances in which they find themselves. For example, if someone is very aroused and agitated, very distressed by auditory hallucinations or other intrusive experiences, I explain that there are drugs that appear to dampen down those experiences but that they do this by dampening down all our mental activity. And then it is really for the patients to evaluate whether this state will be preferable to the state that they find themselves in due to the symptoms of the psychiatric disorder.

OKHAI: But is it really possible to explain what the likely effects of the drugs are going to be when you are presented with an acutely psychotic patient who is hearing voices and is in a disturbed state? Is that patient likely to be able to take in your balanced view of the effects of drugs? If not, what do you do in that case?

MONCRIEFF: You have to treat them in what you think is their best interests. In that case, I am guided by the drug-induced effects that I believe different drugs have and by how useful I think they will be in each individual patient's circumstances. But having said that, when patients have settled down a little, they *are* able to have these discussions and they are very aware of the global effects the drugs have on them. All doctors spend an awful lot of time talking to patients about issues of compliance, trying to persuade patients that they should take drugs that patients find unpleasant and don't really want to take, and all those discussions, I think, are different if you take a drug-centred approach. The discussion is then not simply, "Look, you have this disease; you need to take this drug to make you better": the discussion is, "You have had these problems. This drug might be able to dampen them down, but the consequences of this will be that you may feel mentally slower, tired, mentally more restricted, emotionally flattened. Does that seem to you a price worth paying?"

OKHAI: And if they think it isn't?

MONCRIEFF: Then you get into the territory of social control. Doctors have to ask themselves what is the real purpose of the medication. If it is to help the patient, and the patient doesn't think it will be helpful, then the patient should be able to take that decision, as long as they are in a fit state to make a decision. If the purpose of medication is to reduce the risk and inconvenience of a patient's behaviour, then this should be made explicit. If we are going to force people to take medication they don't want to take, we should be open and honest about why we are doing this. We should not pretend we are doing something to benefit the patient when we are really trying to control and contain them.

OKHAI: I agree entirely. I think you will agree, though, that most psychiatrists believe that anti-psychotic drugs have a more specific action than dampening down all mental activity. Do you have any comments to make as to why so many psychiatrists are so blind to this fact? I know that in my own case, it was seeing that most of the patients on these drugs were not getting better than led me towards concentrating on psychotherapy.

MONCRIEFF: Psychiatrists are blind to this fact because they want to feel like real medical doctors, treating and curing real medical illnesses. They want to believe that they are administering sophisticated and specific remedies, not that they are simply using chemical restraints. It is incredible to me, walking round a psychiatric ward, where patients look so obviously drugged up to the eyeballs, that anyone can ignore the general neurological suppression that neuroleptic drugs produce. The fact that so many psychiatrists do not see this testifies to the strength of the need to believe otherwise.

OKHAI: I suppose it is hard to admit to yourself that what you are doing is 'drugging' people rather than treating them. You have talked about discussing drug effects with people who have psychotic symptoms. Do you also discuss the pros and cons of drugs with people who have depression?

MONCRIEFF: In cases where people are diagnosed with depression, the equation is slightly different. As I explain in my book, there aren't any currently known drug-induced effects that look likely to be particularly useful in someone with depression.

OKHAI: That would have been an astounding statement to me till recently, but perhaps not so much since the publication of the study in *Public Library of Science Medicine*, which looked at outcomes in both published and unpublished trials and found little between antidepressants and placebo. It got a lot of media coverage. I have always been sceptical about the exaggerated claims made for antidepressants but I had thought, from the statistics that get bandied about, that antidepressants are supposed to work for a third of patients. But your own review of trials had already led you to feel that, on balance, they have no useful effects, and on the contrary, might even make people worse because of the withdrawal symptoms when stopped. These aren't called withdrawal symptoms, of course; to disguise that this is what they are, they are labelled 'discontinuation symptoms'.

MONCRIEFF: Yes, indeed. You could also argue that the experience of being in a drug-induced state is likely to impair somebody's ability to address the problems that have led them to seek help in the first place. So, with someone with depression – I don't deal with many people with depression in my current practice, but I have done in the past – I would try to explain just that: that I don't think that there are any drug-induced effects that are likely to be helpful for them. In a few cases, people might benefit from a sedative drug to help them sleep. But I think that's about the only valid use of drugs in depression, according to the drug-centred model.

OKHAI: As you point out so eloquently in your book, and I quote, "most doctors and health professionals want to help people to help themselves over depression. … What they fail to realise is that every prescription they issue conveys a message of hopelessness and powerlessness. Every time they recommend antidepressants they contradict the message they should be reinforcing about the ability of human beings to overcome adversity." This is, of course, a very different view from that of the NICE (National Institute for Health and Clinical Excellence) guidelines, which purport to be based on scientific evidence. But you make the startling case that, in drawing its conclusions, the NICE panel members actually ignored scientific evidence that they themselves had gathered, because it didn't accord with current thinking. It is really quite shocking. Could you say something about this?

MONCRIEFF: The process of the NICE review on depression was a very interesting example of how consensus opinion is arrived at. The full version of the NICE guidelines includes a meta-analysis that the NICE panel members themselves conducted on recent trials of SSRI (selective serotonin reuptake inhibitor) antidepressants. The main outcome used in these trials was scores on depression rating scales, and when they compared the depression rating scales' scores of the groups on antidepressants and the groups on placebo, the difference, although it was statistically significant, was so small that it was considered to be clinically insignificant. They then used exactly the same data to look at categorical outcomes. So what they did was they took the depression scores and said that everyone who got above a certain score should be classified as showing substantial improvement and everyone who got below that score should be classified as not improved. When they looked at the data in this way, they decided that the difference between the groups on antidepressant and placebo was clinically significant.

OKHAI: And you brought this discrepancy to their attention before publication.

MONCRIEFF: Yes. Irving Kirsch, professor of psychology at the University of Hull, and I wrote a response to this meta-analysis when the draft guidelines were circulated. We pointed out that the categorical analysis had been based on exactly the same data that had shown no clinically significant differences in the primary analysis of the depression scores. We got a response to every other comment that we made but the box for a response to that comment was simply left blank and the full guideline, when it was published, repeated the views of the guideline

committee that the meta-analysis had found a clinically significant difference between antidepressants and placebos, and this was based on the categorical analysis.

The guideline is a very interesting document because it has a very long introductory section before you get to the meta-analysis section and the introduction contains quite a thorough critique of antidepressant research and all the problems involved. And they perform this meta-analysis and again they do this quite thoroughly, using different forms of analysis, and yet the conclusions from all this work are exactly the same as the view on antidepressants before these guidelines were ever produced. They are exactly the same as the views presented in the Defeat Depression campaign, run by the Royal College of Psychiatrists in the early '90s, which was probably responsible for some of the huge escalation in the use of antidepressants. So, although the NICE guidelines committee didn't *find* a clinically significant difference between antidepressants and placebo in the primary analysis of the data they looked at, they concluded that antidepressants should be used, and have benefit, in moderate to severe depression.

I think the process by which the depression guidelines were produced is a very instructive example of how difficult it is to contradict the current consensus. The guideline committee actually did an analysis which showed that the data did not support the current consensus and yet they were unable to follow that through with conclusions that matched the data that they had produced.

OKHAI: That doesn't augur well for the current state of psychiatry if scientific information, based on good studies, is not believed. You state in your book, psychiatric drugs may be responsible for long-term brain damage. How strong is this risk, and which class of drugs is most likely to do this?

MONCRIEFF: The evidence I looked at on brain damage was mostly to do with the neuroleptic, or antipsychotic, drugs. The evidence is twofold. The first lot of evidence comes from the well-known fact that neuroleptic drugs induce tardive dyskinesia. Tardive dyskinesia is a condition that consists of repetitive, uncontrollable movements of parts of the body, usually involving the tongue, lips and jaw but sometimes affecting other parts of the body such as the limbs and trunk. Although some people suggest that it was recognised before the use of neuroleptic drugs, epidemiological studies show that it is clearly related to long-term use of neuroleptics. In fact, upwards of 20 per cent of people placed on long-term treatment with older types of neuroleptics are likely to develop it. However, when I started doing the research for the book, I realised that there is quite a lot of research suggesting that tardive dyskinesia is not simply a movement disorder; it often seems to involve more general cognitive impairment. Knowing what we do about other movement disorders, that would make sense. Most neurological diseases that involve disorders of movement also involve more general intellectual impairment, especially as the condition progresses.

The other set of evidence comes from the brain-imaging studies that have looked at people on drugs. The imaging studies of people who have been on long-term drug treatment show shrunken brains and increased brain spaces (increased ventricles), which are highly suggestive of loss of brain cells, and this has always been attributed to the underlying disease of schizophrenia. But no one has satisfactorily ruled out the effects of drugs on the brains of these people.

There have been a few studies recently that suggest that even just a few weeks of drug treatment can cause some shrinkage to the grey matter of the brain and an expansion of the ventricle volume. Is this clinically significant? It is difficult to tell, but studies in young people indicate that the brain shrinkage is of the order of 10 to 20 per cent, which doesn't seem like a trivial amount. And these are studies that are looking at a fairly short timescale, as well.

So these are the two bits of evidence that link neuroleptics with brain damage. I wouldn't say that this link has been definitely proven. I think the state of play at the moment is that there is enough evidence to suggest that it may be the case that neuroleptics cause brain damage, and it should be enough to worry us into doing a lot more research into this area. Unfortunately, it doesn't seem to be a subject of much interest.

OKHAI: You have now spent years researching the validity, or otherwise, of drug use in psychiatry. But when did you first begin to doubt the conventional teaching on the use of psychiatric drugs?

MONCRIEFF: I think I've doubted the orthodox perspective on psychiatric drugs since I started in psychiatry. You only have to wander through a psychiatric ward to see quite clearly that patients are altered and impaired by drug treatment. The drugs they are being given are not returning them to normality; they are putting them into a drug-induced state. Many patients describe the way the drugs make them feel as turning them into zombies, and I think that, if you walk through a psychiatric ward, that impression is confirmed.

OKHAI: Indeed. But when, as a junior psychiatrist, I saw similar patients and wondered about why the drugs were so ineffective, the answer from my superiors was that it was the depression that was making them like zombies. There seemed to be no way one could respond to that.

MONCRIEFF: What also struck me was that different psychiatrists can have completely different impressions of the same clinical encounters. So many psychiatrists will tell you that they know quite conclusively that antidepressants are effective, because again and again, they see people who respond to them. I was told this repeatedly when I was training, and yet I did not see the same thing. It didn't seem to me that people were responding to antidepressants; it seemed to me that people had a huge range of problems, some of which lifted and improved over time and some of which didn't.

OKHAI: Another, and I have to use the word 'dramatic', finding in your book is that it is highly likely that lithium has little, if any, efficacy in the treatment or prevention of bipolar disorder – manic depression – and that the same goes

for the anticonvulsants (carbemazepine, valproate semisodium and sodium valproate), which are now commonly used for bipolar disorder. Might they be worse than not using anything at all, because if a patient stops using these drugs suddenly, he or she is more likely to have a relapse of the illness than someone who did not take them?

MONCRIEFF: I do think it is likely that for many years, we have been treating people with bipolar disorder with drugs that make their outlook worse, not better. All the drugs we use are nervous system suppressants of one sort or another, and lithium is a particularly toxic one. When people stop taking lithium there is good evidence that they are likely to be tipped into a manic episode they would not otherwise have had. This fact is now accepted by authorities on bipolar disorder, but it doesn't seem to have made the impact that it should have made.

The risk of discontinuation is not only bad news in itself; it undermines the validity of all the studies of long-term treatment for people with manic depression. The trouble with these studies is that people in the placebo group have always been on drug treatment prior to entering the study. When they enter the study and get allocated to take placebo, their medication is stopped. Therefore they are vulnerable to the adverse consequences of medication discontinuation. People who continue to take medication appear to do better, because the placebo group are suffering from discontinuation-induced withdrawal and relapse.

In other words, the studies just show that coming off long-term medication is risky. They do not establish that taking maintenance treatment in the first place is better than not taking it at all.

OKHAI: That is deeply alarming, both the finding and the fact that it hasn't had much impact on prescribing. As you said before, there seems to be a strong need to believe in the efficacy of drugs. It must, therefore, have been hard, especially when you were still in training, to keep trusting the evidence of your own eyes and not be swayed by the explanations that senior people would have made very cogently in support of their views. How have you coped with the conflict that taking a different stand must have caused with your professional colleagues, both equals and those above you in the hierarchy?

MONCRIEFF: I have obviously come across many people who disagree with my views, and I have had some quite heated exchanges in various meetings, but I would also like to emphasise that I've come across an awful lot of psychiatrists who sympathise with what I'm saying and, even if they don't agree with it entirely, see some sense in it and would go along with my views to a certain extent. I also find that many colleagues agree with me in theory, and we can have very amicable discussions about the uses of the drug-centred model; but when we actually have a case discussion, they revert to the orthodox way of doing things: they want to know what the diagnosis is and then derive the supposedly appropriate treatment that will help to address and reverse that particular disease. I think that is partly because the orthodox view is a safe one; it allows psychiatrists to put people's problems in boxes, and therefore they don't have to confront behaviour that can be very challenging to their authority.

OKHAI: Can you elaborate on what you mean by that?

MONCRIEFF: Well, the sort of thing I mean is when a patient is challenging the system. Say, for example, someone wants to stay in hospital, even though they don't apparently need to be there, and will do almost anything to achieve this goal. Many psychiatrists would opt to diagnose a person in the situation as having schizophrenia, and being in need of curative drugs, rather than face the fact that there is a conflict of interests between the patient and the institution. The whole mental health system operates in this way. Rather than admitting that there are conflicting interests at stake, the system hides behind a diagnosis that allows it to present as medical treatments measures that are really aimed at containing behaviour.

OKHAI: So that brings us to the huge question that you raise in your book – should psychiatry be a branch of medicine at all? Would the abolition of psychiatry eliminate a lot of difficulties for the medical profession? It would certainly save a lot of young doctors from the distress of not fitting in with colleagues in other specialities. Why not abolish psychiatry from the medical profession altogether and leave it to others who might be better suited to dealing with human problems? Of course, I realise this begs the question as to who such people might be. Some might suggest psychotherapists or social workers or clinical psychologists, but we seem to have lost the understanding that many people are simply not suited to do this sort of work, even if they have the required qualifications, because they lack the innate ability to connect empathetically with other human beings.

MONCRIEFF: I think there is a role for medicine in the management of people who have psychiatric problems – or what are today called psychiatric problems – but psychiatry is not intrinsically, or properly, a medical speciality. I think there is some role for drug treatment, and therefore, there is a role for people who are informed about the effects of drugs and the way that research on drugs is, and should be, conducted. And, of course, there is a role for doctors in assessing the physical health of psychiatric patients. But I agree that psychiatric problems are not fundamentally medical problems, and I think that a lot of the difficulties and contradictions that psychiatry throws up are to do with its claim that they are. I also think that the claim that psychiatric problems are medical problems allows society and governments to avoid lots of difficult questions that psychiatric problems raise.

OKHAI: Such as?

MONCRIEFF: Such as how to deal with social disturbance that does not fulfil the criteria for the criminal law; such as how to care for people who do not manage to become, or to remain, independent; such as when it might be right to deprive someone of their liberty in the interests of other people. These are questions that I feel should be debated publicly, and there should be a proper democratic response to them. At the beginning of the 19th

century, there was a debate about whether the medical profession should have any special role in managing people who were considered to be mad. It was well covered by Andrew Scull, a sociology professor who wrote a booked called *Masters of Bedlam: the transformation of the mad-doctoring trade*.[2] He suggests that there was a significant body of opinion that asylums should be run by lay people, as doctors didn't have any special expertise to offer. I think it would be better if people who made the ultimate decisions about how to manage and help people who are disturbed or distressed were not doctors and if these decisions were not viewed as medical decisions but ones that ordinary people could and should be involved in. But as I said, I see a partial role for people with medical training in the management of people with psychiatric problems.

OKHAI: The difficulty I see is that, whilst a lot of mental health workers are often opposed, sometimes vehemently, to medical management, they often shy away from this when they are given the opportunity to take charge, and resort to asking for 'a medical opinion'. No one wants to be blamed if anything goes wrong. So the role of the doctor/psychiatrist seems to be to shoulder responsibility for the mentally disturbed, even though there are good arguments for psychiatry being removed from the medical arena. So, for the moment, we are stuck with doctors being in psychiatry, although for not very good reasons.

So far, we have talked about different drug approaches in psychiatry: don't you think that there are similar difficulties with the psychotherapeutic approach in psychiatry? Aren't there controversies in different schools or psychotherapy believing different things about the same patient?

MONCRIEFF: In some respects, I think, psychotherapy has filled the same role as drug treatment, in being regarded and presented as a panacea for all sorts of problems. Even though psychotherapy obviously involves trying to identify the root of the problem, it is problematic because it focuses on the individual rather than the society. Having said that, psychotherapy at least looks at a person as an individual and seeks to understand their life story, rather than putting them in a box, under a diagnosis, and giving them a treatment according to which box they are placed in. I think to that extent, it takes the right approach to trying to understand suffering and the problems that are experienced by people who become psychiatric patients.

OKHAI: What particular psychotherapy do you practise?

MONCRIEFF: I suppose my own form of psychotherapy is what I've just said, really. It is about trying to see patients as individual people and trying to understand their story, their history, what has led them to where they are today; what elements have formed their character and contributed to the problems that they experience and what elements there might be that could give them the strength to overcome those problems.

OKHAI: You mention approaches that try to find the root of the problem. But I would suggest that there are a lot of approaches that don't have such a narrow focus. For example, solution-focused therapy, or indeed, our own approach of the human givens, which looks at patients in the context of their society and environment and their needs, both in terms of basic requirements such as food and shelter, and other requirements, such as the need for security, connection, status, meaning and so on. So it seems to me that your approach is highly compatible with ours, and indeed, *is* the human givens approach.

MONCRIEFF: I agree. But there is the limitation that as a therapist of any sort, you are always able to work only with an individual or a limited system around that individual, such as their family or friends. The other aspect that needs addressing, which I think the human givens would probably agree with, is the sort of society we live in and how that society makes it difficult for people to find a satisfying role. That has to be addressed at a social or political level, as well as at an individual level.

OKHAI: I would argue with the statement that change has to be at a political level. I would suggest that change, wherever it occurs, always starts at the level of the individual, and that therefore, we should concentrate our efforts on changing at the individual level, just as you are doing in your practice of psychiatry.

MONCRIEFF: I don't think the individual level is ever enough, although I think it is important. My experience of being in the Critical Psychiatry Network (psychiatrists who are critical or sceptical of the dominant view that psychiatry is a form of neuroscience and that psychiatric disorders are caused by discrete, biological abnormalities that can be rectified by physical interventions) is that it has been enormously empowering and enabling to get together with like-minded colleagues. For example, we have submitted our collective views to the NICE guideline reviews, and the review of the Mental Health Act. I don't think that I would have done those sorts of things had I simply been on my own, and even if I had, I don't think people would have taken much notice.

So I think that collective action is very important, and I also believe that the structure of the society that we live in very strongly colours people's views and people's actions. Obviously, society cannot be changed without the action of individuals, but I think that if individuals simply work in isolation without looking at the nature of the society that they live in and trying to address that, they won't get very far. For example, we live in an intensely competitive society at the moment. The idea of work for its own sake or activity for its own sake is falling by the wayside. Activities and work are not seen as valuable any more unless they are profitable. Everything is being commercialised and corporatised – the NHS very strongly so at the moment, as you well know. Every service within the NHS has to demonstrate whether it can be profitable and whether it is a source of future profits, in order to make its case for its place within the foundation trusts. Individuals, therefore, live with this constant feeling that they should be performing at a certain level, and feel inadequacy if they don't. You have to see these phenomena at a societal level for people really to be able to challenge them and be able to understand their adverse impact on themselves.

OKHAI: I still wonder whether you are underestimating the importance of these actions at the individual level. In fact, as you note yourself, although there is little evidence for lithium being an effective treatment for bipolar disorder, it is widely prescribed, and you document how this widespread use of lithium may be due to the efforts of just one Danish psychiatrist, Mogens Shou, who began using it in the 1950s!

However, I understand your point that change at the societal level is more likely to occur as a consequence of enough like-minded individuals emerging. I suppose that until then, one has to continue doing the best that one can, as you are clearly doing. Thank you very much for your time, Dr Moncrieff.

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TARANTULAS HELP US UNDERSTAND FEAR

Scientists using tarantulas to unpick human fear have found that the brain responds differently to threats based on proximity, direction, and how scary people expect something to be.

Researchers from the Cognition and Brain Sciences Unit in Cambridge, England, used functional magnetic resonance imaging to track brain activity in 20 volunteers as they watched a tarantula placed near their feet, and then moved closer.

Their results suggest that different components of the brain's fear network serve specific threat-response functions and could help scientists diagnose and treat patients who suffer from clinical phobias.

"We've shown that it's not just a single structure in the brain; it's a number of different parts of the fear network and they are working together to orchestrate the fear response", Dean Mobbs, who led the study, said.

Mobbs's team assessed the volunteers' brain activity during three sections of study: first when the tarantula was in a segmented box near their foot and then moved to either nearer or more distant compartments of the box, and also when the spider walked in different directions.

"It seems that when a spider moves closer to you, you see a switch from the anxiety regions of the brain to the panic regions", said Mobbs.

He said there was more activity in the brain's panic response centre when the tarantula crept closer than when it retreated, regardless of how close it was in the first place.

He explained that the volunteers were actually watching a video of a tarantula, which they believed was near their foot, since getting the spider to do the same thing for each volunteer would have been impossible.

The scientists also asked volunteers beforehand how scared they thought they might be of the tarantula, and found that those who thought they would be most scared had a false impression afterwards of how large the spider was.

The scientists think it may be this so-called "expectations error" that could be the key to people developing a phobia – an irrational intense persistent fear of certain things, people, animals or situations.

"This may be one cognitive mechanism by which people acquire phobias", said Mobbs. He said that since the expectation of great fear appeared to make a person exaggerate the size of the threat in their mind this could trigger a "cascade effect", distorting the other processes in the brain to react to a larger threat and panic yet more as it came closer.

Editor: when I read this I thought this supports one process of treating a phobia – by making the client visualise the phobic object becoming smaller and also slowly encouraging the client to move the phobic object further away and then closer and closer, helping them to control their anxiety and fear. It is teaching the client to control as opposed to fear.

This article appeared in the *South China Post* dated Wednesday, November the 10th 2010. The Editor read this paper daily on his recent holiday in Hong Kong when visiting his daughter and son-in-law, who now live and work there.

Does this support the saying that an Editor's work is never done?

WHO SAID THAT?

You should not criticise anybody until you have walked a mile away from them in their shoes. A. H.

PRESS RELEASES

Mike Dillon

Press releases are one of the most challenging aspects of a therapist's marketing strategy, but very rewarding if you get them right. A quality press release can significantly raise your profile, and this can bring about a lot of positive advantages in many ways.

Most editors will accept a press release if you also pay for advertising in the publication they are responsible for. For a press release to be accepted on merit alone, however, editors need to be assured of the following.

The first question any editor will ask when they pick up a press release and start reading it will always be, **"Is this article important for the readers of my publication?"** The conclusion they reach will determine whether they read on or toss the release aside. The writer has one paragraph, perhaps twenty seconds, to seize the reader's attention or **lose it.**

"Important" means that the article is based on a development that the publication's readers will find interesting because it is **new** and **matters to them.** So when submitting a press release, ask yourself how your new improved service could be important from the publication's point of view, and then write your press release to emphasise that importance.

Before sitting down to write a press release, make sure you have something worthwhile to say. Equally important is to tackle the main point immediately, in the first paragraph. Make it with absolute clarity. Editors will judge your article in a matter of seconds and what they are looking for are **facts.**

Many press releases are not used because the editor considers that the central idea is obscure or unimportant **–** it glorifies the service provided but does not show any clear benefit for the reader.

Never try to use fancy writing. Editors do not have any time to untangle tricky phrasing. They spot it at a glance, run out of patience, and your press release goes into the wastepaper basket. It does not take long for you to acquire a reputation for being safe for editors to ignore.

Once you have decided what the important aspect of your article is, get to the point fast. **Say it in the first paragraph.** Make your point quickly, with every word clear and meaningful.

So, to sum up:

Make sure your subject is important to the readers of the publication to which you send your press release.

Present the essential facts immediately, in the first paragraph.

Use a simple, straightforward style, so your information is easy to follow and understand. Clarity is imperative. Fancy pretentious writing can only obscure your message.

Try to personalise your press release by quoting some authority for what you are saying. This breathes life into your message. Make sure the quoted person says something important to help make what you have to say authoritative.

If your press release quotes research to support your message, make sure you quote the source correctly.

Make sure you send your press release to the appropriate sub-editor **–** health, complementary therapies, or whichever one is appropriate.

If your press release covers an event that will happen in the future, make sure you include full details of the event. A last-minute press release may cause problems with people being unable to attend. Timing is often the difference between success and failure.

Make sure you are up to date with the names of sub-editors who are likely to be interested in your press releases. Do not address it to a predecessor: this can give the impression that you are careless and unprofessional.

Always remember that a relevant photograph will attract people to your press release: always send one in the hope it will be used. The more interesting the photograph is, the more likely it is to be used.

Avoid labelling your press releases as 'special', 'personal', or 'exclusive'. Using these words recklessly can brand you as unsophisticated, someone whose work should be regarded sceptically.

Always show a specific date, month and year on your press release. Avoid the phrase "For immediate release". If the publication can't meet your request they will probably ditch it.

As well as your name, always include your telephone number, email address and website address if you have one. People can then find out more about you and what you do in an easily accessible way.

Be willing to give additional facts if they are requested or add additional information if it is asked for. Editors will then mark you down as person who is willing to be co-operative and helpful to them.

If you follow these rules, you are well on the way to getting your press releases accepted as important copy by the publications you send them to.

WHO SAID THAT?

Yesterday's liberating insight is today's jailhouse of stale thinking. Anon

PARAPROSDOKIANS

(Submitted by the Journal Editor).

A paraprosdokian is a figure of speech in which the latter part of a sentence or phrase is surprising or unexpected in a way that causes the reader or listener to reframe or reinterpret the first part.

It can be used effectively in therapy to help encourage a client to think differently. Some examples are as follows:

I asked God for a bike, but I know God doesn't work that way. So I stole a bike and asked for forgiveness.

Do not argue with an idiot. He will drag you down to his level and beat you with experience.

I want to die peacefully in my sleep, like my grandfather. Not screaming and yelling like the passengers in his car.

Going to church doesn't make you a Christian any more than standing in a garage makes you a car.

The last thing I want to do is hurt you. But it's still on the list.

The speed of light travels much faster than sound. This is why some people are much brighter than the way they talk suggests.

If I agreed with you we would both be wrong.

We never really grow up; we only learn how to act in public.

War does not determine who is right – only who is left.

Knowledge is knowing a tomato is a fruit; wisdom is not putting it in a fruit salad.

The early bird might get the worm, but the second mouse always gets the cheese.

Evening news is where they begin with 'Good evening', and then proceed to tell you why it isn't.

To steal ideas from one person is plagiarism. To steal from many is research.

A bus station is where a bus stops. A train station is where a train stops. On my desk I have a workstation.

How is it one careless match can start a forest fire, but it takes a whole box to start a campfire.

Dolphins are so smart that within a few weeks of captivity, they can train people to stand on the very edge of a pool and throw them fish to eat.

I thought I wanted a career; turns out I just wanted pay cheques.

A bank is a place that will lend you money, if you can prove you don't need it.

Whenever I fill out an application, in the part that says "If an emergency, notify:" I put "DOCTOR".

I didn't say it was your fault, I said I was blaming you.

I saw a woman wearing a sweatshirt with "Guess" on it…so I said "Implants?"

Why does someone believe you when you say there are four billion stars, but always check when you say the paint is wet?

Women will never achieve equality with men until they can walk down the street with a bald head and a beer gut, and still think they are sexy.

Why do Americans choose from just two people to run for president and fifty for Miss America?

Behind every successful man is his woman. Behind the fall of a successful man is usually another woman.

A clear conscience is usually the sign of a bad memory.

You do not need a parachute to skydive. You definitely need a parachute to skydive twice.

The voices in my head may not be real, but they have some darned good ideas!

Always borrow money from a pessimist. He won't expect it back.

A diplomat is someone who can tell you to go to hell in such a way that you look forward to the trip.

Hospitality: making your guests feel like they're at home, even if you wish they were.

I discovered I scream the same way whether I'm about to be devoured by a great white shark or if a piece of seaweed touches my foot.

Some cause happiness wherever they go. Others whenever they go.

There's a fine line between cuddling and holding someone down so they can't get away.

I used to be indecisive. Now I'm not sure.

I always take life with a pinch of salt, plus a slice of lemon, and a shot of tequila.

When tempted to fight fire with fire, remember that fire fighters usually use water.

You're never too old to learn something stupid.

To be sure you hit the target, shoot first and call whatever you hit the target.

Nostalgia isn't what it used to be.

Some people hear voices. Some see invisible people. Others have no imagination whatsoever.

A bus is a vehicle that runs twice as fast when you are after it as when you are in it.

Change is inevitable, except from a vending machine.

'Whether the weather be fine, whether the weather be not, we must weather the weather, whatever the weather, whether we like it or not.'

POSITIVE NEWS: WHERE TO FIND IT

Submitted by the Editor.

By the nature of our work as therapists we are presented every day of our working life with anxious and depressed clients. A comment I frequently hear from them is that the news they read, listen to and watch is always dismal and just makes them feel worse. Isn't it so true, that the media in general contain mainly bad depressing news and very little positive news?

So how can we help our clients and indeed ourselves to address this problem?

Some time ago I came across the newspaper *Positive News*. This publication prints only good positive news from around the world. It was really refreshing to read it. It pioneers solution-focused journalism, reporting positive change, which promotes hope rather than doom and gloom.

Positive News is a quality international newspaper that focuses on issues rarely covered by the mainstream media (which are too busy reporting about everything that is wrong with the world) and promotes the many individuals and enterprises that are working to create a more healthy, humane and environmentally sustainable world.

The publication tries to give a voice to all the small, determined fishes swimming against the tide of big corporate seas, and rewards them for their efforts through honest impartial media publicity. The newspaper provides a place where young and old can feel safe to tell their stories without fear of indifference or misrepresentation.

A regular youth section invites journalists and entrepreneurs, schools, colleges, universities and community groups to publicise their positive projects and achievements to other young readers across the globe. The underlying aim is to inform, inspire and change.

I enjoy reading the publication myself, and frequently recommend it to appropriate clients to help them towards a more positive and uplifting state of mind. Many of my clients have taken up the suggestion and have found the newspaper helpful in brightening up their outlook on life.

For further information contact: www.positivenews.org.uk